2009–10 Annual Report

HEALTH CARE COMPLAINTS COMMISSION

HEALTH CARE
COMPLAINTS
COMMISSION

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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.

HEALTH CARE COMPLAINTS COMMISSION

The Hon Carmel Tebbutt MP
Minister for Health
Governor Macquarie Tower
Level 30, 1 Farrer Place
SYDNEY NSW 2000

Dear Minister

Report of activities for the year ended 30 June 2010

I am pleased to provide the Annual Report and financial statements of the Health Care Complaints Commission and the Office of the Health Care Complaints Commission for the financial year ended 30 June 2010 for presentation to the Parliament of NSW.

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

Kieran Pehm
Commissioner

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About the Commission

Vision

The NSW Health Care Complaints Commission is an independent body that deals with complaints about health service providers to protect the health and safety of the public.

Charter

The Commission was established by the *Health Care Complaints Act 1993* to deal with complaints about health service providers in NSW, including:

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

The Commission:

- responds to inquiries from health consumers
- assesses complaints about health service providers
- assists in the resolution of complaints
- investigates complaints that raise serious issues of public health and safety
- takes action in relation to unregistered health practitioners
- prosecutes serious complaints against registered health practitioners.

In addition to these complaint-handling functions, the Commission informs the public and its stakeholders about its work.

Code of Practice

The Commission's Code of Practice summarises what the public can expect from the Commission when it deals with complaints.

The Code of Practice is available on the Commission's website.

Values

The trust and confidence of the public are essential to the Commission successfully performing its role.

The standards of professional and ethical conduct that guide the Commission's work include:

- independence
- impartiality
- accountability
- accessibility
- responsiveness
- timeliness
- confidentiality.

Stakeholders

The Commission works within a complex network of stakeholders that can be grouped into three broad categories.

The first category – health consumers and the community – covers:

- patients, their families and carers
- health consumer bodies – many of whom are represented on the Commission's Consumer Consultative Committee
- the diverse communities of NSW
- the media.

The second category – health professionals – includes:

- registered health practitioners
- health registration authorities
- unregistered health practitioners
- health professional bodies, including colleges and associations
- health services such as hospitals
- universities and other health education providers.

The third category – NSW government stakeholders – covers:

- Parliament and its Committee on the Commission
- the Minister for Health
- the Department of Health
- Area Health Services
- the Clinical Excellence Commission
- other public sector agencies.

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Commissioner's foreword

The environment in which the Commission works changed significantly on 1 July 2010 when the national registration scheme for health practitioners started.

Although NSW has maintained the role of the Commission in dealing with complaints, the standardisation of the law guiding prosecutions across all registered health professions has brought substantial change. The Commission is working effectively with its co-regulators, the health professional councils, and the changes are expected to improve the handling of complaints in future.

The Commission's work continued to expand. The number of inquiries and written complaints increased from previous years but, despite the extra load, the Commission managed to keep pace.

Complaints about public hospitals are a significant part of the Commission's work. The Commission has found that the local 'root cause analysis' of serious incidents has become better in identifying systemic issues and recommending measures to prevent similar incidents from happening again.

In addition, public health service providers have increasingly engaged in 'open disclosure' about the reasons for adverse events to patients and their families.

Both recommendations for systemic improvements and better explanations to patients and their families have helped the Commission in deciding on the best way of dealing with complaints and identifying the serious complaints that require formal investigation.

As a result, fewer complaints have been assessed for investigation. At the same time, the proportion of investigations that lead to the prosecution of individual practitioners or recommendations for systemic improvements has increased.

A growing area of work for the Commission is complaints about unregistered health practitioners. To identify appropriate standards in the broad area of alternative health services, the Commission has worked with relevant professional bodies to obtain expert views on acceptable standards.

Increasing complexity in the delivery of health services and high public expectations of patient-centred care will make the Commission's work more demanding in the future.

I would like to thank the hard working staff of the Commission who continue to rise to the increasing challenges of their work.

Kieran Pehm
Commissioner

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Executive summary

2009-10 was a challenging year for the Commission. For the fourth consecutive year, there have been increasing numbers of inquiries and complaints.

The introduction of the national registration scheme for health practitioners saw substantial changes to the legal and organisational environment in which the Commission operates.

The new registration scheme started on 1 July 2010, and the Commission must establish working relationships with the new national boards and the Australian Health Practitioner Regulation Agency that provides the national boards with administrative support. In addition, the Commission will continue to work with its co-regulators, the NSW Professional Councils, and the Health Professional Council Authority in NSW.

The continuation of the co-regulatory system in NSW is evidence of the strong work of the Commission. The support shown by the registration boards and other stakeholders for the Commission's continued role in investigating and prosecuting registered health practitioners demonstrates their trust in the Commission and recognises the value of its work in past years.

The coming year will bring major changes with the introduction of the hospital network reforms. It is anticipated that the current structure of the public health system in NSW will be replaced by smaller hospital networks. The Commission will have to establish relationships with each of these new networks and inform them on its role and work in order to deal with complaints about public health providers in an effective and timely manner.

Legislative changes

There were significant legislative changes resulting from the introduction of the national registration scheme for health practitioners. These are summarised in chapter 5.

In addition, a number of other legislative amendments affected the Commission's work. These are discussed in chapter 6, together with recommendations for amendments to the *Health Care Complaints Act* by the Parliamentary Committee on the Health Care Complaints Commission.

Financial summary

In 2009-10, the Commission had a total budget of about $10.7 million. The Commission has operated within a decreased budget, while having to deal with an increased number of complaints. Despite this, the Commission managed to finish the year with only a small deficit of $61,000 in the net cost of services.

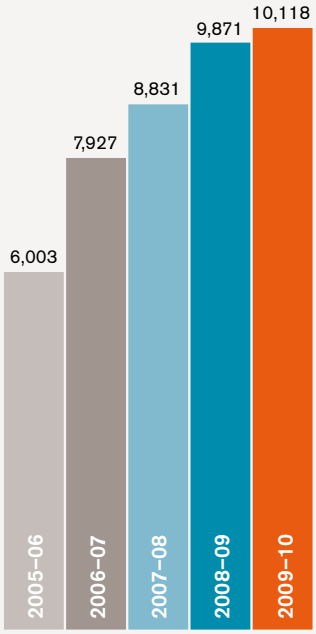
Corporate goals

The Commission's achievements, as measured against its corporate goals for 2009-10, are summarised throughout the report:

- Comprehensive and responsive complaints handling – chapters 11 and 12
- Investigating serious complaints – chapter 13
- Prosecuting serious complaints – chapter 14
- Being accountable – chapter 7
- Continuously improving the Commission – chapter 16.

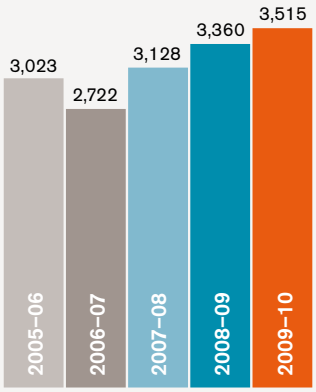
Key indicators of the Commission's performance as compared to previous years are summarised on the following pages.

Chart 4.1
Number of inquiries received
2005-06 to 2009-10



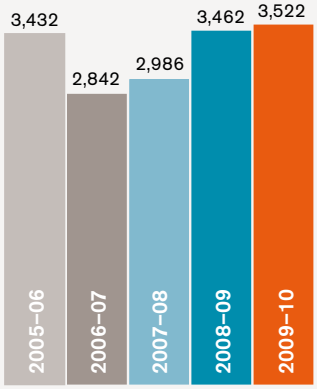
Counted by inquiry

Chart 4.2
Number of complaints received
2005-06 to 2009-10



Counted by provider

Chart 4.3
Number of complaints finalised
2005-06 to 2009-10



Counted by provider

Inquiries

In many cases, the Inquiry Service is the first point of contact for people who wish to make a complaint about health care. Inquiry Officers can talk people through options to resolve their concerns without the need to lodge a formal complaint. They can also assist people to put their concerns in writing.

In 2009-10, the Commission dealt with more than 10,000 inquiries – a rise of 2.5% from the previous year. As shown in Chart 4.1, the number of inquiries has continued to grow significantly over the past five years.

Written complaints

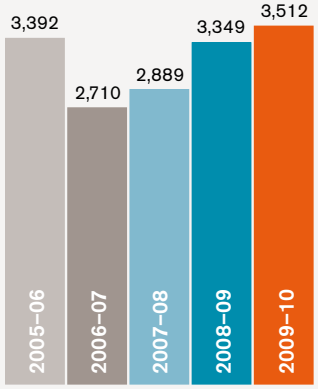
2009-10 also saw an increase in the number of written complaints to the Commission. As shown in Chart 4.2, the number of complaints increased to a record 3,515 – a rise of 4.6% from the previous year.

Complaints finalised

Chart 4.3 sets out the number of complaints finalised over the last five years. The high number of complaints finalised in the last two years reflects the high number of incoming complaints in the same period.

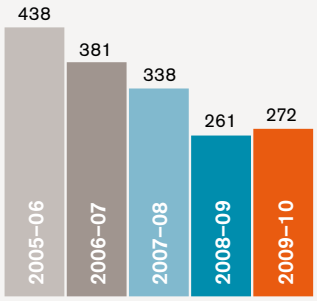
In general, the Commission has managed to keep up with the higher number of incoming complaints with a decreased number of staff.

Chart 4.4
Number of assessments finalised
2005-06 to 2009-10



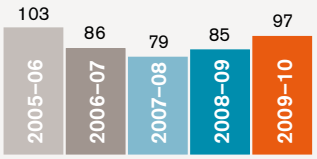
Counted by provider

Chart 4.5
Number of investigations finalised
2005-06 to 2009-10



Counted by provider

Chart 4.6
Number of legal matters finalised
2005-06 to 2009-10



Counted by matter

Assessments finalised

As shown in Chart 4.4, the Commission finalised the assessment of 3,512 complaints in 2009-10, keeping up with the 3,515 complaints that were received during the same period.

