HEALTH CARE COMPLAINTS COMMISSION

2017-18

Annual Report

protecting public health and safety

HEALTH CARE COMPLAINTS COMMISSION

Concerned about your health care?

We encourage all complaints to be lodged electronically to expedite the process and assist you to track your complaint. Please visit:

ecomplaints.hccc.nsw.gov.au/

Contact the Commission

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Website: www.hccc.nsw.gov.au

Disclaimer – Rounding of statistical figures

As percentages have been rounded, there may be discrepancies between the totals and the sums of the component items. Published percentages are calculated prior to rounding, and therefore there may be some discrepancy between these percentages and those that are calculated from rounded figures.

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Letter of submission

HEALTH CARE COMPLAINTS COMMISSION

The Hon Brad Hazzard MP
Minister for Health
52 Martin Place
SYDNEY NSW 2000

Dear Minister

Report of activities for the year ended 30 June 2018

I am pleased to provide the Annual Report and financial statements of the Health Care Complaints Commission and the Health Care Complaints Commission Staff Agency for the financial year ended 30 June 2018 for presentation to the NSW Parliament.

The report has been prepared and produced in accordance with the provisions of the *Annual Reports (Statutory Bodies) Act 1984*, the *Public Finance* and *Audit Act 1983* and the *Health Care Complaints Act 1993*.

Yours faithfully

Sue Dawson
Commissioner

Commission at a glance

Our aims and objectives

The Commission has a unique and central part to play in maintaining the integrity of the NSW health system, with the overarching consideration of protecting the health and safety of the community.

The Commission is established by the *Health Care Complaints Act 1993* as an independent body to deal with complaints about all health service providers in NSW, including:

- registered health practitioners, such as medical practitioners, nurses, dentists and pharmacists
- unregistered health practitioners, such as naturopaths, massage therapists and alternative health care providers
- health organisations, such as public and private hospitals, and medical centres.

Our strategy is to do this through:

- Informing the public about options for raising concerns about their experiences in the health system and learning about what works best for people who need to make a complaint – through the Commission's Inquiry Service, our web based information, our outreach programs and our user survey process.
- Receiving, assessing and resolving complaints about health service providers.
- Working with the health professional councils to ensure that practitioners who are below the required professional standards are assessed and directed into programs designed to ensure they meet those standards and that the public is not at risk from any impairments or skill gaps they may have.
- Providing resolution and conciliation services where there is a need for a safe and respectful process to bring parties to a complaint together to better understand and resolve the issues.
- Investigating and prosecuting more serious complaints that raise significant issues of public health and safety.
- Making recommendations to public health services where investigations show that there are procedures or practices that need to improve and monitoring/ auditing implementation.
- Analysing complaints data to identify areas where there may be patterns across complaints or system wide issues to be addressed.
- Contributing to the development of health regulation, policies and practices nationwide.

Our values

In all interactions with the public, health care providers and within the Commission we apply our core values and supporting behaviours:

- public health and safety is paramount
- we act impartially and independently in the public interest
- we treat all people fairly and equitably
- we strive for excellence and efficiency
- we respect each other and collaborate with our partners
- we are responsive and accountable
- we foster open and honest communication and information sharing as a tool for improving health service delivery
- we develop our capability and use innovative processes to improve our service.

These principles are reflected in the Commission's Code of Conduct and Code of Practice, both of which are available on the Commission's website.

Stakeholders

The Commission's diverse stakeholders comprise:

- health consumers, including:
  - patients, their families and carers
  - health consumer bodies
  - the diverse communities of NSW.
- health service providers, including:
  - registered and unregistered health practitioners
  - health organisations, such as hospitals and clinics
  - health professional councils and registration bodies
  - colleges and associations
  - universities and other health education providers.
- NSW government stakeholders, including:
  - the Parliament and the Joint Parliamentary Committee on the Health Care Complaints Commission
  - the Minister for Health
  - the Ministry of Health and Local Health Districts
  - the Clinical Excellence Commission.
- State and National regulatory and enforcement agencies including:
  - New South Wales Police
  - New South Wales Coroner's Court
  - Australian Health Practitioner Regulation Agency
  - NSW Fair Trading
  - Therapeutic Goods Administration.

A message from the Commissioner

Twenty five years on, the fundamental principles and concerns that motivated the establishment of the NSW Health Care Complaints Commission are as relevant and important as ever.

With the passage of the Health Care Complaints Act 1993, the Commission was established as an independent statutory body to receive and investigate health care complaints. This was a landmark in the evolution of our health system in NSW.

The legislation recognised the need for formal arrangements to help maintain standards of treatment and care across all health services in NSW. It embedded the fundamental objectives of supporting the rights of health consumers to have their concerns and complaints considered openly and objectively, and to have them resolved wherever possible. It also established transparent arrangements for investigating serious complaints and determining whether disciplinary action should be taken, built on the bedrock of natural justice.

Protection of public health and safety remains the paramount consideration in all aspects of the Commission's work.

While these founding principles endure, what is very different today is the social, operational and policy context in which complaints handling is occurring.

In 1993 there were 1,230 complaints, and 80 per cent of these were about a doctor.

In 2018 the number of complaints has reached 7,084 – around 500 per cent increase since the establishment of the Commission. This growth in health service complaints is not unique to NSW. It is a national and international pattern driven by population growth and ageing, diversification of health services, and a conscious effort to empower and inform health consumers – including accessible avenues to seek solutions when treatment and care go wrong.

Health service delivery simply does not look the same as it did twenty five years ago. As a result, the nature and complexity of complaints has changed.

Doctors now comprise less than a third of all complaints received, consistent with the fact that the complaints regulation arrangements now cover a much wider spectrum of practitioners – be they registered or unregistered.

It is becoming much rarer for a complaint to be about a single service provider or a single incident. Increasingly a complaint will refer to multiple providers and multiple aspects of service delivery.

We also see novel types of health services – for which there are less well established standards and protocols.

The complaints handling regulatory framework has evolved to respond to changes in the nature and breadth of health services and in the organisational structures to deliver those services. New classes of registered practitioners have been gradually added and the complaints handling system now includes practitioners such as those delivering occupational therapy, Chinese medicine, medical radiation, and most recently, paramedics. NSW was the first jurisdiction to establish a Code of Conduct for Unregistered Practitioners and to expand complaints handling to address breaches of the Code. Protective features such as the ability to issue public warnings on health services or treatments that pose a health risk have also been extended.

National standards have now been in place for half a decade. Research confirms that the standards are having very tangible, positive impacts on the safety and quality of care provided. They have become a very strong driver of improved governance and consumer involvement in service planning.

This report canvasses the many challenges and opportunities for the Commission in this changing health services and regulation landscape.

The primary challenge is year on year increases in the volume and complexity of complaints. This poses the risk of delays in assessing and investigating complaints and associated difficulties in meeting the legitimate expectations of all parties about the timeliness and quality of outcomes. This report highlights the emphasis that the Commission continues to place on refining its systems and processes to address these risks and to seize opportunities to maintain and strengthen our capability and responsiveness.

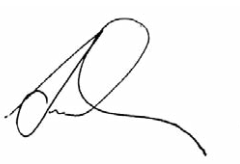
Our business improvement program has a number of core elements. There is emphasis on optimal automation of complaints lodgment and handling processes to reduce the administrative steps associated with each complaint. A refined system of triaging complaints has been introduced. This means that complaints are classified according to their seriousness and complexity. Assessment actions are then tailored to deliver more timely and effective outcomes based on this classification. Where a complaint is more straightforward and able to be addressed more quickly and informally, it will be. This will free up capacity to manage more serious clinical and conduct matters more effectively. Additional performance monitoring and reporting data is also being developed to support improved case management practices for all assessment, resolution and investigation functions.

We are strengthening customer and stakeholder engagement, so that everything we do is designed to resolve problems that arise in the most direct and immediate way, and ideally before they become a formal complaint. Our Inquiry Service is central to this, as is the collaboration with health service providers to support development of their local patient support and complaints resolution functions. Behind every complaint are people – be they patients, their families, advocates, or health providers. The Commission is committed to receiving and learning from the feedback we receive. This will help us to continuously improve the accessibility, efficiency and effectiveness.

It is clearer than ever before that our success will rely on new and stronger partnerships with other regulatory bodies. The Commission maintains very close operational ties with all regulatory and investigative partners – the professional councils, the Pharmaceutical Regulation Unit, Public Health Units, NSW Police, the NSW Ombudsman Office, NSW Coroner's Court and NSW Fair Trading. We are also expanding our operational partnerships on a national level, including formal linkages with the Therapeutic Goods Administration, the Australian Health Practitioner Regulation Agency, the Australian Competition and Consumer Commission, and the Australian Sports Anti-Doping Authority. These partnerships recognise the reality of the national, global and increasingly electronic nature of health service delivery, with the need for a wide circle of activity to be effective in preventing and addressing poor standards of health products and services.

I have the privilege of holding the office and title of Commissioner, but it is the work of all Commission staff whose care, knowledge, and overriding motivation to make a difference to heath care in NSW is admired and valued. Their professionalism, responsiveness to workload pressures and careful and sensitive management of the confronting issues in complaints is greatly appreciated.

Finally, we know that the most common reason why people make a complaint is that they do not want others to go through the same experience. They want to see improvements in health care and treatment. I therefore take this opportunity to thank those who have taken the time to make a complaint and to the service providers who have assisted us to understand and resolve issues raised in these complaints. Only with this openness can we draw out the lessons from individual complaints to inform system wide improvements.



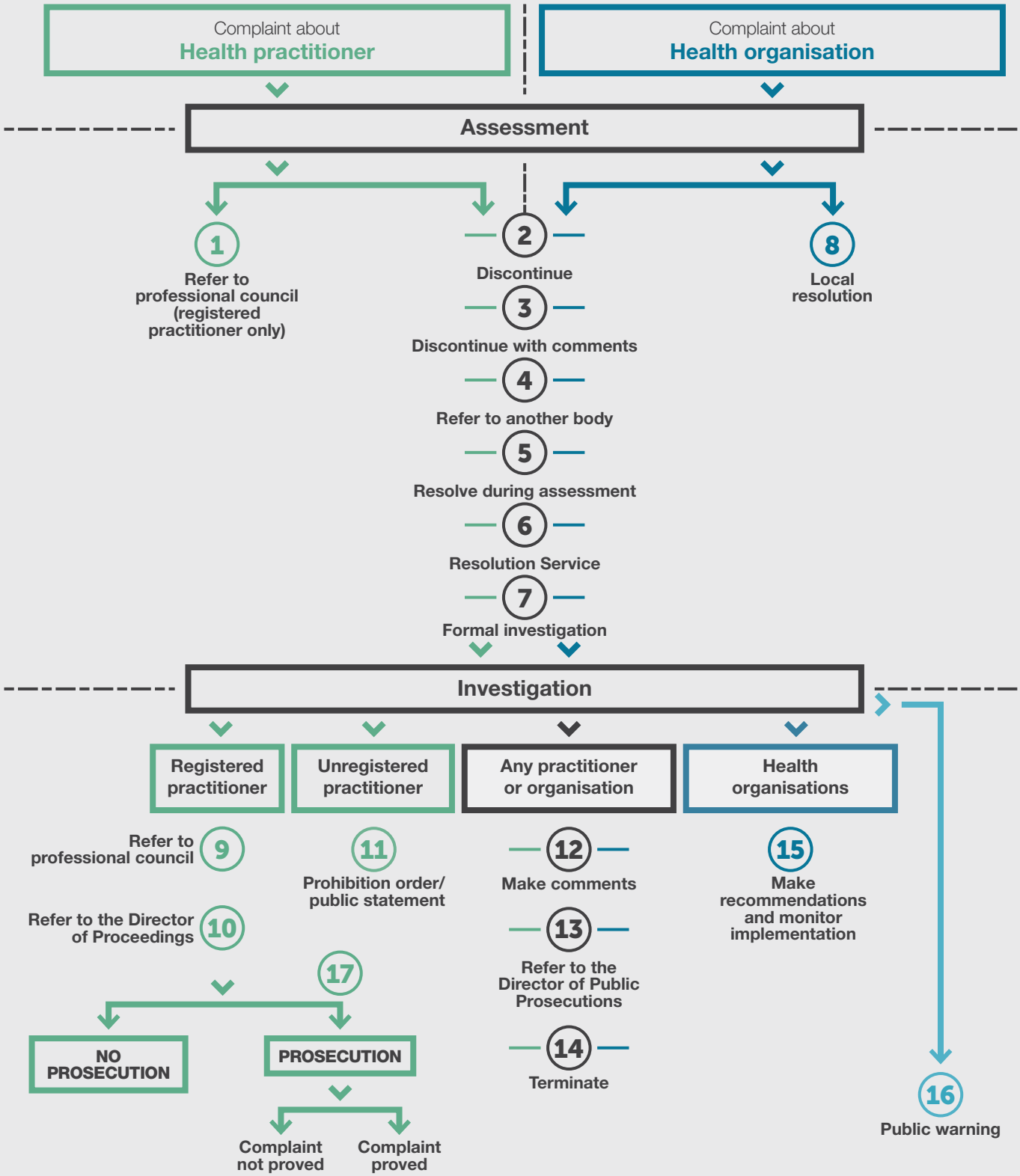
Sue Dawson
Commissioner

Complaints management framework

The Commission deals with complaints about both individual health practitioners and health organisations.

Complaints about individual practitioners can be about registered practitioners (such as medical practitioners, nurses and dental practitioners) or unregistered health practitioners (such as naturopaths, massage therapists or other alternative health service providers).

Where the complaint is about a registered practitioner, the Commission must consult with the relevant professional council about the most appropriate outcome. If a matter progresses to investigation, the outcomes available vary depending on whether the complaint is about a registered or unregistered practitioner or an organistion.



POSSIBLE OUTCOMES OF ASSESSMENT ARE:

1. Refer a complaint to the relevant professional **council** to consider action to address poor performance or conduct, or an impairment of a registered practitioner.
2. **Discontinue the complaint** – for example, if records or responses gathered do not support the allegations or the complainant does not wish to provide details that are needed to proceed.
3. **Discontinue with comments** if the issues raised are minor but corrections to practices or procedures are required.
4. Refer the **complaint to another body** that is more suitable to deal with the issues of concern. For example, a complaint about conditions in a nursing home can be referred to the Aged Care Complaints Commissioner.
5. Complaints may be **resolved during assessment**, if the complainant is satisfied that the health service provider has addressed their concerns.
6. Referral to the Commission's **Resolution Service** provides an option of independent facilitation to help bring the provider and complainant to a better understanding and agreement on action.
7. **Investigation** of complaints that raise a significant risk to public health or safety or, if substantiated, would provide grounds for disciplinary action.
8. **Refer for local resolution** where a public health provider is able and willing to work directly with the complainant to address concerns.

WHERE THE COMMISSION INVESTIGATES A COMPLAINT, IT MAY:

9. In the case of a registered practitioner, **refer the complaint to a professional council** to address poor performance, conduct or health problems.
10. In the case of a registered practitioner, refer the complaint to the independent **Director of Proceedings**, who determines whether a registered health practitioner should be prosecuted before a disciplinary body having regard to the protection of the health and safety of the public, the seriousness of the allegation, the prospects of a successful prosecution and any submissions made by the practitioner.
11. In the case of an unregistered practitioner, **impose a Prohibition Order** to ban or limit the health practitioner from providing health services and issue a public statement about the order.
12. **Make comments to practitioners** where there has been poor care or treatment, but not to an extent that would justify prosecution and where there is no risk to public health or safety. **Make comments to a health organisation** where the health care was inadequate, but the organisation has already taken measures to prevent a re¬occurrence in the future.
13. Refer the complaint to the **Director of Public Prosecutions** to consider criminal charges.
14. **Terminate** the complaint and take no further action where the investigation has not found sufficient evidence of inappropriate conduct, care or treatment, or where the risk has already been removed.
15. In the case of a health organisation, **make recommendations** where there has been poor health service delivery and systemic improvements are required. Recommendations are communicated to the Secretary of the Ministry of Health and the Clinical Excellence Commission. Implementation is monitored. If the Commission is not satisfied with implementation, it may make a special report to Parliament.
16. In the case of a particular treatment or health service, issue a **public warning** during or at the end of the investigation to address any immediate risk to public health and safety.

WHERE A REGISTERED HEALTH PRACTITIONER IS PROSECUTED:

17. Prosecution will be before either a Professional Standards Committee or the New South Wales Civil and Administrative Tribunal (NCAT). Both forums may reprimand, fine and/or impose conditions on the practitioner if a complaint is proven. Only NCAT can suspend or cancel the registration of a practitioner.

Performance summary

Assessing and resolving complaints

7,084
complaints received

19.4%
increase
in complaints assessed

But average assessment time is longer – **72 days** compared to 60 days in 2016-17

2017-18
84.0%
Complaints resolved in assisted resolution

5.0%
complaints review requests compared to 11.5% in 2005-06

Investigating complaints

More investigations commenced
2016-17
329
2017-18
401

282
investigations
FINALISED

65.6%
investigations finalised within
12 months
FINALISED

Robust investigations
95.9%
Matters referred for prosecution that did not need further information

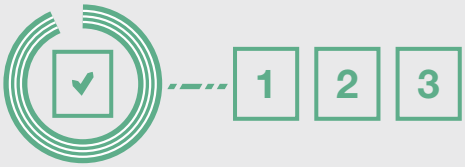
Prosecuting complaints

146

Complaints referred for consideration of disciplinary action

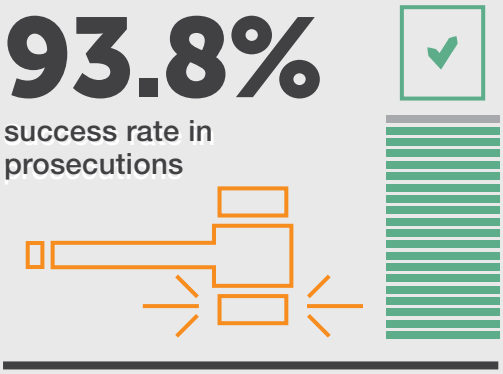
92.8%

of determinations by Director of Proceedings within three months



93.8%

success rate in prosecutions



92

legal matters finalised

Access and outreach

22.2%

more website visitors

2016-17

475,148

2017-18

580,686

11,398

inquiries received

83.0%

of complainants were satisfied with service

Two public warnings issued about:

- unsafe and illegal practices in beauty and cosmetic clinics
- extreme body modifications

Executive summary

2017-18 continues more than a decade of year on year increases in the volume of complaints. The 7,084 complaints received by the Commission shows a more intensive rate of growth than last year.

Since 2008-09 the cumulative growth is 110.8%. As has been noted in previous Annual Reports, this trend is not unique to New South Wales and reflects the experience of health care complaints bodies both nationally and internationally. The increase in the volume of complaints is attributed to a broad range of factors including:

- population growth
- an aging population, whose members are more likely to have interactions with the health system
- growing demand for healthcare services
- advances in medical research and technology combine to offer more new and experimental health services and treatments
- greater consumer expectations of the health system and access to medical information through the internet and social media
- greater awareness of complaint management pathways and bodies
- expanding types of health services and alternative therapies, and
- mandatory reporting requirements.

Increased complexity and diversity continues to be observed in complaints as well.

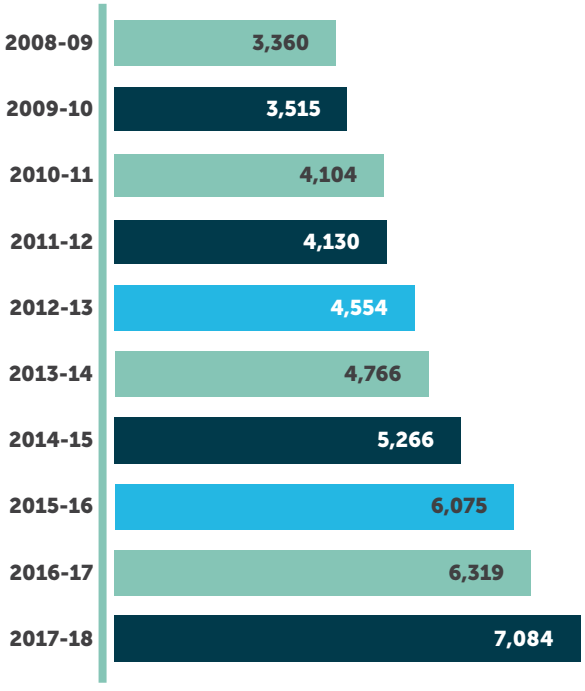
There are four dimensions of complexity that can be discerned from complaints data:

- Inherently complex complaints eg. a complaint with a single patient who has been treated by multiple individual providers or a complaint where a single provider is alleged to have departed from standards of care in relation to multiple patients, over a long period and over multiple locations.
- Complex complainant scenarios eg. the subject or complainant could possibly be physically or mentally unwell while the complaints process is underway, or those where there may be disagreement about core issues such as guardianship, powers of attorney, and consent to access records.
- Jurisdictional complexity: these issues typically arise where there is a question as to whether the matter complained of relates to the delivery of a health service eg. medico legal reports.
- Process complexity: this relates to managing the interdependencies between the Commission's own processes and the processes and priorities of other entities (eg. NSW Police, the Coroner's Court) and sourcing all of the information and evidence that is required to finalise a matter.

Recognising and understanding this increasing complexity continues to be essential in considering how we adapt our complaints handling processes, systems and resources to be effective and responsive.

Diversity is reflected in the new types of health services such as stem cell therapy, cosmetic treatments and web-based services and products. Managing new and diverse complaints is a key driver of our new complaints management strategy, as illustrated in the focus on challenges posed by the evolution of cosmetic services which is discussed at length in the Focus Area chapter of this report.

CHART 1 | Number of complaints received from 2008-09 to 2017-18



Counted by provider identified in complaint

Complaints received

The 7,084 complaints received in 2017-18 is an increase of 12.1% on the previous year. This compares to the more modest 4.0% increase last year and returns to the higher rates of growth seen prior to 2016-17. There has been a 48.6% increase in complaints within the period between 2013-14 and 2017-18.

More information on the nature of these complaints, including what types of providers and services are the subject of complaints and the issues raised in them can be found in the chapter, Profile of complaints.

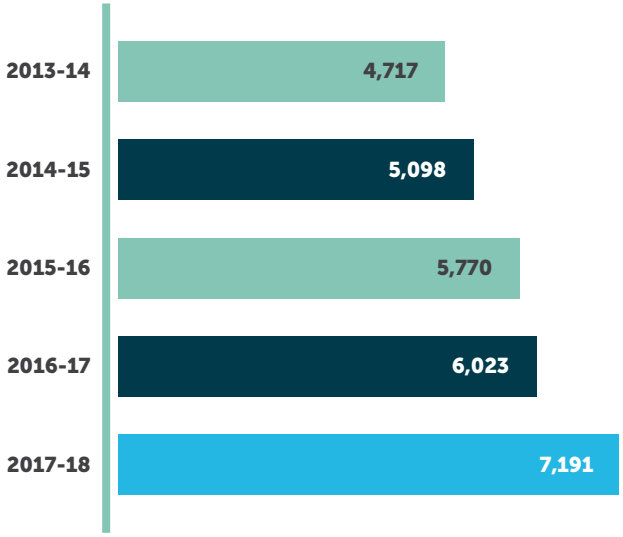
Assessing complaints

The Commission assessed a total of 7,191 complaints in 2017-18, compared to the 6,023 complaints assessed in 2016-17. This represents an increase of 19.4% and means that matters assessed have exceeded the number of new complaints received. It also represents a 52.4% increase in complaints assessed since 2013-14. This significant increase in productivity is the result of active strategies to streamline processes and systems for assessing complaints and adjust resources to respond to operational pressures throughout the year.

The increased volume, complexity and diversity of complaints poses significant operational challenges. In particular, timeliness in completing assessments and investigations has deteriorated.

The proportion of complaints assessed within the 60 day timeframe has declined with a corresponding increase in the average time taken to assess each complaint. In 2017-18, 54.7% of complaints were assessed within 60 days, compared to 64.5% in 2016-17. On average, new complaints were assessed in 72 days, up from 60 days in 2016-17.

CHART 2 | Complaints assessed from 2013-14 to 2017-18



Counted by provider identified in complaint

In addition to redirection of resources to deliver additional staff and further training and development for the assessments functions, there has been a business improvement project that has included:

- improved triaging for new complaints
- rapid referral of matters to other bodies where this is appropriate
- automation of manual activities wherever possible
- streamlined processes for gathering clinical advice
- removal of unnecessary steps in the process; and
- measures to maintain effective consultation with professional councils in the assessment process.

Continuation of these initiatives, combined with the full implementation of electronic complaints lodgement, are expected to deliver further productivity and improved timeliness in 2018-19.

More information on the outcomes of complaints assessed and assessment performance can be found in the chapter, Assessing and resolving complaints.

Resolving complaints

A complaint can be resolved through three possible pathways: early resolution, referral to the Commission's Resolution Service or referral for local resolution by a public health organisation.

In the early resolution stream, the singular focus is on complaints that are amenable to quick, informal intervention to solve misunderstandings and more minor problems, such as waiting times, rudeness and difficulties in accessing medical records. In 2017-18, 308 complaints were resolved during assessment and the Commission will be looking to further increase the number of complaints addressed in this way.

In addition to those complaints resolved during assessment, 221 complaints were referred to the Commission's Resolution Service, through which the parties to a complaint are assisted to work through the issues of concern and address them in the most appropriate way. This is consistent with the previous year's figure of 217 complaints, although as a proportion of all assessments finalised, there has been a decline in matters, from 4.0% last year to 3.4% in 2017-18.

The Commission's Resolution Service finalised 185 complaints in 2017-18. Of these, 86.0% were finalised within six months which is slightly less than the 88.8% finalised in this timeframe in 2016-17. 30.6% were finalised within two months of referral, compared with 34.5% in the previous year. Of the complaints that proceeded to resolution or conciliation, 84.0% were fully or partially resolved, which is consistent with 85.2% in 2016-17 and shows a sustained improvement in outcomes.

There continues to be increasing utilisation of the local resolution pathway under the complaints management framework. For less serious and/or complex complaints, the Commission has long observed that the best solution complaints is likely to occur when there is a speedy and direct response to issues raised by the service provider. Local resolution, when operating effectively, offers this. In 2017-18, a total of 754 complaints were referred for local resolution, an increase of 48.7% on the previous year.

More information on the resolution functions can be found in the chapter, Assessing and resolving complaints.

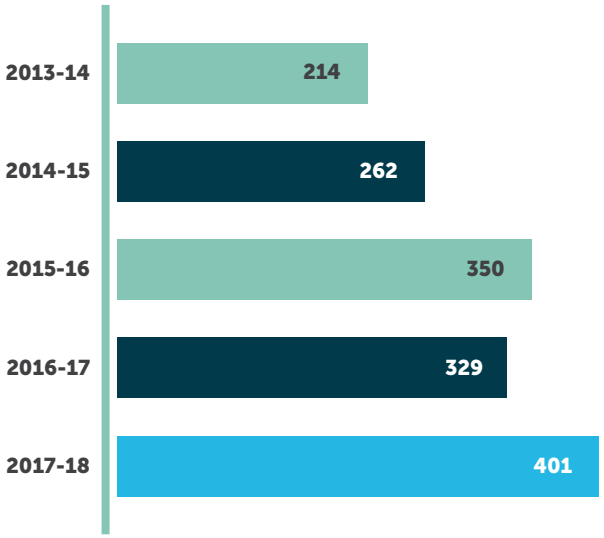
Investigating complaints

In 2017-18, 401 complaints were referred for investigation, compared to 329 in the previous year. While this represents a 21.9% increase from the previous year, the proportion of all complaints referred for investigation was 6.1%, which remains consistent with previous years (5.8% in 2016-17 and 5.9% in 2015-16).

Some of the notable trends in complaints referred for investigation are:

- a small number of practitioners who are the focus of multiple investigations eg. complaints about one particular registered health practitioner resulted in 29 investigations;
- cosmetic and beauty treatments and procedures, including extreme body modifications;
- proliferation of issues relating to prescribing and/or compounding of medication; and
- increasing complaints about boundary violations and sexual misconduct.

CHART 3 | Investigations received from 2013-14 to 2017-18



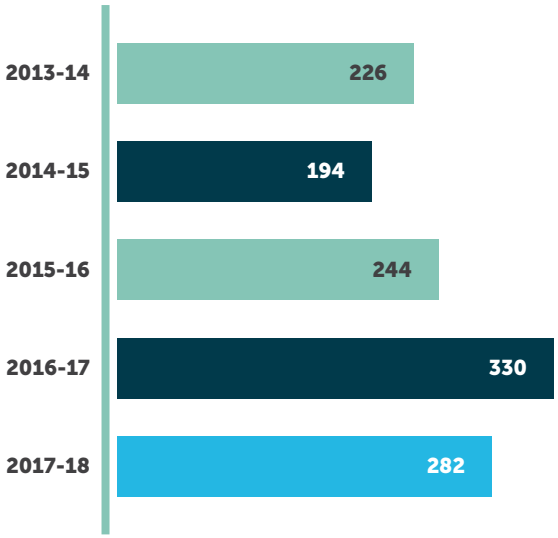
Counted by provider identified in complaint

The number of investigations finalised tends to fluctuate year on year and the fluctuation is a result of the interplay between the number and type of complaints referred into investigation. The Commission finalised 282 investigations in 2017-18, which is fewer than the 330 finalised in 2016-17, but more than the 244 in 2015-16. With more new investigations commencing as well as the complexity of matters subject to formal investigation during the year, the rate of finalisation has slowed.

The timeliness of investigations was also adversely affected by the increased workload. Fewer investigations were finalised within 12 months (65.6% compared with 72.4% in 2016-17). As a result, investigations were finalised on average within 304 days, compared to 273 days in 2016-17.

More information can be found in the chapter, Investigating complaints.

CHART 4 | Number of investigations finalised from 2013-14 to 2017-18



Counted by provider identified in complaint

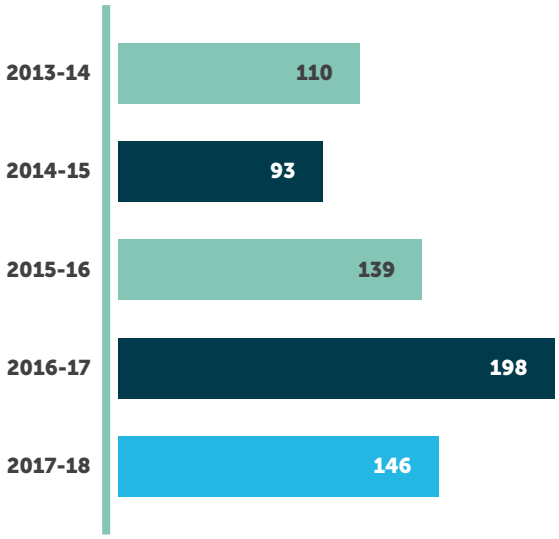
Prosecuting complaints

The Commission referred 146 investigations to its Legal Services Division, compared with 198 in the previous year. This decrease is a result of fewer investigations being finalised, as well as a slightly lower proportion of completed investigations being referred to the Director of Proceedings.

The Director of Proceedings made 164 determinations whether or not to prosecute a complaint, which is 57.7% more than last year (2016-17: 104). Of the 164 determinations, 133 were to prosecute a complaint before the NSW Civil and Administrative Tribunal (NCAT) and 12 before a Professional Standards Committee. The Director of Proceedings determined not to prosecute 19 complaints, of which seven were referred back to the Commissioner for consideration.

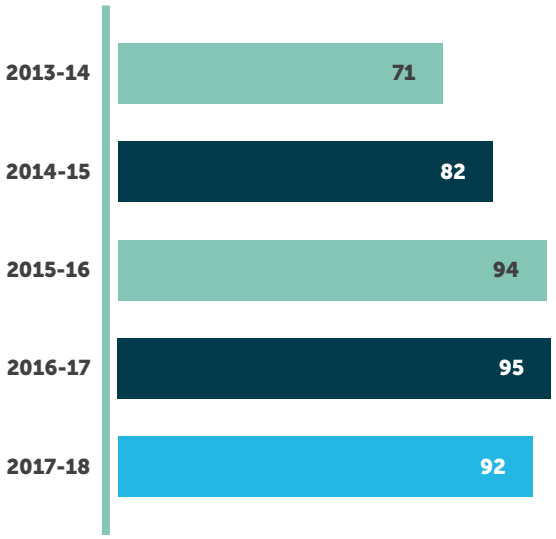
It should be noted that where a number of investigations and associated determinations relate to the same practitioner this becomes one prosecution.

CHART 5 | Investigations referred to Director of Proceedings from 2013-14 to 2017-18



Counted by provider identified in complaint

CHART 6 | Number of legal matters finalised from 2013-14 to 2017-18



As shown in Chart 6, the Legal Division finalised 92 matters in 2017-18 which is broadly consistent with the 95 matters finalised in 2016-17. The overall success rate of prosecutions before Professional Standards Committees and NCAT remained very high, at 93.8%.

In 2017-18, the registration of 34 health practitioners was cancelled or disqualified. Four practitioners were suspended and had conditions placed on their registration. A further 18 health practitioners had both conditions placed on their registration and reprimanded or cautioned. Three practitioners solely had conditions placed on their registration and two practitioners received a reprimand.

More information can be found in the chapter, Prosecuting complaints.

Financial summary

The Commission benefited from additional funding in 2017-18. The total expenditure budget for the year was $15.6m which included grant funding comprised of $14.6m for recurrent purposes and $0.325m for capital. This enabled the Commission to increase resourcing for assessments and investigations and implement important systems and process improvements, such as the eComplaints project.

The Commission's Net Result was a surplus of $65,000 which was marginally lower than the $81,000 surplus foreshadowed in the Budget. This was primarily due to higher than budgeted expenditure associated with system improvements and equipment upgrade and maintenance.

The full financial statements for both the Health Care Complaints Commission and the Health Care Complaints Commission Staff Agency are included in the Finance chapter.

The Commission has received a significant increase to its grant (through the Ministry of Health) for 2018-19. This increase of $2.043m takes the recurrent funding grant for the Commission to $16.67 million, which represents a 14% increase. This funding will allow the creation of 17 additional full time positions with the majority of these resources directed at frontline operations and ongoing improvements to business systems to address increased volume and complexity of complaints and associated workloads.

Corporate goals

The Commission's performance, measured against its corporate goals for 2017-18, is summarised in Appendix B and throughout this report:

- Comprehensive and responsive complaints handling – pages 35-50
- Investigating serious complaints – pages 51-61
- Prosecuting serious complaints – pages 62-67
- Accountability – pages 68-79
- Our organisation – pages 80-96.