The Commission's Assessment Officers have managed the increased number of incoming complaints with only a slight drop in the timeliness of finalising assessments.

In 2009-10, 82.3% of complaints were assessed within the statutory 60-day period, as compared to 88.9% in 2008-09. On average, new complaints were assessed within 46 days in 2009-10, as compared to 42 days in the previous year.

Investigations finalised

A smaller proportion of complaints were referred for investigation because the Commission has become more thorough during its assessment of complaints.

In 2009-10, 223 complaints were assessed as raising serious issues that warranted investigation. In the same period, the Investigations Division finalised 272 investigations, as shown in Chart 4.5. The majority of these were referred to the Director of Proceedings to consider disciplinary action.

The timeframes for investigation remained stable, with an average turnaround time of 278 days, as compared to an average of 274 days in 2008-09.

Legal matters finalised

The Legal Division dealt with an increasing number of matters being referred to it. In 2009-10, the Division finalised 97 matters – an increase of 14.1% on the previous year.

The overall success rate of prosecutions before Professional Standards Committees and Tribunals was 90.5%. In 2009-10, thirteen nurses, ten medical practitioners, three psychologists, two pharmacists, one dentist and one physiotherapist were deregistered. In addition, two nurses, one medical practitioner, one dentist and one psychologist were suspended. A further 29 registered health practitioners were cautioned, reprimanded and/or had conditions imposed on their registration.

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Legislative changes National registration scheme

In 2008, the Council of Australian Governments agreed to establish a national registration scheme for health practitioners by 1 July 2010. Health practitioners who previously had to register in one or more states or territories of Australia are now registered once at a national level and entitled to practise anywhere in Australia.

There are national registration boards for ten health professions, including medical practitioners, nurses and dentists. All of the national boards are administratively supported by the Australian Health Practitioner Regulation Agency.

Dental technicians and optical dispensers, who were previously registered practitioners in NSW, are not part of the national registration scheme.

Legal changes

In 2009, the NSW Parliament passed the *Health Practitioner Regulation (Adoption of National Law) Act*. This Act implemented the national registration scheme in NSW, with the exception of the part dealing with the handling of complaints. It came into effect on 1 July 2010.

In June 2010, the NSW Parliament passed the *Health Practitioner Regulation Amendment Act*. This Act amended a variety of health-related legislation in NSW to complement the national registration scheme and maintain the effect of the existing complaint handling arrangements in NSW. The Act took effect on 1 July 2010.

Impact of the changes

Outside NSW, the national health profession boards are responsible for handling complaints about registered health practitioners, including the investigation and prosecution of complaints. In NSW, the Commission continues to investigate complaints about registered health practitioners and, where appropriate, prosecutes them.

To maintain the co-regulatory relationships between the Commission and the health professional boards for handling complaints about registered health practitioners, NSW has established councils that liaise with the Commission. Where a complaint is made to a national board or a NSW council about a practitioner practising in NSW, the complaint must be notified to the Commission. The Commission must also notify the council of complaints that it receives and consult on the appropriate way of dealing with them.

The health and performance assessment programs of the former NSW Medical Board and Nurses and Midwives Board are being continued by the relevant NSW councils. The legislation also allows for similar programs to be established for all other registered health professions as of 1 July 2010.

The NSW legislation has extended the model for the prosecution of medical practitioners before Professional Standards Committees to nurses and midwives. This means that:

- Professional Standards Committees are generally open to the public
- decisions are generally publicly available
- chairpersons are legally qualified
- legal representation is allowed at hearings.

Mandatory reporting

Since October 2008, medical practitioners in NSW had a legal obligation to report another medical practitioner to the NSW Medical Board where they reasonably believed that the other practitioner had:

- practised while intoxicated by drugs or alcohol
- practised in a way that was a flagrant departure from accepted standards of professional practice or competence, and risked harm to some other person
- engaged in sexual misconduct in connection with the practice of medicine.

The national registration scheme has imposed mandatory reporting obligations on all registered health practitioners as well as on their employers and education providers. Practitioners and employers are required to make a report to the Australian Health Practitioners Regulation Agency where they have a reasonable belief that a practitioner has engaged in 'notifiable conduct' – that is, the practitioner has:

- practised their profession while intoxicated by drugs or alcohol
- engaged in sexual misconduct in connection with the practice of their profession

- placed the public at risk of substantial harm in the practice of their profession because they have an impairment
- placed the public at risk of harm because they have practised in a way that constitutes a significant departure from accepted professional standards.

Practitioners must report notifiable conduct by any registered health practitioner. For example, if a nurse reasonably believes that a doctor has engaged in notifiable conduct, the nurse is required to report the matter.

Protection from liability

Practitioners are protected from civil and criminal liability and have a defence to any defamation claim, if they make a report in good faith. The same protection applies to a person who provided information on the basis of which the notification was made or was otherwise involved in the making of a notification.

Exemptions from mandatory reporting

Practitioners are exempt from mandatory reporting where they:

- know or reasonably believe that the notifiable conduct has already been reported
- are providing advice about notifiable conduct for the purpose of legal proceedings or the preparation of legal advice
- work for an insurer that provides professional indemnity insurance, and become aware of notifiable conduct as a result of legal proceedings or the provision of legal advice arising from the insurance policy
- are also a legal practitioner, and are providing legal services to a health practitioner, who has allegedly engaged in notifiable conduct, for legal proceedings or legal advice
- are a member of a quality assurance committee, health professional council or other approved health body, and are prohibited by legislation from disclosing the notifiable conduct.

Failing to make a mandatory report

A practitioner's failure to make a mandatory report is not a criminal offence. However, it could form the basis for a complaint about the practitioner that might become the subject of an investigation and, in a serious case, lead to the practitioner being prosecuted before a disciplinary body.

Dealing with reports of notifiable conduct

If the Australian Health Practitioner Regulation Agency receives a mandatory report about a practitioner in NSW, it will forward it to the relevant NSW council. The council can take immediate temporary action to protect the public health and safety, such as suspending the practitioner or imposing conditions on their practice. The council may also deal with the practitioner through its impairment program and/or performance assessment program.

If the council makes a complaint about the reported conduct to the Commission, the Commission is required to assess the complaint. The assessment process could result in the Commission investigating the complaint and referring the matter to the Director of Proceedings to determine whether disciplinary proceedings should be instituted.

Further information about mandatory reporting

The Commission has included detailed information about the new mandatory reporting obligations on its website. The various national boards have also developed guidelines to assist practitioners in understanding their reporting obligations, and these can be accessed through the boards' websites.

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Other legislative changes

As well as the legislative changes resulting from the introduction of the national registration scheme, as discussed in chapter 5, there were other legislative amendments during the year that had an impact on the Commission.

In addition, the Parliamentary Committee on the Health Care Complaints Commission recommended a number of changes to the *Health Care Complaints Act*.

This chapter summarises the relevant legislative amendments and the Parliamentary Committee's recommendations.

Extended powers for the Commission

Investigating a dental technician

In 2009, the Commission investigated a complaint that a dental technician had been carrying out dentistry, even though he was not qualified to do so. The Commission's investigation involved obtaining and executing a search warrant on the dental technician's premises, during which he admitted that he was not qualified to provide dental services but had nevertheless been doing so.

The Commission then prepared a draft report and, as required by the procedural fairness provisions of the *Health Care Complaints Act*, invited the dental technician's submissions on this report. The Act required the Commission to give the dental technician 28 days to make submissions.

The Commission's final report found that the dental technician had been performing dentistry although not qualified to do so. As a result of this finding, the Commission issued a prohibition order banning him from performing dentistry.

Shortcomings in the Commission's powers

While the outcome of this investigation was satisfactory, the case revealed a number of shortcomings in the Commission's powers.

First, the Commission's ability to seize documents during the execution of a search warrant was limited. The Commission could only take documents with the consent of the occupier. Furthermore, even if consent was given, the Commission could only retain the documents for a maximum period of 24 hours to copy them, after which the documents had to be returned. While the Commission had the power to copy documents on site, there could be practical difficulties if there were a large number of documents relevant to the investigation.

Second, the Commission had no power to seize drugs. To overcome this problem in the case of the dental technician, the Commission had to bring along an inspector from the Pharmaceutical Services Branch of the Health Department who was authorised to seize drugs.

Third, the Commission could only make a prohibition order banning an unregistered health practitioner from providing health services after it had completed the investigation. During the investigation and the period within which the practitioner was entitled to make submissions, the practitioner would still be able to provide health services even though this posed a serious risk to public health or safety.

To overcome all of these problems, the Commission recommended that appropriate amendments should be made to the *Health Care Complaints Act*.

The new powers

In June 2010, the NSW Parliament passed the *Health Practitioner Regulation Amendment Act*. This legislation, which came into effect on 1 July 2010, amended the section of the *Health Care Complaints Act* that governs the Commission's powers of entry, search and seizure. This means that the Commission may now remove records to take copies. The records must be returned 'as soon as practicable', rather than within 24 hours. In addition, the Commission can seize drugs and other substances from the premises.

The amending legislation also added a new section to the *Health Care Complaints Act* which permits the Commission to make an interim prohibition order against an unregistered health practitioner during the investigation. The Commission can make such an order if it:

- reasonably believes that the practitioner has breached the code of conduct for unregistered health practitioners, and
- considers that the practitioner poses a serious risk to the health or safety of members of the public, and that an interim prohibition order is therefore necessary.

An interim prohibition order may ban the practitioner from providing health services and/or place appropriate conditions on the practitioner. The order remains in force for eight weeks or a shorter specified period.

Changes to the code of conduct for unregistered health practitioners

As a result of the introduction of the national registration scheme, optical dispensers and dental technicians are no longer registered health practitioners in NSW. Practitioners in these two professions are now governed by the code of conduct for unregistered health practitioners.

To accommodate this, and also to enhance the code of conduct, some amendments to the code were made by the *Health Practitioner Regulation Act 2010*.

The following two provisions were added to the requirement of the code that practitioners must provide health services in a safe and ethical manner:

- Unregistered health practitioners must not provide services that they are not qualified to provide.
- They must not use their qualifications to mislead or deceive clients about their competence in their field of practice or their ability to provide treatment.

In addition, a new clause was added that is specifically directed to the sale and supply of optical products. This provides that a health practitioner must not sell or supply:

- an optical appliance (other than cosmetic contact lenses) – unless there is an appropriate prescription
- contact lenses – unless they were licensed under the *Optical Dispensers Act*, or have an optical dispensing certificate or equivalent qualification.

A health practitioner who sells or supplies contact lenses must also provide the client with written information about the care, handling and wearing of contact lenses, and possible adverse reactions.

Review of the 'root cause analysis' legislation

Where a serious adverse event happens in a public hospital, the *Health Administration Act* requires the Area Health Service to appoint a 'root cause analysis' (RCA) team to report on any systemic factors that may have contributed to the event. The RCA process is protected by a legal privilege, meaning that the information obtained by the RCA team cannot be disclosed or used in civil or disciplinary proceedings.

As required by the legislation, the Department of Health conducted a review of the RCA process. This involved the publication of a discussion paper in June 2009[1] and the consideration of submissions from various stakeholders, including the Commission.[2]

The Department's report was published in August 2009[3] and made the following recommendations about the RCA privilege:

- The privilege should be retained.
- Communications for the 'dominant' purpose of an RCA should not be disclosed. (The test under the existing legislation was whether the communication was 'solely' for an RCA.)
- The legislation should clarify that an RCA report can be disclosed to any person.
- An RCA report should not be admissible in any proceedings except those concerning an act or omission by the RCA team or one of its members. (This recommendation was designed to make RCA reports inadmissible in coronial proceedings.)

The review report also made recommendations about the operation of RCA teams, including:

- There should be a discretion to establish an RCA team for a clinical incident other than the most serious type where the incident potentially raises systemic issues.
- The legislation should clarify that an RCA team did not have to make recommendations if the incident did not raise any systemic issues.
- RCA teams should be able to immediately notify systemic issues involving a risk of serious and imminent harm to patients.

1 Department of Health, *Discussion Paper – Statutory privilege in relation to root cause analysis and quality assurance committees*. The discussion paper can be accessed through the Department of Health's website www.health.nsw.gov.au
2 The Commission's submission can be accessed through the Commission's website http://www.hccc.nsw.gov.au
3 Department of Health, *Final report – Review of statutory privilege in relation to root cause analysis and quality assurance committees under the Health Administration Act 1982*. The report can be accessed through the Department of Health's website www.health.nsw.gov.au

- Where an RCA team has concerns about an individual practitioner, it should be required to disclose the name of the practitioner and the nature of the concerns.
- The Clinical Excellence Commission or another appropriate body should be permitted to carry out an annual review of a sample of RCA investigations and reports to ensure the integrity of RCA processes.

All of these recommendations were implemented through the *Health Legislation Amendment Act 2010*, which amended the RCA provisions of the *Health Administration Act* and the *Private Health Facilities Act*. The amendments therefore apply to both public hospitals and private health facilities.

The amendments have not yet come into effect because the Department of Health plans to coordinate their commencement with a revised Incident Management Policy that complements the legislation. The Department has advised the Commission that the changes to the RCA regime will be in place in late 2010.

The review report also recommended that the Department of Health develop a plain English guide for patients and their families to explain what the RCA process can and cannot achieve. This is to ensure that patients and their families understand that:

- the RCA process focuses on systemic issues and not the conduct or performance of individual practitioners
- the RCA report will not necessarily answer all of their questions about the adverse event
- there are alternative avenues available to them to pursue any complaints or outstanding concerns.

The Department of Health has advised that this recommendation is still being considered.

Recommendations to amend the *Health Care Complaints Act*

In October 2008, the Parliamentary Committee on the Health Care Complaints Commission initiated an inquiry into the operation of the *Health Care Complaints Act*. The Committee published a discussion paper in September 2009, considered submissions from a variety of stakeholders, and held public hearings in March 2010 at which 17 witnesses gave evidence. The Commission provided two submissions and gave evidence at the public hearing.[4]

In June 2010, the Committee published its final report[5] and recommended a number of amendments to the *Health Care Complaints Act*:

- The Act should include governing principles for the Commission and related government agencies – accountability, transparency, fairness, effectiveness, efficiency and flexibility.
- The Commission should have the power to initiate 'own motion' investigations into issues of public interest or public safety.
- The Commission should be able to extend the 60 day period for the assessment of complaints in 'exceptional circumstances'.
- The Commission should have to give reasons for its assessment decisions and post-investigation decisions to both complainants and health service providers.
- In addition to the existing power to notify the practitioner's employer at the time of the incident, the Commission should also notify the practitioner's current employer of a complaint where this is necessary to effectively investigate the complaint or is otherwise in the public interest.
- Area Health Services should notify the Commission of the most serious adverse events in public hospitals. The Commission should assess whether it should investigate the incident and report back to the Area Health Service.
- The Parliamentary Committee's role should be expanded to reviewing the functions of the NSW councils for registered practitioners.

Government is considering the Committee's recommendations.

4 The Committee's discussion paper, the submissions to the Committee, and the transcript of the public hearing can all be accessed through the NSW Parliament website www.parliament.nsw.gov.au

5 The Committee's final report can be accessed through the NSW Parliament website www.parliament.nsw.gov.au

07

Outreach

Performance in 2009–10

Corporate goal 'to promote complaint resolution services to people across NSW'

- Commission staff made 79 presentations to community and health professional groups across NSW.

Corporate goal 'to report publicly about the work of the Commission'

- The Commission's annual report for 2008-09 was tabled in Parliament on 26 November 2009.
- In reviewing the annual report, the Parliamentary Committee on the Health Care Complaints Commission commended the Commission on its ongoing improved performance.

  "In terms of the Commission's performance, the Committee in its last Review noted that significant improvements had been made during 2007-08.

  Committee Members are therefore pleased that the Commission's performance has continued to improve, and that the NSW Ombudsman's 'mystery shopper audit' found that Commission staff were 'consistently professional and treated matters of sensitivity well and in a sympathetic manner'.

  Overall, the Committee was pleased to note a concerted effort at both improving the provision of services by the Commission and ensuring that the Commission's services are widely known and utilised."
- Clean audit certificates for the financial statements of both the Health Care Complaints Commission and the Office of the Health Care Complaints Commission were received on 20 October 2009.
- The Commission distributed 198,163 brochures, posters and other information material to stakeholders across NSW (as compared to the 19,073 brochures, posters and other information material distributed in 2008-09).
- The Commission re-launched its website in September 2009.
- There were 40,440 unique visitors to the Commission's website and a total of 3,298,873 hits. (The comparable figures for 2008-09 were 38,987 and 649,424 respectively.)
- In addition to the 79 presentations to community and health professional groups, the Commission provided 21 articles and information packages to special interest media and health professional bodies.

Corporate goal 'to provide timely, accurate and relevant reporting to the Minister and the Parliamentary Joint Committee'

- The Commission provided quarterly reports on its complaint-handling performance to the Minister for Health and the Parliamentary Committee on the Health Care Complaints Commission, with no questions or requests for further information being received.
- The Commission provided 37 responses to Ministerial requests for information about the Commission's handling of particular complaints. On average, responses were provided within 5.7 days, with 89.2% sent within 14 days (target 90%).

The Commission's outreach activities are designed to raise awareness among health consumers, health providers and the general public about the role of the Commission and the services that it provides.

Information material

The Commission uses its experience in complaint handling to provide helpful information to both health consumers and health service providers.

The information for health consumers encourages them to try to resolve any concerns about their care or treatment directly with the relevant health service provider and gives them tips on how to do so.

The Commission also provides advice on issues that are frequently raised by health consumers. For example, the Commission has an information

sheet on fees and costs that explains the differences in fees for public and private patients, and addresses common misunderstandings about bulk-billing and gap payments.

Information for health service providers is intended to help them understand the sort of factors that can lead to complaints, so that they can prevent or resolve complaints in the future. The Commission also provides information on its complaint process to assist providers in responding appropriately to a complaint.

In September 2009, the Commission launched its new website, which offers extensive information to health consumers, health service providers, unregistered health practitioners and expert reviewers. The Commission's annual reports and other corporate documents are also available on the website. In addition, the website includes a new 'frequently asked questions' section, and people can now lodge complaints online.

The website was regularly reviewed and updated throughout the year.

Some publications are available in printed form, including:

- Complaint form
- *Concerned about your health care?* (both a brochure and a poster)
- *Resolve concerns about your health care* (brochure)
- *Assisting you to resolve your complaint* (brochure)
- *Conciliating your complaint* (brochure)
- *Code of Conduct for unregistered health practitioners* (poster)
- Annual reports.

In January 2010, the Commission released an information film entitled 'What happens with health care complaints' that explains the role and functions of the Commission.

The Commission distributed over 500 DVDs of the film to its stakeholders, including health professional bodies and health education providers. The film can also be accessed on the Commission's website.

Assisting people with special needs

To assist people from non-English speaking backgrounds in accessing the Commission's services, key information material and the complaint form are available in 20 community languages on the Commission's website. This information has also been made available through the website of the NSW Multicultural Health Communication Service.