Profile of complaints

This section outlines the characteristics of complaints received by the Commission in 2017-18 with comparisons over a five year period.

It covers the volume of complaints received, analysis of who is complained about and the service areas involved, as well as the issues raised in complaints. Analysis of complaints by location is also provided.

It is important to note that the Commission's data is not a comprehensive indicator of the overall standard of health care delivery in NSW. The number of complaints to the Commission is relatively small considering the volume of health services provided across the state. Often complaints are addressed by the relevant health service provider directly, without the Commission being involved. This is increasingly the case as the Australian National Safety and Quality Standards require health service organisations to have an incident management system; a complaints management system that includes partnerships with patients and carers; and an open disclosure process.

It is also important to note that the Commission receives complaints about both individual health practitioners and health organisations. Many complaints involve a number of practitioners and organisations and most raise a number of issues in a single complaint. The relevant counting method is indicated underneath the graphs in the following section, with "counted by provider" indicating that each complaint about a unique health service provider has been counted, and "counted by issue" indicating that each individual issue raised in a complaint has been considered.

Volume and nature of complaints received

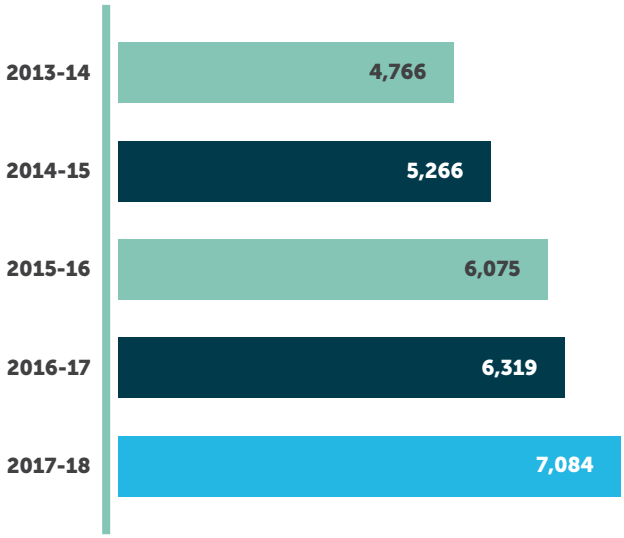
COMPLAINTS RECEIVED

Chart 7 shows that the Commission received 7,084 complaints in 2017-18 – a 12.1% increase compared to the previous year. This compares to the more modest 4.0% increase last year and returns to the higher rates of growth seen prior to 2016-17.

As outlined in the Executive Summary, there is no single explanation contributing to the rise, but rather a multitude of factors which include:

- population growth
- an aging population, whose members are more likely to have interactions with the health system

CHART 7 | Number of complaints received from 2013-14 to 2017-18



Counted by provider identified in complaint

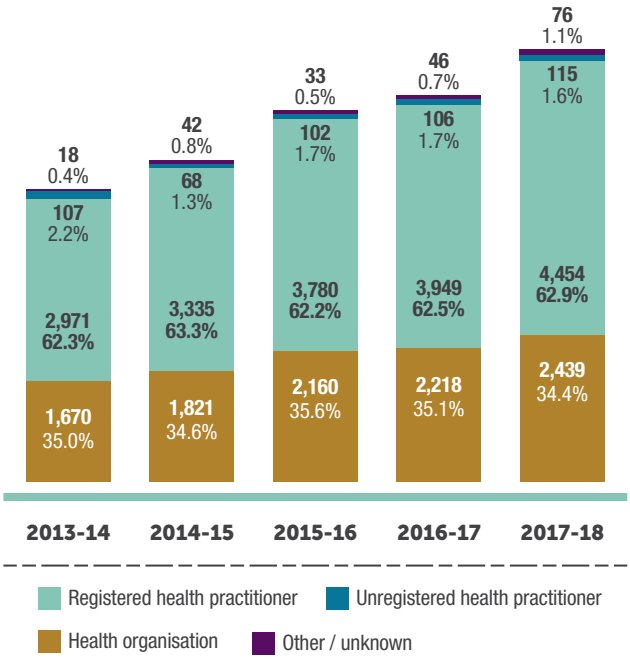
- growing demand for healthcare services
- advances in medical research and technology combine to offer new and experimented health services and treatments
- greater consumer expectations of the system and their access to medical information through the internet and social media
- greater awareness of complaint management pathways and bodies
- expanding alternative therapies, and
- mandatory reporting requirements.

COMPLAINTS RECEIVED BY TYPE OF HEALTH SERVICE PROVIDER

Chart 8 shows the number of complaints received by the Commission over the five year period since 2013-14 and breaks this down by the type of health service provider complained about.

The proportions of complaints for each category of health service provider have remained consistent during the five year period. Individual health practitioners continue to make up the highest proportion of all complaints.

CHART 8 | Complaints received by health service provider 2013-14 to 2017-18



Counted by provider identified in complaint

In 2017-18: 62.9% (2016-17: 62.5%) were about registered health practitioners; 34.4% of complaints received were about health organisations (2016-17: 35.1%); and 1.6% were about unregistered health practitioners (2016-17: 1.7%). A very small proportion (1.1%) of providers was other/unknown (0.7% in 2016-17). This classification may be applied where the complaint is not clear about the provider's details and/or the matter does not relate to a health worker, is withdrawn immediately, or is otherwise not in jurisdiction and therefore further details were not required to determine the matter.

Complaints about health practitioners

Chart 9 shows the number of complaints about individual health practitioners received by the Commission in the period covering 2013-14 to 2017-18.

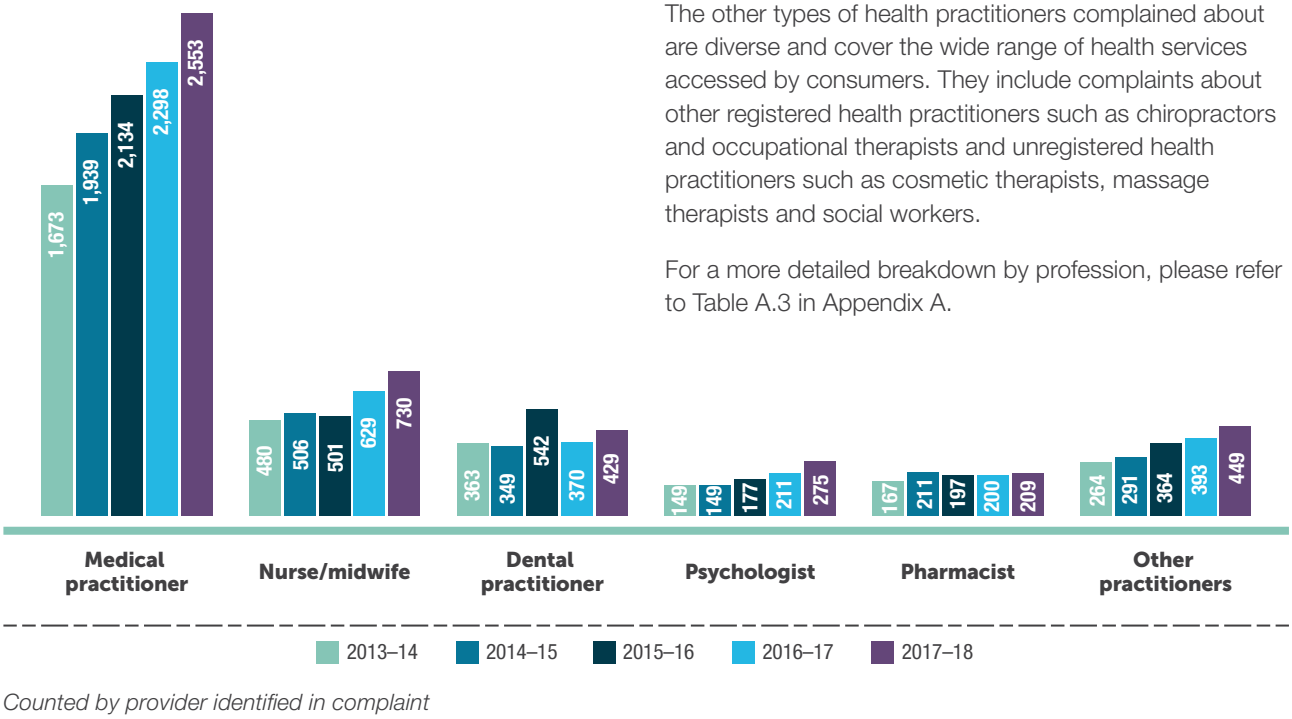
In 2017-18, the Commission received a total of 4,645 complaints about individual registered, unregistered and unknown health practitioners, a 13.3% increase on the previous year.

Medical practitioners, nurses and midwives, dental practitioners, pharmacists and psychologists were the health professions most commonly complained about. Complaints about these professions accounted for 90.3% of all complaints received about individual practitioners in 2017-18.

The other types of health practitioners complained about are diverse and cover the wide range of health services accessed by consumers. They include complaints about other registered health practitioners such as chiropractors and occupational therapists and unregistered health practitioners such as cosmetic therapists, massage therapists and social workers.

For a more detailed breakdown by profession, please refer to Table A.3 in Appendix A.

CHART 9 | Complaints received about health practitioners 2013-14 to 2017-18



Counted by provider identified in complaint

COMPLAINTS ABOUT MEDICAL PRACTITIONERS

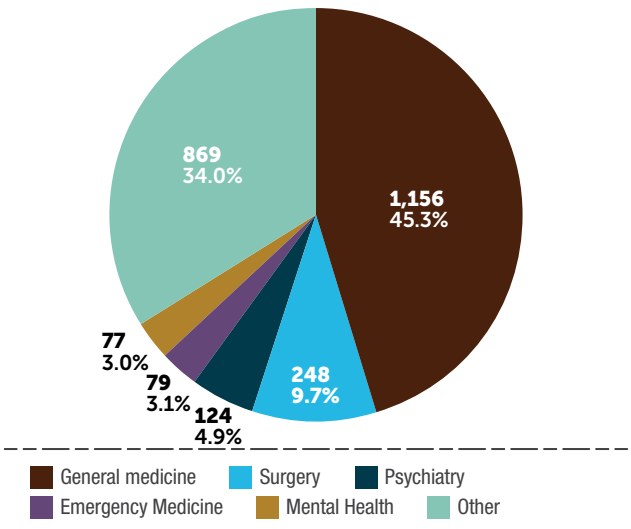
Complaints about medical practitioners continue to be the most common. In 2017-18, the Commission received 2,553 complaints about medical practitioners, an 11.1% increase on the 2,298 received in the previous year. Complaints about medical practitioners made up 55.0% of all complaints about all individual health practitioners in 2017-18.

As shown in Chart 10, in 2017-18, complaints about medical practitioners most commonly related to those in the service areas of general medicine (45.3%; 2016-17: 45.6%), surgery (9.7%; 2016-17: 10.1%), psychiatry (4.9%; 2016-17: 5.4%), mental health care (3.0%; 2016-17: 4.0%) and emergency medicine (3.1%; 2016-17: 2.7%). Complaints about these areas accounted for 66.0% (2016-17: 67.8%) of all complaints received about medical practitioners during the year. The remaining 34.0% of complaints were across a wide range of service areas such as cosmetic, oncology, obstetrics, anaesthesia, aged care, cardiology and drug and alcohol.

The high proportion of complaints relating to general medicine should be seen in the context of the number of patient-practitioner interactions in the primary health care sector – Medicare Australia reported just over 41 million GP attendances in NSW in 2017-18.

A more detailed breakdown of complaints received about medical practitioners by service area over the past five years is included in Table A.4 in Appendix A of this report.

CHART 10 | Most complained about area of practice for medical practitioners



Counted by provider identified in complaint

COMPLAINTS ABOUT OTHER HEALTH PRACTITIONERS

In 2017-18, the Commission received 730 complaints about nurses and midwives, 16.1% more than the previous year. This increase continues to reflect the rise in complaints about professional conduct issues and self reporting of health issues. The majority of professional conduct complaints for nurses/midwives fall into the behaviour category, which includes complaints about nurses and midwives behaving in a manner that is perceived as rough, aggressive or intimidating. The fact that they tend to have longer and more frequent interactions with their patients/clients than the other professions may explain the high proportion of professional conduct complaints received about nurses and midwives compared to other registered health practitioners.

The Commission received 429 complaints about dental practitioners during 2017-18, a 15.9% increase on the 370 received in the previous year. Given the significant decrease of 31.7% observed in 2016-17, some level of correction was perhaps to be anticipated.

There were 275 complaints received about psychologists during the year, a 30.3% increase from 2016-17, which follows the 19.2% increase seen in 2015-16. This continues a pattern of substantive increase in complaints to the Commission about psychologists. This appears to be driven by professional conduct issues, arising from the close and personal therapeutic relationships that psychologists engage in and the boundary management issues that can arise in this context. The number of mandatory notifications received about psychologists is also rising.

The Commission received 209 complaints about pharmacists in 2017-18, a minor 4.5% increase on the 200 complaints received in 2016-17 which follows an equally modest 1.5% in 2015-16. The Commission continues to work with the Pharmacy Council of NSW to identify specific pharmacists involved in complaints about pharmacies and to ensure that timely and effective action is taken.

COMPLAINTS ABOUT UNREGISTERED HEALTH PRACTITIONERS

The number of complaints about unregistered practitioners in 2017-18 continues to represent a very small proportion of complaints received overall (1.6%; 2016-17: 1.7%). The 115 complaints received was largely consistent with last year (2016-17: 106). As a proportion of all complaints about individual health practitioners (2.5%), it essentially remained the same as last year (2.6%).

Complaints about cosmetic therapists were the largest proportion of complaints received about unregistered practitioners (14.8%; 2016-17: 8.4%). The Focus Area commentary on cosmetic service complaints provides more detail on this area of practice. The proportion of complaints about massage therapists also increased in 2017-18 (from 7.5% to 13.9%). Complaints about counsellors/therapists, which had been the most likely unregistered profession to be complained about the previous two years, declined almost five percentage points, from 17.8% in 2016-17 to 13.0% this year. There was a similar percentage point decrease in the proportion of complaints about social workers (10.4%; 2016-17: 15.0%). The proportion of complaints about assistants in nursing (7.0%; 2016-17: 12.1%) and alternative health providers (7.0%; 2016-17: 11.2%) declined marginally. Administrative/clerical staff (7.8%; 2016-17: 8.4%) was consistent with 2016-17.

Complaints about health organisations

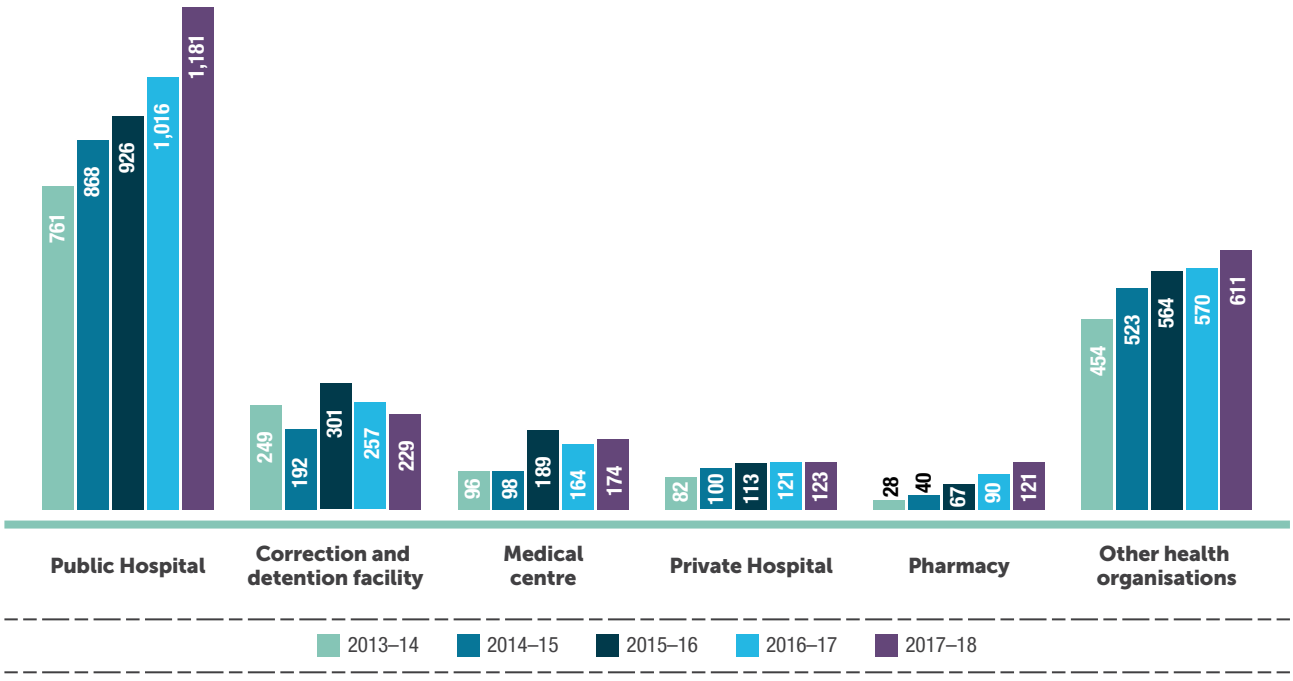
Chart 11 shows the number of complaints received about health organisations in the period 2013-14 to 2017-18.

In 2017-18, the Commission received 2,439 complaints about health organisations, a 12.9% increase on the previous year. A 46.0% increase in complaints about health organisations has been observed within the period between 2013-14 and 2017-18, broadly in line with the overall 48.6% increase in complaints over this period.

Public hospitals, correction and detention facilities, medical centres, private hospitals and pharmacies were the health organisations most commonly complained about. Complaints about these organisations accounted for 74.9% of all complaints received about health organisations in 2017-18 (74.3% in 2016-17).

The other types of health organisations complained about included psychiatric hospitals/units, community health services, day procedure facilities, pathology centres and cosmetic health facilities.

CHART 11 | Complaints received about health organisations 2013-14 to 2017-18



Counted by provider identified in complaint

COMPLAINTS ABOUT PUBLIC HOSPITALS

In 2017-18, the 1,181 complaints about public hospitals constituted an increase of 16.2% on the previous year and accounted for 48.4% of all complaints against health organisations, compared to 45.8% in 2016-17 and 42.9% in 2015-16.

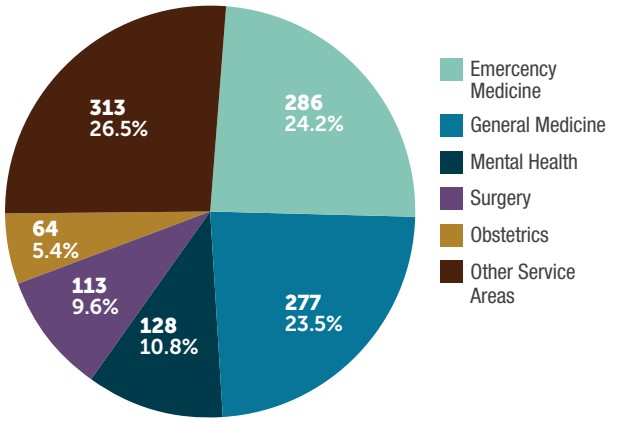
The number of complaints about public hospitals should be seen in the context of the number of services provided. In 2017-18 there were 2,880,708 emergency department attendances in NSW public hospitals (2016-17: 2,781,852), 1,917,272 discharges from hospital (2016-17: 1,953,706) and 13,660,536 outpatient services provided (2016-17: 13,617,485).

Chart 12 shows the public hospital service areas that were subject to the most complaints in 2017-18. The complaints most commonly related to emergency medicine (24.2%; 2016-17: 28.7%), general medicine (23.5%; 2016-17: 5.2%), mental health care (10.8%; 2016-17: 12.7%), surgery (9.6%; 2016-17: 13.6%) and obstetrics (5.4%; 2016-17: 7.0%).

Complaints about these five service areas accounted for 73.5% (2016-17: 67.2%) of all complaints about public hospitals during the year. The high proportion of complaints about emergency medicine and to a lesser extent this year, surgery, are largely attributed to the fact that these are health services associated with high risk, where complications and unexpected treatment outcomes can be more prevalent. It is noted that while there was a significant increase in complaints regarding general medicine, a similar result was observed in 2015-16.

A more detailed breakdown of complaints about public hospitals by service area over the past five years can be found in Table A.7 in Appendix A.

CHART 12 | Most complained about service area in public hospitals 2017-18



Counted by provider identified in complaint

COMPLAINTS ABOUT OTHER HEALTH ORGANISATIONS

Complaints about health organisations other than public hospitals were a lower proportion of the total number of complaints received about health organisations in 2017-18, accounting for 51.6% of complaints about health organisations .

Complaints about correction and detention facilities decreased by 10.9% from 257 in 2016-17 to 229 in 2017-18. This may be a reflection of the changes to the Justice and Forensic Mental Health Network processes which also led to changes in the Commission's Inquiry Service during 2017-18. Corrective Services inmates are now able to raise matters more directly within the corrections facility, particularly for access and medication issues, therefore negating the need for a formal complaint.

In 2017-18, the Commission received 174 complaints about medical centres compared to 164 in 2016-17, a minor increase of 6.1%.

The number of complaints about private hospitals was consistent with the previous year, with 123 received in 2017-18, compared to 121 the previous year.

Complaints about pharmacies rose 34.4% from 90 in 2016-17 to 121 in 2017-18, which follows a 34.3% increase from the year before. Many of these complaints related to compounding that was not compliant with the Pharmacy Guild regulations and were received from both consumers and pharmaceutical companies.

Complaints about dispensing errors were also common, as were complaints about pharmacists issuing absence from work certificates for a fee.

The number of complaints about psychiatric hospitals/ units increased slightly, from 71 in 2016-17 to 77 in 2017-18, representing an 8.5% increase.

A five-year breakdown of complaints about all types of health organisations can be found in Table A.6 in Appendix A of this report.

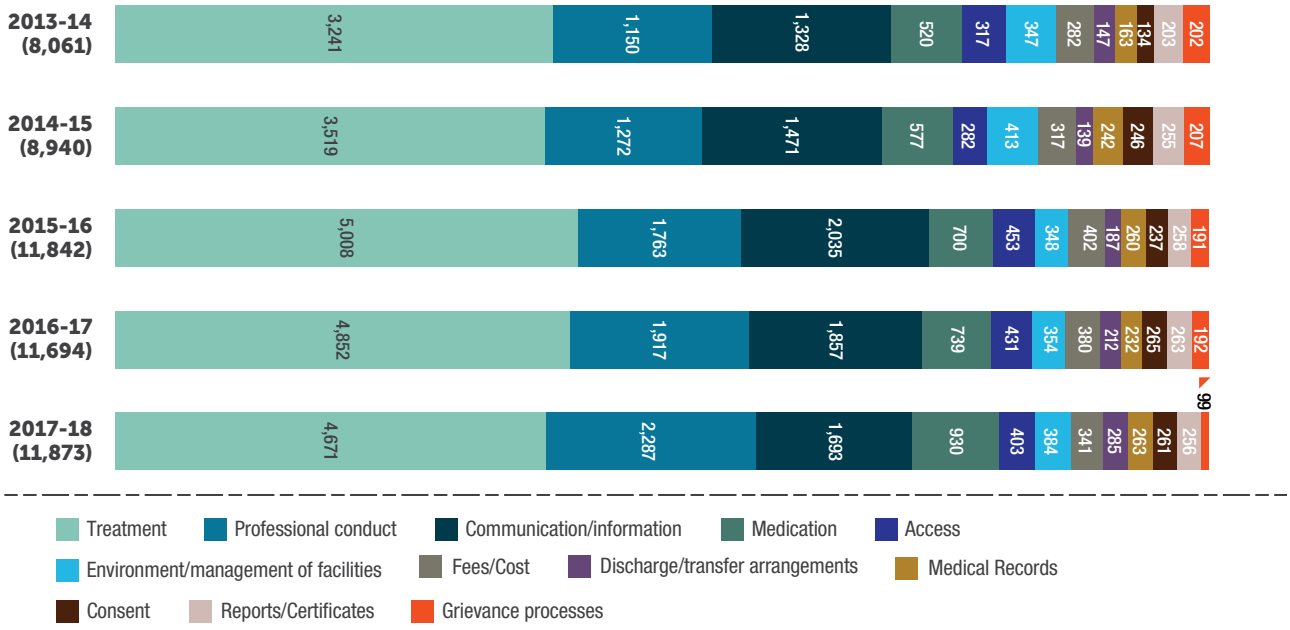
Issues raised in complaints

A single complaint will often raise a number of issues. Chart 13 shows the issues raised in complaints over the last five years. In 2017-18, 7,084 complaints received raised 11,873 issues – an average of 1.7 issues per complaint, which is consistent with the previous year (1.9).

In 2017-18, the three most common issue categories were treatment (39.3%; 2016-17: 41.5%), the professional conduct of the health service provider (19.3%; 2016-17: 16.4%) and communication (14.9%; 2016-17: 15.9%). For the first time last year, the number of complaints that raised professional conduct issues surpassed those raising communication issues. This has continued in 2018-19 and indeed become more pronounced – a 0.5 percentage point difference between the two categories last year has increased to five percentage points in 2017-18. Professional conduct issues range from more serious issues such as boundary violations and sexual misconduct through to more administrative issues such as advertising and not lodging annual declarations.

A detailed breakdown of all issues in complaints received in 2017-18 can be found in Table A.2 in Appendix A.

CHART 13 | Issues raised in all complaints received 2013-14 to 2017-18



Counted by issue raised in complaint

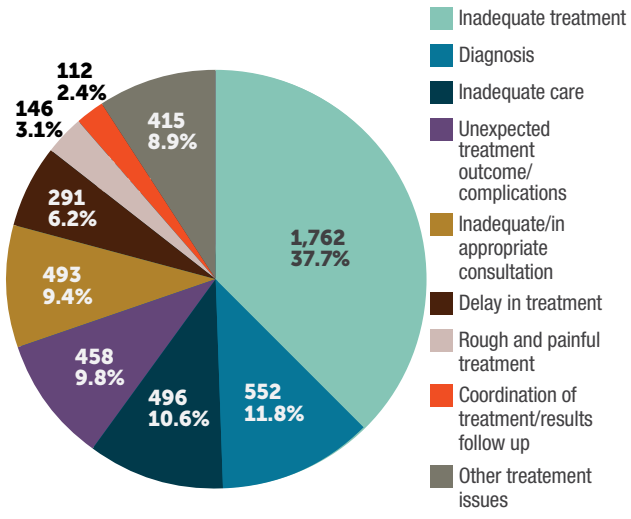
COMPLAINTS ABOUT TREATMENT

As shown in Chart 14, the most common issues raised in the treatment category were inadequate treatment (37.7%; 2016-17: 30.5%), diagnosis (11.8%; 2016-17: 11.9%) and inadequate care (10.6%; 2016-17: 10.7%).

Other common treatment-related issues were unexpected outcome/complication (9.8%; 2016-17: 10.3%), inadequate or inappropriate consultation (9.4%; 2016-17: 6.6%), delay in treatment (6.2%; 2016-17: 7.2%), rough and painful treatment (3.1%: 2016-17: 1.5%) and coordination of treatment or follow up of results (2.4%; 2016-17: 3.8%).

Other treatment issues such as no/inappropriate referral, infection control and withdrawal of treatment account for 8.9% of issues raised in this category (2016-17: 10.3%).

CHART 14 | Most common treatment issues raised in complaints received 2017-18



Counted by issue raised in complaint

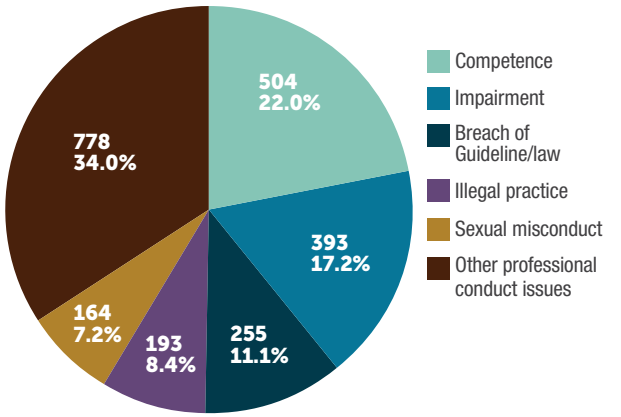
COMPLAINTS ABOUT PROFESSIONAL CONDUCT

As shown in Chart 15, where the complaint related to professional conduct, the most frequently raised issue related to the practitioner's competence (22.0%; 2016-17: 13.8%).

A proportion of professional conduct complaints raise issues regarding impairment (17.2%; 2016-17: 19.3%), which may negatively impact upon a health practitioner's ability to carry out their professional duties. In most of these cases, unless there is also evidence of departures in conduct and/or a significant risk of harm, the complaint would be referred to the relevant professional council which can assist these practitioners through its Health Program, to ensure they receive the necessary treatment and support.

Other frequently raised issues within professional conduct include a breach of guidelines or law (11.1%; 2016-17: 15.8%), illegal practice (8.4%; 2016-17: 15.0%) followed by sexual misconduct (7.2%; 2016-17: 7.1%). Other professional conduct-related issues (such as misrepresentation of qualifications, inappropriate disclosure of patient information, boundary violations and financial fraud) accounted for 34.0% of all complaints raising a professional conduct concern (2016-17: 29.0%).

CHART 15 | Most common professional conduct issues raised in complaints received 2017-18



Counted by issue raised in complaint

COMPLAINTS ABOUT COMMUNICATION

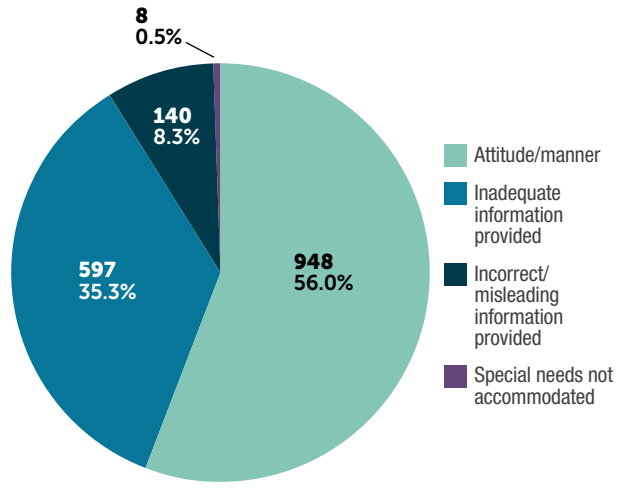
As shown in Chart 16, just over half of communication and information-related issues concerned the attitude and manner of the health practitioner. This is an increased proportion compared to the previous year (56.0%; 2016-17: 48.8%). Other issues in this category relate to inadequate information (35.3%; 2016-17: 32.4%) and incorrect/misleading information (8.3%; 2016-17: 17.6%) from the health service provider.

A reduced proportion of complaints (0.5%; 2016-17: 1.2%) involved the failure to accommodate the special needs of a patient.

Communication issues are often coupled with treatment issues in complaints. Strong and open communication between a health care provider and consumers remains as important as ever in ensuring quality treatment. Many complaints can be prevented by a practitioner making the effort to discuss treatment options and decisions, obtain and record informed consent, and addressing concerns and questions raised so that the consumer is fully informed. This advice is regularly provided through the Commission's outreach and training sessions to health service providers.

A detailed breakdown of all issues in complaints received in 2017-18 is included in Table A.2 in Appendix A.

CHART 16 | Most common communication/information issues raised in complaints received 2017-18



Counted by issue raised in complaint

ISSUES RAISED ABOUT REGISTERED HEALTH PRACTITIONERS

Chart 17 sets out the types of issues raised in complaints about medical practitioners, dental practitioners, nurses and midwives, psychologists and pharmacists, compared to all practitioners in 2017-18.

As in the previous two years, treatment issues were most prominent in complaints about dental practitioners (55.1%; 2016-17: 56.8%) and medical practitioners (43.0%; 2016-17: 44.0%). The proportion of treatment related complaints about nurses and midwives declined this year (17.5%; 2016-17: 24.3%) and remains low compared to other professions except pharmacists (0.7%).

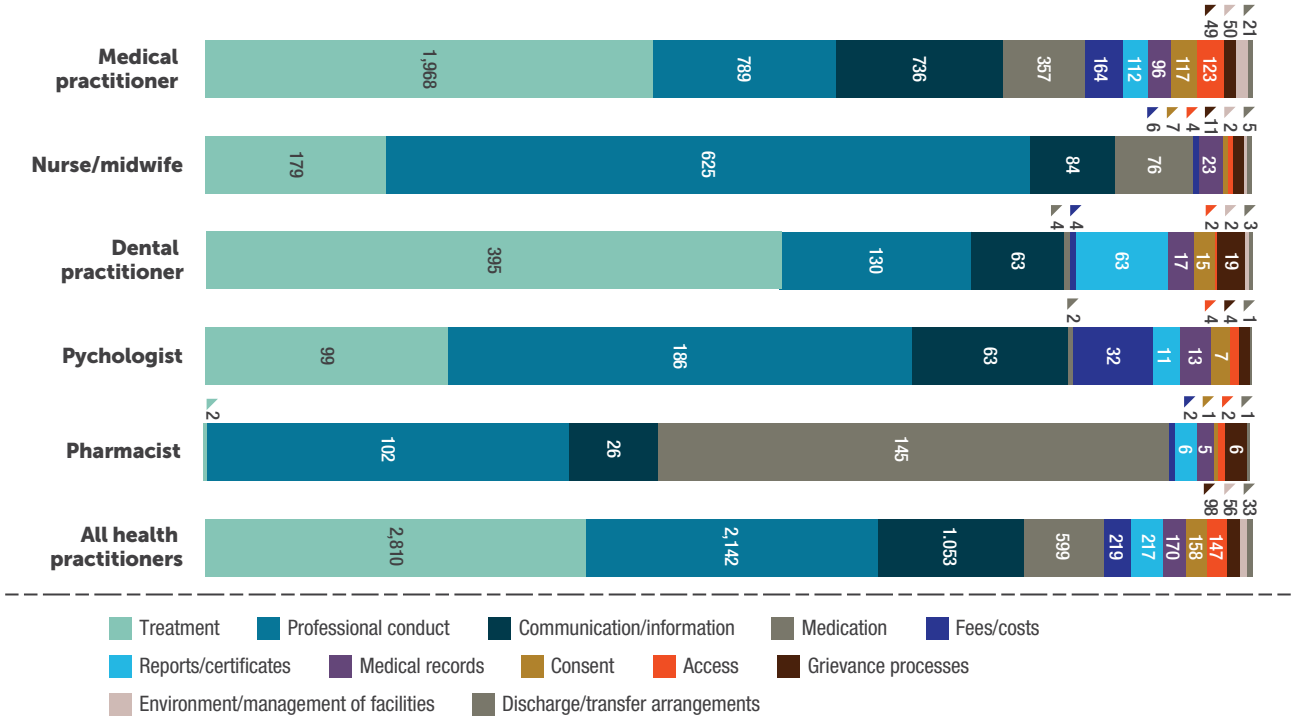
This year, medication issues were the most frequent issue in complaints about pharmacists, rising 9.2 percentage points to 48.7% (2016-17: 39.5%). Pharmacists attracted a lower proportion of complaints about professional conduct this year compared to last year (34.2%; 2016-17: 42.8%) which include complaints relating to illegal practice, breaches of guidelines or laws, and impairment.