Bi-lingual Commission staff can assist parties to a complaint in their native language. In addition, the Commission regularly arranges for telephone, oral and written interpreter services in a broad range of community languages.

During the year, the Commission used an email service of the Community Relations Commission to distribute the Commission's translated information resources to community groups representing 10 non-English speaking communities in NSW. The Commission also offered to make presentations to local community groups.

During the year, the Commission liaised with the Department of Immigration's Refugee Settlement Program. As a result, the Department's 2010 edition of 'Beginning a life in Australia' includes information about the Commission and how to access its services. This resource for new migrants is available in 38 languages. The Commission also made presentations to refugee settlement and migrant support services in NSW.

The Commission, in cooperation with the NSW Deaf Society, has translated its information film 'What happens with health care complaints' into the Australian sign language AUSLAN. This translation, which is available on the Commission's website, will help people with hearing impairments to access the Commission's services and be guided through the complaint-handling process.

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

The Commission also worked with the NSW Council for People with Intellectual Disability to develop a web-based fact sheet 'Not happy with the doctor'. This illustrated fact sheet is designed to assist people with an intellectual disability to raise concerns about their health care and to access the Commission's services. The fact sheet is available on the Commission's website.

Outreach to the community

An important forum to assist the Commission's understanding of health consumer concerns is the quarterly Consumer Consultative Committee, which brings together representatives of the following organisations:

- Aboriginal Health & Medical Research Council
- Alzheimers Australia NSW
- Association for the Wellbeing of Children in Healthcare
- Carers NSW
- Combined Pensioners and Superannuants Association
- Community Restorative Centre NSW
- Council on the Ageing (NSW)

- Ethnic Communities Council
- Health Consumers of Rural and Remote Australia
- Mental Health Coordinating Council
- NSW Council of Social Services (NCOSS)
- NSW Consumer Advisory Group – Mental Health
- NSW Council for Intellectual Disability
- People with Disability Australia
- Positive Life NSW
- Women's Health NSW
- Youth Action & Policy Association NSW.

Members of the Committee can raise specific issues of current concern and also provide feedback on the Commission's work, especially ways to improve the Commission's outreach.

To increase the awareness of the role of Commission among health consumers and health professionals, the Commission has provided almost 200,000 brochures, posters and other information material across NSW.

Commission staff gave 79 presentations to community groups and health service providers about the Commission's functions and services. This included staff giving three media interviews, including on Spanish and Filipino radio programs.

The Commission continued its commitment to the 'Good Service Forum', a collaboration of 10 complaint-handling bodies. Four forums were held during the year that specifically aimed at providing information and support to members of Aboriginal communities in accessing complaint services.

The Commission published 69 media releases during the year. Most of these were about the outcome of the Commission's prosecutions of registered practitioners.

Outreach to health professions

The Commission provided 17 articles and reports for health professionals. This included eight articles by the Commissioner in 'Australian Doctor', the leading publication for Australian general practitioners.

The Commission reviewed its expert reviewer panel and developed a targeted training plan for its experts. The six training sessions organised by the Commission in 2009-10 were attended by 98 experts.

The Commission continued to consult with the various registration authorities and other health service provider representatives, as well as with the Area Health Services and the Department of Health.

The Commission also provided the Clinical Excellence Commission with its recommendations arising from its investigations of health organisations regarding systemic improvements to the provision of health services. The Clinical Excellence Commission uses these reports for its data analyses and work on system improvements.

Research and international projects

The Commission was involved in a number of national and international research projects. During the year, the Commission:

- supported a doctoral project at Griffith University about decision-making in relation to complaints about counselling and psychotherapy
- assisted in the recruitment of participants for an international study on the relevance of trust between patients and medical practitioners in conflicts resulting from adverse events
- supported a research project on quality and safety improvements resulting from complaint investigations. This joint project of the Australian National University and the University of Sydney is being financially supported by the Australian Research Council, and will be conducted over the next two years.
- assisted the Chinese Hospital Association's research into Australian health care and complaint-handling systems. A delegation of the association visited the Commission in April 2010.
- collaborated with the Clinical Excellence Commission and the University of Sydney on a long-term project examining ways to improve health literacy for patients.

The year ahead

The Commission:

- will consider the broader use of the illustrated information resource 'Not happy with your doctor' for people with low levels of literacy
- will continue its commitment to the 'Good Service Forum'
- will provide further input into the health literacy project.

08

Trends in complaints

The Commission reports on the complaints that it receives and how it deals with them. In addition, the Commission records the issues raised in complaints to identify trends. These may be useful in providing information to health service providers about possible areas of concern that could be addressed by improvements in health service delivery.

The Commission receives complaints about both individual health practitioners and health organisations. If a person complains that they were prescribed the wrong medication, the relevant provider is the individual practitioner. If a person complains that their medical records have been lost at a hospital, the relevant provider is the health organisation. Many complaints raise issues about both individual practitioners and health organisations. Sometimes, issues relating to the conduct of a practitioner interact with broader systemic issues.

On 1 July 2008, the Commission introduced an improved categorisation system to allow for a more comprehensive recording of the issues raised in complaints. This has enabled the Commission to undertake a more detailed analysis of the complaints that it receives, and assists in understanding the issues that commonly arise in particular areas of health service delivery.

The Commission's classification system uses the following categories, which include further specific issues:

access – delay in admission or treatment, or a refusal to admit or provide treatment

communication and information – the provision of wrong or inadequate information

consent – no or insufficient consent to treatment

discharge and transfer – lack of review prior to the discharge of a patient, delay in discharge, or inappropriate discharge

environment and management of a facility – inadequacies in administration, hygiene, staffing, the physical environment of a facility, or adherence to accreditation standards

fees and costs – billing practices, cost of treatment, issues of financial consent

grievance processes – failing to respond to a patient's concerns, lack of information about complaint procedures, retaliation as a result of a complaint being lodged

medical records – record keeping and management, access to records, transfer of records

medication – administering, dispensing and prescribing medication

professional conduct – lack of competence, assault, sexual misconduct, fraud, inappropriate disclosure of information

reports and certificates – refusing to provide a report, delay in doing so, cost of preparing a report

treatment – wrong or inadequate diagnosis or treatment.

The new issues categorisation system has been adopted by several other Australian and New Zealand health complaint bodies. This has meant that the Commission can for the first time include in this annual report a comparison across several jurisdictions of the number of complaints received and the issues raised.

At the same time, it should be noted that, as a result of the new issues categorisation system and the practice of recording more issues for each complaint, the data for 2008-09 and 2009-10 cannot be readily compared to the data for previous years.

The Commission tries to record all of the issues that are raised by a complaint. For example, if a complainant claims that the doctor failed to follow up a test result and therefore failed to review the patient's medication, the complaint would be recorded as raising both the issue of 'treatment – co-ordination of treatment/results follow-up', and the further issue of 'medication – prescription'.

The introduction of the revised system on 1 July 2008 and the practice of identifying more issues has led to a higher number of issues per complaint for the last two years. In 2009-10, the Commission received 3,515 complaints raising 5,841 issues – an average of 1.7 issues per complaint. This can be compared to the figures for 2005-06 when there were 1.1 issues per complaint.

Complaint numbers in perspective

The analysis of complaints can highlight areas where there may be opportunity for improvement. However, it is also important to recognise that, in a complex and diverse health system, it is not only the Commission that handles complaints. Complaints are often handled by hospital management or the Area Health Service without the Commission being involved. As a result, the number and nature of the complaints received by the Commission cannot be a comprehensive indicator of the overall standard of health care delivery in NSW.

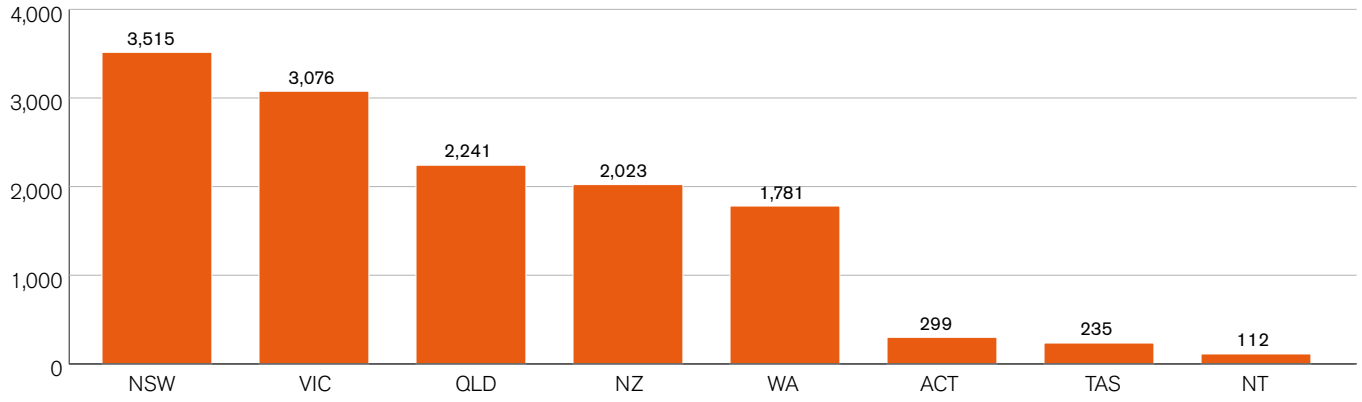
In 2009-10, the Commission received 614 complaints about public hospitals, which can be contrasted with a total number of 2,442,982 attendances at public hospital emergency departments during the year.

Similarly, the Commission received 2,170 complaints about registered practitioners in 2009-10. There were 192,097 registered health practitioners in NSW.