The proportion of complaints about the professional conduct of nurses and midwives rose by 12.4 percentage points (61.2%; 2016-17: 48.8%), which is primarily reflecting the changes in the legislation (requiring that self notifications from practitioners about impairments to be processed as complaints).

Communication issues were common in complaints across all professions, however, were more prominent in complaints about medical practitioners (16.1%; 2016-17: 18.0%) and psychologists (14.9%; 2016-17:16.7%) and less prominent in complaints about nurses (8.2%; 2016-17: 11.9%) and pharmacists (8.7%; 2016-17: 11.6%).

A detailed breakdown of issues within each registered practitioner group is included in Table A5 in Appendix A.

CHART 17 | Issues raised in complaints received about health practitioners 2017-18



Counted by issue raised in complaint

ISSUES RAISED ABOUT UNREGISTERED HEALTH PRACTITIONERS

The issues raised in complaints about unregistered health practitioners follow a different pattern to those raised in complaints about registered health practitioners. Unregistered health practitioners are far more likely to be the subject of a complaint about professional conduct issues (45.1%; 2016-17: 45.5%). Treatment issues are the second most common area complained about, rising marginally compared to last year (27.3%; 2016-17: 24.5%). The proportion of communication complaints received about unregistered health practitioners remained relatively stable at 15.4% (2016-17: 16.5%).

These three issues were the most commonly raised for complaints about counsellors/therapists, social workers, alternative health practitioners, naturopaths, administrative/clerical staff and psychotherapists.

A detailed breakdown of issues raised for unregistered practitioners is provided in Table A5 in Appendix A.

ISSUES RAISED IN COMPLAINTS ABOUT HEALTH ORGANISATIONS

Chart 18 shows a breakdown of the issues raised in complaints about public and private hospitals and other specific health organisations compared to all health organisations in 2017-18.

Issues relating to treatment accounted for over half of all complaints about public hospitals (53.3%, 2016-17: 53.8%), and 49.6% of all complaints about private hospitals (2016-17: 44.4%).

Communication and information-related issues were the second most commonly complained about issue in relation to both public and private hospitals, and also medical centres. Communication and information related issues accounted for 16.6% (2016-17: 17.9%) of complaints about public hospitals, 18.4% of complaints about private hospitals (2016-17: 13.5%) and 20.7% of complaints about medical centres (2016-17: 22.8%).

In 2017-18, issues regarding the environment and management of the facility accounted for 17.1% of complaints about medical centres (2016-17: 7.7%); 8.4% of complaints about private hospitals (2016-17: 13.2%) and 5.2% of complaints about public hospitals (2016-17: 5.8%).

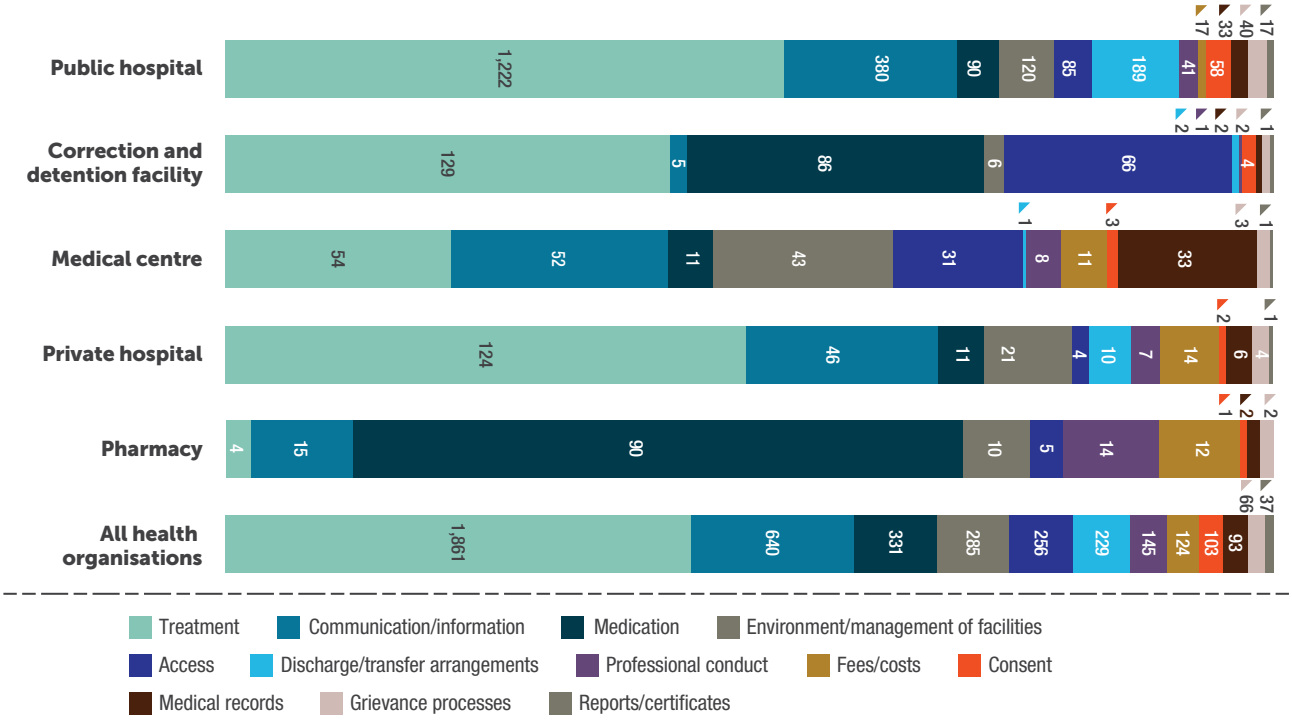
As in the previous two years, treatment issues were less prominent in complaints about medical centres, with only 21.5% raising this issue (2016-17: 26.3%). This may reflect that patients at medical centres present with less serious conditions, are more likely to involve continuity of care for chronic conditions and it is possible that they are more reluctant to complain about a practitioner with whom they may have a long-standing therapeutic relationship.

Complaints about medical records were more likely to be received about medical centres than to any other health organisation, with 13.1% of complaints raising this issue (2016-17: 9.7%). These complaints mainly concerned access to, or transfer of records.

This year the proportion of complaints about medication issues within correction and detention facilities rose significantly (28.3%; 2016-17: 15.3%), however, the proportion relating to access declined (21.7%; 2016-17: 28.3%). Consistent with previous years, correction and detention facilities still attract a higher proportion of complaints about access than other health organisations mostly relating to waiting lists and service availability. The Commission continues to work very closely with the Justice Health Network to address these complaints.

As a result of the significant increase in complaints about pharmacies, there were more issues raised about such facilities, placing them in the top five health organisations this year. As to be expected, pharmacies attracted a higher proportion of complaints about medication than other health organisations (58.1%; 2016-17: 46.4%), as well as professional conduct (9.0%; 2016-17: 13.6%) and fees/costs (7.7%; 2016-17: 12.8%).

CHART 18 | Issues raised in complaints received about health organisations 2017-18



Counted by issue raised in complaint

COMPLAINTS BY LOCATION

Care needs to be taken in analysing and explaining data based on location for a number of reasons.

Location information is not always provided in a complaint, for example, when a complaint is made online or via email with only an email as contact detail. Furthermore, locational analysis of a complaint can be done in relation to the location of the complainant or the location of the service provider. A patient may travel, for example, from regional NSW to visit a Sydney-based specialist.

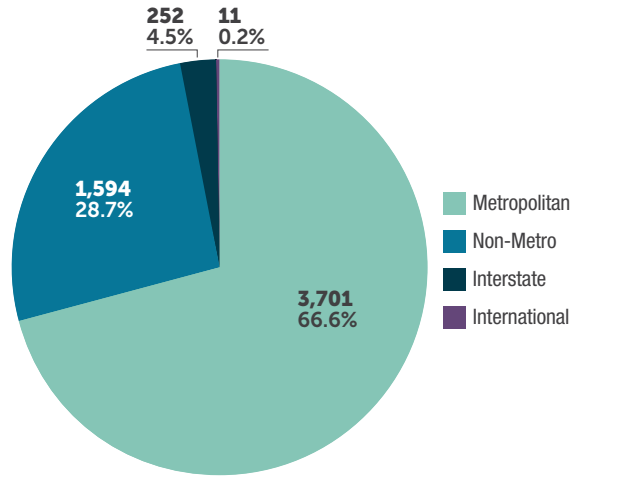
In relation to analysis of LHD by LHD data, the significant differences in the volume and types of services provided need to be recognised.

LOCATION OF COMPLAINANTS

Chart 19 shows breakdown of complaints received by the location of complainants. In 2017-18 location details were not provided by 1,632 complainants. The Commission received 3,701 complaints from complainants who indicated that they were located in metropolitan NSW. This represents 66.6% (2016-17: 65.1%) of all complaints where the complainant location was known. 1,594 complaints were received from complainants located in regional NSW, accounting for 28.7% (2016-17: 29.9%) of all complaints with location details. 252 complaints were received from interstate complainants (3.5%, 2016-17: 4.8%) and 11 from international complainants (0.2%, 2016-17: 0.2%).

For a more detailed breakdown of the location of complainants over a five year period, please refer to Table A.13 in Appendix A of this report.

CHART 19 | Location of complainants



Counted by complainant

LOCATION OF PROVIDERS

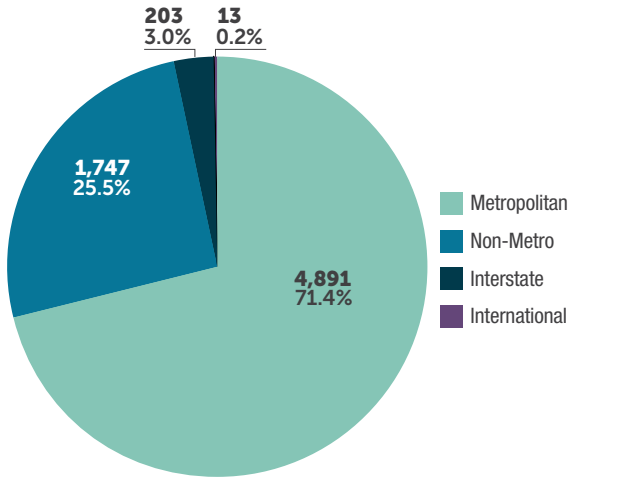
In 2017-18 location details were not able to be identified for 230 providers.

Chart 20 shows the breakdown of complaints received by the location of health service providers. In 2017-18, the Commission received 4,891 complaints about health service providers in metropolitan NSW, which was 71.4% of all complaints with a known provider location. This is consistent with the previous year's figure of 70.8%.

1,747 complaints (or 25.5%) were about health service providers in regional areas, which is marginally below the previous year's figure of 26.2%. A small number of providers were from interstate (203, or 3.0%) and 13 were international (0.2%). These are consistent with last year's figures of 2.9% and 0.1% respectively.

For a more detailed breakdown of the location of providers, please refer to Table A.14 in Appendix A of this report.

CHART 20 | Location of providers



Counted by complainant

The complaints information across each Local Health District can be found at Table A8 in Appendix A. It shows that complaint numbers are small when compared to the number of services provided and also that the percentage of total complaints for each LHD is generally proportionate to their share of the services provided across the state.

ISSUES RAISED IN COMPLAINTS FROM METROPOLITAN AND REGIONAL COMPLAINANTS

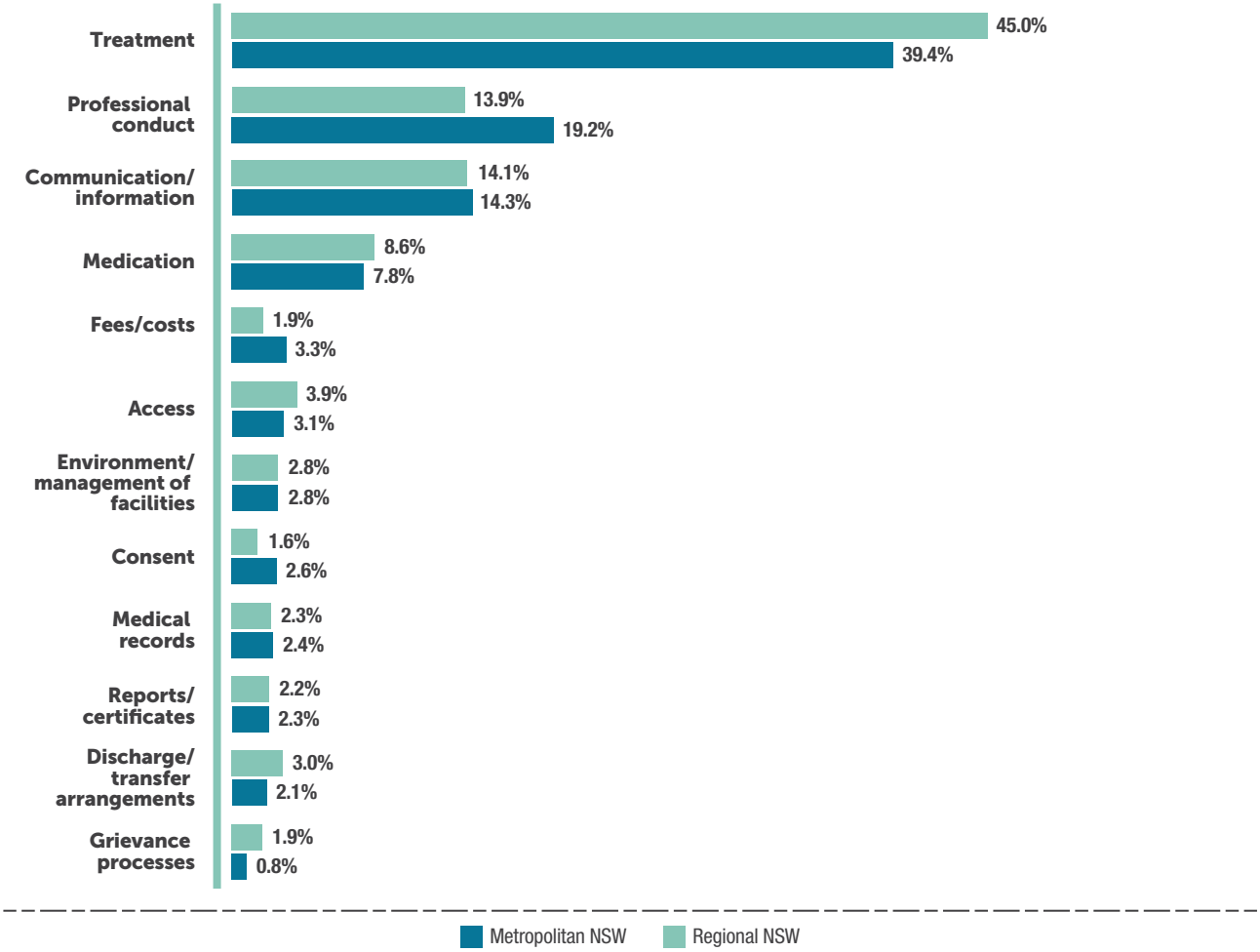
Chart 21 shows the issues raised by individual complainants located in metropolitan and regional NSW, excluding complaints made by organisations.

There continue to be a small number of areas where there are differences in the issues raised.

Treatment is more likely to be raised by complainants living in regional areas (45.0%; 2016-17: 48.8%) compared to those in metropolitan areas (39.4%; 2016-17: 40.8%). Conversely, professional conduct issues continue to be more likely to be raised by metropolitan complainants (19.2%; 2016-17: 15.6%) than regional complainants (13.9%; 2016-17: 10.2%).

Access and discharge/transfer matters arise more frequently in a regional context while fees and costs continue to be a more common issue for metropolitan than regional complainants.

CHART 21 | Issues raised by metropolitan and regional complainants



Counted by issue raised in complaint

Focus area – Cosmetic service complaints

Issues and Challenges

Complaints about cosmetic services are indicative of the complexities that arise in complaints received by the Commission.

One of the main challenges in cosmetic services is that the term "cosmetic services" itself has no clear definition. It is a term that can capture a wide range of services and procedures, with varying degrees of invasiveness and risk.

These services do have the common characteristic that the service or procedure does not typically involve curing or preventing an illness, but rather involves achieving changes in appearance. The term can therefore capture minor, non-invasive treatments (such as laser treatments, hair removal, skin whitening, and addressing minor skin blemishes) through to more invasive procedures (such as breast or buttock reduction/augmentation, body modification, and implants of varying types). The latter may have more of a surgical character, by virtue of aspects such as anaesthetisation, surgical incisions and suturing.

These services pose regulatory challenges for a number of reasons:

- The sector is diffuse, with risky procedures delivered alongside other non-risky treatments and in a commercial rather than clinical environment, often within business structures which do not have clinical governance practices embedded.
- The services provided will continue to take many different forms. The nature of services delivered by cosmetic health providers to change appearance are developing rapidly and now include procedures such as eyelid suturing, nose bridge lifts, face lifts, the administration of Botox and dermal fillers, facial threading, and sub dermal implants.
- The services may be beyond the usual definitions of health services – posing questions about the expertise and training held or required by those providing services, the jurisdiction of health regulators, and the suitability of health regulation frameworks to successfully address the problems and risks.

The types of services that are currently of particular concern to the Commission include beauty and body modification clinics where there are potential risks to consumers that may arise from a number of factors:

- These services may require administration of prescription medications such as Botulinum toxin Type A – and the prescription should only be provided by a registered health practitioner who conducts a proper heath assessment prior to prescribing – this may not be occurring.
- The service may be making unsubstantiated claims about the efficacy of certain treatments. Advertising may suggest results that are not achievable and may be directed at vulnerable consumers.
- The practitioners involved may be undertaking procedures that are beyond their scope of practice and/or for which they do not have training.
- Surgical procedures may be being delivered without appropriate expertise, licensing and/or equipment.
- There may be risks to the treatment that are not being explained or for which there is not informed consent.
- The services may be using non ARTG registered devices or medicines.
- Devices and medicines that are being used may be illegally imported and not quality controlled.
- The services may not be using appropriate infection control practices.
- Consumers may be offered cost reductions or other incentives to have treatment – e.g. low cost loans from lending entities in which the practitioner/facility has a financial interest.

What complaints have been received by the Commission

Due to the diffuse nature of cosmetic services, the data must be regarded as indicative of the issues and trends rather than definitive and it is difficult to collate and analyse the data in a comprehensive way. For instance, if a complaint is made about anaesthetic during a cosmetic procedure, it may be classified as a complaint about anaethetisation in day surgery – rather than as a complaint about a cosmetic procedure and this would not be captured in the data extracted for cosmetic services.

COMPLAINTS DATA

The number of complaints classified as complaints about cosmetic services is relatively small but the overall trend is an increase in number. Table F1 shows the complaints received by the Commission since 2013-14 where the primary classification of the complaint was cosmetic services.

TABLE F1 | Complaints where cosmetic service is primary categorisation, 2013-14 to 2017-18

	No.	% of complaints
2013-14	88	1.8%
2014-15	43	0.8%
2015-16	94	1.5%
2016-17	94	1.5%
2017-18	148	2.1%

The Commission has observed a number of other features of cosmetic service complaints that are important to highlight:

- Often complaints are anonymous or complainants wish to withhold their identity. While we cannot be certain of the reason for this, it seems likely that complainants have a degree of self-consciousness about the treatment they sought and /or a desire not to compromise the ability to get corrective treatment or a refund for ineffective treatment.
- A proportion of complaints are made by other cosmetic service providers.

WHO IS COMPLAINED ABOUT?

As seen in Chart F1, just over three quarters of complaints (78.3%) refer to individual practitioners (registered and unregistered) with the remaining quarter referring to health organisations. Amongst individual practitioners, there has been a general increase in the number and proportion of complaints relating to unregistered practitioners.

CHART F1 | Complaints about cosmetic services by provider type, 2013-14 to 2017-18

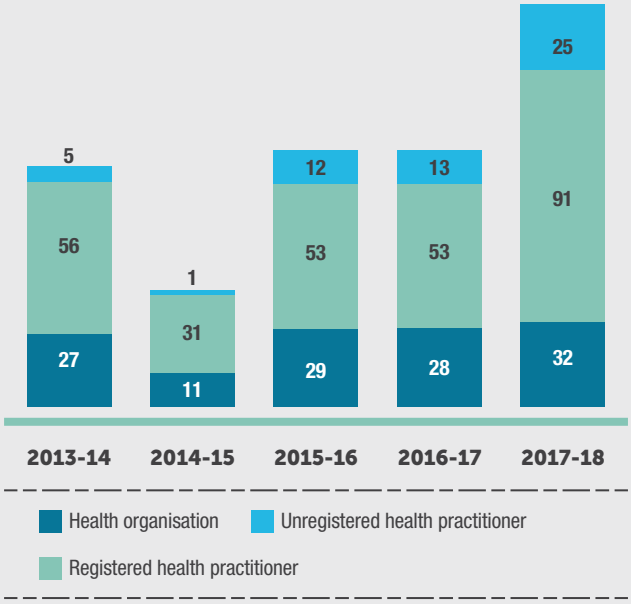


CHART F2 | Cosmetic service complaints about unregistered practioners, 2013 to 2017-18

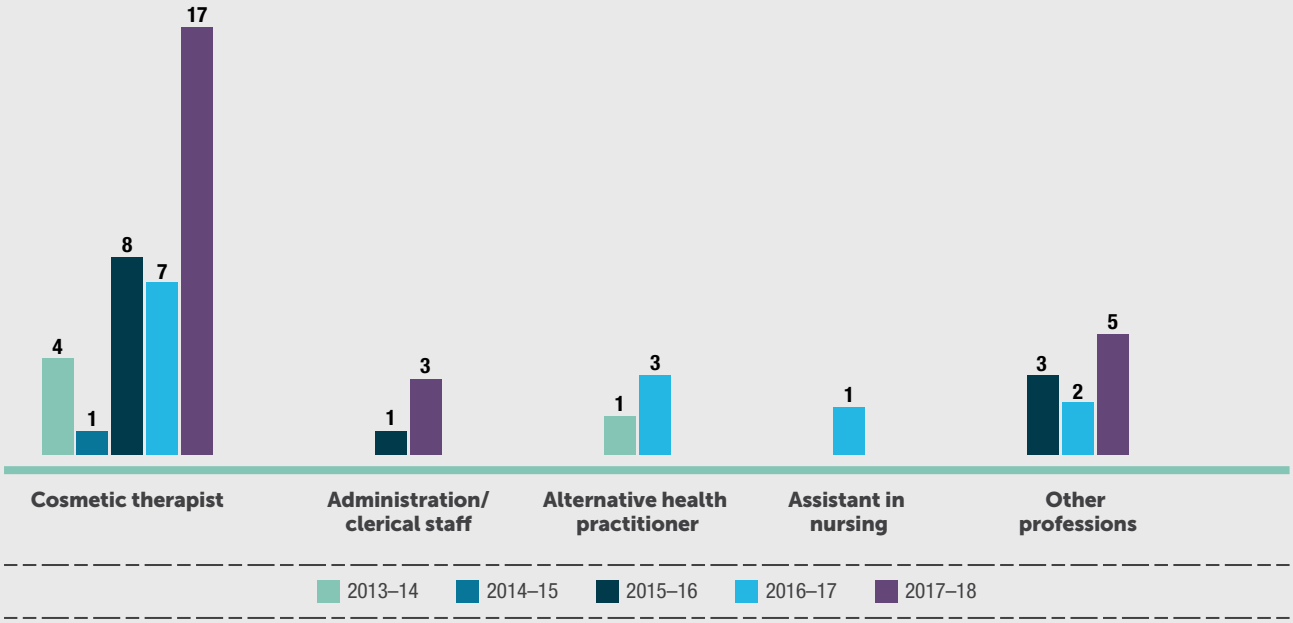
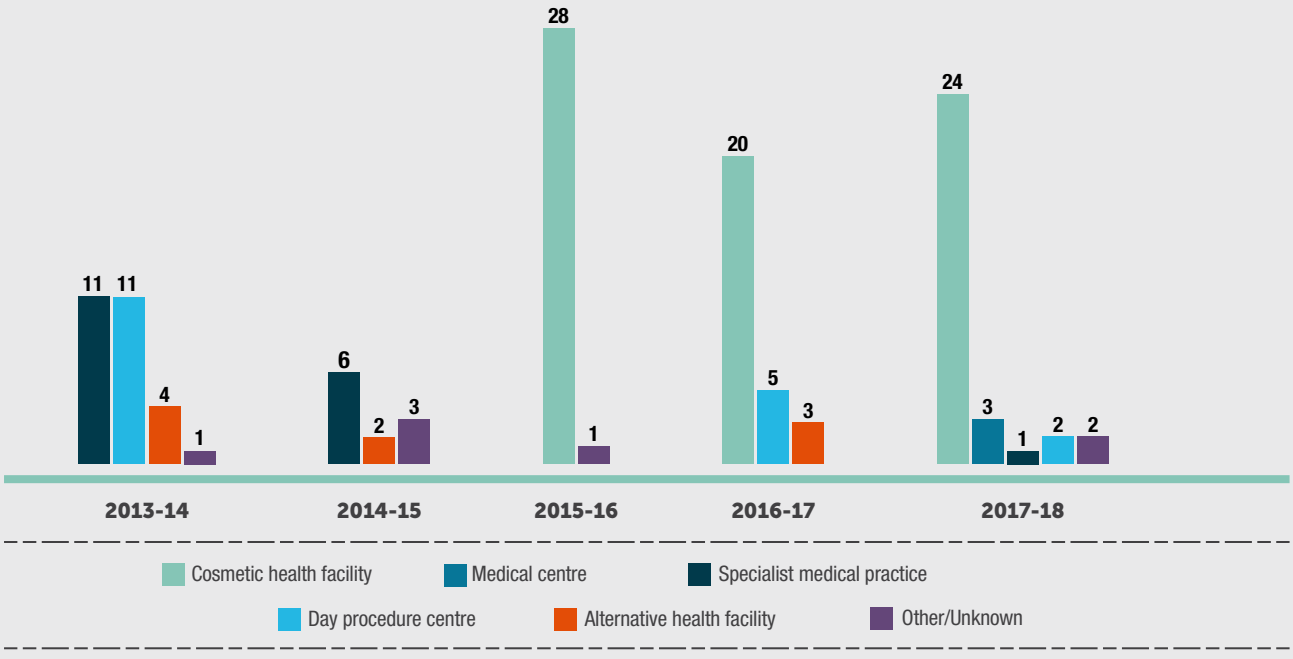


Chart F2 above presents the breakdown of cosmetic service complaints about unregistered practitioners for the period 2013-14 to 2016-17 by profession, which shows that cosmetic therapists and alternative health providers are predominant.

Chart F3 presents the breakdown of cosmetic service complaints about health organisations, which shows that cosmetic health facilities, day procedure centres and alternative health facilities are the most complained about. It should be noted that the category "cosmetic health facility" was only introduced by the Commission in 2015-16.

CHART F3 | Top 5 cosmetic service complaints about health organisations, 2013-14 to 2017-18



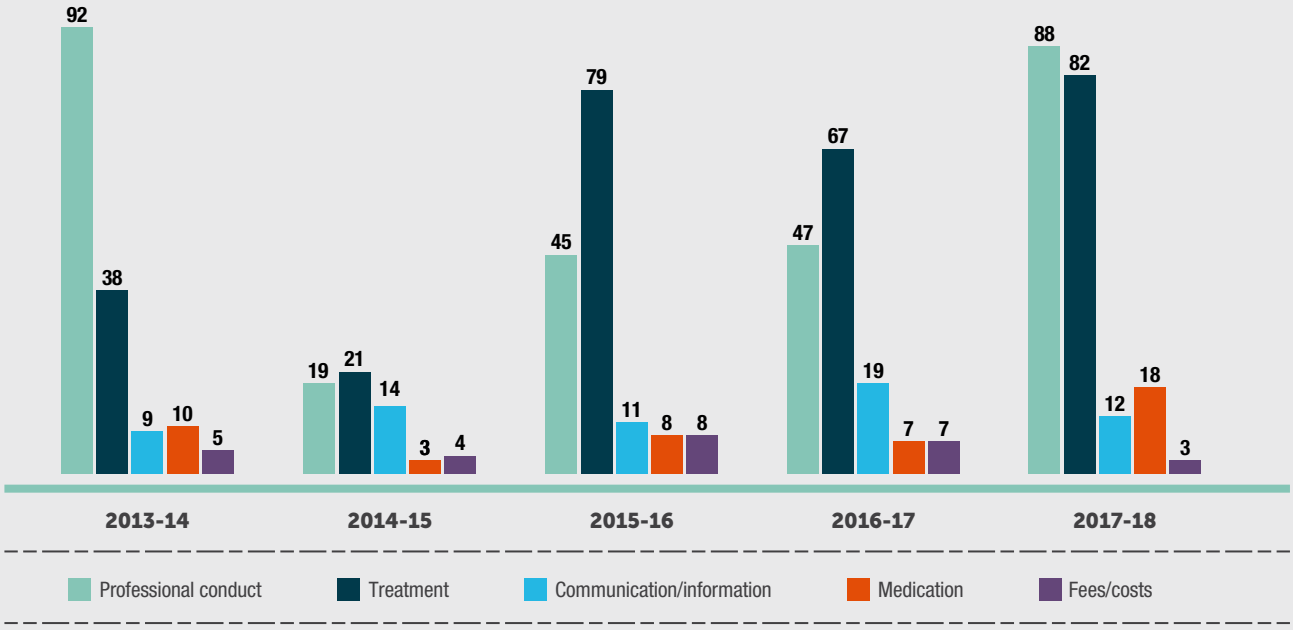
WHAT IS COMPLAINED ABOUT?

Chart F4 below shows that the predominant issues raised in complaints about cosmetic services have consistently been professional conduct and treatment.

Within the professional conduct category, "illegal practice" and "breach of guideline/law" account for approximately two thirds of this issue category (65.2%) over the past five years.

Within the treatment category, "unexpected treatment outcome/complications" and "inadequate treatment" accounted for 75.3% of all treatment issues raised in complaints over the past five years.

CHART F4 | Top 5 issues raised in complaints about cosmetic services 2012-13 to 2017-18



HOW HAS THE COMMISSION MANAGED THESE COMPLAINTS

Over the past few years, the regulatory actions taken to date on beauty clinics and cosmetic services by the Commission have included:

- The Commission has used its "own motion" complaint power in relation to cosmetic services on a number of occasions, including following the tragic death of a woman in a beauty clinic in Sydney about several individual health practitioners, as well as about an unrelated cosmetic clinic following receipt of complaints about individual practitioners who worked there.
- The Commission commenced 60 investigations over the past three years – 55 investigations into individual registered and unregistered practitioners and five into health organisations delivering cosmetic procedures. It finalised 59 investigations (53 individual practitioners and six health organisations).
- Issuing three public warnings about cosmetic services:
  - The first was issued on 30 June 2016 that warned of cosmetic surgical and medical procedures being performed by unregistered health practitioners in residential premises and hotel rooms in the Sydney area. This was highlighted in the Commission's 2016-17 Annual Report.
  - A further public warning was issued on 28 September 2017 following an escalation in complaints regarding cosmetic procedures being undertaken in cosmetic clinics and the risks to the health and safety of people attending those clinics. See at the end of the focus area.
  - On 16 April 2018 a public warning was issued in regard to extreme body modifications involving subdermal implants. This is highlighted in the Access and outreach chapter.
- Making recommendations to two private health facilities which changed their policies, procedures and business practices and influenced changes in the regulations relating to cosmetic procedures. See the following case study relating to one of these health facilities.

- Consideration of prosecution of private premises detected as performing procedures while not correctly licensed.
- Referral of a number of complaints relating to the supply and administration of medicines to the Pharmaceutical Regulation Unit of NSW Health.
- Referral of complaints that raise issues relating to the qualifications of registered practitioners or a person holding out to be a registered practitioner and misleading advertising matters to AHPRA.

In 2017-18, 135 complaints relating to cosmetic services were assessed and the outcomes of these assessments are set out in Table F2 below.

TABLE F2 | Outcomes of cosmetic services complaints, 2017-18

	2017-18	
	No.	**%**
Discontinue	36	26.7%
Refer to Another body	39	28.9%
Investigation	34	25.2%
Refer to Council	11	8.1%
Discontinue with comments	13	9.6%
Resolved during Assessment Process	2	1.5%
Local Resolution (No RO)	0	0.0%
Resolution	0	0.0%
Total	**135**	**100.0%**

This table shows that:

- Over a quarter of the complaints (28.9%) were referred to another body. Of the 39 complaints referred, 29 were referred to AHPRA , two to the Pharmaceutical Regulatory Unit and five to other government departments.
- One quarter (25.2%) were referred for investigation, which is considerably higher than the proportion of all complaints referred for investigation – which is typically around 5%.
- 8.1% were referred to the relevant Professional Council.
- 26.7% were discontinued, with a further 9.6% discontinued with comments.

BETTER OUTCOMES THROUGH BROADER CROSS-JURISDICTIONAL COLLABORATION

It has become increasingly apparent that success in addressing the problems in this expanding service area requires a strategy that brings the powers and actions of state and national regulators together in a coordinated fashion.

Furthermore, because the services involved are beyond the traditional health services sector and because the business model operated on national and international scales, the response must work across the boundaries of health, business and consumer regulation. It is only through judicious and effective use of powers across these areas that there will be the ability to disrupt the activities of disreputable and risky individuals and clinics.

At the planning and strategy level, NSW has become a member of the national Consumer Health Regulators Group. This Group was formed in April 2017 and consists of regulators from across Australia with an interest in consumer health.

The Group is currently chaired by the Australian Competition and Consumer Commission and other members include AHPRA, the Therapeutic Goods Administration and the Private Health Insurance Ombudsman and the NSW Health Care Complaints Commission. The focus of the group is on sharing information that will enable earlier identification of risks to health consumers and setting in place clearer and more coordinated arrangements for addressing those risks.