Comparison with other jurisdictions

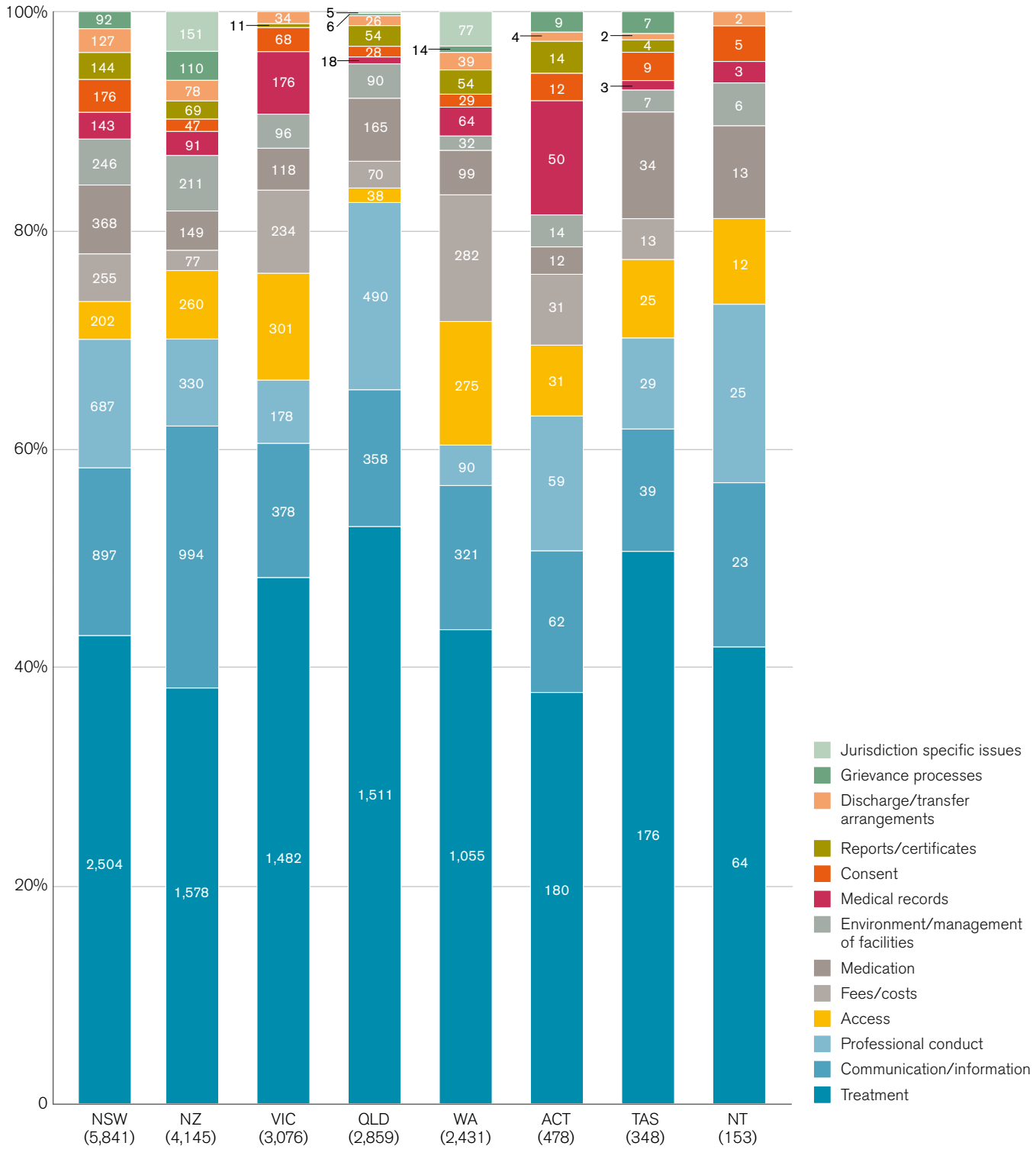
The Commission has included a comparison of the number of complaints received by its counterparts in other jurisdictions. Chart 8.1 below shows that the NSW Commission received the greatest number of complaints in 2009-10, followed by the Victorian and Queensland Commissions. The greater number of complaints in NSW may be the result of the co-regulatory arrangement that requires all complaints to registration boards to be notified to the Commission. This requirement did not exist in all other jurisdictions.

Chart 8.1 Number of complaints received by health complaint bodies in 2009-10



Counted by provider (data for South Australia not available)

Chart 8.2 Comparison of issues raised in complaints received by health complaint bodies in 2009–10



Counted by issues (data for South Australia not available)

Chart 8.2 compares the issues raised in complaints received by health complaint bodies across Australia and New Zealand. The issues have been matched to the closest NSW issue.

Complaints about treatment represent a very high proportion of the complaints to all health complaints commissions. Issues relating to access to medical services are more common in jurisdictions outside NSW, except for Queensland. Complaints about fees and the costs of health services are more common in Western Australia and Victoria than in other jurisdictions.

Issues raised in complaints

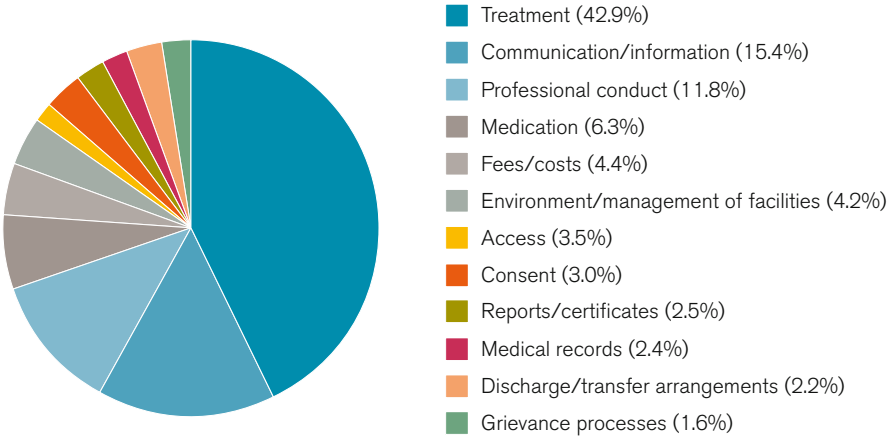
Chart 8.3 shows the breakdown of the 5,841 issues raised in the 3,515 complaints received by the NSW Commission in 2009-10.

The three most common issues raised in complaints related to treatment (42.9%), communication between practitioner and patient (15.4%), and the professional conduct of the health service provider (11.8%).

The issues raised in written complaints to the Commission differ from those raised in inquiries. In many cases, people contact the Inquiry Service first to discuss their concerns. Experienced officers provide advice on the available options and strategies for directly resolving less serious issues. Often this is a faster and more efficient way to address people's concerns.

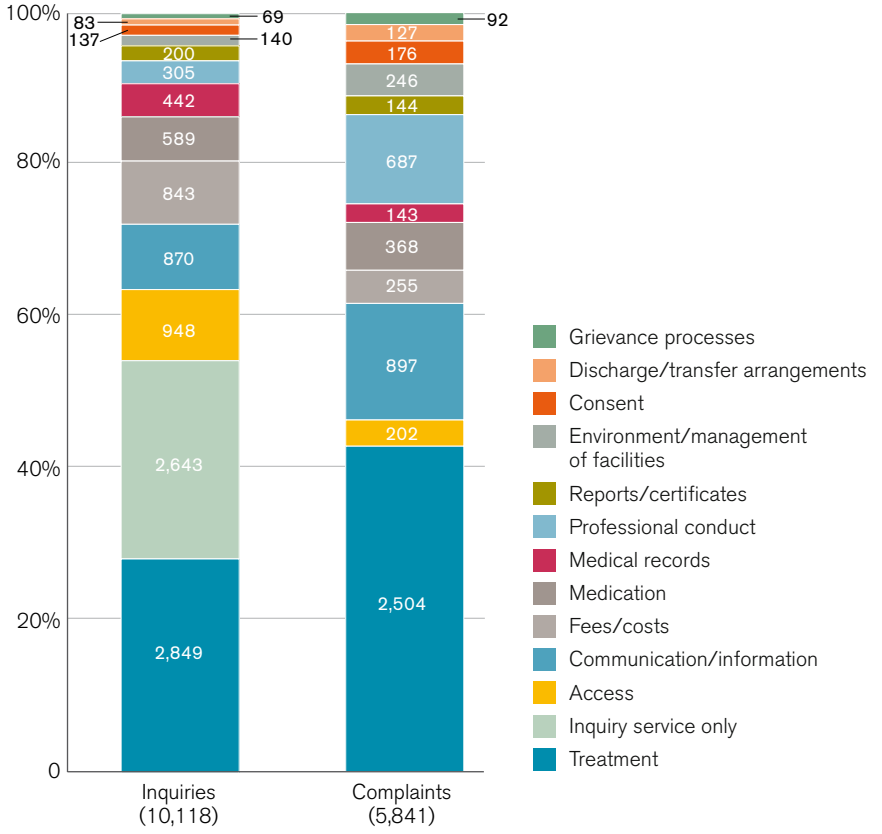
Chart 8.4 compares the type of issues raised in inquiries to the issues raised in written complaints. It shows that a great number of inquiries relate to the role and functions of the Commission and the complaint process. In addition, the proportion of concerns about fees and costs is much higher in inquiries than in written complaints. This is an area where Inquiry Officers can explain

Chart 8.3 Issues raised in all complaints received 2009-10



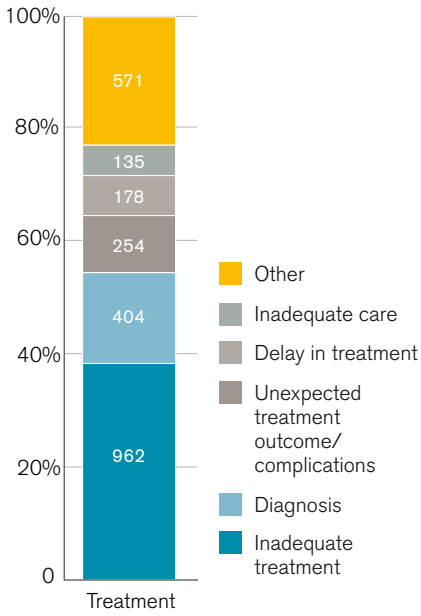
Counted by issues raised in complaint

Chart 8.4 Issues raised in inquiries and in written complaints received in 2009-10