At an operational level (and building on the connections made through the Consumer Health Regulators Group) the Commission and the Ministry of Health have commenced a regime of joint operations and collaboration across Commonwealth and State agencies to identify and respond to risks. The focus for the Commission has been on linking with the Therapeutic Goods Administration (TGA), Border Force (and potentially a broader suite of Commonwealth regulators) in addition to strengthening collaboration on matters referred to AHPRA.

Public Warning under s94A of the Health Care Complaints Act – Unsafe and Illegal Practices at Beauty and Cosmetic Clinics: 28 Sep 2017

The NSW Health Care Complaints Commission is concerned about complaints regarding cosmetic procedures undertaken in cosmetic clinics and the risks to the health and safety of people attending those clinics.

WHAT SHOULD CONSUMERS DO TO PROTECT THEMSELVES?

The Commission strongly urges those individuals seeking cosmetic procedures or cosmetic surgery to be vigilant in their research prior to proceeding. In all cases the following factors should be considered before committing to the procedure or surgery:

1. Is the procedure supported by a practitioner who is appropriately qualified, experienced and accredited?

Cosmetic procedures typically involve the use of Schedule 4 drugs which include, but are not limited to, Botulinum toxin type A (Botox) and hyaluronic acid injection preparations (Dermal fillers) and medications designed to numb tissue such as Lidocaine in injectable and cream form. For these medications, the consumer is required to have a consultation with a registered medical practitioner (in person or by video), for a management plan to be created and for that medical practitioner to prescribe the restricted substance. The consumer is required to be under the direct care or supervision of the medical practitioner.

2. Is the facility appropriately registered, infection controlled and equipped?

Cosmetic procedures are wide ranging and there are a number of relevant requirements in legislation regarding the licensing and registration requirements of these facilities.

Consumers considering skin penetration procedures should be mindful that if there is no registered practitioner working at premises where skin penetration procedures are performed, the facility must be notified to the relevant local council. This enables random inspections to be conducted to monitor compliance with the Regulations. Consumers should also satisfy themselves of the following:

The premises needs to be clean and hygienic, have a waste disposal bin, have a hand basin that has a clean supply of water and have liquid soap and single use towels or a hand dryer for drying hands;

Protective equipment needs to be worn by the person carrying out the procedure, including the use of gloves that have never been worn and a clean gown or apron;

Needles used must not have been previously used and need to be disposed of using an appropriate sharps container.

Medication ampoules must only be used once and the consumer is entitled to ask that the single use ampules are shown to them before and / or during the procedure.

3. Are you having cosmetic surgery?

There are extra protections in place for consumers who are undergoing cosmetic surgery (which includes procedures such as significant liposuction, fat transfer, facial implants that are on the bone or involve deep tissue surgery, breast augmentation or reduction, and “tummy tuck”).

These procedures are the subject of new legislative requirements that came into operation in March 2017. The full list of cosmetic surgical procedures which need to be conducted at licensed premises is at http://www.legislation.nsw.gov.au/regulations/2016-288.pdf.Consumers should assure themselves that any facility that involves the administration of anesthetic (including a general, epidural or major regional anesthetic to achieve more than conscious sedation) or that involves cosmetic surgery of the kind listed in the regulation is in fact licensed.

Cosmetic surgical procedures are also required to be performed by a medical practitioner and the consumer should be assessed by that medical practitioner before scheduling the procedure. Consumers are encouraged to ask a medical practitioner about their qualifications, training and experience. They can also check to see if a practitioner is registered in Australia through the Australian Health Practitioner Regulation Agency (AHPRA) website on www.ahpra.gov.au. If the practitioner is not registered in Australia, you should not proceed.

4. Are you appropriately informed?

The practitioner performing the procedure should provide the consumer with enough information to make an informed decision about whether to have the procedure. Consumers should be provided with at least the following information:

- What does the procedure involve?
- Is the procedure new or experimental?
- What products are being used in the procedure and are these products registered?
- What are the range of possible outcomes of the procedure?
- What are the risks and possible complications associated with the procedure?

5. Why is this warning being issued?

In NSW consumers are increasingly spending money on a range of cosmetic services. These services include a range of skin penetration procedures including micro-needling and Platelet Rich Plasma treatment, non-surgical breast and hip enhancements, nose bridge lifts, double eyelid suturing and anti-ageing facial treatments.

The procedures often include the administration of Schedule 4 prescription-only medication including Botulinum toxin type A (Botox) and hyaluronic acid injection preparations (Dermal fillers), in addition to medications designed to numb tissue such as Lidocaine in injectable and cream form.

The issues raised in the complaints received include:

- Whether the products being used in these treatments are registered or unregistered products. Use of unregistered products which may be of inferior quality and untested pose a health risk. The import and supply of medication that is not on the Australian Register of Therapeutic Goods (ARTG) is unlawful and dangerous since there is no way of determining the efficacy and safety of the medicines.
- Whether the person prescribing the medication is registered under the Health Practitioner Regulation National Law. The Schedule 4 medications typically used in cosmetic treatments must be prescribed to the individual by a registered medical practitioner. The administration of medications by unregistered and unqualified persons without a prescription is dangerous because there is no informed assessment of the clinical risks associated with the treatment and no validation of their qualifications and experience. Consumers who receive treatment in these circumstances are taking unnecessary risks that could ultimately lead to life changing injuries or indeed death.

In response to these complaints the Commission has completed and is conducting a range of investigations. One key element of this work is the active investigation of complaints concerning the care and treatment of a woman who died following a cosmetic procedure at the Medi Beauty Laser and Contour Clinic in Chippendale, NSW.

The Commission is also involved in joint operations with the NSW Department of Health's Pharmaceutical Regulatory Unit to inspect beauty/cosmetic clinics in a number of areas across Sydney to examine their operations and identify and address any areas of non-compliance.

The Commission has serious concerns that persons are carrying out medical-related procedures to 'improve' aesthetic appearance whilst not appropriately registered as a medical practitioner. No registered medical practitioners were present during the inspections of any of these clinics. The inspections also provided evidence that medicines that are not on the ARTG continue to be unlawfully imported into Australia and used in beauty/cosmetic clinics.

A number of non ARTG medications were seized during the joint operation. These included Lidocaine cream with significant strength (ranging from 10.5 to 19.8 %), Erythromycin Ointment, (an antibiotic) and Schedule 4 medication unlawfully imported in bulk from China, and non ARTG Botulinum toxin type A imported from South Korea. In addition, Hyaluronidase, A (an injectable enzyme solution that speeds the natural breakdown of hyaluronic acid) was seized. This medication is used to counteract the effects of hyaluronic acid based fillers for patients whose original dermal filler treatments did not turn out as they expected. Non ARTG approved Iodine and Vitamin B and C injections were also seized together with anesthetic lip and eyebrow paste.

A significant amount of non- ARTG medical devices imported from China were also found. These included Cannulas, needles, sutures, gauze, masks and gloves. These devices must be sterile and such imported devices cannot be guaranteed to have been sterilized to Australian standards therefore potentially increasing the risk of infection to consumers.

Case study – Joint operations for a cosmetic health facility

In September 2017 the Commission and the NSW Ministry of Health's Pharmaceutical Regularity Unit (PRU) joined forces to inspect a Sydney beauty clinic ('the Clinic'). This inspection arose out of an increasing number of complaints to the Commission regarding the use of non-approved Australian Register of Therapeutic Goods (ARTG) medicines and medical devices in a number of clinics in NSW.

The Commission and PRU seized non ARTG approved items during the site visit including;

- lignocaine anaesthetic cream
- erythromycin ointment
- hyaluronic acid injections
- hyaluronidases
- aciclovir tablets.

As a result of the inspection, the Commission raised an own motion complaint and commenced an investigation which not only considered the Clinic's possession of non ARTG medicines, products and devices but also whether staff handling and administering injectable medication, were appropriately trained and registered

The investigation found that the Clinic was displaying signage and advertising on its website offering procedures and treatment including double eye-lid procedures, eye bag removal, upper eyelid lifting, breast/hip augmentation, facial contouring, dermal filler, 'Botox' and Platelet Rich Plasma (PRP) injections. Many of these procedures required administration of restricted Schedule 4 prescription only medication.

The Clinic also possessed restricted medicine, products and devices displaying labels not in accordance with approved markers to signify ARTG approval and appeared to be imported from China and Korea in contravention of the *Therapeutic Goods Act 1989*. The investigation concluded that there was evidence the Clinic had poor administrative processes and inadequate supervision in the ordering of ARTG approved restricted medicines, products and devices. The Commission made numerous recommendations to the Clinic under section 42 of the *Health Care Complaints Act 1993*, with the aim of ensuring full compliance with relevant legislative requirements.

The clinic was required to:

- provide evidence of protocols to ensure that only goods included on the ARTG are used and only appropriately trained and experienced Australian registered medical practitioners are responsible for the ordering and prescribing of scheduled medications to clients.
- demonstrate that all staff employed at the Clinic receive awareness training about the requirement to use only goods included on the ARTG when providing health services, and the health risks associated with using non-ARTG goods.
- have signage (in multiple languages) that explains to clients of the Clinic that schedule 4 medicines (including Botulinum A toxin and Hyaluronic acid) can only be injected once there is a prescription from a registered health provider, which allows for a proper health assessment.
- ensure that all clients of the Clinic who are administered schedule 4 medicines (including Botulinum A toxin and Hyaluronic acid) have first undergone a consultation with a registered medical practitioner and this consultation is to be done in person or video, with a management plan created and documented in the relevant clients treatment record.

The Clinic provided the Commission with all relevant documentation and evidence to confirm that these recommendations have been fully implemented. The Commission will continue to work with PRU to monitor compliance.

Assessing and resolving complaints

The nature and purpose of the assessment process

All complaints submitted to the Commission must be in writing and once a complaint is received it must be assessed.

If the complaint contains sufficient information, the Commission may make its assessment without further inquiries, however this is rare. It is more common that further information is required and the Commission will typically:

- Seek a response from the relevant health service provider or any other person who may have knowledge of the matter.
- Gather appropriate medical records.
- Access any relevant reports that may have been undertaken by other bodies.
- For clinical matters, internal medical or nursing advice will usually be obtained, and where necessary, external expert opinion may be sought.
- Seek further information from the complainant if necessary.

In all cases relating to registered health practitioners, following its assessment of a complaint, the Commission must consult with the relevant professional council to determine the final assessment outcome.

As has been outlined in the overview of the Complaints Management Framework, there are a number of possible outcomes from an assessment process. The determination of an outcome is based on the nature and seriousness of the issues raised. In summary, there are eight possible outcomes of a complaint which are as follows:

- Referred for investigation
- Referred to a professional council
- Referred for local resolution
- Resolved during assessment
- Referred to the Commission's Resolution Service
- Referred to another body or person
- Discontinued with comments to the practitioner or health service
- Discontinued (which also includes complaints that are withdrawn by the complainant).

In some cases, the information gathered during assessment could suggest a potentially significant issue of public health or safety; significant departures from clinical treatment standards that have caused harm to patients; and/or grounds for disciplinary action. These cases are **referred for investigation**.

In complaints involving registered practitioners, there may be evidence of a less significant departure from clinical standards, that a practitioner is impaired or lacking in relevant professional knowledge. In these cases the complaint would generally be **referred to the relevant professional council**. The council would be able to undertake assessments of the practitioner, place them in an impairment or performance program. If new information is presented during the council's management of the complaint that suggests that there is a significant risk to public health and safety, the council may refer the practitioner back to the Commission for investigation.

For complaints that pertain to a public health facility, the Commission may determine that the health service provider is in the best position to address concerns that have been identified. In these cases, the complaint can be **referred for local resolution** by the Commission.

A focus of the Commission continues to be in identifying those complaints that can be **resolved during the assessment** process more quickly and informally. The Commission continues to develop its early resolution capability and processes, noting that quick resolution of a complaint is the most desirable outcome wherever it can be achieved.

Referral to the Commission's Resolution Service will apply in those cases where there have been significant and complex issues with treatment and care and also a loss of rapport or trust between the service provider and the complainant. This offers complainants and health service providers the support of dedicated and trained resolution staff to focus on identifying the outstanding issues, clarifying the outcomes sought and setting in train a reasonable path to successful and timely resolution. The process is voluntary, and tailored to meet the needs of the parties.

In a proportion of complaints, there are issues raised that

are within the jurisdiction of other bodies. Where that is the case, the complaint is **referred to another body** by the Commission. For instance, a complaint may raise a concern about access to or content of a health record and in these cases, it is referred to the Information and Privacy Commission. Or a complaint may raise a concern about systems at an aged care facility in which case, referral to the Aged Care Complaints Commissioner would be most appropriate.

A proportion of complaints raise lower level issues (such as practitioner rudeness, poor information or long waiting times at medical centres). These issues are of understandable concern to the consumer but do not raise more significant issues of risk to public health and safety. In these cases, the priority for the Commission is to provide guidance to the practitioner or service about necessary improvements in practice. Determining to "**discontinue with comments**" enables this guidance to be provided, whereas previously the complaint would simply have been assessed as discontinue.

A complaint will be **discontinued** where:

- assessment uncovers information that corrects misapprehensions in a complaint and indicates that there has not been substandard care or treatment, or unsatisfactory conduct
- a clinical expert examines all relevant records and responses and does not find that there were any departures in the care and treatment provided
- the complaint is found to be made in bad faith, vexatious or frivolous.
- the complaint is already the subject of legal proceedings or investigation by another person or body.

A complaint may also be withdrawn by the complainant.

Complaints assessed

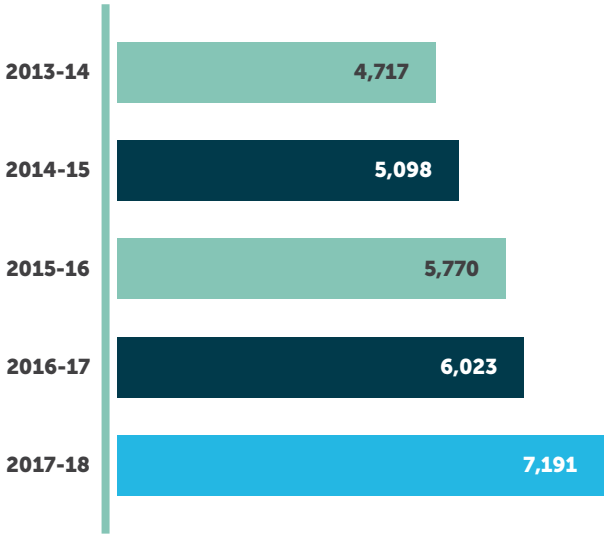
In 2017-18 there were 7,191 complaints assessed by the Commission – a significant 19.4% increase from the previous year (2016-17: 6,023). This shows a significant increase in the Commission's productivity, and is the result of active strategies to intensify and streamline the assessment of complaints and adjust resources to address operational pressures throughout the year.

Key elements of business improvement initiatives in 2017-18 have included:

- improved triaging for new complaints
- rapid referral of matters to other bodies where this is appropriate
- automation of manual activities wherever possible
- streamlined processes for gathering clinical advice
- removal of unnecessary steps in the process
- development and use of case management reports and tools, and
- measures to maintain effective consultation with professional councils in the assessment process.

Continuation of these initiatives, combined with the full implementation of electronic complaints lodgement, are expected to deliver further productivity and improved timeliness in 2018-19.

CHART 22 | Complaints assessed from 2013-14 to 2017-18



Counted by identified in complaint

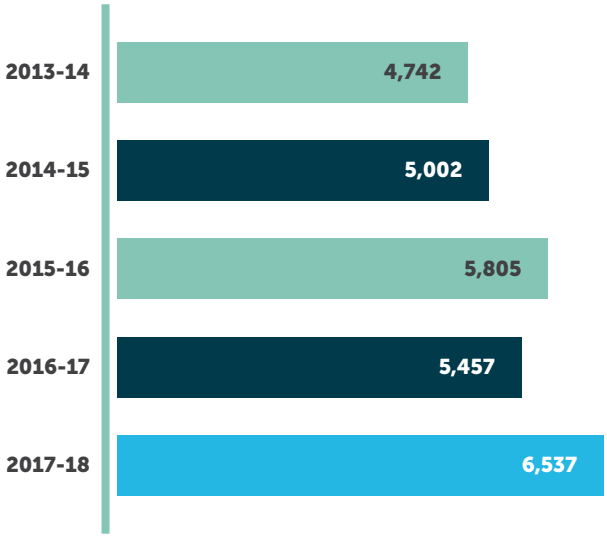
Assessments finalised

The Commission also records the number of assessment files finalised and closed, which is the means of monitoring the completion of all necessary administrative steps to achieve file closure following assessment of a complaint. Once a matter is assessed the remaining steps are to undertake consultation with the relevant professional council (for complaints relating to a registered health practitioner), prepare decision letters and audit and close the case file.

In total, there were 6,537 assessments files finalised and closed in 2017-18, which is a significant 19.8% increase from 2016-17. This is largely a result of targeted resourcing at specific times of the year, to address any backlog of decision letters that had arisen.

It should be noted that 'Assessments finalised' is used as the basis for the analysis of assessment outcomes that follows (as per standard practice for previous Annual Reports). This is because the final outcome of a complaint about a registered health practitioner may change after the Commission's assessment recommendation is made as a result of consultation with the professional council.

CHART 23 | Assessments finalised from 2013-14 to 2017-18



Counted by provider identified in complaint

Assessment outcomes

Chart 24 shows the Commission's assessment outcomes for complaints for 2017-18 compared to the previous four years. It shows that:

- The 6.1% of complaints referred for investigation in 2017-18 is marginally higher than the proportion referred in 2016-17 (5.8%).
- One in five complaints was referred to a professional council (21.1%) for its action in relation to identified concerns about poor performance, conduct or possible health issues for the practitioner. This proportion is consistent with previous years.
- The decline in the proportion of matters resolved during assessment (4.7% compared to 7.8% in 2016-17) is one area of concern, as the effective resolution of complaints as early as possible and as informally as possible is a key business objective. The reduced performance is a result of the delays arising from increased complaint numbers. By definition, if a complaint is delayed the opportunity for early resolution is lost. In resourcing decisions, recruitment and training going forward, a focus will be on increasing the capacity and capability to resolve matters during assessment.
- The trend of a higher proportion of matters referred for local resolution has continued. For 2017-18, 11.5% of complaints were referred for local resolution. This reflects the continued development of front line complaints management functions across the health system, supported by the work of the Commission to build local complaints management capability through its complaints management training across Local Health Districts and hospitals.

- With an increased proportion of complaints assessed for local resolution, a slightly lower proportion has been referred to the Commission's Resolution Service in 2017-18 – 3.4% compared to 4.0% of all assessment decisions in 2016-17. The Resolution Service remains the outcome that will be used for the most complex, sensitive and contentious matters that need the benefit of independence, objectivity and skilled facilitation to work through the issues.
- A small but increasing proportion of complaints (4.8%) were referred to another body or person for consideration (2016-17; 3.9%). This reflects the expansion of quality/safety based regulation in areas related to the Commission work (including the establishment of the Aged Care Complaints Commission at national level) and a stronger framework for working across agencies to cross refer to agencies best placed to resolve complaints.
- Together the categories of discontinued and discontinued with comments continue to make up less than 50% of outcomes (48.4%). There is a slight rise in the proportion discontinued (39.8%; 2016-17: 36.8%) relative to the proportion discontinued with comments (8.6%; 2016-17: 11.2%).

Case study – Facilitating access to care and treatment through local resolution

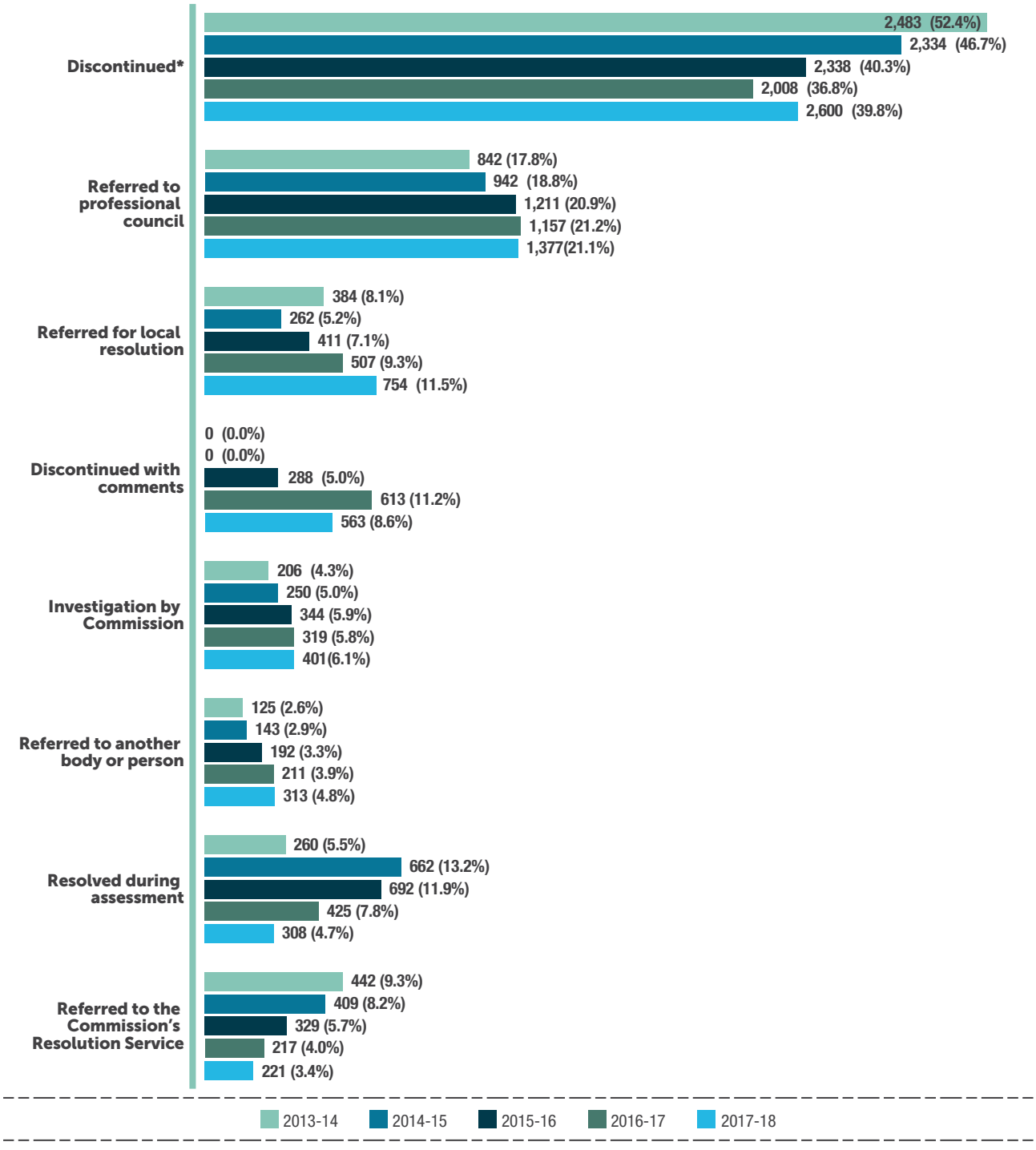
A complaint was received from Patient A's sister who was concerned about access to appropriate care and treatment for her brother, who was morbidly obese. They attended a local public hospital's obesity clinic to receive medical advice on what options were available. Patient A was advised that surgery was the recommended option. However, as he did not live in the catchment area, he was ineligible to have it performed at the clinic. The consultation reportedly ended without any further advice being provided about where he might go to obtain treatment.

The Commission contacted the relevant Local Health District to see how Patient A might be assisted. The LHD agreed to consider the matter more closely and the complaint was therefore assessed for local resolution. Patient A was found to live in a catchment area with no existing weight loss program. The LHD arranged to offer Patient A enrolment in an accessible program within the LHD.

A clinic representative called Patient A and apologised for his situation. The representative described their program, its enrolment criteria, suitability for surgery, and exclusions. They also emailed him their patient information sheets and sent him their website details for further information, as well as the specific steps that needed to be taken to enter the program.

The patient was appreciative and satisfied with the information given to him, and considered the matter resolved.

CHART 24 | Outcome of assessment of complaints 2013-14 to 2017-18



Counted by provider identified in complaint

Assessment decisions by type of health practitioner

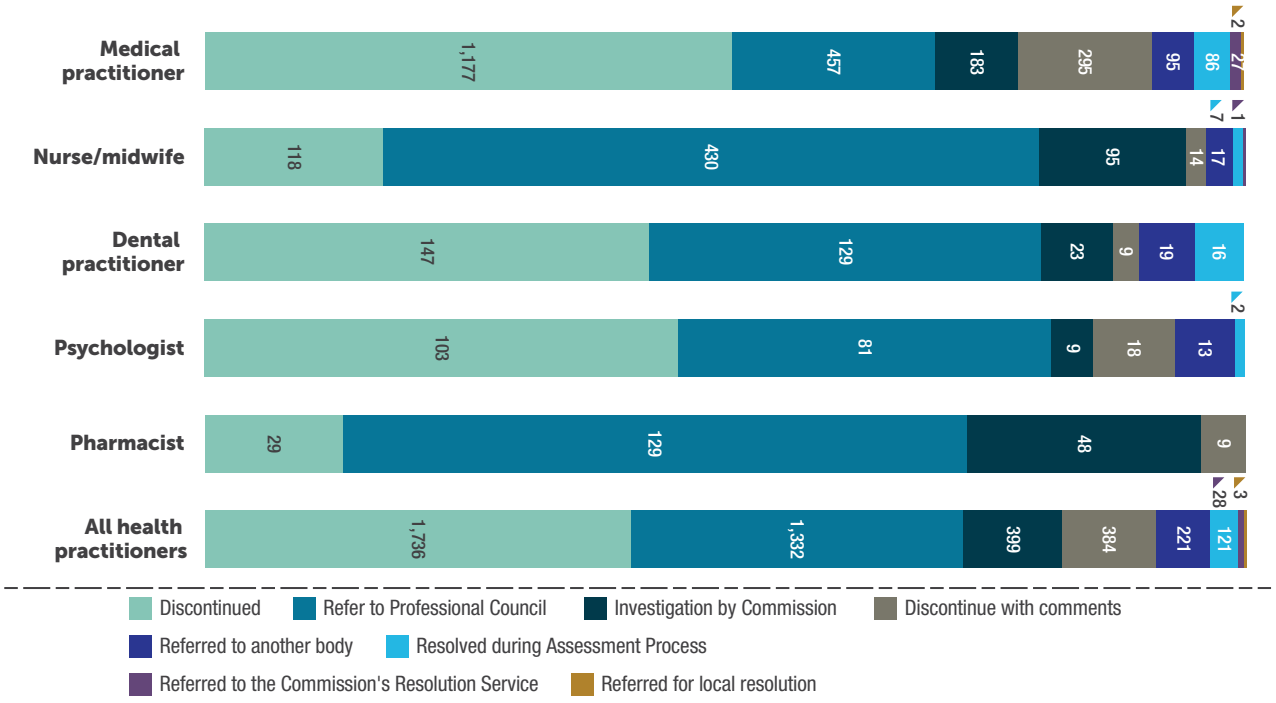
Chart 25 below sets out how the Commission dealt with complaints in 2017-18 by the type of health practitioner involved. The chart compares the assessment decisions for each of the top five most complained about health practitioners to the assessment decisions for all 4,224 complaints finalised about individual health practitioners (registered and unregistered).

In 2017-18, a slightly higher proportion of complaints about medical practitioners were discontinued (50.7% compared to 46.8%; 2016-17). Almost the same proportion were referred to the Medical Council of NSW (19.7% as compared to 19.4% in 2016-17). A higher proportion of complaints were referred to another body this year (4.1% compared to 1.9% in 2016-17). The proportion of complaints resolved during assessment declined from 5.5% to 3.7% which highlights the need to continue to strengthen the Commission's focus on early resolution of complaints. Complaints that were discontinued with comments declined slightly, from 16.3% to 12.7%, although still remains the highest proportion across all health professions.

The most likely outcome for complaints about nurses, psychologists and pharmacists was referral to the relevant professional council. This is due to the fact that effective consideration of clinical and specific technical compliance issues are frequently central to addressing the concerns raised in complaints. In addition, highly technical subject expertise is able to be accessed through these councils which allows thorough exploration of clinical concerns by the relevant experts.

For nurses and midwives the proportion of complaints that was referred to the professional council was slightly higher than last year (63.0% to 60.6% in 2016-17). The proportion of complaints discontinued decreased further this year, from 23.6% to 17.3% and is the second lowest proportion across all professions after the pharmacist profession. The proportion of complaints that had investigation as an outcome rose in 2017-18 to 13.9% (2016-17: 8.6%) which primarily related to professional conduct and impairment issues.

CHART 25 | Outcome of assessment of complaints by health practitioner, 2017-18



Counted by provider identified in complaint

The proportion of psychologists referred to the professional council was slightly less this year (35.8%; 2016-17: 41.8%), as was the proportion discontinued (38.0% compared 38.3% in 2016-17). There was a further decline in the proportion of complaints referred to investigation (from 7.6% to 4.0%). Similar to other professions, the proportion of complaints that were discontinued rose this year, from 38.0% in 2016-17 to 45.6%

Complaints about pharmacists continued to be most likely to be referred to the Pharmacy Council (60.0%), which is small increase from last year's result (57.2%). The proportion of complaints referred for investigation increased again in 2017-18, from 16.4% to 22.3% which reflects the continuing trend of complaints relating to both inappropriate and over prescribing of medications, as well as compounding matters.

This proportion of complaints investigated is the highest across all health practitioners by some margin (the next highest is nurses/midwives at 13.9%) and is over twice the proportion for all health practitioners (9.4%). Conversely, pharmacists have the lowest proportion of complaints discontinued across the health professions (13.5%; 2016-17: 14.5%) and around three times less than the proportion for all health practitioners (41.1%).

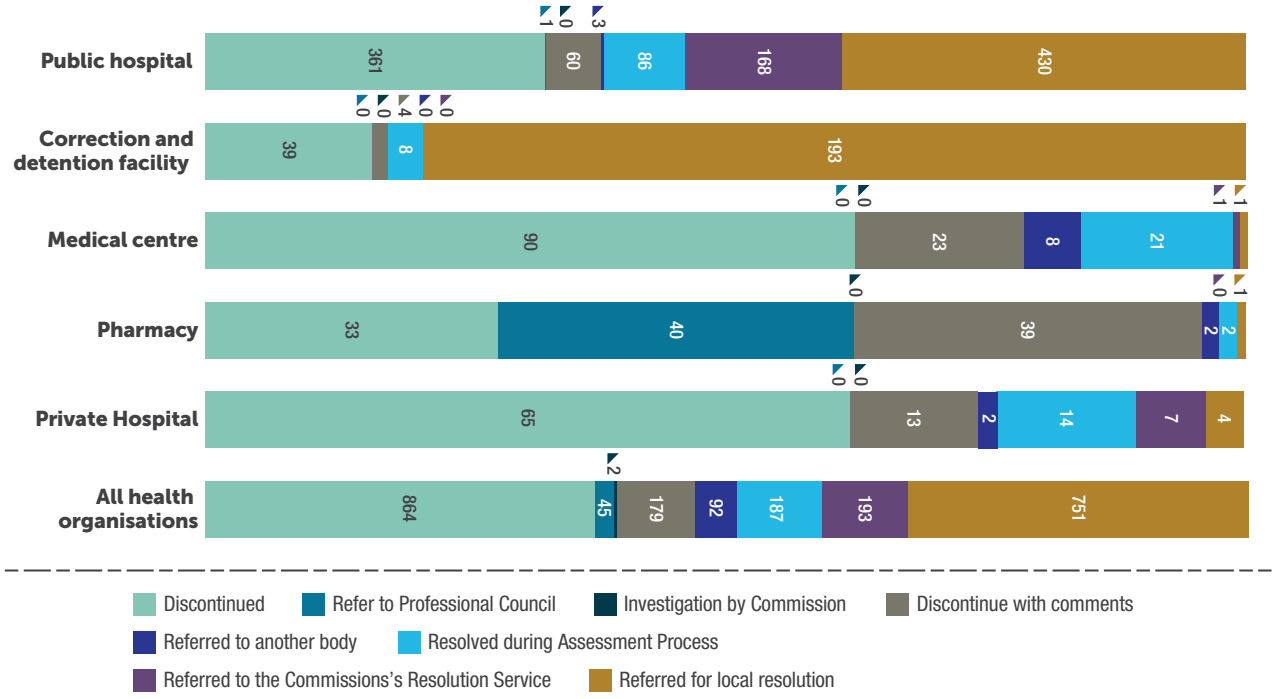
After the significant decline seen last year, the proportion of complaints referred to the Dental Council further declined this year, from 42.2% in 2016-17 to 37.6%. There was a significant decline of 7.9 percentage points in the proportion of complaints that were discontinued with comments (2.6%; 2016-17: 10.5%). The corresponding increase was seen in the discontinued category (from 31.2% to 42.9%).

For more detailed information about assessment decisions by the type of health practitioner complained about, please refer to Table A.19 in Appendix A of this report.

Assessment decisions by type of health organisation

Chart 26 below sets out how the Commission dealt with complaints in 2017-18 by the type of health organisation. The chart compares the assessment decisions for each of the top five most complained about types of health organisations to the assessment decisions for all complaints about health organisations.

CHART 26 | Outcome of assessment by health organisation 2017-18



Counted by provider identified in complaint

In 2017-18 complaints about public hospitals were slightly less likely to be discontinued compared to 2016-17 (32.6%, down from 33.9%). More of these complaints continue to be referred to local resolution (38.8%) compared to last year (27.9%) and as a result the proportion of complaints about public hospitals referred to the Commission's Resolution Service also continues to decline, from 18.6% to 15.1%.

Nearly four in five complaints about correction and detention facilities (79.1%, 2016-17: 67.2%) were referred for local resolution to Justice Health, the provider of health services in most of these facilities. For security reasons, assisted resolution is not commonly used in that context. Local resolution is an effective outcome in the correctional setting as it provides immediate visibility of the problem for the clinical service providers. Furthermore many of the complaints received related to healthcare policy changes within the corrections system, such as access to the methadone program and non-smoking policies and issues like these are best communicated, explained and addressed directly by the service provider.

Improvements in local complaints pathways have been explained elsewhere in this report and foster a higher level of confidence that matters receive a more active response than in the past. In this context, fewer Justice Health complaints have been discontinued this year (16.0% compared to 21.5%).

Complaints about medical centres were most likely to be discontinued (62.5%; 2016-17: 51.3%). The proportion of complaints that were discontinued with comments remained consistent (16.0% compared to 16.5% the previous year). Compared to other health organisations, there is a higher proportion of complaints resolved during the assessment process (14.6% compared to 8.1% for all health organisations). This reflects the type of complaints about these facilities which often involve a dispute about fees and costs associated with treatment; access to medical records, or waiting times. A 12.0 percentage point decline in this category requires a more concerted focus on the early resolution function going forward.

Pharmacies are now in the top five health organisations (displacing psychiatric hospitals/units), reflecting the trend of a year-on-year increase in complaints received about such organisations. These predominantly relate to advice about, access to and dispensing of medication, with periodic issues also arising, such as the current issue regarding their practice of issuing medical certificates. The outcome of complaints about pharmacies is that they are most likely to be referred to the Pharmacy Council, reflecting the common owner-operator nature of that industry. Nearly one in three complaints are discontinued with comments (33.3%) with a slightly lesser proportion discontinued (28.2%).

The most likely outcome for complaints about private hospitals is discontinued, in which there has been a significant rise (61.9%; 2016-17: 44.3%). The corresponding decrease has been seen in the category of discontinued with comments (12.4% compared to 20.8% in 2016-17 and that these facilities are less likely to agree to assisted resolution (6.7%; 2016-17: 15.1%). The addition of a dedicated stakeholder engagement position to the Commission's workforce in 2018-19 is expected to assist with strengthening private facilities' understanding of the Resolution Service as a source of expert advice and assistance in the management of difficult or complex complaints, as well as working more closely with private health organisations in general.

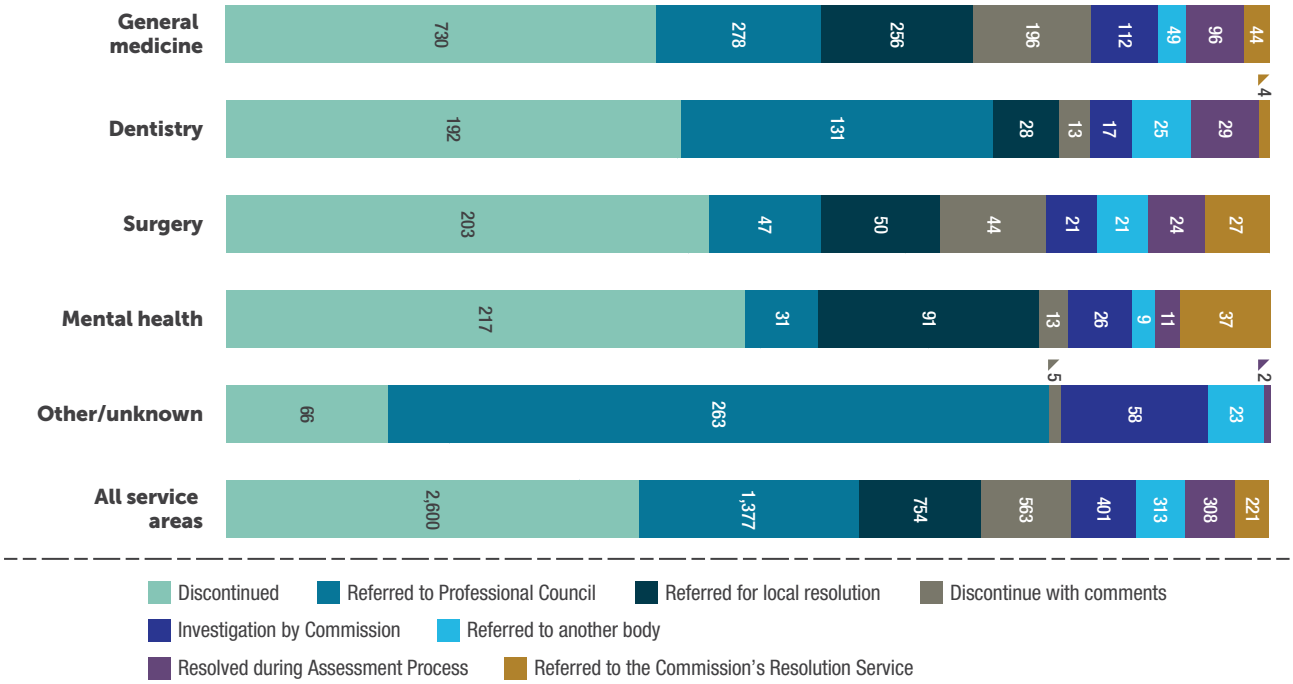
For more information about assessment decisions by type of health organisation complained about, please refer to Table A.19 in Appendix A of this report.

Assessment decisions by service area

Chart 27 looks at the assessment decisions for complaints in 2017-18 by the type of health service that was provided. The chart compares the assessment decisions for each of the top five most complained about service areas to the assessment decisions for all service areas.

In 2017-18, the most likely outcome of complaints about general medicine is discontinued (41.5%) which is consistent with the result last year (39.8%). A slightly lesser proportion were discontinued with comments (11.1%; 2016-17: 14.5%).

CHART 27 | Outcome of assessment of complaints by most common service area 2017-18



Counted by provider identified in complaint

Again, there has been an increase in the proportion referred for local resolution (from 9.7% to 14.5%), reflecting the desire to address the issues raised in the complaint at the point of service delivery.

A slightly smaller proportion of complaints relating to dentistry were referred to the relevant professional council for appropriate action (29.8%, 2016-17: 33.8%). The proportion of complaints that were discontinued in this service area rose significantly by 12 percentage points (from 31.7% to 43.7%). The corresponding decrease was primarily across two categories: discontinued with comments (3.0%; 2016-17:10.3%) and resolved during assessment (6.6%; 2016-17: 11.6%).

A higher proportion of complaints was referred for local resolution for mental health (20.9%; 2016-17: 16.3%). The proportion of complaints about mental health that were discontinued remained relatively stable (49.9%; 2016-17: 52.8%). There were fewer matters resolved during assessment (2.5% compared to 4.9% in 2016-17). Closer review of the appropriateness of complaints relating to mental health services remains a priority going forward, to ensure that our responses reflect a strong understanding and sensitivity to issues that arise in this category of complaints.

In terms of complaints referred to the Resolution Service, complaints about mental health (8.5%) and surgery (6.2%) were more likely to be referred than complaints about other service areas. Whilst not included in the top five service areas this year, 11.3% of complaints about emergency medicine were also referred to the Resolution Service.

In 2017-18 the category of Other (which includes a proportion of unknown) is in the top five service areas. This category appears to predominantly relate to mandatory and self-notifications required under the National Law, which typically concern professional conduct and health impairment issues. Often there is no information about the service area in the complaint because by definition, it is about conduct and not treatment. The conduct may have occurred in a private setting or capacity, for example. The highest proportion of complaints in this category therefore have an outcome of being referred to the relevant professional council (63.1%). The proportion of these complaints referred for investigation is 13.9% as some involve more serious conduct such as criminal offences. Only a relatively small proportion are discontinued (15.8%).

For more information about the assessment decisions by the type of service area, please refer to Table A.18 in Appendix A.

Assessment decisions by type of issue raised

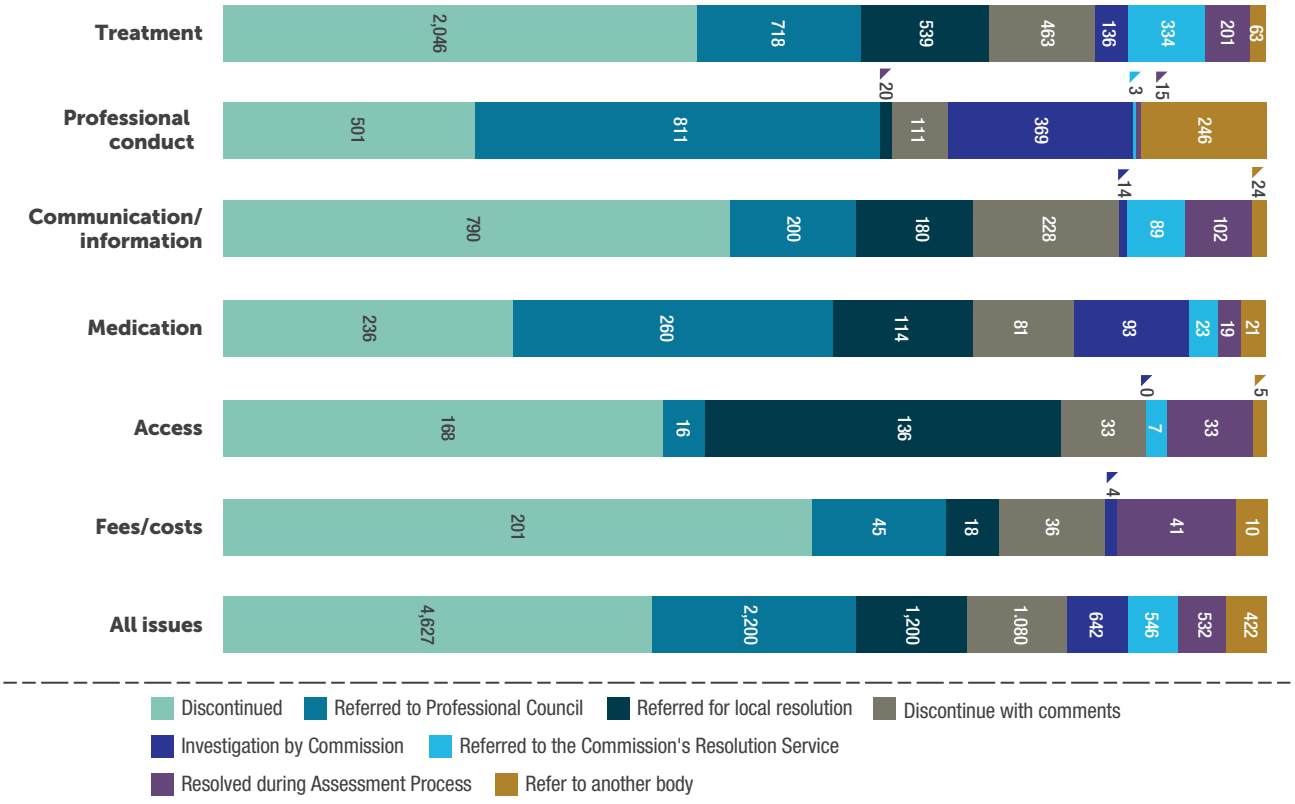
Chart 28 compares the assessment decisions made by the Commission in 2017-18 by the type of issue raised in the complaint. By comparing the assessment decisions for all complaints, to the assessment decisions for the different types of issues raised, the analysis can indicate whether particular assessment decisions are more or less likely to be made, across different issue categories.

There are some types of issues that are likely to be referred for investigation, most notably professional conduct and treatment, generally because if substantiated, there would be a more serious risk to public health and safety. Conversely, there are some types of complaints that are more likely to be discontinued as there is inherit difficulty in substantiating the complaint or less of a risk where the complaint is substantiated. The outcomes for communication and fee complaints are illustrative of this.

Complaints concerning the treatment provided to a patient were more likely to be discontinued than last year (45.5%; 2016-17: 41.4%). They were less likely to be referred to the Commission's Resolution Service than last year (7.4%, 2016-17: 7.7%) or resolved during assessment (4.5%; 2016-17: 13.1%). The proportion of complaints referred to the professional council was relatively consistent (16.0%; 2016-17: 16.5%) whilst the proportion referred to local resolution increased (12.0%; 2016-17: 6.0%).

The outcomes of matters relating to professional conduct were generally in accord with last year. Where a complaint raises significant issues of public health and safety arising from the treatment or where there appears to be evidence of gross negligence or a significant departure from relevant professional standards, the Commission investigates the complaint. Where the issues do not reach this threshold, which is set out in s23 of the Health Care Complaints Act, the complaint may be referred to the relevant professional council to take appropriate action. Professional conduct was only slightly less likely to be referred for investigation by the Commission (17.8%, 2016-17: 18.2%) or referred to the relevant professional council (39.1%, 2016-17: 43.4%). Slightly more were likely to be referred to another body (11.8%; 2016-17: 8.1%).

CHART 28 | Outcome of assessment of complaints by issues raised 2017-18



Counted by issues raised in complaint

The proportion of complaints about professional misconduct that were discontinued was consistent with last year (24.1% compared to 21.4%).

Complaints about communication typically result from a lack of understanding or a misunderstanding on the part of the patient or their family about the health service they received. The prompt facilitation of correct and fuller information and provision of scope for an apology by direct interaction with the service provider is the preferred outcome.

To this end, the proportion of complaints about communication issues that were referred for local resolution increased to 11.1% compared to 8.1% in 2016-7. There were decreases in the proportion of complaints that were referred to the Commission's Resolution Service (5.5%; 2016-17: 6.4%).

Whilst the most likely outcome of complaints about access is discontinued (42.2%), a high proportion of complaints about access are referred to local resolution (34.2%; 2016-17: 35.3%) with the expectation of a direct and timely response to improving access.

The most likely outcomes for complaints about medication were referral to a professional council, rising slightly to 30.7% (2016-17: 26.4%) followed by discontinue (27.9%; 2016-17: 33.6%).

For more information about the assessment decisions by the type of issue raised, please refer to Table A.17 in Appendix A of this report.

Case study – Referral to Council to improve pharmacy practice

A complaint was received from a patient regarding concerns about his prescription for a Schedule 8 medication. The complainant had presented at a pharmacy with a prescription for one bottle (50 tablets) of the Schedule 8 medication but was instead provided with five bottles (250 tablets).

The Commission sought a response from the pharmacist as well as the prescribing and dispensing records. It was established that a dispensing error had occurred. Following consultation with the Pharmacy Council of NSW (the Council), the complaint was referred to it for further management.

The Council inspected the pharmacy premises to ascertain the quality of record keeping and systems in place for the safe storage of Schedule 8 medication. The inspection revealed record keeping deficiencies and the pharmacist was requested to attend a performance interview with the Council. During the interview, concerns were raised about the pharmacist's limited knowledge of the legislation related to Schedule 8 medications as well as shortcomings in the pharmacy's procedures.

As a result of these concerns, the pharmacist was referred for a formal performance assessment under the Health Practitioner Regulation National Law. The assessment identified key issues to be addressed and the pharmacist agreed to undertake remedial action and to present a tutorial to Council on the identified issues.

The pharmacist presented his tutorial and was able to demonstrate that he had undertaken appropriate remediation. The Council was satisfied that he had addressed the issues identified in the performance assessment and the complaint was closed.

Assessment timeliness

Timeliness continues to be the key performance pressure for the Commission. The average time taken to assess each complaint has increased – it is now at 72 days, compared to 60 days in 2016-17 and 47 days in 2015-16. For 2017-18, 54.7% of assessments were completed within the 60 day timeframe, compared to 64.5% in 2016-17 and 85.8% in 2015-16.

The primary factors driving delays in assessment are the high growth in the number of complaints received and the more complex nature of those complaints. For 2017-18 a further driver of the decline in timeliness was the conscious decision in the latter half of the year to focus on clearing out a historical backlog of complaints that had been with the Commission for over 60 days. This work was extremely successful and an unprecedented number of older complaints were finalised, but had the flow on effect of increasing the average number of days required to finalise a complaint assessment.

There is also a decline in timeliness in advising the outcome of a complaint and its reason to complainants and providers within 14 days. The 41.0% compliance with the 14 day timeframe in 2017-18 compares with 62.7% in the previous year.

Improving timeliness will continue to be the highest operational objective for the Commission in 2018-19 and beyond. As noted in the Executive Summary, the Commission has received a significant budget enhancement for 2018-19 and it is directing additional resources to these areas. The additional staff will be complemented by the ongoing program of enhancements to business systems and processes, particularly in the areas of consultations with professional councils, internal assessment meetings and better integration with the Australian Health Practitioner Regulation Agency and Health Professional Councils Authority. Collectively, it is anticipated that there is improved efficiency, effectiveness and customer responsiveness in all aspects of the work of the Commission

Reviews

Under section 28(9) of the *Health Care Complaints Act 1993*, complainants are provided with the opportunity to request a review of the Commission's assessment decision.

In 2017-18, the Commission received 326 requests for a review of an assessment decision, compared with 238 review requests received in 2016-17. Whilst this is an increase in actual reviews, review requests were lodged for 5.0% of all assessments finalised, which is a marginal increase on the 4.4% result recorded in 2016-17 and remains historically low. It is, however, subject to close monitoring and should the trend continue, strategies can be implemented to address it promptly.

In 2017-18, 300 reviews were completed, and the original assessment decision was confirmed in 85.7% of these matters. The timeliness of reviews, however, remains an issue. A number of strategies have been implemented in the latter half of 2018-19 to address this, including establishing a dedicated Review Officer position and a new process of triaging all review requests to focus the review actions on the outstanding issues and analysing of new information.

Resolution service

Chart 29 shows the outcome of resolution and conciliation processes over the past five years.

While the total number of matters referred to the Resolution Service has decreased, there continues to be a very high proportion of complaints resolved or partially resolved. The vast majority (84.0%) of complaints achieve this outcome once the parties consent to participate, which is consistent with last year (2016-17: 85.2%)

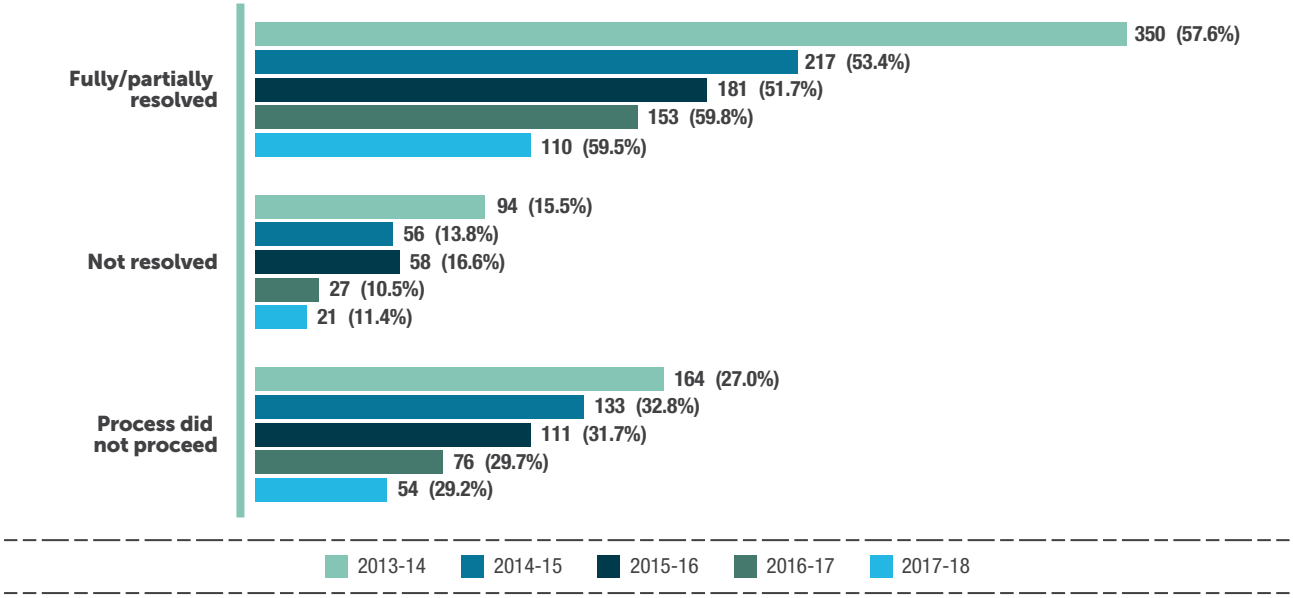
In 2017-18, 21 complaints (11.4%; 2016-17: 10.5%) were not resolved, of all complaints finalised by the Resolution Service. Typically the reasons that complaints do not get resolved include irreconcilable disagreements over key facts central to the complaint; an irretrievable breakdown in relations between the parties; and/or one or both parties withdraw from a meeting or the process entirely.

In 2017-18, of all complaints referred to the Resolution Service, nearly one in three (29.2%) did not proceed, which continues a gradual pattern of decline year-on-year since 2014-15. A reduced number of matters not proceeding is a positive sign that the most appropriate matters are generally selected for resolution, noting that resolutions do not proceed largely due to one or both parties withdrawing their consent to participate in the process. For example, the complainant determines that the outcome they are seeking cannot be delivered through the process; they may have a change in their personal circumstances, or health or wellbeing issues preclude them from participating.

The detailed outcomes of resolution processes can be found in Tables A.23 and A.24 in the Appendix of this report.

The timeliness of resolutions matters is consistent with the previous year. In 2017-18, 71.0% of matters were resolved within four months and 86.0% of complaints within six months (compared with 70.9% and 88.8% respectively in 2016-17.)

CHART 29 | Outcome of resolution processes 2013-14 to 2017-18



Counted by provider identified in complaint

Case study – Assisted resolution leading to systemic improvements

Mr B was an inpatient at a private hospital. He underwent back surgery to insert a spinal cord stimulator. During recovery he was threatened by another patient in his room. He moved his body in self-defense. This resulted in the spinal cord stimulator placed in his back becoming dislodged.

Mr B's concern was that an aggressive patient was placed in his shared room. Whilst he was very complimentary of the ward staff who attended to him at the time, he was critical of the manner in which his complaint was dealt with by the hospital management.

The Commission's assessment found that the hospital's initial response did not deal with all of Mr B's concerns (and in particular, why an aggressive patient was placed in his room). The matter was referred to assisted resolution to address the outstanding issues.

A resolution meeting was held with Mr B and the hospital. The issue of the aggressive patient was discussed. Mr B was of the view that the patient was known to be aggressive prior to being moved into his shared room. The hospital apologised to Mr B for his experience and explained that the hospital did not have any knowledge or concerns about the patient becoming aggressive. The hospital did acknowledge that patients receiving certain types of treatment (in this case, ketamine infusion) may have an increased risk of changes in behaviour, but because the hospital received the patient without any background information, a risk assessment could not be done. To address this issue the hospital agreed to undertake a major project into practices for obtaining more pre-admission history of patients and for further assessment of patients attending for this sort of treatment at the hospital.

The resolution also canvased Mr B's disappointment that the hospital did not contact him to follow up on his wellbeing. A new policy was implemented to ensure contact with patients within 48 hours of discharge following an incident. It was also agreed that further education would be provided to hospital staff about communicating effectively when issues arise.

The matter was fully resolved and Mr B was able to re-establish a trusting relationship with the provider.

Case study – Assisted resolution leading to better education of health practitioners

Mrs A complained to the Commission that her husband, who had metastatic brain cancer, had recently passed away in the palliative care unit at a local hospital. She was concerned that her husband had been uncomfortable and distressed in the final hours before he passed away. She felt staff had not provided adequate pain relief for him and that they had also not adequately managed the situation when family members became distressed. The family was traumatised by the events and she was making the complaint in the hope that their feedback may prevent another family having a similar experience.

The complaint was referred to the Commission's Resolution Service.

The resolution officer organised a meeting between Mrs A and the relevant hospital representatives. Mrs A was able to provide an overview of her experience and the concerns that had led her to make the complaint. The hospital representatives acknowledged her experience and apologised to her for the shortcomings in care that had been identified. The hospital undertook to provide further education and feedback to clinical staff in relation to strategies for managing uncontrolled pain. With Mrs A's permission they also used this episode of care as a case study to assist in further educating nursing and emergency department staff. The hospital also gave a commitment to provide palliative care patients and their families with more information about what they can expect, and what they could possibly experience, during the end of life process. Additionally, they arranged to follow up with Mrs A to provide ongoing counseling and support to her and other family members who were still grieving the loss of Mrs A's husband.

The parties to the complaint were satisfied the complaint had been resolved.

Case study – Investigation and prosecution of pharmacist distributing counterfeit medication

A complaint was received from the Pharmaceutical Regulatory Unit, alleging that Mr Mina Attia, a registered pharmacist and wholesaler of pharmaceutical goods had been involved in the distribution of counterfeit Viagra®, which is used for the treatment of pulmonary arterial hypertension (amongst other uses). The counterfeit Viagra® was on-sold to a Sydney hospital, where a pharmacist became suspicious of the product while crushing the tablets in preparation for medicating patients.

The investigation undertaken by the Commission provided strong evidence to support a prosecution before the NSW Civil and Administrative Tribunal ('the Tribunal'). The investigation led to allegations that Mr Attia had engaged in unsatisfactory professional conduct and professional misconduct because he:

- Breached his pharmaceutical wholesaler's licence by purchasing the Viagra® from an unlicensed supplier.
- Knew or ought to have known the product he purchased was not genuine.
- Failed to ensure that the product was genuine by contacting the manufacturer (Pfizer).
- Provided false and misleading information during a related investigation by the Therapeutic Goods Administration.

The Tribunal cancelled Mr Attia's registration and ordered that he must not apply for a review of the cancellation order for a period of 12 months. The Tribunal did not accept Mr Attia as a truthful witness and commented that it could not be confident that Mr Attia would act with complete candour in future dealings with regulators. The Tribunal stressed that the health and safety of the public demands that health practitioners fully cooperate with those charged with the responsibility for overseeing and regulating the health sector.

Mr Attia appealed the cancellation primarily on the basis that in selling the Viagra®, he was acting as a wholesaler and not as a pharmacist, but his appeal was dismissed in August 2017.

In August 2018 the Tribunal dismissed Mr Attia's application for reinstatement as a registered pharmacist and prevented any further review of the cancellation period of 12 months.

Investigating complaints

The nature and purpose of investigations

The Commission must refer a complaint for investigation where:

- it raises a significant issue of public health or safety
- raises a significant question as to the appropriate care or treatment of a patient by a health service provider
- there would be grounds for disciplinary action, or would involve gross negligence on the part of a registered health practitioner if the complaint is substantiated
- if the Commission or the appropriate professional council is of the opinion that the complaint should be investigated.

Investigations may be of individual practitioners (be they registered or unregistered) or they may be about a health organisation (which may be one of many different types of organisations – a public or private hospital, pathology service, a general practice medical centre, etc).

The purpose of the investigation process is to determine if there has been a significant departure from clinical treatment standards that have caused harm to patients, or pose a significant risk to public health or safety; and whether there are grounds for disciplinary action. During an investigation the Commission obtains evidence from complainants and relevant witnesses and seeks a response from the provider identified in the complaint. Statements, information and medical records may be obtained, as well as evidence from other related parties such as the police, coroner or other health regulators. On completion of the investigation a report is prepared summarising the allegations, detailing the evidence gathered and setting out the Commission's findings.

When investigating certain complaints, and in all clinical matters, the Commission engages an independent expert who is provided with all of the relevant investigation documents. The expert prepares a formal report with an opinion on the standard of care delivered or the particular professional conduct of the practitioner. Independent expert opinions are instrumental in determining whether there has been a departure from relevant professional and clinical standards and the seriousness of any identified departure.

There are several possible outcomes from an investigation process:

- Referred to Director of Proceedings
- Referred to a professional council – either during or at the end of an investigation
- Issue a prohibition order and make a public statement about an unregistered practitioner
- Make recommendations to a health organisation
- Make comments to an individual practitioner or health organisation
- Issue a public warning under s94
- No further action – but may be referred to another body or the National board informed.

If at the end of an investigation, the Commission proposes to take further action, the provider will be informed of the nature of the proposed action and the justification for the proposed action and the provider has the opportunity to make a submission.

The most frequent outcome of an investigation is for the complaint to be **referred to the Director of Proceedings**. In these circumstances, evidence has been found that a registered practitioner has significantly departed from the expected standard of clinical care and treatment, or unsatisfactory professional conduct has been substantiated. The Director of Proceedings then determines whether pursuing disciplinary action is appropriate or not.

A complaint may be **referred to the relevant professional council** if a review of all available evidence shows that the alleged care and treatment or misconduct did not meet the threshold for disciplinary action, but there is still of sufficient concern to warrant further action to address health performance or conduct issues. Complaints may also be **referred to the relevant professional council under section 20A** which is during the course of an investigation, rather than awaiting the end of an investigation.

For unregistered practitioners, the Commission may decide to impose a **prohibition order** on the unregistered health practitioner. Such an order would be made where the Commission finds that the unregistered health practitioner poses a risk to the public. Prohibition orders may prevent an unregistered health practitioner from providing a health service or specific health services for a period of time or permanently. **Breaches of a prohibition order may be found which are referred to the Commissioner** for the consideration of appropriate action.

The Commission may also cause a public statement to be issued in the form of a **public warning under section 94A** of the *Health Care Complaints Act 1993*. Public warnings are reserved for situations where the Commission is of the view that a particular treatment or health service poses a risk to public health or safety.

The Commission also conducts investigations into health organisations, including public and private hospitals, medical centres, and other treatment services. When investigating a health organisation, the focus for the Commission is on examining the systems and procedures that are in place, and recommending improvements that will improve patient safety.

Recommendations to a health organisation may cover a multitude of clinical scenarios. Some are of an educative nature, such as a requirement for a hospital to embark on activity aimed at increasing practitioner awareness in relation to a specific policy or treatment pathways. The Commission may also recommend that a hospital formulate new policy designed to strengthen current practices or to overcome and rectify identified flaws in the delivery of patient care.

The Commission directs that the hospital provide it with evidence of the implementation of the Commission's recommendations. The Commission monitors implementation of recommendations which are not recorded as implemented until the Commission has received documentary evidence to substantiate compliance. Any delays in implementation or a failure to comply are reported to the Secretary of the Ministry of Health.

In addition to making recommendations, the Commission is also implementing a program of follow up visits to public hospitals, to audit continued compliance with recommendations previously made. Commission audits are carried out by Commission staff and clinicians who have been trained by the NSW Clinical Excellence Commission. These audits also offer the Commission and LHD staff the opportunity to share ideas around best practice and drive systemic improvements. The Commission's audit reports are provided to the Chief Executive team of the LHD and the Secretary of the Ministry of Health.

If the investigation finds that there are no significant issues of risk to public health and safety, but still issues of understandable concern, then the Commission may **make comments** to the practitioner or organisation about necessary improvements in practice.

Where the investigation does not find any evidence to pursue the complaint further, then **no further action** will be taken.

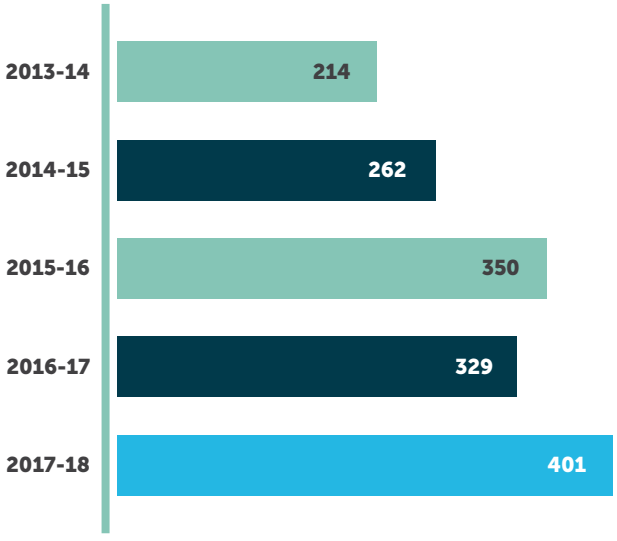
In some instances the National Board is informed (eg. where the registered practitioner has retired or removed themselves from the register) so that the matters covered in the investigation can be considered if the practitioner seeks to re-register or change their registration status.

In some cases, the investigation may be **referred to another more appropriate organisation** for investigation.

Investigations referred

In 2017-18, 401 complaints were referred for investigation. As shown in Chart 30, this represents a significant 21.9% increase on the 329 complaints referred in 2016-17 and reflects the rates of growth seen in years prior to 2016-17. Some of the key drivers have already been outlined in the Executive Summary.

CHART 30 | Investigations referred 2013-14 to 2017-18

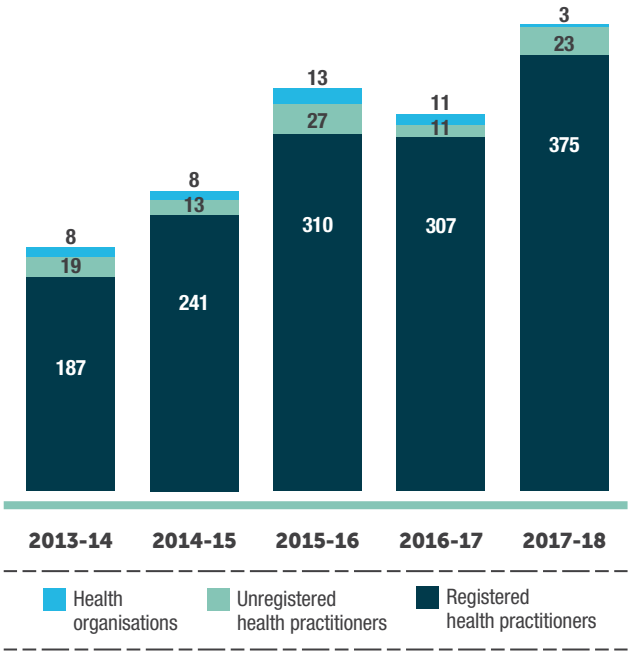


Counted by provider identified in complaint

Chart 31 shows that there are fluctuations over time in the number and proportions of practitioners and organisations which form the basis of investigations. The 2017-18 investigations data show that:

- Individual registered practitioners remain the most frequent focus of investigations, with 93.5% of all investigations. This is consistent with 2016-17 (93.3%).
- There continues to be a trend of individual practitioners who generate multiple investigations – six individual practitioners generated 59 investigations (14.7% of all complaints referred for investigation) in 2017-18. As already noted, one individual practitioner alone generated 29 investigations.
- The number of investigations about unregistered practitioners more than doubled from 2016-17 (11 to 23 in 2017-18), however, this figure fluctuates from year to year with no discernible pattern.
- There were three investigations into health organisations in 2017-18. There are typically fewer investigations into health organisations compared to the individual health practitioner categories and the episodic nature of investigations means it can be difficult to predict if this may be a trend. The Commission will be closely monitoring this in 2018-19.

CHART 31 | Investigations referred by health service provider 2013-14 to 2017-18



Counted by provider identified in complaint

Issues raised in investigations

Chart 32 outlines the issues raised in all investigations finalised over a five year period, noting that more than one issue will generally be raised in an investigation.

Professional conduct, medication and treatment remain the three top issues triggering investigation, which reflects the fact that these issues, if substantiated present the most serious risks to public health and safety.

Treatment is raised in about one in three investigations (35.2%), noting that these treatment issues would be particularly serious and complex, as matters of a more straight forward clinical nature are typically managed by the relevant professional council. Nearly two in three investigations (63.8%) raised professional conduct as an issue in 2017-18. Nearly one in four investigations (24.1%) raised medication as an issue, which is an increase from 16.7% in 2016-17.