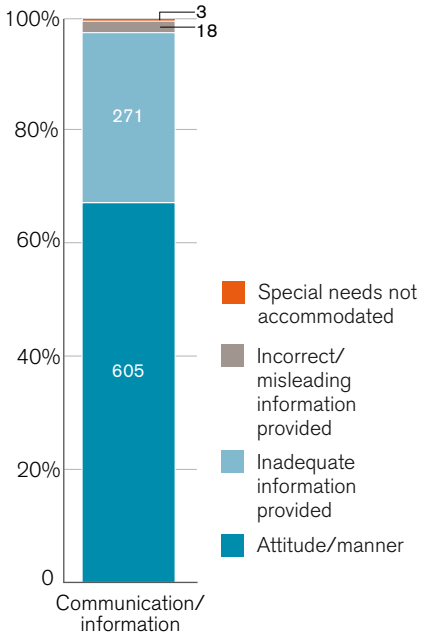
Counted by issues raised in inquiry or complaint

Chart 8.5 Proportion of issues in the category treatment 2009-10



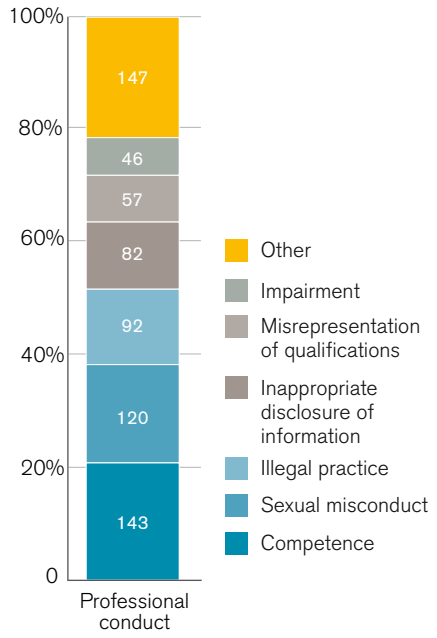
Counted by issues raised in complaint

Chart 8.6 Proportion of issues in the category communication/ information 2009-10



Counted by issues raised in complaint

Chart 8.7 Proportion of issues in the category professional conduct 2009-10



Counted by issues raised in complaint

fees and costs, and provide advice on how to resolve concerns directly with the health service provider.

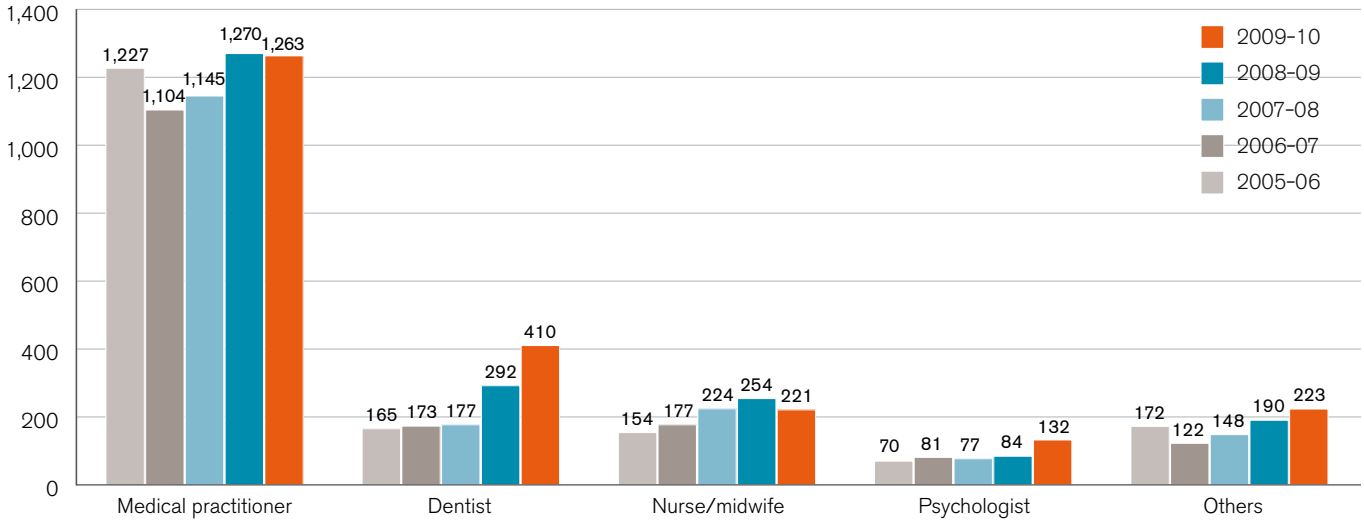
Chart 8.5 sets out the types of treatment-related issues raised in complaints.

Of the 2,504 issues about treatment, a large number concerned inadequate treatment (962). This was followed by diagnosis (404), unexpected treatment outcomes and complications (254), delay in treatment (178) and inadequate care (135). There were 571 other treatment-related issues.

There were 897 communication issues, making this the second most common issue dealt with by the Commission. As shown in Chart 8.6, there were 605 issues concerned with attitude, 271 with inadequate information, and 18 with wrong or misleading information. A few cases (3) involved special needs not being accommodated.

Chart 8.7 shows that, of the 687 issues of professional conduct, 143 were about competence, 120 concerned sexual misconduct, 92 illegal practices, 82 the inappropriate disclosure of information, and 57 alleged that the health service provider had misrepresented their qualifications. There were also 46 complaints alleging that the practitioner was impaired. The remaining 147 raised other professional conduct issues.

Chart 8.8 Complaints received about health practitioners 2005-06 to 2009-10



Counted by provider identified in complaint

Trends in complaints about health practitioners

In 2009-10, the Commission received 2,249 complaints about individual health practitioners – an above average increase of 7.6% on the previous year.

Chart 8.8 shows the four health professions most commonly complained about – medical practitioners, dentists, nurses and psychologists. Complaints about these professions accounted for 90.1% of all complaints about practitioners in 2009-10.

People mainly complained about medical practitioners. In 2009-10, the Commission received 1,263 complaints about medical practitioners – a similar number to last year. This number of complaints is relatively small, considering that there are 31,420 medical practitioners registered in NSW. On average, one in 25 medical practitioners was the subject of a complaint in 2009-10.

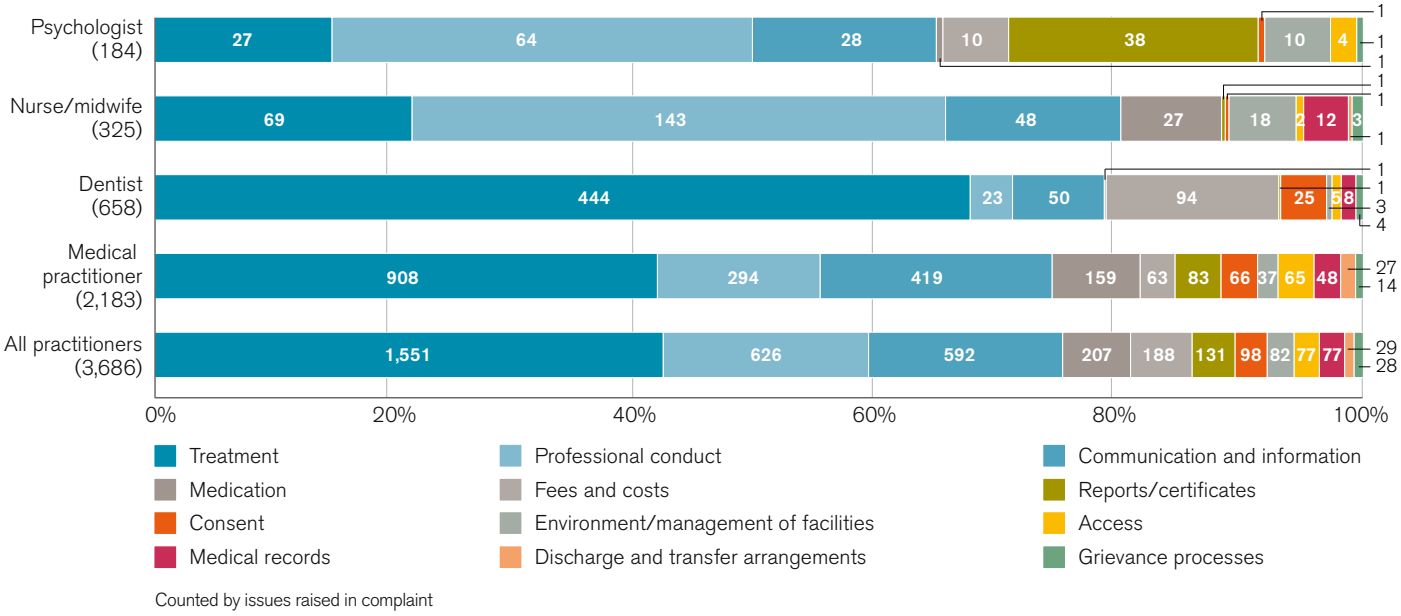
The Commission received 410 complaints about dentists during the year – an increase of 40.4% on the previous year. In 2009-10, there were 5,599 dentists registered in NSW. On average, one in 14 dentists was the subject of a complaint. Issues involving the administration of the Medicare Dental Scheme for people with chronic illnesses remained a common source of complaint.