Other issues such as communication (6.0%; 2016-17: 10.9%) and medical records (2.5%; 2016-17: 4.2%) are also raised, which tend to be ancillary elements of the investigation, but may still form a critical part of it. For example, a poor outcome of a medical procedure may also reveal poor record keeping or raise concerns around informed consent.

Investigation outcomes

The number of investigations finalised during the year was 282. This is fewer than the 330 finalised in 2016-17, but is broadly consistent with the longer term trends (244 in 2015-16). The main drivers of the lower number of investigations finalised were the combined impacts of receiving a higher proportion of extremely complex, multifaceted complaints and the volume of new complaints referred for investigation in addition to those already on hand.

Chart 32 shows the outcomes for the investigations finalised in 2017-18 compared to the previous four years.

It is important to note that not all investigations reveal serious issues. In 2017-18:

- 16.3% of all investigations finalised by the Commission were not significantly serious enough to warrant disciplinary proceedings and they were referred to the relevant council for management under its health, performance or conduct processes.
- 11.7% of investigations led to no further action being taken by the Commission, primarily because the investigation did not find sufficient evidence to substantiate the allegation/s and warrant further action.
- A further 12.8% of investigations also led to no further action being taken, however, the relevant National Board was informed.

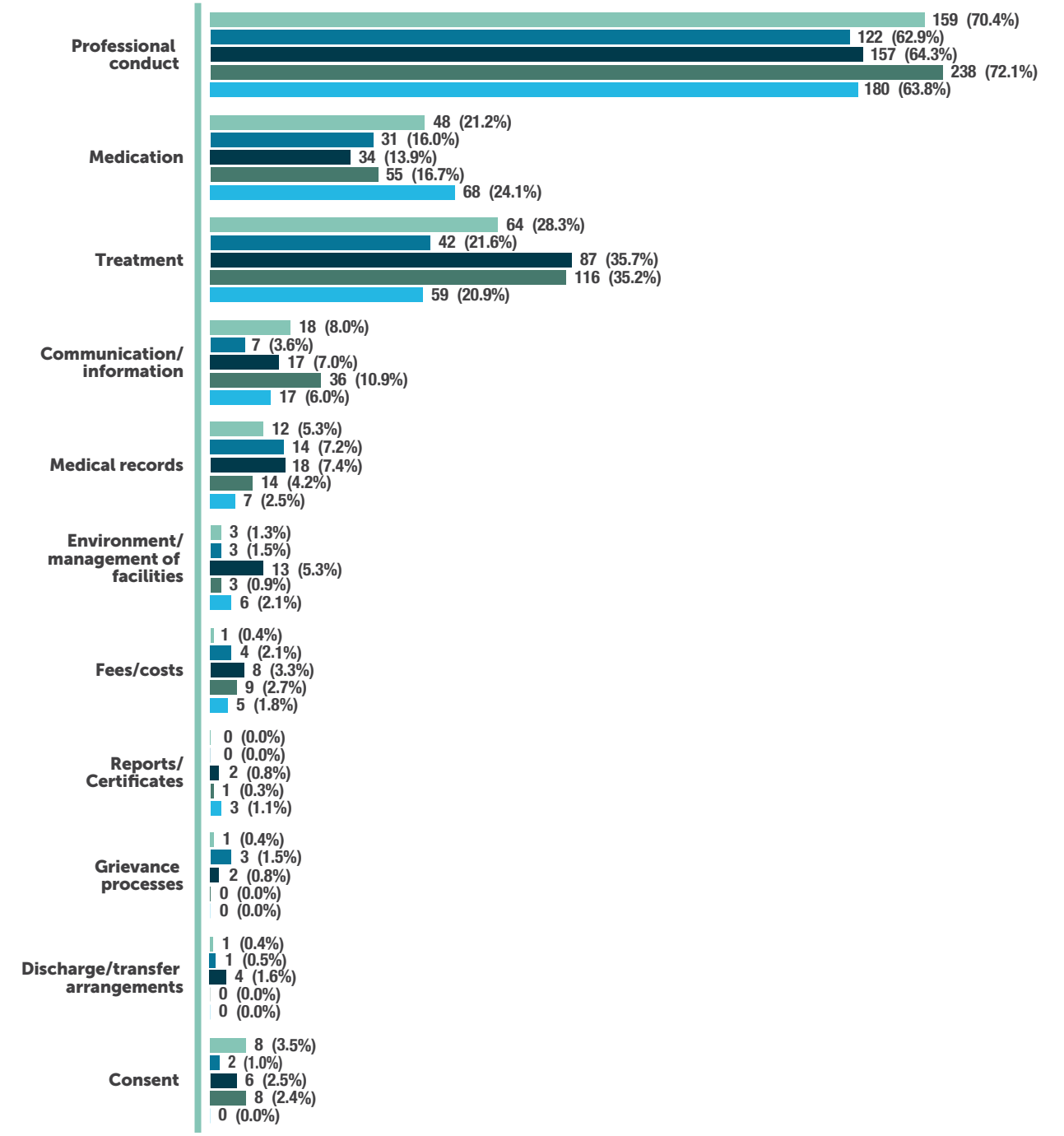
The details of outcomes for each category of registered practitioners, unregistered practitioners and health organisations is presented in Table A26 in Appendix A and is the source of the analysis below.

OUTCOME OF INVESTIGATIONS INTO UNREGISTERED HEALTH PRACTITIONERS

The Commission finalised 13 investigations into unregistered health practitioners in 2017-18:

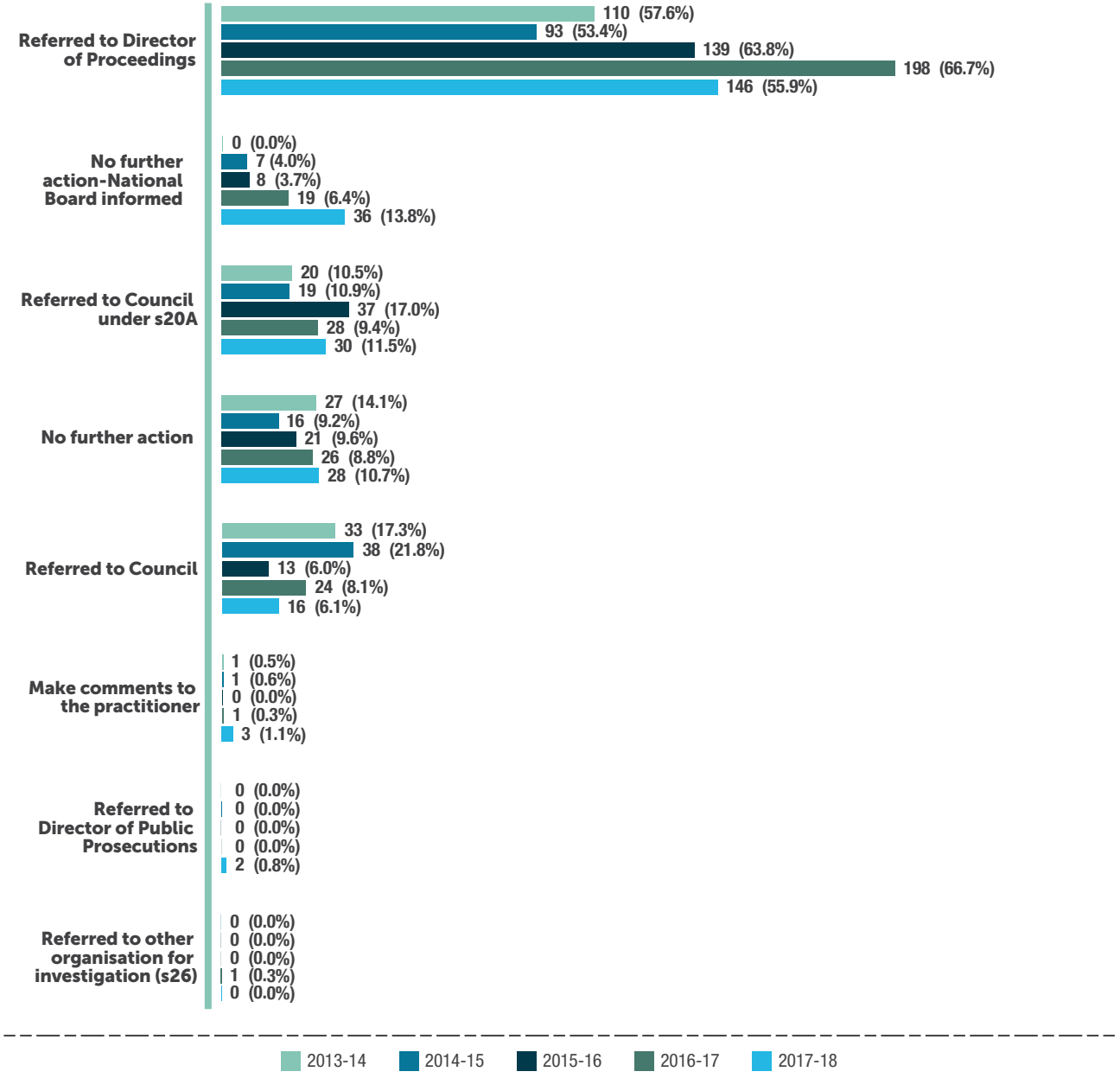
- In five of these matters a permanent prohibition order was issued on the basis that the practitioner had seriously breached the Code of Conduct for Unregistered Health Practitioners and posed an ongoing risk to public health and safety.
- In four of these matters, the confirmed departures in practice were not sufficiently serious to require prohibition, but comments and guidance were provided to the practitioner.
- In one matter there was another organisation that was more appropriate to undertake further inquiries and investigation, and the matter was referred to it to enable that to occur.
- In the final three matters, the evidence available was not sufficiently strong to support any further action.

CHART 32 | Issue category raised in investigations finalised 2013-14 to 2017-18



Counted by issue category raised in complaint.
Note that in the 2016-17 Annual Report, where there were multiple instances of the same issue category, each were counted.

CHART 33 | Outcomes of investigations into registered health practitioners 2013-14 to 2017-18



OUTCOME OF INVESTIGATIONS INTO REGISTERED HEALTH PRACTITIONERS

Of the 282 investigations finalised, 261 (92.6%) related to registered health practitioners. Chart 33 shows that of these investigations, 146 (55.9%) resulted in a referral to the Director of Proceedings for consideration of disciplinary action. This proportion is lower than 2016-17, but fluctuations year on year in this proportion are usual depending on the types of matters that come forward.

It is also noted that the proportion notified to the National Board is higher, being 13.8% of the investigations finalised (6.4% in 2016-17). This outcome reflects an increasing tendency for practitioners to remove themselves from the register at the time an investigation commences, generally with the intention of retiring from practice. In such a case the National Board is notified because it is able to take into account the material raised in the investigation in the event that the practitioner attempts to reapply for registration. If re-registration is sought, the Board may consider triggering a new complaint which would have the effect of reopening of the investigation. It should also be noted that a complaint can still be progressed to prosecution even if the practitioner has removed themselves from the register if the investigation referred to the Director of Proceedings it is determined that this is in the public interest.

The Commission referred a total of 46 complaints (17.6% of all investigation outcomes) to the relevant professional council in 2017-18. This outcome typically applies where the evidence and/or the advice of an independent expert indicates that there are departures in the clinical skill, knowledge or judgment of the practitioner, but not of such a significant nature as to warrant disciplinary action. Of the complaints referred to the relevant professional council, an increasing proportion were referred during investigation (under s.20A of the Act), as opposed to referrals following an investigation (under s 39(1) (c)). This reflects the desirability of ensuring that matters most appropriate for management by the professional council are referred in the most efficient and timely fashion. It is also in accordance with the Commission's legislative obligation to keep its assessment of a complaint under review, including during an investigation.

In 28 investigation cases (10.7%), the outcome was no further action which is consistent with last year (8.8%). This outcome is typically due to insufficient evidence to substantiate the allegations or when expert opinion on complex clinical issues did not determine that there were departures from acceptable standards of care.

OUTCOME OF INVESTIGATIONS INTO HEALTH ORGANISATIONS

The focus when investigating a health organisation is on examining the systems and procedures that are in place and identifying improvements that will deliver benefits for all patients.

Such recommendations may cover a multitude of clinical scenarios. Some are of an educative nature, such as a requirement for a hospital to embark on activity aimed at increasing practitioner awareness in relation to a specific policy or treatment pathways. The Commission may also recommend that a hospital formulate new policy designed to strengthen current practices or to overcome and rectify identified flaws in the delivery of patient care.

Eight investigations into health organisations were finalised in 2017-18 (2016-17: 11). In four of these investigations recommendations for corrections or improvements were made to the organisation. In two investigations, comments were made. The final two investigations did not identify issues that warranted further action.

In terms of the audits of health organisations this year, the Commission worked with the Department of Justice's Inspector of Custodial Services to plan an audit program to examine the provision of health services across NSW correctional facilities and the Investigation manager was part of the inspection at one of the five facilities that was subject to a detailed inspection under this program. The audit method focused on:

- relevant legislation and standards
- the operation of different service delivery models, including policies, procedures and practices
- the health status and needs of inmates
- the health services available to inmates, including primary, specialist and allied health services
- inmates' access to health services, including the impact of resourcing and custodial regimes

The Commission will be involved in discussing actions to be taken in relation to the audit findings and recommendations through its quarterly meetings with the Justice Health and Forensic Mental Health Network's executive team.

Case study – Investigation for breach of professional boundaries and inappropriate prescribing

The Commission received two complaints about the conduct of Dr Ian De Saxe, a registered psychiatrist. The complaints alleged the practitioner had engaged in the following conduct:

- breached professional boundaries with three male patients, all of whom he was treating for serious psychiatric issues
- engaged in sexual acts with Patient A in his private rooms, including engaging in sexual intercourse
- inappropriately massaged Patient B's legs during a treatment session and made inappropriate comments
- made inappropriate comments to Patient C, who had been charged with child sex offences involving a 15 year old male
- offered to lie for Patient C in a court report relating to criminal proceedings
- invited Patient C to engage in a sexual act during a treatment session
- inappropriately prescribed drugs of addiction to Patient A without an authority
- inappropriately self-prescribed medications including benzodiazepines
- failed to provide adequate care and management for Patient C during his inpatient treatment as a psychiatric patient
- failed to keep adequate patient records

Through the investigation the practitioner admitted the conduct involving Patients A and B, his self-prescribing and inadequate record keeping, but he denied the conduct in relation to Patient C.

On completion of the investigation, the matter was referred to the Director of Proceedings for consideration of prosecution. On the basis of the evidence gathered in the investigation, a decision was made to prosecute a complaint in the NSW Civil and Administrative Tribunal (the Tribunal) in relation to conduct relating to all three patients named in the complaint.

On 12 September 2017, the Tribunal found the complaints against Dr De Saxe proven, finding him guilty of both unsatisfactory professional conduct and professional misconduct. The Tribunal found Patient C to be a credible witness and rejected Dr De Saxe's evidence. An interim order was made imposing a suspension of Dr De Saxe's registration as a medical practitioner, effective as of 12 September 2017.

On 29 March 2018 the Tribunal made the following orders:

- Dr De Saxe's registration is cancelled
- Dr De Saxe may not apply for a review of the cancellation order for two years
- Dr De Saxe is prohibited from providing any health services as defined under section four of the *Health Care Complaints Act 1993* on either a paid or voluntary basis, whether provided as a public or private service, until such time as he brings an application for review and is re-registered as a medical practitioner.

Case study – Unsafe treatment by an unqualified unregistered practitioner

In June 2016, the Commission received a complaint from Dr H at a regional NSW hospital advising that he and his colleagues had treated Patient A who had presented to the Emergency Department with a complicated infection of his left scrotum following surgery. He alleged this surgery was performed at a local hotel by Mr Allan Matthews.

Dr H stated that Patient A had been seeking the removal of his left testicle due to ongoing pain and discomfort from swelling. Dr H also stated that he was informed by Patient A that he had been approached on an online forum by Mr Matthews, who had stated he was a retired Doctor and could provide the surgery. Patient A agreed to and had the surgery (a left orchidectomy) and subsequently developed a wound infection requiring treatment.

The Commission's investigation found that Mr Matthews was not and had never been a registered medical practitioner. In addition, following a NSW Police investigation, Mr Matthews pleaded guilty to and was convicted of several criminal offences.

The investigation determined that Mr Matthews breached numerous clauses of the Code of Conduct for Unregistered Health Practitioners by:

- providing a health service in an unsafe and unethical manner
- providing a health service which was outside his training and experience
- providing a health service which he was not qualified to provide
- misrepresented himself as being medically trained and as such, did not have the necessary qualifications and training to undertake the procedure, when he performed the left orchidectomy on Patient A.
- performed a surgical procedure on Patient A which carried an inherent risk of significant harm and indeed led to Patient A requiring revision surgery and administration of IV antibiotics to treat a complicated infection.

The Commission was satisfied that Mr Matthews posed a risk to the health and safety of the public.

The Commission imposed a prohibition order on Mr Matthews under section 41A(2)(a) of the *Health Care Complaints Act 1993* permanently prohibiting him from providing any health services in any capacity, either paid or voluntary.

Operational partnerships

As complaints become more complex and multifaceted; as health services continue to evolve and take on a more commercial character; and as health products and the sources of those products diversify, effective regulatory responses rely on joint investigation effort. The Commission therefore has a strategic focus on building new operational partnerships and tools to support those partnerships.

The Commission works closely with its co-regulatory partners, the professional councils, as well as the Ministry of Health's Pharmaceutical Regulatory Unit and Public Health Units, NSW Police, NSW Fair Trading and increasingly national regulators (eg. Therapeutic Goods Administration and Australian Competition and Consumer Commission). Through both formal Memoranda of Understanding and joint operations planning and execution, operational intelligence is shared and combined. This affords an approach to gathering evidence which ensures that each regulator can rely on the evidence to take actions, and this delivers the most efficient, effective and timely approach to protecting the health and safety of the public. In January 2018 this operational collaboration was extended when the Commission and the Australian Sports Anti-Doping Authority (ASADA) signed a Memorandum of Understanding which enables each agency's information and evidence to be shared more quickly and efficiently.

Preventative techniques

The ability to use public warnings about unsafe treatment or services, under s94A of the Act, is an important feature of our focus on preventing consumer exposure to identified risks and a critical part of our strategy to increase public protection and safety. The Commission is able to make such warnings not only at the end of an investigation but during an investigation, in cases where any further delay in issuing the statement poses a risk to an individual or to public health or safety. In 2017-18 two warnings were issued.

In September 2017 a public warning was issued about unsafe and illegal practices at beauty and cosmetic clinics, following significant concerns about complaints regarding cosmetic procedures undertaken in cosmetic clinics and the risks to the health and safety of people attending those clinics. The details of the warning issued are outlined in the Focus Area: Cosmetic Service Complaints.

A second warning was issued in April 2018 about unsafe practices involving subdermal implants inserted for "extreme" body modification purposes.

The Commission was concerned about complaints regarding surgical procedures involving the insertion of subdermal implants for these purposes and the risks to the health and safety of consumers undergoing these procedures, particularly infection and nerve damage. This warning is detailed in the Access and Outreach chapter.

The use of the public warning enabled the Commission to swiftly identify to the public at large the dangers of engaging in such programs and provided a rapid and effective tool for ensuring that the public are aware of the inherent dangers in not consulting with suitably registered health practitioners and/or attending appropriately licensed private facilities.

The Commission continues to consider ways to assess the effectiveness of such public warnings.

Investigation timeliness

As the number and complexity of complaints referred for investigation has increased, there has been an impact on investigation timeliness. The proportion that took more than 18 months to complete increased to 12.4% (2016-17: 4.5%). As a result the average time to complete an investigation increased from 273 days in 2016-17 to 304 days in 2017-18 (excluding the time a Commission investigation may be suspended while the complaint is being investigated as part of a coronial inquest or where there are related criminal proceedings).

Whilst the number of average days increased, it is positive to note the increase in the proportion of investigations completed within nine months, from 48.2% to 52.8%. This is a tangible reflection of improvements arising from new investigation planning and triaging techniques. This includes earlier determination of matters where initial evidence gathering shows less serious issues than originally thought (and referral to a professional council is most appropriate) and also matters that can be managed more efficiently by collaborating with regulatory partners (such as NSW Police or the Pharmaceutical Regulatory Unit).

The details of timeframes for investigations finalised is outlined in Table A.32 in Appendix A.

Case study – Failure to conduct patient observations

The Commission prosecuted a complaint before the NSW Civil and Administrative Tribunal ('the Tribunal') against Vicki Tripodis, a registered nurse working in the Medical Subacute Unit at the Long Bay Correctional Complex. Ms Tripodis had been working on a night shift when a patient with a history of laryngeal cancer, lower limb amputation and who had recently undergone a total laryngectomy was found deceased in his cell early the following morning. It was later determined that the patient had died of a pulmonary embolism.

The complaint alleged that Ms Tripodis did not provide the required level of care to the patient because she failed to:

- do any observations of the patient after 8.40pm when she should have done two hourly observations, and
- supervise the patient's administration of medication.

On 30 January 2018 the Tribunal found Ms Tripodis guilty of unsatisfactory professional conduct and professional misconduct. The Tribunal severely reprimanded Ms Tripodis for behaviour which it considered reflected acceptance of a poor culture in that particular working environment and did not otherwise reflect what was required of a registered nurse generally. Ms Tripodis' registration was suspended for a period of six months, or until she completed a course in ethics and professional practice. The Tribunal also ordered that following the suspension, conditions apply to her registration including supervision and not to be in charge of any shift.

Prosecuting complaints

The nature and purpose of prosecutions

Following an investigation, the Director of Proceedings makes determinations under the *Health Care Complaints Act 1993* ('the Act') following investigations in relation to whether a complaint against an individual registered health practitioner should be prosecuted and if so, in which forum. Prosecutions are disciplinary proceedings taken against individual practitioners, with the primary purpose of protecting public health and safety.

In considering whether a complaint should be prosecuted, the Director of Proceedings is independent and is required to have regard to the following criteria:

- the protection of the health and safety of the public
- the seriousness of the alleged conduct the subject of the complaint
- the likelihood of proving the alleged conduct
- any submissions made under section 40 of the Act by the health practitioner concerned.

Complaints referred for consideration of prosecution include allegations of impairment, lack of competence, criminal conviction, and not being a suitable person for registration, as well as unsatisfactory professional conduct and professional misconduct.

The prosecution forums available are a Medical Professional Standards Committee, a Nursing and Midwifery Professional Standards Committee, or the NSW Civil and Administrative Tribunal (NCAT).

Complaints about unsatisfactory professional conduct of nurses, midwives or medical practitioners will usually be prosecuted before a Professional Standards Committee. Complaints about professional misconduct (serious enough to justify suspension or cancellation) will be prosecuted before NCAT. NCAT hears complaints about all other registered health professions.

NCAT can cancel or suspend the registration of a practitioner and may also make a prohibition order that bans or limits the practitioner from practising in another area of health service. For example, a psychiatrist whose registration is cancelled can be banned from working as a counsellor. Conditions may be placed on a practitioner's registration, for example, that they engage in mentoring or complete further education or training. NCAT may also formally reprimand or caution the practitioner.

Proceedings can be brought even if the practitioner is no longer registered at the time that the prosecution is brought. Proceedings will also continue even if the practitioner chooses not to attend or to be legally represented.

If the Director of Proceedings decides not to prosecute a complaint, it can be referred back to the Commissioner to consider other appropriate action or it can be discontinued.

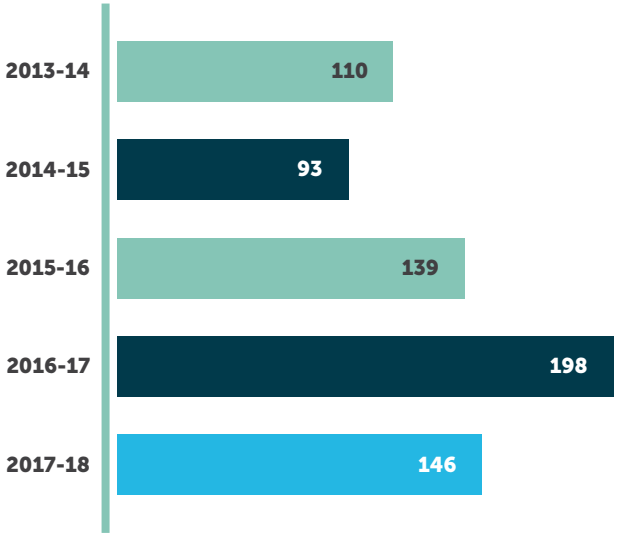
In terms of working to support efficient and effective prosecution processes, the Commission continued to be represented by the Director of Proceedings on the NSW Civil and Administrative Tribunal Liaison Group which is chaired by the President of NCAT and meets bi-annually. Representatives from the Legal Services Division also participate in periodic NCAT Occupational Division user group forums.

Referrals to the Director of Proceedings

In 2017-18, 55.9% of investigations into registered health practitioners resulted in referral to the Director of Proceedings for consideration of prosecution. This is lower than the result in 2016-17 (66.7%) but more in line with previous years.

Chart 34 shows that in 2017-18, there was a decrease in the number of complaints referred following investigation to the Director of Proceedings, from 198 in 2016-17 to 146 in 2017-18. The factors contributing to this are the lower number of investigations finalised in 2017-18 combining with a slightly lower proportion of complaints about health practitioners with an outcome of referral to the Director of Proceedings.

CHART 34 | Investigations referred to Director of Proceedings 2017-18



Counted by provider identified in complaint

During the year, the Director of Proceedings made 164 determinations on whether to prosecute a health practitioner before a disciplinary body. This compares to 103 determinations for the previous year. 92.8% of the determinations made in 2017-18 were considered within three months of the complaint being referred which is slightly higher than 89.4% in 2016-17.

Of the complaints referred to a disciplinary body, 133 were referred to the NSW Civil Administration Tribunal (NCAT) and 12 to a Professional Standards Committee. In 19 complaints, the Director of Proceedings decided not to prosecute the health practitioner, of which six were referred back to the Commissioner for consideration of other action. The reasons for this included that the practitioner was no longer registered, had previously been prosecuted and there was no reasonable prospect of a successful prosecution. The percentage of matters referred for prosecution within 30 days of consultation with the relevant professional council was slightly higher than last year (84.4%; 2016-17: 82.4%).

Prosecution outcomes

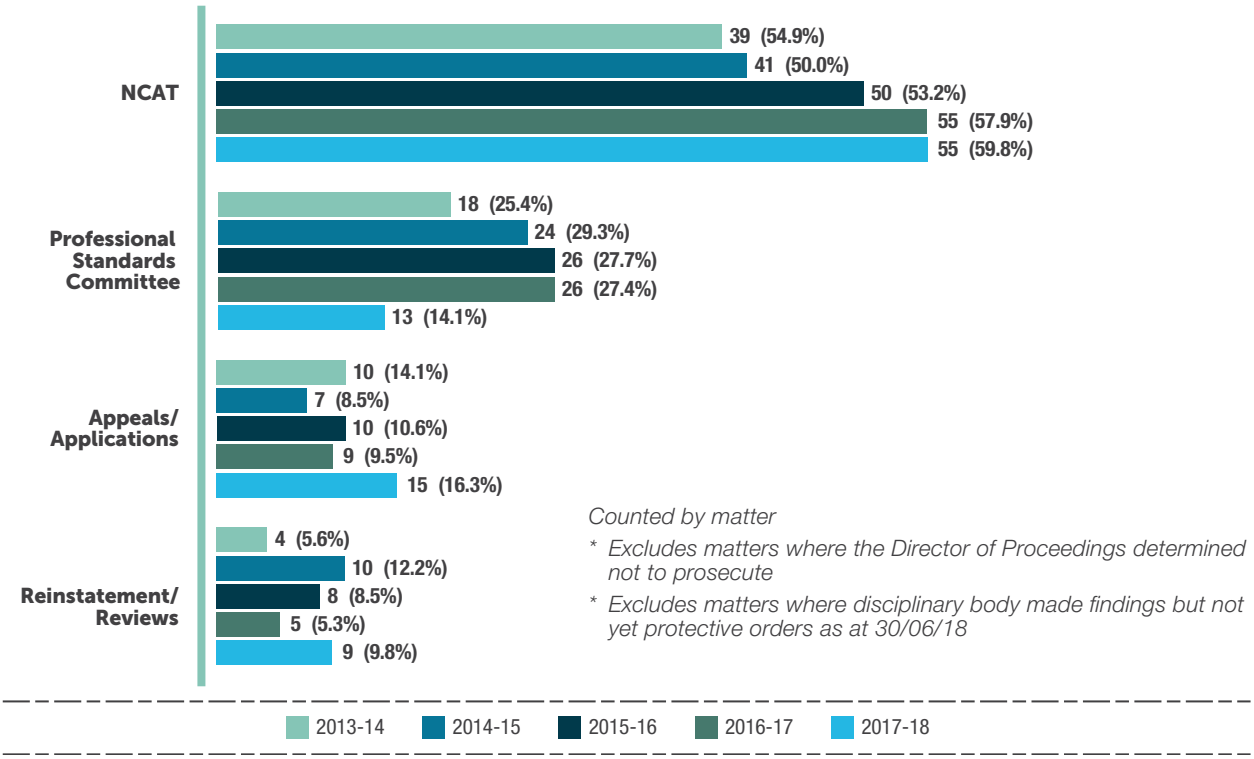
The number of matters finalised by the Legal Division in 2017-18 was 92, which is broadly in line with the previous year (95 in 2016-17).

Whilst this number may have been anticipated to be higher given the 198 matters referred last year, there are a number of factors that have influenced this. In 2016-17 multiple investigations were against the same health practitioner. When the Commission prosecutes a practitioner, the investigations are combined into a single prosecution. For example, three practitioners accounted for 24 investigations referred to the Director of Proceedings in 2016-17, so these constituted three matters finalised before NCAT.

A compounding factor is that matters which have multiple complaints tend to be complex and supported by voluminous evidence and expert advice. As such, they often have a longer 'life span' in the Tribunal system. They typically have some time between their initial listing, directions hearing and the hearing itself. They also may require more hearing days.

As shown in Chart 34, the 92 matters finalised included 55 matters before NCAT, 13 matters before a Professional Standards Committee,15 appeals and other applications, and nine review and reinstatement matters. The outcomes of these matters are detailed in Table 1.

CHART 35 | Legal matters finalised 2013-14 to 2017-18



Pleasingly, the rate of successful prosecutions remains very high. Of all matters that were heard and finalised before NCAT or a Professional Standards Committee, 93.8% were found proved.

Both the Commission and a practitioner may appeal a decision. Whilst there has been a slight increase in the number of appeals against decisions this year (from 9 to 15), it has remained relatively consistent over the five year period between 2013-14 to 2017-18. The majority of appeals by respondents brought against the Commission were ultimately dismissed or withdrawn. If an appeal is dismissed, the original decision stands.

A practitioner who has had their registration cancelled may apply to NCAT for reinstatement after any non-review period has expired. Excluding those for medical practitioners, the Commission appears in reinstatement applications and may oppose, support or take a neutral stance, as is deemed appropriate. If a reinstatement application is successful, the practitioner may apply for re-registration with their National Board who will then make a decision on whether to grant registration.

NCAT has the power to impose conditions on a practitioner's registration if an application for reinstatement is successful, dismiss applications for reinstatement, and/or set a further non-review period.

Case study – Prosecution for inappropriate treatment of vulnerable patients

The Commission prosecuted Dr Andrew Istephan, a dentist before the NSW Civil and Administrative Tribunal ('the Tribunal'), alleging that Dr Istephan failed to provide appropriate treatment of 69 elderly patients, residing in five aged care facilities, in circumstances where:

- the treatment provided was largely invasive, irreversible and not clinically indicated
- 52 of the 69 patients were incapable of providing informed consent and no consent was obtained from those 52 patients, and
- the provision of treatment was inappropriately influenced by the benefits available under two Commonwealth Government dental schemes.

In addition to the allegation that the conduct amounted to professional misconduct, the Commission argued that it justified an additional finding that Dr Istephan was not a suitable person to practise the profession of dentistry as Dr Istephan had been convicted of criminal offences in NSW, namely causing actual bodily harm and aggravated assault in respect of eight of the patients.

Dr Istephan made full admissions to the complaint, but did not agree that he was not a suitable person to practise as a dentist. He conceded that "*a major motivation of his conduct was greed*".

The Tribunal published its decision on 1 August 2017, finding Dr Istephan guilty of unsatisfactory professional conduct, professional misconduct, criminal convictions and that he is not a suitable person to practise the profession of dentistry. The Tribunal commented that "*the practitioner's conduct was of the most serious kind. The conduct requires strong denunciation. It is hard to imagine a more vulnerable group of patients*". The Tribunal also found that Dr Istephan was not a witness of truth and is still unable to take full responsibility for his conduct, falling short of *"demonstrating the qualities of integrity and honesty he alleges he now possesses"*.

The Tribunal ordered that Dr Istephan's registration be cancelled and imposed a non-review period of two years.

TABLE 1 | Outcome of disciplinary matters finalised in 2017-18

Forum Name	Orders	No.
1. Professional Standards Committee		
Medical Professional Standards Committee	Withdrawn	1
	Conditions	1
	Reprimand	1
	Reprimand and Conditions	5
	Caution and Conditions	2
	Not proved	2
Nursing and Midwifery Professional Standards Committee	Reprimand and Conditions	1
Total Professional Standards Committee		**13**
2. Tribunal		
NCAT – Chinese Medicine	Conditions	1
NCAT – Chiropractic	Reprimand and Conditions	1
NCAT – Dental	Cancellation	2
	Disqualified	1
NCAT – Medical	Cancellation	12
	Conditions	1
	Disqualified	3
	Reprimand and Conditions	4
	Suspension and Conditions	2
NCAT – Medical Radiation	Cancellation	1
NCAT – Nursing and Midwifery	Withdrawn	2
	Not proved	1
	Cancellation	6
	Disqualified	3
	Reprimand and Conditions	3
	Suspension and Conditions	2
NCAT – Pharmacy	Cancellation	2
	Disqualified	2
	Reprimand	1
NCAT – Physiotherapy	Cancellation	1
NCAT – Psychology	Not proved	1
	Cancellation	1
	Reprimand and Conditions	2
Total Tribunal		**55**

Forum Name	Orders	No.
3. Appeals/Applications		
Court of Appeal	Appeal dismissed	3
NCAT – Administrative & Equal Opportunity Division	Application withdrawn	1
	Application by practitioner – Application dismissed	2
NCAT – Appeal Panel	Appeal by practitioner – Appeal dismissed	1
Supreme Court of ACT	Application by practitioner – Application dismissed	1
Other	Application by practitioner – Application actioned	1
NCAT – Medical	Application withdrawn	1
Supreme Court	Appeal by Commission – Appeal withdrawn	1
	Application by practitioner – Application dismissed	1
	Appeal by Commission – Appeal allowed. Decision varied	1
	Appeal by practitioner – Appeal allowed. Decision varied	1
Local Court	Application by Commission – Application withdrawn	1
Total Appeals/Applications		**15**
4. Reinstatements		
NCAT – Nursing and Midwifery	Withdrawn	1
	Dismissed	1
	Condictions on registration varied	1
	Reinstatement order	1
NCAT – Osteopathy	Dismissed	1
NCAT – Pharmacy	Withdrawn	2
NCAT – Pharmacy	Dismissed	1
NCAT – Psychology	Withdrawn	1
Total Reinstatements		**9**
Total Legal matters finalised		**92**

Counted by matter, please note that multiple complaints can be prosecuted as one legal matter.

Case study – Inappropriate prescribing of drugs of addiction

The Commission prosecuted a complaint against Dr Arthur Echano, a general practitioner practising in regional NSW, before the NSW Civil and Administrative Tribunal ('the Tribunal').

The complaint alleged unsatisfactory professional conduct and professional misconduct in relation to Dr Echano's inappropriate prescribing of Schedule 8 drugs of addiction (including fentanyl and oxycodone) and Schedule 4D benzodiazepines (including diazepam and temazepam) as well as his failure to maintain adequate medical records in relation to 12 patients. The conduct was characterised by:

- A failure to carry out proper medical assessments prior to prescribing.
- A failure to make timely and appropriate specialist referrals.
- Prescribing for an improper purpose and in inappropriate quantities.
- Prescribing without an authority as required by statute.
- Failing to respond to drug-seeking behaviour.

On 5 March 2018, the Tribunal found the complaint proven in its entirety. It formed the view that despite the practitioner's steps to improve his practise and demonstration of remorse, he continued to present a risk of offending and remained unfit to practise.

The Tribunal ordered that Dr Echano's registration be cancelled and that he be prohibited from applying for a review of the cancellation order for a period of one year.

The Tribunal remarked that "*it is critical to the protection of the health and safety of the public that doctors exercise sound professional judgment and adhere to applicable laws in prescribing opioids and other restricted substances.*"

Access and outreach

Provision of information to the public about the independent role of the Commission and supporting patient centred care and effective complaints management across the health system are central to our work. These functions assist to promote our overarching objective of protecting public health and safety and contribute to the integrity of the health system. The Commission achieves this primarily through: being accessible; raising awareness; working with others; and being responsive to consumers.

Being accessible

The Commission's website is one of its primary points of access. On its website, the Commission offers information about its functions, services and how to access these. The Commission also provides translated resources for the public to access. For example, the complaint form and key information fact sheets are available in 20 community languages.

When dealing with inquiries and complaints, bilingual Commission staff can assist clients in their native language. The Commission also regularly uses telephone, oral and written interpreter services in a broad range of languages.

The Commission's information film, 'What happens with health care complaints', is available in the Australian sign language AUSLAN, as well as with Arabic and Chinese subtitles.

People with a hearing impairment can contact the Commission using the TTY number (02) 9219 7555 or through the National Relay Service on 133 677.

People with an intellectual disability and people with low literacy levels have access to a simple, illustrated fact sheet about how to make a complaint. Inquiry staff are also able to assist people in making a complaint.

Finally, people may come to the Commission between 9am – 5pm on weekdays to discuss their concerns or lodge a complaint.

INQUIRY SERVICE

The Commission recognises that navigating the health sector can be a challenge for people, given the extensive services offered, and they may be unsure as to the next step – whether it be seeking additional information, referral to another service provider, or whether to lodge a complaint.

The Commission offers an Inquiry Service which enables health consumers to have direct one-on-one communication in real time. Inquiry Officers are able to provide a range of advice and assistance including:

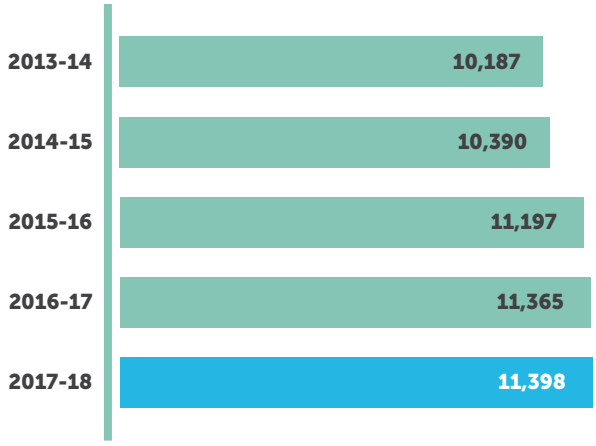
- information regarding health providers and services delivered in NSW
- assistance to bring the person's concerns to the attention of a health provider or service
- advice on how to raise a complaint directly with a health provider or service
- assistance to lodge a complaint with the Commission.

Ideally the Inquiry Service can help resolve issues in the early stages without the need to escalate it to a point where a complaint is formally lodged.

As seen in Chart 36, in 2017-18 the number of inquiries to the Commission continues to plateau, with negligible growth shown in 11,398 inquiries received. This pattern of negligible growth appears to be largely attributable to the increasing computer literacy of the community and the direct and ready access that this affords to a wide range of services and information service providers are also more attuned to providing clear information directly to consumers.

Another important operational factor reflected in the pattern of inquiries is the change to the regime of

CHART 36 | Number of inquiries received from 2013-14 to 2017-18



Counted by inquiry

communication and access for inmates seeking health services within the Justice Health and Forensic Mental Health Network. Historically inmates could not make direct contact with health clinics within correctional facilities, and where they needed information they called the Commission's Inquiry Service.

Inquiry calls from corrections inmates therefore made up around a third of all calls to the Inquiry Service. These calls were often repeat callers about service access and medication issues, which could only be answered by staff working in the health clinic of the correctional facility in question. The Commission therefore negotiated a change in process for inmates inquiring about their care. They now have direct access to Justice Health clinics to ask questions such as when they will receive treatment and adjustment to medication. This has the dual benefits of offering a more immediate response to the health needs of inmates and enabling the Inquiry Service to devote more time to calls (including those from inmates) where there is a need for independent assistance to address concerns about the standards of care provided or the conduct of health practitioners.

This change took effect in the early part of 2018 and the reduced number of calls since then suggests that this has had a positive impact.

Telephone access remains the most frequent way in which people access the service, with 92.7% of inquiries being received by phone (2016-17: 90.2%). A slightly lower proportion of people accessed the inquiry service via email, with 393 email inquiries being received (3.4% of inquiries; 2016-17: 4.6%)

INQUIRY OUTCOMES

Chart 37 shows that, as with previous years, the provision of information remains the most significant outcome, making up 44.8% of the outcomes for callers to the Inquiry Service (2016-17: 42.5%).

The sustained increases in the proportion of inquiries where strategies for resolution were discussed (12.1%; 2016-17: 10.4%) and where the caller was referred to another body (10.7%; 2016-17: 9.3%) are welcome, as this is a tangible and positive reflection of the emphasis being placed on supporting and empowering callers to resolve issues directly and early wherever this is possible.

The decrease in the number of assisted referrals (a reduction of 5.9 percentage points as a proportion of inquiries) relates to the changes to management of inmate calls, as described above. The assisted referral outcome is assigned to inquiries where the Inquiry Officer identifies that the caller needs to speak with a particular individual or service, and makes that first contact on behalf of the caller. As corrections inmates can now directly contact Justice Health, this has dramatically reduced the volume of calls from inmates and the assisted referral outcome can be expected to be less common.

Case study – Ensuring appropriate follow-up care and treatment

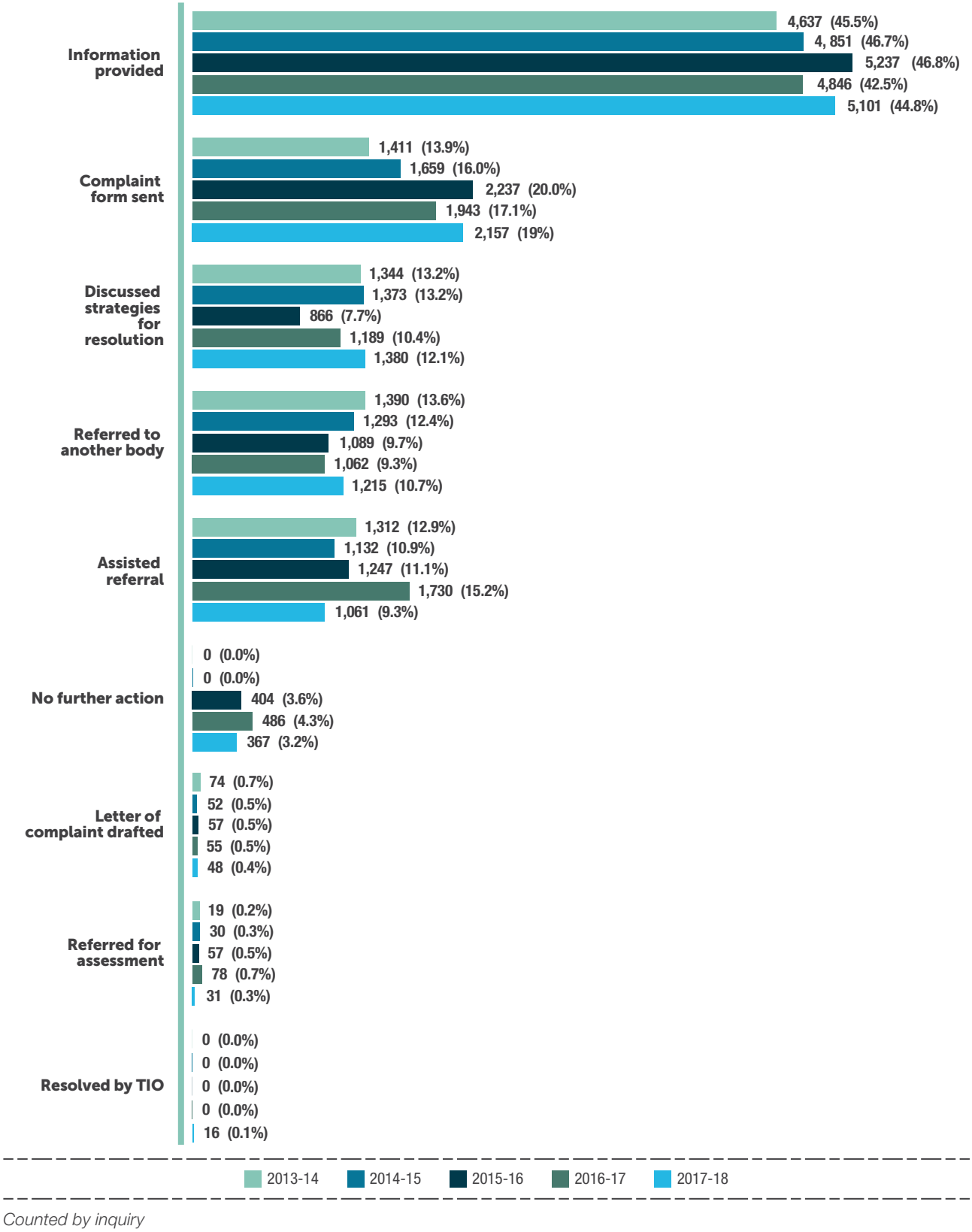
A patient phoned the Inquiry Service advising that they had just had 17 teeth removed in the day surgery centre of their local hospital. The patient was distressed as they were in significant pain and claimed not to have been prescribed antibiotics or pain relief.

The Inquiry Officer phoned the hospital's day surgery. The nursing unit manager (NUM) agreed with concerns expressed about the patient's wellbeing and advised that the patient should return to the day surgery centre. The NUM said she would also directly follow up with the day centre in the meantime and would also phone the patient to provide further assistance and reassurance.

The Inquiry Officer phoned the patient to advise them to return to the hospital and that they could expect a phone call from the NUM shortly.

The caller was very appreciative of the assistance of the Inquiry Officer in helping them in such difficult circumstances.

CHART 37 | Outcome of inquiries 2013-14 to 2017-18



Counted by inquiry

Case study – Assisting with medical records

A caller to the Inquiry Service said he and his wife were moving from New South Wales to Queensland. As his wife was pregnant, they wanted advice on obtaining a copy of the records from the hospital in relation to the birth of their last child so that they could provide this to the doctors in Queensland. He said he had obtained a copy of the discharge summary and he was concerned that there may be an error with what is written. He was concerned that he may be providing incorrect information to the doctors in Queensland and that this could potentially cause problems for the upcoming birth if they have wrong information about her medical history.

The Inquiry Officer discussed strategies for addressing his concerns. The Inquiry Officer suggested he could speak with the Nursing Unit Manager at the maternity ward at the hospital to get an understanding of what is written on the discharge summary, and to try to better understand if there was an error or incomplete information, or a misunderstanding. The Inquiry Officer reassured the caller also that if he does go on to request a full copy of the records, these records would give a much clearer picture of what treatment his wife had and that he can provide these to the doctors in Queensland. Also, if the records are not complete, he may seek to have additional information added via the Office of the Information and Privacy Commissioner.

The caller said he felt more at ease having spoken to the Inquiry Officer and that he would speak with the nursing unit manager as he has her name and contact details, and that he would also request the full copy of the records.

Raising awareness

PRESENTATIONS AND WORKSHOPS

Commission staff delivered 44 presentations, workshops and information sessions in 2017-18 to health service providers and community groups in NSW. The presentations focused on the Commission's role, functions and the services it provides, together with discussing case studies that demonstrated best practice in managing communication with patients and resolving complaints.

The strong focus on working closely with Local Health Districts (LHDs) on best practice in complaints management continued. The aim is to assist them in strengthening quick front line responses where problems occur and to ensure effective responses to matters that are referred by the Commission for local resolution. There were 24 presentations and workshops delivered by Commission staff across seven LHDs, which comprised three Sydney LHDs, Central Coast, Hunter New England, Illawarra Shoalhaven and Western NSW LHDs. This training and development program will continue in 2018-19.

Presentations on the role of the Commission are also being developed for delivery to private health providers and delivery to this sector will be a priority for the Commission in 2018-19 and beyond.

The Commission continued its outreach program with the Aboriginal community, and this included a presentation to Mayling Aboriginal elders group in Wellington.

Community outreach included Community Carers in Wallsend, a Prisons to Community presentation in Wellington and Mercy Services in Newcastle.

The Commission also presented workshops on the complaints management framework and key topics such as applying public interest considerations in determining outcomes with its professional council partners (including the Medical Council and Pharmacy Council) as well as inductions for new council members.

PRACTITIONER EDUCATION

The Commission continued its commitment to presenting to health practitioner students at TAFE and universities in NSW. This is part of the Commission's efforts to educate practitioners at the earliest stages of their careers about the benefits of patient centred care and communication, mandatory reporting obligations and how to deal with complaints constructively and effectively.

The Commission also continued its involvement with Sydney LHD in presenting to Mental Health Transition Nurses in Sydney.

A presentation was also provided to Ausmed, which is a provider of Continuing Professional Development education for nurses, midwives and other health professionals.

PUBLIC STATEMENTS AND WARNINGS

Under section 41A of the *Health Care Complaints Act*, the Commission may make a public statement about an unregistered health practitioner that identifies concerns about their suitability to provide health services and any actions that have been taken to protect the public from associated risks. Typically, these statements relate to those who have had prohibition orders made against them. Three public statements were made in 2017-18.

These public statements are distinguished from public warnings. The Commission is able to make public warnings under section 94A of the Act which relate to a particular treatment or health service that in its view, poses a risk to public health or safety. In 2015 the Commission was given a new power under this section to issue a public warning about unsafe treatment or health services that is detected during the course of an investigation. Previously the Commission could only issue a warning at the end of an investigation. This year the Commission utilised this power to issue a public warning on two occasions:

- in September 2017, concerning unsafe and illegal practices at cosmetic and beauty clinics
- in April 2018, regarding unsafe practices involving subdermal implants inserted for "extreme" body modification purposes.

The Commission believed it was important to raise awareness of these practices due to the high risk to public health and safety, and urged those individuals seeking to undergo such procedures to seek appropriate medical advice from a registered health professional.

These public warnings are translated into other languages where appropriate and made publicly available on the Commission's website.

Public Statement (extract): Ms Marie Bensley

Under Section 41A(1)(b) of the *Health Care Complaints Act 1993*:

Ms Bensley was employed as an Assistant in Nursing at the Bourke Street Health Service in Goulburn.

The Commission found that Ms Marie Bensley has breached the Code of Conduct for Unregistered Practitioners – Public Health Regulation 2012, Schedule 3, Clause 3(1), in that she failed to provide care in a safe and ethical manner when:

- On 23 November 2017, the daughter of Patient A informed staff of the Bourke Street Health Service that her father's Debit MasterCard was missing. Bank statements supported that the debit card had been used from 20 November 2017 to 24 November 2017 with a total expenditure of approximately $1495.19. Patient A's daughter notified Police.
- On 27 November 2017, Patient B informed staff that her credit card was not in her purse and that her credit card statement showed many unauthorised purchases. On further investigation by Police it was found that Patient B's account had been accessed with an accumulative expenditure and interest charges of approximately $3024.37 between 19 October 2017 and 27 November 2017.
- Police investigations found that Ms Bensley had made 25 fraudulent transactions using Patient A's Debit MasterCard and 98 fraudulent transactions using Patient B's credit card.
- During preliminary enquiries by NSW Police, Ms Bensley was identified through CCTV and witness statements. This information was confirmed on review of credit card statements.
- On 28 November 2017, Ms Bensley was arrested and held in custody. Ms Bensley was charged with the following offences namely, Larceny (2 counts), under Section 117 of the Crimes Act 1900, Dishonestly Obtaining Financial Advantage by Deception (5 counts) under Section 192e(1)(B) of the Crimes Act 1900 and Dishonestly Obtaining Property by Deception (3 counts) under Section 192e(1)(A) of the Crimes Act 1900.
- On 17 January 2018, Ms Bensley appeared before Goulburn Local Court, convictions were entered on all 10 charges and Ms Bensley was sentenced to a Community Services Order for 250 hours (due to expire on 16 January 2019). She was also ordered to compensate the victims of her crimes.
- Ms Bensley was responsible for the care of elderly residents who are vulnerable due their age and at times underlying health conditions. Family members placed trust in Ms Bensley to deliver appropriate care and treatment to Patients A and B and Ms Bensley betrayed their trust and in doing so undermined the health and wellbeing of all residents at Bourke Street Health Service.

The totality of the evidence supports a finding that Ms Bensley represents a risk to the health or safety of members of the public which necessitates the making of the following Prohibition Order pursuant to Section 41A(2)(a)(i) of the Act:

- Ms Bensley is prohibited for three years from providing any health services in either a paid or voluntary capacity. For the purpose of this order "health service" carries the meaning given by section 4 of the *Health Care Complaints Act 1993*.

Public Warning under s94A of the *Health Care Complaints Act* – Unsafe practices involving subdermal implants inserted for "extreme" body modification purposes – issued in April 2018

The NSW Health Care Complaints Commission is concerned about complaints regarding surgical procedures involving the insertion of subdermal implants for "extreme" body modification purposes and the risks to the health and safety of consumers undergoing these procedures.

There is a growing trend of consumers in NSW seeking a range of procedures (whether medical or not) to alter their appearance.

Subdermal implants used for "extreme" body modification purposes come in a variety of shapes including horns, snowflakes, skulls, crowns or other objects and are generally made from silicone.

Unlike more traditional body art or "body modification" procedures, such as tattooing and piercing, the insertion of subdermal implants involves surgery.

These procedures involve incisions being made with a scalpel through the skin and subcutaneous tissue, instruments being used to open the pocket in which the implant will be inserted and suturing of the incision site.

As such, these procedures involve serious health risks and complications, which include:

- Infection – this may arise as a result of poor infection control standards, poor sterilisation of equipment or the implant itself, or could arise after the procedure due to a number of factors including an exposed wound or poor aftercare. Infection carries real risks and in some cases may result in sepsis. In the most serious cases, sepsis can be fatal.
- Nerve damage – this may result from the procedure being poorly executed or from placement of the implant itself which might interfere with nerve function or other internal structures, such as muscles, tendons and ligaments.

Other complications include allergic reactions to the materials used and/or the body rejecting the implant itself. These complications may require the consumer to seek urgent medical attention, to undergo revision procedures and may leave the consumer with scar tissue or other permanent damage.

What should consumers do to protect themselves?

The Commission strongly urges consumers seeking the insertion of subdermal implants for body modification purposes to be vigilant in their research prior to proceeding. In all cases the following factors should be considered before committing to the procedure:

1. Is the procedure being performed by a practitioner who is appropriately qualified, experienced and accredited?

Generally, implant procedures carried out for "cosmetic" rather than medical purposes (e.g. breast, facial or calf implant procedures) are carried out by registered medical practitioners in licensed health facilities.

However, there are persons in the "body modification" industry who offer services involving the insertion of subdermal implants who are not medically trained and are not suitably qualified to carry out surgical procedures.

A person may be qualified to perform skin penetration procedures, including tattooing and piercing, yet not be suitably trained and qualified to carry out body implant procedures.

Further, the body implant procedure itself is painful and generally anaesthetics would be used for these types of procedures. Such medications are restricted substances and carry risks if prescribed or administered inappropriately. Unapproved imported anaesthetic agents are of unknown quality, safety and efficacy.

It is illegal for a person who is not a registered health practitioner or otherwise authorised under the Poisons and Therapeutic Goods Act 1966 to supply or administer a restricted substance to another person.

2. Is the facility appropriately registered, infection controlled and equipped?

Subdermal implant procedures carried out by tattoo or piercing artists may be carried out in non-sterile premises, including tattoo parlours. Such premises must be notified to local councils as carrying out skin penetration procedures and comply with infection control standards in accordance with the Public Health Regulation 2012 (NSW).

However, this in no way guarantees that the measures are adequate to ensure the health and safety of consumers undergoing a subdermal implant procedure.

3. Are the implants safe?

The subdermal implants used in "extreme" body modification are not subject to the same stringent research and testing as other types of implants, such as medical grade silicone breast implants.

Subdermal implants used by tattooists and others providing these services are not approved medical devices in Australia. As they are not approved by the Therapeutic Goods Administration (TGA), the quality and safety of the material being placed beneath your skin in these types of procedures cannot be guaranteed.

4. Have you sought medical advice?

Consumers should not entertain undergoing a body implant procedure without seeking the advice of their doctor. It is important to be informed of the risks and complications involved in undergoing such procedures and steps that can be taken by the consumer to protect themselves from injury or other adverse outcomes.

A medical practitioner will also consider making a referral to an appropriate mental health professional in circumstances where a consumer may be suffering from Body Dysmorphic Disorder (BDD) or other condition which is contributing to their desire to alter their appearance.

Consumers should exercise caution in accepting the claims of any person who claims to be qualified in carrying out subdermal implant or other surgical procedure who cannot demonstrate that they are a registered medical practitioner with relevant surgical training and qualifications.

If you have undergone a body implant procedure and have not been reviewed by a medical practitioner, you should speak with your doctor.

If you hold concerns that the wound or area around the implant is infected, you should seek urgent medical attention.

Why is this warning being issued?

The Commission has received complaints about body modification services being provided in NSW, including procedures involving the insertion of subdermal implants for "extreme" body modification purposes.

The issues raised in the complaints received include:

- Whether the person(s) carrying out these procedures are suitably trained and qualified to be providing these services
- Whether these services are being carried out in a sterile and appropriately equipped setting
- Whether the services are being provided in a safe and ethical manner
- Whether consumers receiving these services are receiving appropriate follow up care, and
- Whether scheduled medications are being used for the purpose of the procedures in breach of the Poisons and Therapeutic Goods Act 1966, and
- Whether consumers are being urged to inform their treating medical practitioner of the services they are receiving
- The Commission is investigating these complaints and inquiries are presently ongoing.
- The Commission has serious concerns that unregistered health practitioners are carrying out surgical procedures to "alter" the appearance of consumers:
  - without being appropriately trained or qualified, and/or
  - failing to do so in a safe and ethical manner.

MEDIA

The Commission responds to media inquiries and provides information on its functions noting that s99A of the *Health Care Complaints Act 1993* heavily restricts the disclosure of information relating to complaints. Media inquiries predominantly related to health professionals that the Commission had prosecuted before the NSW Civil and Administrative Tribunal, and complaints under investigation.

The Commission also published 58 media releases which related to decisions of disciplinary bodies, public warnings and prohibition orders made about unregistered practitioners. These releases are published on the Commission's home page and subscribers to its media release mailing list are automatically notified of each new media release.

BROCHURE DISTRIBUTION

The Commission continued to have its key brochures "Concerned About Your Health Care?" and "Resolve Concerns About Your Health Care" distributed across medical practices and facilities in NSW.

Working together

WITHIN NSW

When dealing with complaints, the Commission regularly consults with the various professional councils, The Australian Health Practitioner Regulation Agency (AHPRA), the NSW Ministry of Health and the Local Health Districts (LHDs).

The NSW Regulators Forum was established in early 2017. It meets quarterly and is chaired by the NSW Ministry of Health. Its initial focus has been on strengthening policy and operational linkages between the various elements of health regulation and policy – including the Commission; the Pharmaceutical Regulatory Unit, Public Health Units and Health Protection, Regulation and Compliance within the Ministry; Health Professional Councils Authority; and the Medical, Nursing and Dental Councils of NSW.

The Forum takes a data and evidence driven approach to identifying emerging risks to public health and safety. It ensures strategic consideration of the respective roles and responsibilities and powers, as a framework for operational collaboration. The next development that is now occurring is inclusion of NSW Fair Trading on operational planning and implementation.

Quarterly meetings are also held between Commission senior staff and the Secretary of Health and other senior Ministry of Health staff to discuss current issues and offer strategic guidance and advice on matters of shared interest.

Consultation with the professional councils in relation to the outcome of all complaints relating to registered practitioners is regarded as a core strength of the NSW co-regulatory complaints management system. It ensures that there is clear identification of departures from treatment, conduct, standards or problems of impairment and expert driven decisions about the action that should be taken.

After an investigation, where the Commission had made recommendations to a health organisation to improve systems, it also provides a copy of these to the Clinical Excellence Commission to support its work on systemic improvement.

The Commission continues to maintain a very strong working partnership with the LHDs across the state, consistent with the view that health consumers will get the very best results if any problems and concerns can be identified and addressed at the time as far as this is possible. The LHDs and hospitals are also in possession of information that if provided quickly to consumers, can prevent problems from escalating.

The Commissioner continues to visit LHDs across the state. This provided the opportunity to understand the continuing improvements to governance and patient safety that are occurring under the National Safety and Quality Framework; discuss the LHD's complaints trends and performance comparative to other LHDs and/or regions; as well as to identify areas where the Commission's processes and interactions with them could be improved.

An outcome of the Commission's assessment of a complaint is that it may be referred to an LHD for local resolution. The Commission has previously discussed with LHDs that it would be valuable for there to be an "end –to-end" picture of the complaints process where complaints are referred on, as this would assist in understanding the experience of the complainant and the eventual outcome of the complaint from the consumer perspective. During 2016-17 a feedback mechanism was established and the Commission is now working on a project to ensure appropriate analysis of this feedback to inform improvements to the complaints management process.

CROSS-JURISDICTIONAL COLLABORATION

The Commission participates in a range of cross-jurisdictional fora to ensure that it is involved in key decision-making related to the health complaints management environment, and to establish and maintain appropriate operational partnerships and information sharing arrangements.

This includes:

- In November 2017 and May 2018 the Commissioner participated in the National Health Commissioners conferences. This is an important forum for considering complaint trends nationally, identifying strategies for improved complaints management and discussing management of matters that cross jurisdictional boundaries.
- The Commissioner was also a member of the Medical Board of Australia's Consultative Committee on revalidation for medical practitioners.
- In early December 2017, the Commission hosted representatives from the office of the New Zealand Health and Disability Commissioner, which amongst its responsibilities, has a complaints handling function. This was an opportunity to discuss complaint trends, learn about each agency's operations and understand common challenges, and identify opportunities to adopt practices and processes that would lead to improvements for each agency.
- Established in April 2017, the Consumer Health Regulators Group consists of regulators with an interest in consumer health. Currently chaired by the Australian Competition and Consumer Commission (ACCC), other members include the Australian Health Practitioner Regulation Agency (who work in partnership with 14 National Boards in the National Registration and Accreditation Scheme), the Private Health Insurance Ombudsman and the Therapeutic Goods Administration. The Federal Department of Health participates in the Group as an observer. Group members come together to exchange information, including about emerging issues of interest or concern, and to ensure responsibilities and functions of each regulator within the consumer health industry are understood and consistently applied. The Group meets quarterly, or otherwise as needed.
- The national working group on the development of a National Code of Conduct for unregistered health practitioners. NSW already has a state Code of Conduct for these practitioners and continues to have input into activities in this area.

Consumer responsiveness

Understanding the concerns of health consumers and health service providers is very important for the Commission. We seek and review comments from people who lodged a complaint as well as health service providers who were involved in a complaint about their experience with the Commission's services. The Commission uses this feedback to inform staff of both positive and negative feedback, and to improve in the delivery of its complaints management process.

CONSUMER CONSULTATIVE COMMITTEE

The Commission has a Consumer Consultative Committee (CCC) which in previous years has provided health consumer organisations with the opportunity to raise current issues and provide valuable feedback on the Commission's work.

Following a review of the Committee's terms of reference, including its purpose and operation, it was agreed that a preferred model would be to move to topic-based forums so that there is the ability to drill down into matters of particular importance and to broaden involvement in those forums with additional attendees based on interests in the topics.

The Director, Customer Engagement and Resolution and the Executive Director, Health Consumers NSW held further discussions about possible topics and other opportunities for engagement with the Commission, at the project level. This work will be further developed as part of the preparation of a Stakeholder Engagement Strategy. This work will be further supported by the establishment of a dedicated Stakeholder Engagement and Communications Officer in 2018-19.

COMPLAINANT AND PROVIDER FEEDBACK

The Commission receives complaints and feedback from consumers about the complaint process or the outcome of their complaint. The Commission commits to address and resolve as quickly as possible dissatisfaction that is expressed by consumers or health service providers when it is raised in an attempt to resolve the problem as quickly as possible. Where such resolution is successful, no formal complaint is recorded.

The *Health Care Complaints Act* entitles complainants to a review of Commission decisions in relation to the assessment and investigation of complaints.

At the completion of each assessment process, both the health service provider and the complainant are invited via a questionnaire to provide feedback to the Commission. The information contained in the questionnaire assists the Commission to understand the experience of the parties in a complaint's assessment process.

The rate of response from complainants was 3.4%. Of these, 83.0% stated they were satisfied with the Commission's service. The rate of response from health service providers was 6.9% – of these 45.0% stated they were satisfied with the Commission's service.

COMPLAINTS ABOUT THE COMMISSION

In 2017-18, the Commission was notified of three external formal complaints about its staff. Two complaints concerned staff contact with people who had made a complaint and concerned their conduct of their complaints. Following reviews of the conduct these staff were counselled about appropriate and respectful communication and the Commission's values and obligations in this regard.

The other complaint related to an unidentified Inquiry Service officer. Whilst specific action could not be undertaken, all inquiry officers were reminded of the importance in maintaining professionalism and courtesy in their dealings with the public.

COMPLAINTS TO THE OMBUDSMAN

If a complainant remains dissatisfied with the Commission's processes and procedures at any point in handling the complaint, the complainant is able to make a complaint to the NSW Ombudsman Office.

The NSW Ombudsman has advised that in 2017-18, it received 47 complaints about the Commission, compared to the 20 complaints it received in 2016-17. The complaints were mostly related to alleged failures to respond to people and other delays and the overall deterioration in this timeliness of managing complaints has been the main factor in this. The Commission has confirmed the steps that it is taking to improve both timeliness and communication with parties to a complaint with the Ombudsman's office.

Of the 47 complaints received:

- 24 were declined at the outset (because the complaint was: premature, no jurisdiction, concurrent, no evidence of wrong conduct)
- 11 were declined after inquiries were made with the Commission (no evidence of wrong conduct found)
- Eight were resolved after inquiries were made with the Commission (issue raised by complainant resolved to the Ombudsman's satisfaction).
- Four were still open.

In addition to the 47complaints in 2017-18, the Ombudsman recorded 82 inquiries about the Commission (62 in the previous year).

PRIVACY

The Commission has a privacy management plan developed in accordance with the *Privacy and Personal Information Protection Act 1988*.

In 2017-18, the Commission received four requests for internal review under this Act. Two of these related to access to Commission records which the Commission had refused due to the non-disclosure provisions in its own Act or the *Government Information (Public Access) Act 2009*. All reviews found that no breach of the Act had occurred. One request alleged a breach of privacy which also found that no breach of the Act had occurred. The remaining request also alleged a breach of privacy and the conduct was proven. A formal apology was made to the complainant for both the breach and the distress that it had caused them.

One further request was made under the *Health Records and Information Privacy Act 2002* which also related to access to records which the Commission had refused. This review also found that no breach of that Act had occurred.

Your feedback

"I am satisfied at how my complaint has been managed and feel that this has been done sensitively and [with] professionalism. Thank You"
– **complainant feedback**

"I feel like anyone who is not a trained professional would really struggle with this process"– **complainant feedback**

"Thank you very much for the prompt action and response to my complaint. You understood my issue and I am very happy with your Assessment. The result is what I hoped for. I have no ill feelings towards the doctor or the hospital. Your recommendations to the doctor or registrar to personally examine the patient, along with better note taking is very acceptable"
– **complainant feedback**

"I was pleased to find that finally someone was listening to me. I didn't know who to turn to or who could help me. I was pleasantly surprised at how quickly my case was dealt with. I am grateful to the HCCC for the help you have given me. It is reassuring to know that even us little people can get help Thank you"– **complainant feedback**

"Firstly I wanted to thank you for following up with my complaint. I really appreciate it being taken seriously. I can totally understand the need for more evidence in order to take any further action. If this complaint has perhaps made Dr [redacted] be a little bit more aware of how she is treating new parents, then that is a successful outcome to me"
– **complainant feedback**

"AHPRA/HCCC etc are very unclear in who manages what I feel"
– **complainant feedback**

"I wish to thank the Commission and the Medical Council of NSW for understanding my response. I am sorry that the patient misunderstood my very best intention in trying to look after him and I hope we would find another practitioner whom he would be comfortable in managing his medical problems"– **provider feedback**

"I acknowledge the vital role HCCC played in this complaint and that the case required more than a review of the care and treatment provided to the client of our mental health services. The case has focused our teams on the need to communicate and involve family members which has led to improvements in our approach to mental health care"– **provider feedback**

Organisation and governance

Corporate structure

Changes to the Commission's structure took effect in July 2017 and are reflected in Chart 38. The core elements of the functional arrangements are:

- The **Complaints Operations Division:** This Division integrates complaints assessment and investigation functions that have previously been separate. This fosters improved sharing of capability and expertise throughout all steps in managing complaints.