In 2009-10, the Commission received 221 complaints about nurses and midwives – a drop of 13.0% from the previous year. This number should be read in the context of the 121,000 nurses and midwives registered in NSW. On average there is one complaint for every 548 nurses or midwives.

There were 132 complaints about psychologists in 2009-10 – an increase of 57.1% on the previous year. There are 10,776 psychologists registered in NSW – so on average, the Commission received a complaint about one in every 82 psychologists.

A breakdown of complaints about other health professions can be found in Table 18.3 in the appendices to this report.

Chart 8.9 Issues raised in complaints received about medical practitioners, nurses, dentists and psychologists 2009-10



Counted by issues raised in complaint

Issues raised about health practitioners

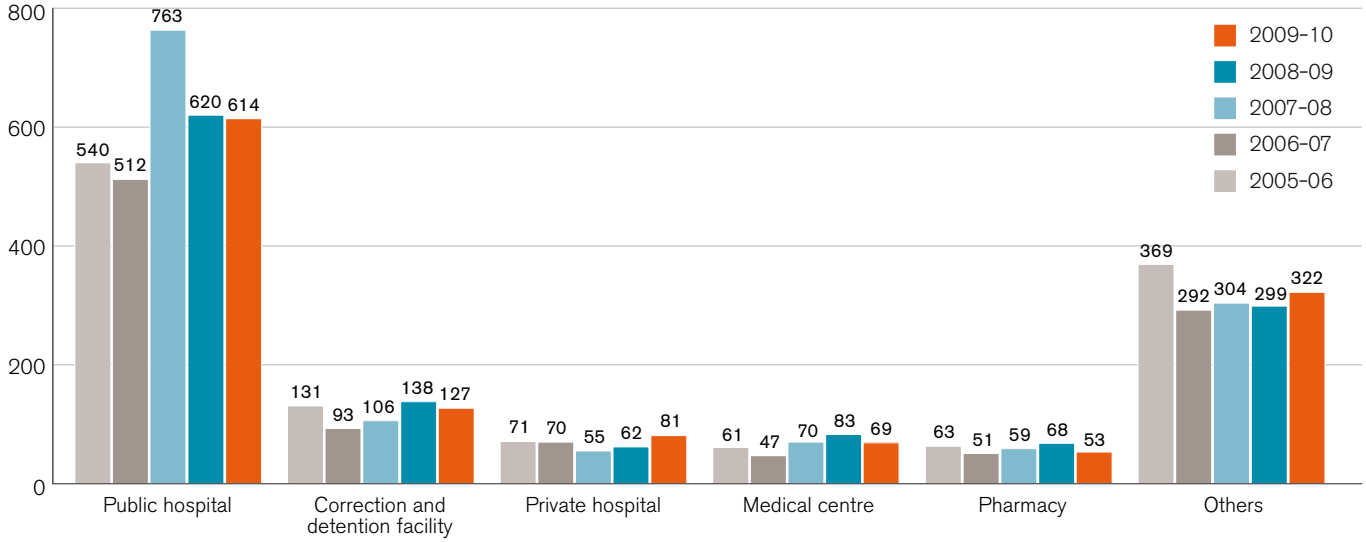
Chart 8.9 sets out the types of issues raised in the complaints about medical practitioners, dentists, nurses and psychologists.

Treatment was the main issue of complaint, particularly for dentists, where it accounted for almost two-thirds of all complaints.

The proportion of treatment-related complaints is lower for nurses, because they more commonly provide care rather than treatment to patients. However, nurses have a higher proportion of complaints involving issues of professional conduct than the other three professions. The Commission commonly deals with complaints about nurses that raise issues of competence, illegal practice or impairment.

Communication issues are commonly raised in complaints across all professions.

Chart 8.10 Complaints received about health organisations 2005-06 to 2009-10



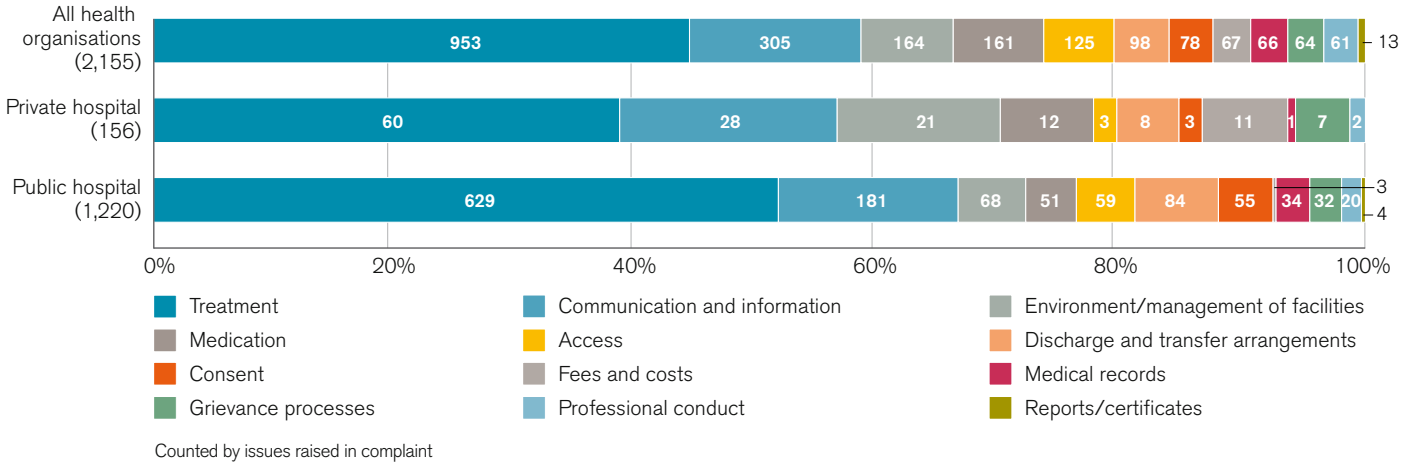
Counted by provider identified in complaint

Trends in complaints about health organisations

Chart 8.10 sets out the number of complaints received about different types of health organisations over the last five years. Most complaints were about public hospitals. This reflects the great number of patients receiving treatment in public hospitals, together with the complex range of health services provided by public hospitals and the risks associated with these services.

The unusual peak of complaints about public hospitals in 2007-08 was largely attributable to a significant number of complaints about public hospitals being referred to the Commission by the Garling Special Commission of Inquiry into Acute Care in Public Hospitals.

Chart 8.11 Issues raised in complaints received about public and private hospitals 2009–10



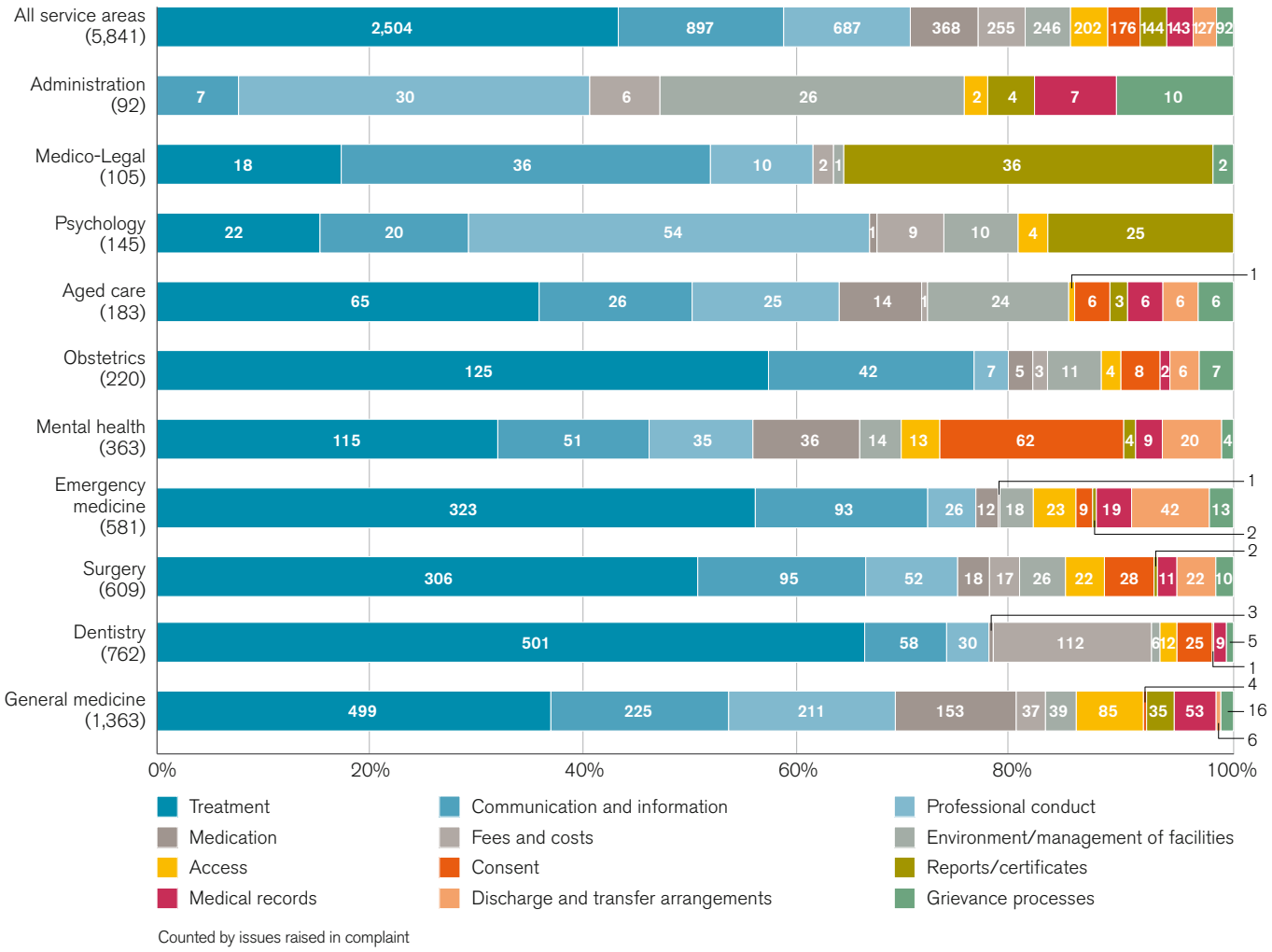
Counted by issues raised in complaint

Issues raised in complaints about hospitals

Chart 8.11 shows the sorts of issues raised in complaints about public and private hospitals, compared to all other types of health organisations.