Assessment functions are arranged in a way that responds to the need for effective triaging of complaints; have a strong focus on early resolution of complaints; have appropriate access to internal medical advice; monitoring of complaints performance; and maintains effective investigation capability.

Where a matter is serious, it is imperative that the assessment process is focused and disciplined and that any subsequent referral to investigations provides a strong platform to progress the investigation in a timely and effective way.

- The **Resolution and Customer Engagement Division**. This Division has been formed to place renewed emphasis on the needs and experiences of customers. This will ensure that customer responsiveness and access is a guiding consideration for everything that the Commission does. The Commission's expertise and commitment to complaints resolution will continue.
- The **Legal Services Division.** This Division provides legal and procedural advice and prosecution decisions are undertaken by the independent Director of Proceedings. This ensures that the Commission is taking appropriate disciplinary action where this is required and also using the experiences from individual cases to inform legal policy decision making and regulatory reform.
- The **Corporate Operations Division.** This division ensures that all resources, equipment and systems are used in an efficient and effective way. Increased emphasis is being placed on driving system and process reforms to streamline our functions and making a successful transition to digital complaints management. Capability building and financial diligence are also core functions of the Division.
- The **Executive Unit** supports strong accountability and governance arrangements and focuses on performance reporting, data analysis and strategic advice.

CHART 38 | Organisation Structure

Commission staff

The Commission employed a total of 103 full and part time staff as at 30 June 2018.

TABLE 2 | Staff numbers by employment category 2013-14 to 2017-18 (as at 30 June 2018)

Employment basis	2013-14	2014-15	2015-16	2016-17	2017-18
Permanent full-time	54	52	59	62	**68**
Permanent part-time	8	7	3	4	**8**
Temporary full-time	8	10	9	12	**11**
Temporary part-time	5	4	4	4	**1**
Contract – Senior Executives	4	4	4	5	**5**
Contract non senior executive			1	3	**-**
Training positions	-	-	-	-	**7**
Retained staff	-	-	-	-	**-**
Casual	4	4	4	5	**3**
Total	**83**	**81**	**84**	**95**	**103**
Sub totals					
Permanent	62	62	61	70	**81**
Temporary	13	15	16	16	**12**
Contract	4	4	3	3	**7**
Full-time	62	66	68	79	**84**
Part-time	13	15	7	8	**9**

TABLE 3 | Average full-time equivalent staffing 2013-14 to 2017-18

2013-14	2014-15	2015-16	2016-17	2017-18
74.3	72.6	74.3	77.0	84.8

PUBLIC SERVICE SENIOR EXECUTIVES

Public Service Senior Executives are employed under the *Government Sector Employment Act 2013*. The executive structure complies with the Senior Executive Implementation Plan prepared for the Public Service Commission in June 2015.

The Commissioner, Ms Sue Dawson commenced a five year term on 7 December 2015.

In 2017-18 and following the development of the new organisational structure, the Commission had a total of five Public Service Senior Executives, with two transitional officers during the transition to the new structure:

- Commissioner, Senior Executive Band 3 – Sue Dawson, Bachelor of Laws (Hons 1) (LLB), Master of Urban Planning, Bachelor of Social Work (Hons 1), Executive Fellow, Australia New Zealand School of Government
- Executive Director, Complaints Operations, Senior Executive Band 2 – Tony Kofkin, Bachelor of Arts (BA), former Detective Chief Inspector at Kent Police (UK)
- Director, Legal Services and Director of Proceedings, Senior Executive Band 1 – Karen Mobbs, Bachelor of Arts (BA) and Bachelor of Laws (LLB)

- Director, Corporate Operations & Chief Financial Officer (CFO), Senior Executive Band 1 – Edward van den Bempt, Bachelor of Commerce and Bachelor of Commerce (Hons), Member of the Institute of Chartered Accountant Australia & New Zealand and the South African Institute of Chartered Accountants.
- Director, Customer Engagement & Resolutions, Senior Executive Band 1 – Delia Gray, Bachelor of Applied Science (Occupational Therapy).
- Acting Director, Director, Corporate Operations and Chief Financial Officer (CFO) – March 2016 – September 2017 – Michael Doran, Bachelor of Science (Hons) Psychology and Master of Science Organisation Psychology . This role was filled permanently in August 2017 by Mr Edward van den Bempt.
- Acting Director, Assessments & Resolutions – January 2017 – July 2017 – Celia Murphy, Bachelor of Applied Science (Exercise and Sport Science), Postgraduate Diploma in Health Administration and Legal Profession Admission Board. This acting role replaced the previous Director, Assessments & Resolutions, Mr Ian Thurgood, and existed during the transition to the integrated Complaint Operations structure.

11.6% of the Commission's employee related expenditure in 2017-18 was related to senior executives, compared with the 10.7% in 2016-17.

TABLE 4 | Senior Executive as at 30 June 2018

Band	2017		2018	
	Female	Male	Female	Male
Band 3 (Commissioner)	1	0	1	0
Band 2 (Executive Director)*	0	0	0	1
Band 1 (Directors)	2	2	2	1
Totals	**3**	**2**	**3**	**2**

** One temporary*

TABLE 5 | Remuneration of Senior Executives as at 30 June 2018

Band	Range $	Average remuneration	
		2017	2018
Band 3 (Commissioner)	328,901 – 463,550	$369,000	$387,225
Band 2 (Executive Director)	261,451 – 328,900	n/a	$261,451
Band 1 (Directors)	183,300 – 261,450	$223,149	$227,220

STAFF CHANGES

In 2017-18, 35 employees took leave or resigned as follows: six employees went on maternity leave for up to 12 months, one employee retired, one employee was on leave without pay for seven months, two employees were seconded to other agencies, three employees permanently transferred to another agency, 11 ended fixed term contracts and 14 employees resigned.

CONDITIONS OF EMPLOYMENT AND MOVEMENT IN SALARIES AND ALLOWANCES

Employees of the Commission, including Senior Executives are appointed under the *Government Sector Employment Act*.

Conditions of employment are principally set by the *Government Sector Employment Act* and, for the majority of employees, by the Crown Employees (Public Service Conditions of Employment) Award. Employees' conditions and entitlements are managed in accordance with the guidelines, policies and directions set by the Public Service Commission of NSW and the Commission's own workplace agreement and internal policies.

Employees under the Crown Employee (Public Service Conditions of Employment) Award received a 2.5% increase in salary and related allowances from the first full pay period in July 2017. The Commission employs medical advisers who are employed under the Crown Employees (Health Care Complaints Commission) Medical Advisers Award and they received a 2.5% annual increase from October 2017.

The Statutory and Other Officers Remuneration Tribunal (SOORT) determined a performance-based increase of 2.5% for the Commissioner and other Public Service Senior Executives in August 2017.

The Commission has a number of policies and procedures regarding conditions of employment, work health and safety, equity, security and other operational requirements which comply with the policies sector wide and also reflect the corporate values.

A review and consolidation of the personnel policies in the Compliance Monitoring Register has commenced and involves consolidation of 38 policies into 18 policies and a gradual program of review of these policies. Five policies were finalised in 2017-18 after consultation and the remainder are expected to be progressed in 2018-19.

PERFORMANCE DEVELOPMENT AND TRAINING

All employees receive an induction program at the Commission and in 2017-18 this program was reviewed and will continue to be strengthened to ensure that all new employees are assisted to quickly understand the strategy and directions, the work of the Commission, their own role and accountability and the systems that they work on.

All employees have a performance agreement that aligns individual job focus and performance expectations with the goals and priorities defined in the Commission's strategy, corporate and business plans. Each employee performance agreement also includes a development plan that incorporates development objectives to build capabilities required in their job or that is required to make the employee ready for an organisation need in the future or a personal career goal.

All employees also have personal development discussions and plans set as part of their annual Performance and Development Plans. The key development themes across these plans have been identified and addressed.

The Commission continued its commitment to regular delivery of training designed to support staff in working in a challenging complaints management environment and in working in a customer centric fashion. The target of an average of greater than 2 days training per employee was met.

A centrepiece of the training provided remains the continued commitment resilience training for all Commission staff. This supports them to work in a sustainable and constructive way with aggrieved, distressed, angry or abusive clients and in working with a wide range of health consumers. Staff feedback is that the resilience related training is valuable and the interactive exercises give them an opportunity to hone their skills in handling the more emotionally demanding side of our work.

The Commission also committed to improving internal and external communication and quality and clarity of the analysis that is provided to inform assessment decisions. The Plain English Foundation trained assessments staff to write content that is clear and to the point and apply plain English tools and style in a highly practical way.

Ongoing support was also provided for leadership development in the Commission.

TABLE 6 | Training offered and attendees

Course name	Number of attendees
Managing Sexual Assault Complaints	8
Trauma Informed Practice and Managing the "Cost of Caring" to Promote Helper Resilience training	33
Resilience Refresher	10
Managing unreasonable complainant conduct	25
Crisis Communication Skills	11
Plain English Essentials	28
Performance and Development Plan training	86
SAP Manager Self Service	12
New starter induction training	17
Emergency Management Program	6
Other training and conferences	197

A leadership program for managers has been developed to improve our people manager capability and enable our leaders and managers to build a culture of performance, accountability, collaboration and capability. This program is being delivered in 2018-19. Executive participation in Public Sector Commission training on Delivering Business Results and Executive Leadership Essentials also occured.

Support for the Continuing Legal Education responsibilities of our legal officers also continued.

In addition to formal training, the Commission also offered a range of other opportunities for the development of employees – these include performing higher duties, leadership or participation in projects, mentoring and coaching, and cross Divisional information sharing and teaching.

Going forward, the Commission's emphasis on training and development will continue to be strengthened to ensure that managers and staff are equipped to work effectively in a changing complaints management landscape. Each of the employees who got a performance rating that identified a need for improvement will be provided with the necessary support and tools to assist in improving performance.

STAFF WELLBEING

The Commission supports staff wellbeing with a range of activities.

Employee assistance program

The Commission reviewed and refreshed its Employee Assistance Program (EAP) in 2017-18. It has engaged Benestar (formerly known as Davidson Trahaire Corpsych) to provide free confidential and professional counselling in relation to any work-related or personal concerns of an employee or their immediate family members.

Flexible work arrangements

Commission offers flexible work arrangements to allow its employees to balance their work with other commitments, including caring for children or elderly parents. In 2017-18, 21 staff had flexible work agreements, including part-time work, parental leave without pay, condensed working hours, adjusted start and finish times and working from home.

Staying healthy

The Commission offered free influenza vaccinations for staff and 35 staff elected to have the vaccination. Staff can also participate in lunch hour on-site Pilates classes, at their own expense.

Charitable work

The Commission gives staff the opportunity to raise funds for charitable projects in their own time. Staff participated in the Cancer Council's Biggest Morning Tea and Jeans for Genes Day.

Governance

GOVERNANCE STRUCTURES

The Executive Management Group meetings take place monthly to set corporate direction and priorities, monitor financial and operational performance and strategic HR matters, and oversee major projects.

The Assessments Management Group (AMG) comprises the Commissioner, the Executive Director, Complaints Operations and the two Managers of Assessments. Its purpose is to review the performance of the Assessment Division and provides a focus on operational strategy and practice that identifies and delivers better business processes across all complaints assessment functions.

The Investigative Review Group (IRG) – made up of the Commissioner, Executive Director, Complaints Operations, the three Investigation Managers, the Legal Manager, Investigations, the Executive Officer and a representative from the Legal Services Division – closely monitors the progress of investigations. All investigations identified as carrying significant risk to public health and safety are reviewed. In addition, the progress of all investigations that involved unexpected and catastrophic health outcomes for complainants and all investigations into unregistered practitioners were reviewed and resources were allocated to ensure effective outcomes.

The ICT Steering Committee meets monthly ICT requirements and oversee the implementation of systems improvements to meet business needs.

The Audit and Risk Committee met quarterly to review the Commission's risk management framework, financial performance and internal controls and provide assurance to the Commissioner on compliance with the relevant Treasury and statutory policies and directives.

The internal audit program is set with the Audit and Risk Committee. The internal auditors conducted an assessment of the Commission's ISMS to ensure it was aligned with the requirements of the DISP by ascertaining the effectiveness of IS controls and identifying key areas for further improvement. The opportunities for improvement covered alleviating resourcing constraints, raising awareness of information security and consolidating the large number of ICT policies to allow for a more effective information security framework. The internal auditors also undertook a review of the Commission's management of legal expenditure to better understand the cost drivers influencing legal costs to inform longer term resource planning. The report is in the process of being finalised.

A comprehensive three-year Internal Audit Plan that covers the period to June 2020 has been developed and was approved by the Audit and Risk Committee.

The Commission received the formal Independent Auditors report from the NSW Auditor General on 25 September 2018.

The Work Health & Safety Committee has met every quarter to ensure early identification and management of all WHS issues across the Commission.

Each division has conducted monthly employee meetings (or more frequent) to identify development and change opportunities, review operational performance and to continue a focus on building culture and engagement.

Cross divisional oversight groups have been formed and continued for major projects and priorities, such as the Business Process Improvement Project and the eComplaints project.

INDUSTRIAL RELATIONS AND THE JOINT CONSULTATIVE COMMITTEE

The Director, Corporate Operations, other Executive members as appropriate, nominated staff and the Public Service Association of NSW meet quarterly as members of the Joint Consultative Committee to discuss issues relating to the conditions of employment and entitlements of staff, including recruitment, training, work health and safety (WHS) matters, and any new policies.

The Commission has a workplace agreement that provides for flexible working hours and conditions, and sets out dispute settlement procedures and avenues for consultation, if issues arise.

There were no industrial disputes involving the Commission in 2017-18.

RISK MANAGEMENT AND INSURANCE ACTIVITIES

The Commission reviewed its business risks as part of the corporate planning process. The Commission's Risk Register and Risk Policy were subsequently amended to reflect revised assessment, evaluation and treatment of risks. The Commission's ISMS Risk Register was also reviewed with improvements identified to reduce risk levels.

The Commission will be reviewing its Business Continuity Plans and ICT Disaster Recovery Plan in 2018-19.

The NSW Treasury Managed Fund provides the Commission with insurance cover for workers compensation, motor vehicles, public liability, property and other items. Workers compensation insurance is provided by QBE Ltd, with GIO General Ltd providing insurance for the remaining categories. From July 2018, Gallagher Basset took up the management of all General Lines claims for Insurance for NSW.

Workers compensation premiums increased by $5,528 (19.7%) from the previous year, due to an increase in estimated claims, and the remaining insurance categories decreased by $2,943 (27.5%) due a reduction in the car fleet.

PUBLIC INTEREST DISCLOSURES

The *Public Interest Disclosures Act 1994* requires the Commission to report public interest disclosures made to it. The Commission reports that in 2017-18:

- No public officials made public interest disclosures in performing their day to day functions.
- No public interest disclosures were made that are not covered by the above that were made under a statutory or other legal obligation.
- No other public interest disclosures were made.

The Commission has a public interest disclosure policy that encourages and guides staff to report potential wrongdoing.

GOVERNMENT INFORMATION

The Commission has a range of information on its website that people can openly access. During the year, the Commission continued to review and update its publicly available information.

In relation to its complaint handling functions, information obtained by the Commission in exercising these functions is deemed to be "excluded information" under the *Government Information (Public Access) Act 2010*.

During the year, the Commission received 10 applications for the release of documents under this Act. All of these were applications for documents that related to the Commission's complaint handling functions and were therefore invalid applications. The tables in Appendix F summarises the applications received in 2017-18 as required under the Act.

INTERNAL AUDIT AND RISK MANAGEMENT STATEMENT ATTESTATION STATEMENT FOR THE 2017-2018 FINANCIAL YEAR FOR THE HEALTH CARE COMPLAINTS COMMISSION

I, Sue Dawson, Commissioner of the Health Care Complaints Commission (HCCC), am of the opinion that the HCCC has internal audit and risk management processes in place that are compliant with the eight (8) core requirements set out in the Internal Audit and Risk Management Policy for the NSW Public Sector, specifically:

Core Requirements	Compliance Status	
Risk Management Framework		
1.1	The agency head is responsible and accountable for risk management in the agency	compliant
1.2	A risk management framework that is appropriate to the agency has been established and maintained and the framework is consistent with AS/NZS ISO 31000:2009	compliant
Internal Audit Function		
2.1	An Internal Audit function has been established and maintained	compliant
2.2	The operation of the internal audit function is consistent with the International Standards for the Professional Practice of Internal Auditing	compliant
2.3	The agency has an Internal Audit Charter that is consistent with the model of the "model charter'	compliant
Audit and Risk Committee		
3.1	An independent Audit and Risk Committee with appropriate expertise has been established	compliant
3.2	The Audit and Risk Committee is an advisory committee providing assistance to the agency head on the agency's governance processes, risk management and control frameworks, and its external accountability obligations	compliant
3.3	The Audit and Risk Committee has a Charter that is consistent with the content of the 'model charter'	compliant

MEMBERSHIP

The chair and members of the Audit and Risk Committee are:

- Independent Chair– Ms Claudia Bels appointed from 1 February 2013 to 31 January 2016, extended to 31 August 2016 and reappointed as Independent Chair to 31 August 2020.
- Independent Member – Mr Ray Petty appointed from 1 September 2012 to 31 August 2015, extended to 31 August 2016 and reappointed as independent member to 31 August 2020.
- Independent Member- Mr Norman Smith appointed from 18 May 2016 to 17 May 2018 and reappointed as independent member to 17 May 2021.

Sue Dawson
Commissioner
Health Care Complaints Commission

25 September 2018

Agency Contact Officer:
Eddie Van Den Bempt
Director, Corporate Operations
and Chief Financial Officer
E EVanDenBempt@hccc.nsw.gov.au

COMPLIANCE WITH THE NSW *CARERS (RECOGNITION) ACT 2010*

The NSW *Carers (Recognition) Act 2010* (the Act) was introduced to formally recognise the significant contribution carers make to the people they care for and the community, by enacting the NSW Carers Charter and establishing the Carers Advisory Council.

The Act requires public sector agencies to:

- take reasonable steps to ensure that staff are aware of and understand the NSW Carers Charter,
- consult with carers or organisations that represent carers when developing policies that impact on carers, and
- have regard to the Carers Charter when developing their human resource policies.

The Act also places additional obligations on human service agencies, of which the Commission is deemed to be one. In addition to their obligations as public sector agencies, human service agencies must ensure that the principles of the Carers Charter are reflected in their core work. Human service agencies are also required to report annually on their compliance with the Act. The Commission report on compliance is:

- **Education strategies:** Staff at the Commission are expected to comply with the Commission's Code of Conduct, which is covered in staff induction training. The Commission's Code reflects the core principles and values outlined in the Carers Charter around integrity, diversity and service. In addition, there was promotional material around the Commission office.
- **Consultation and liaison with carers:** Participation by the Director, Customer Engagement and Resolution in the Carer Rights & Complaints Network. Policies that were reviewed and updated in 2017-18, such as the P Card Policy and Travel Policy and Procedures, were internally focused and did not directly affect carers.
- **Staff carer support:** As outlined earlier, Commission staff have access to flexible working arrangements and these can be utilised by staff who are carers, particularly for children and elderly parents.

Information and communications technology

The Information and Communications Technology (ICT) Strategic Plan 2017-20 outlines the actions to be taken to ensure that the Commission's operations are well supported by secure and efficient information and communication technology. Improvements in this area are central to maintaining performance in a climate of year on year growth in complaints.

Actions taken under this plan in 2017-18 are detailed below.

ICT INFRASTRUCTURE UPGRADE

During this period the Commission:

- Implemented a dedicated secure link to the Government Data Centre site at Silverwater, to enable the secure provision of HR and Finance related outsourced transactional services and GovConnect support services
- Replaced existing servers, storage, network & security infrastructure
- Introduced dual monitor capability across the Commission to facilitate the corporate objective of implementing a 'paperlite' work environment
- Replaced the PABX system with Voice Over Internet Protocol (VOIP) digital telephony. The new VOIP system allows for automated answering which ensures callers are directed to the correct area obviating the need for reception to answer every call, freeing up time to be utilised for other duties. It also provides a better caller experience through call and queue management. This means rather than a staff member needing to be available, a caller can elect to hold or go through to a message service depending on the hold time.
- Installed new multi-functional (MFD) devices capable of copying, scanning and printing
- Implemented faster internet links and provided redundancy for these links
- Improved the secure file transfer (SFTP) service for the provision and receipt of large files from external stakeholders.

ENHANCEMENTS TO THE CASE MANAGEMENT SYSTEM

In 2017-18, the Commission's core case management system (Casemate) has undergone ongoing development to provide staff with new or enhanced features to assist them with the handling of complaints, managing caseloads and monitoring performance.

These improvements include:

- General upgrade of Casemate to deliver:
  - an improved search function
  - more efficient core applications
  - greater support for the latest versions of Microsoft Office
  - greater support for the latest Microsoft Operating Systems.
- Improved system stability and performance.
- Introduction of a workflow module (EMF) which will support the automation of intake and on-boarding of complaints – eComplaints.
- The customisation of stages within the assessment process based on chosen pathway, to reduce the amount of time required to set up new assessment processes and to guide staff through assessment steps that are relevant to the specific types of complaint.
- Improved management information reports to support case management and performance reporting.

INFORMATION SECURITY

Digital Information Security Policy

Measures to continue compliance with the NSW Government's digital information security requirements for the public sector, included:

- Monitoring the Digital Information Security Policy (DISP) to ensure security classifications were being used correctly and staff awareness programs were provided to new staff.
- An audit of the Commission's ISMS (Information Security Management System) to ensure it was aligned to the requirements of DISP (Digital Information Security Policy).

ISO27001 Standard for Information Security

The Commission has actively operated and maintained its Information Security Management System (ISMS) since achieving accreditation to the ISO27001:2005 Standard for Information Security. It continues to maintain its accreditation, by regularly reviewing and updating relevant policies and procedures, ensuring a program of continual improvement for information security, and conducting regular internal and independent external audits.

The last independent annual external audit was successfully completed in November 2017. During this audit, the Commission maintained its certification to the ISO 27001:2013 Standard. The ISMS is a systematic approach to managing sensitive company information so that it remains secure. It includes people, processes and ICT systems by applying a specific risk management process. The next surveillance audit is due in December 2018.

Information security and protection of the Commission's systems data from disruption or inappropriate access or use will continue to be a focus for 2018-19.

RECORDS MANAGEMENT

In 2017-18, the Commission undertook a number of records-related projects, including:

- the ongoing identification and preparation of records for future transfer to the State Archives.
- digitising approximately 7,600 paper-based case and corporate files, which significantly reduced offsite storage costs of paper files

INTERNET AND INTRANET WEBSITE ENHANCEMENTS

During this period the Commission's public website was maintained to ensure ongoing compliance with the Web Content Accessibility Guidelines (WCAG) 2.0 AA accessibility Standard, as required by the Premier's Circular C2012-08.

eComplaints – a reliable, modern and fit-for-purpose online portal

As part of the transition to more flexible and modern complaints management processes, and to maintain a customer focus in everything that it does, the Commission is implementing an eComplaints portal. Complaints may still be lodged in writing rather than via eComplaints but lodgements via the portal deliver clear benefits to a complainant, provider and the Commission.

How it works for users

Launched on 16 July 2018, the eComplaints portal allows a complainant to have real-time access to information on the assessment of their complaint, from the initial lodging of the complaint through to the Commission's assessment decision on the complaint.

Complaints may be lodged using either of two methods:

- Lodging without registering: Once lodged, users are provided with a unique submission ID and passkey which enables them to view the status of that complaint only.
- Create a user profile: They create a new user profile or they also have the convenient option of using their credentials from common social applications such as Facebook and Google. The advantage of a user profile is that users are able to see and monitor all of their complaint history.

Complainants then receive an acknowledgment/ confirmation of their complaint and have access to a "My Matters" page which provides the current assessment status of complaints. They are provided with the details of the assessment officer dealing with their complaint and are given information on the process of assessment as well as the timeline required to finalise the assessment of the complaint.

Once assessed, the complainant is notified of the Commission's decision and is also provided with a URL when decision letters are sent that allows direct access to request a review of the decision for the specific case.

In addition, they are able to submit customer feedback and inquiries electronically through an online form and the data is interfaced into the Commission's case management system.

Providers are also able to track the status of any complaints made about them through creating a user profile.

Benefits for the Commission

This initiative is essential to enabling the Commission to respond in a more timely way to the growing volume of complaints because it replaces manual processes with automated processes and removes duplication of effort.

The eComplaints portal automates the intake of complaints, inquiries, review requests and satisfaction surveys into the complaints management system (Casemate). This new web based online portal allows data to be seamlessly captured and integrated into Casemate, eliminating the previous labour intensive and inefficient efforts, which not only took much longer but also had the potential to introduce data entry errors.

Next stage

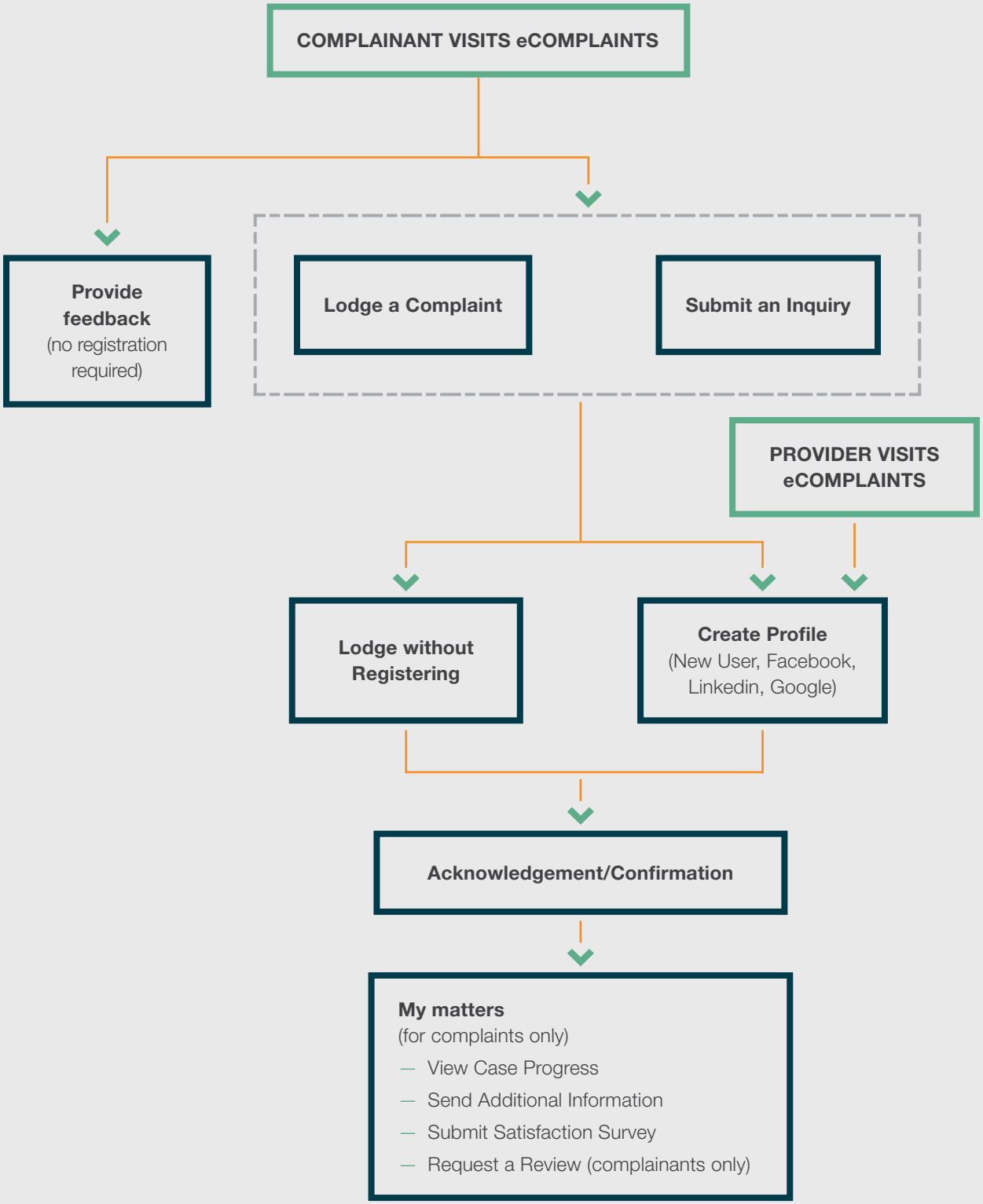
The next stage is to automate all steps relating to the way we exchange complaints and consult on them with the professional councils for registered practitioners. This portal will involve two key functionalities:

(i) Notifications to and from Professional Councils: Daily data feeds will enable the electronic intake of notifications from Professional Councils e.g. where a complaint is made to a Professional Council, this triggers a Section 11 notification by the relevant Council to the Commission. Similarly where a complaint is made about a registered practitioner to the Commission, the Commission must notify the appropriate professional council in terms of Section 10 of the Health Care Complaints Act 1993.

(ii) Professional Council consultation: The system will enable the Councils to log in and review cases set down for consultation. For each case to be consulted on, the details will be listed, together with supporting documentation, and the Commission's recommended outcome. The Council will then be able to review and set whether they agree with the Commission's recommendation, disagree with the recommendation, or wish to discuss the case further. Those cases that have an agreed outcome from both the Commission and Professional Council will be automatically recorded and will not need to proceed to face-to-face consultation meeting.

This will significantly improve the timeframes within which outcomes can be notified to both complainants and providers.

eComplaints Portal Flow



Digital Information Security Annual Attestation Statement for the 2017-18 Financial Year for the Health Care Complaints Commission

I, Sue Dawson, Commissioner am of the opinion that the Health Care Complaints Commission had an Information Security Management System in place during the financial year being reported on consistent with the Core Requirements set out in the Digital Information Security Policy for the NSW Public Sector.

I am of the opinion that the security controls in place to mitigate identified risks to the digital information and digital information systems of the Health Care Complaints Commission are adequate for the foreseeable future.

I am of the opinion that all Public Sector Agencies, or part thereof, under the control of the Health Care Complaints Commission with a risk profile sufficient to warrant an independent Information Security Management System have developed an Information Security Management System in accordance with the Core Requirements of the Digital Information Security Policy for the NSW Public Sector.

I am of the opinion that, where necessary in accordance with the Digital Information Security Policy for the NSW Public Sector, certified compliance with AS/NZS ISO/IEC 27001 Information technology – Security techniques – Information security management systems – Requirements had been maintained by all or part of the Health Care Complaints Commission and all or part of any Public Sector Agencies under its control.

Sue Dawson
Commissioner
Health Care Complaints Commission

Legislative change

In 2017-18 the *Health Practitioner Regulation Amendment Act* (Amending Act) commenced, which made various consequential changes to NSW legislation. The changes, among other things, bring paramedics into the national registration and accreditation scheme. Paramedic registration is expected to commence in December 2018. The Amending Act amends the *Health Practitioner Regulation National Law (*the NSW National Law) to establish the Paramedicine Council which will become the 15th professional council and a coregulatory partner with the Commission to manage complaints about paramedics, once paramedic registration commences. The Amending Act also:

- includes a new s127AA into the NSW National Law which allows a Board to make a NSW review body (which is defined in the NSW Act as a Council) to become the review body for conditions imposed or undertakings given in other jurisdictions.
- if there has been an undertaking given to a National Board by the practitioner, the Council can revoke the undertaking and impose similar conditions instead (as the NSW National Law does not provide for the making of undertakings).
- amends the *Health Care Complaints Act 1993* to, among other things:
  - provide that if a paramedic was subject to a complaint prior to registration, then the provisions relating to the powers of the Commission in relation to unregistered health practitioners continue to apply even if the paramedic becomes registered, and
  - redraft s94B (publication of information about decisions) to clarify that the Commission must publish decisions.
- amends the *Health Services Act 1997* to ensure that the mandatory reporting requirements of chief executives in respect of registered health practitioners apply to the Ambulance Service of NSW.
- amends the *Interpretation Act 1987* to remove the specific definitions of each registered health practitioner and instead to refer to the NSW National Law.

The Health Practitioner Regulation (New South Wales) Amendment (Paramedicine Council) Regulation 2017 (Amending Regulation) also commenced, which sets the composition of the Paramedicine Council, being four practitioner members, a lawyer and a community member.

In addition, the *Health Legislation Amendment Bill (No 2) 2018* was assented to on 30 May 2018 which made a number of amendments to various health-related Acts, as below:

Health Care Complaints Act 1993

- to ensure disqualified health practitioners will be subject to the same provisions relating to publication of Tribunal decisions as cancelled health practitioners.

***Health Practitioner Regulation National Law (NSW)* (Schedule 2)**

- To sections 155C and s163A, to allow the NSW Civil and Administrative Tribunal (NCAT) to review conditions that were imposed on the registration of a health practitioner by a health professional council, such as the Medical Council of NSW, with the practitioner's consent.
- To section 159C, to allow NCAT, in exercising its review functions, to have the same powers as the original decision-making health professional council.
- To section 159, to allow a health practitioner to appeal against a reprimand issued by a health professional council, such as the Dental Council of NSW.
- To Schedule 5E, to remove the ability of the Minister to remove members of an assessment committee. This power will instead be given to the health professional council that appoints members of the committee.
- To sections 150G and 176D, to ensure that suspended health practitioners are not considered registered health practitioners under any legislation, other than Part 8 of the National Law (which relates to dealing with the complaint against the suspended practitioner).

Private Health Facilities Act 2007

- Creates a new offence for a person to provide prescribed services or treatments in an unlicensed private health facility.
- Gives authorised officers expanded enforcement and compliance powers in relation to private health facilities allegedly carrying out cosmetic procedures (requiring people to answer questions and produce documents and enable authorised officers to be accompanied by other officers).

Poisons and Therapeutic Goods Act 1966

- Enables regulations to be made relating to the possession, manufacture, supply, use, prescription, administration, disposal and/or storage of medicines used in cosmetic procedures, such as botulinum toxin (Botox) and dermal fillers.

Public Health Act 2010

- Establishes a legislative framework to allow the Chief Health Officer to issue public health warnings
- Ensures disqualified health practitioners are subject to the same constraints as cancelled health practitioners in relation to providing or advertising health services.