Complaints about treatment make up the greatest proportion of complaints for both public hospitals (51.6%) and private hospitals (38.5%). The higher proportion of complaints about public hospitals may be attributable to the nature of treatment provided and the associated risks. The proportion of complaints about the environment and management of the facility is higher in complaints about private hospitals (13.5%) compared to public hospitals (5.6%), which may reflect the higher expectations of privately insured patients.

Chart 8.12 Issues raised in complaints received by most common service areas 2009–10



Counted by issues raised in complaint

Trends in complaints by service area

Chart 8.12 summarises the issues raised in complaints about the most common areas of service provision.

The proportion of complaints about treatment is highest for dentistry, obstetrics, and emergency medicine.

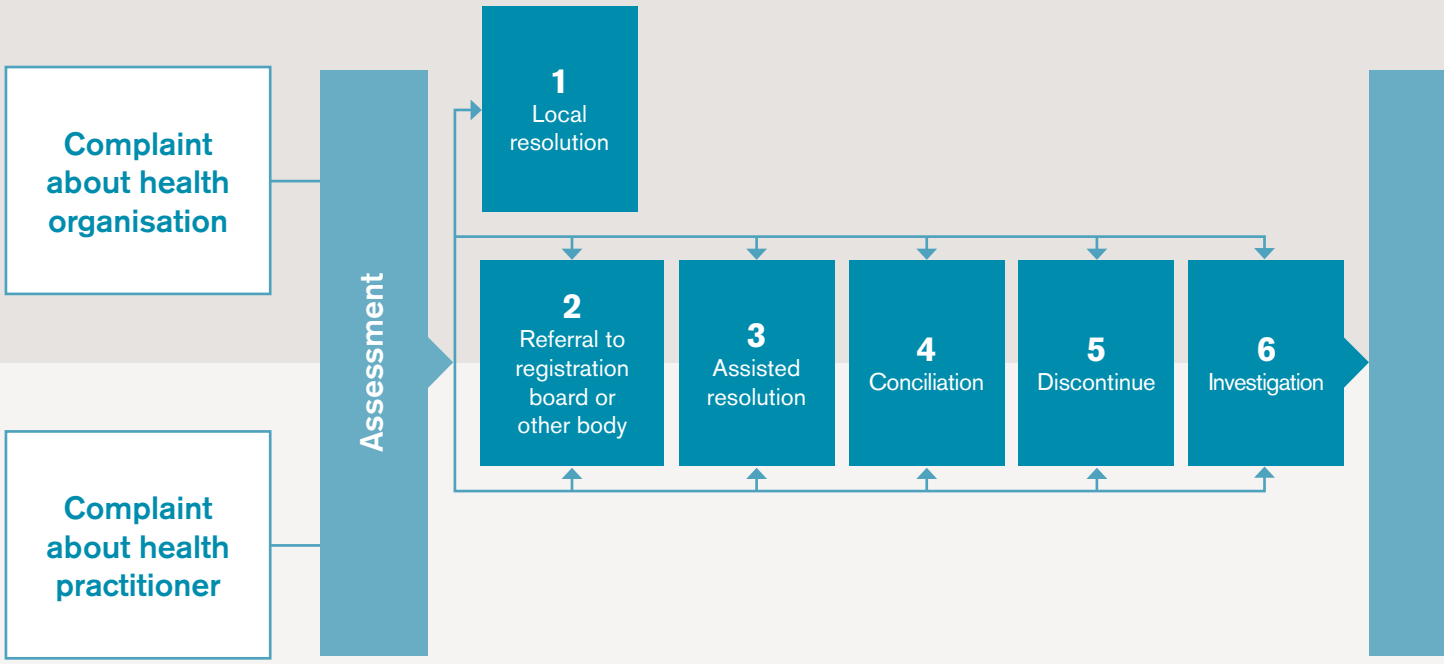
Complaints about professional conduct are most common in the areas of psychology and psychiatry. Such issues are least prominent in the areas of emergency medicine and dentistry.

Complaints relating to medication are most common in general medicine, and the areas of mental health and aged care.

Complaints relating to fees and costs are most common in dentistry, while there is a high proportion of consent issues in complaints relating to mental health services.

09

The complaints process



The Commission deals with complaints about both individual health practitioners and health organisations. Complaints about individual practitioners can concern registered practitioners, such as doctors, nurses and dentists, or unregistered health practitioners, such as naturopaths, massage therapists and practitioners of Traditional Chinese Medicine.

The complaints process will remain largely unchanged with the introduction of the national registration scheme. The main difference is that from 1 July 2010, the Commission must consult with the NSW health professional councils, instead of the previous NSW registration boards, in relation to the handling of complaints about registered health practitioners.

When assessing a complaint, the Commission contacts the complainant to clarify the issues. In addition, the Commission usually notifies the health service provider and seeks their response. Where clinical issues are involved, the Commission may obtain health records and seek advice from an internal medical or nursing adviser. The Commission assesses all relevant information. Where the complaint concerns a registered practitioner, the Commission must consult with the relevant registration board (or, from 1 July 2010, the relevant NSW council).

The possible outcomes of assessment are:

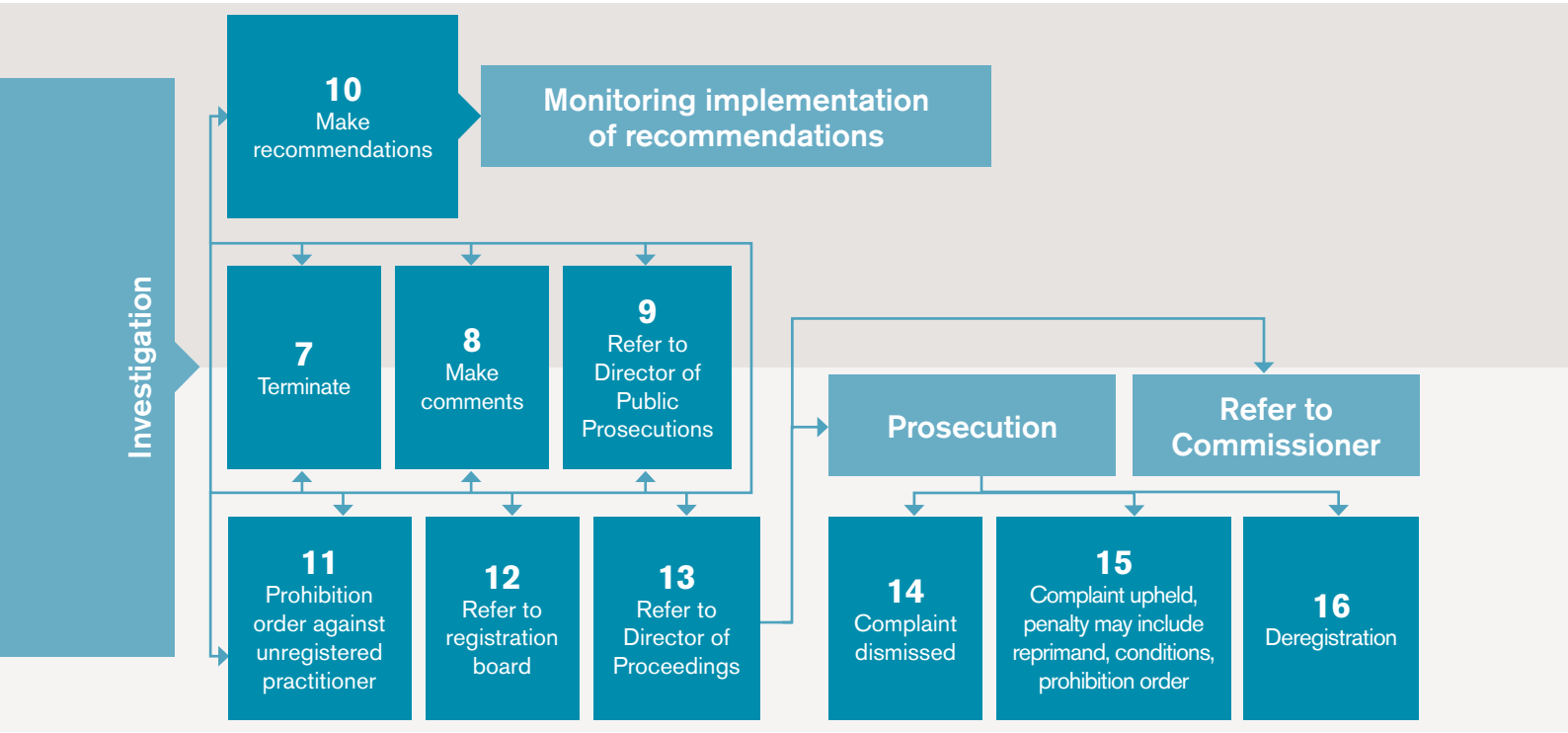
1 The Commission can refer a complaint about a public health organisation back to the organisation to try to **resolve the matter locally** with the complainant, if it agrees to this.

2 In some cases, it is appropriate to **refer the complaint to another body** to be dealt with by them. This can include referral to the Director-General of the Department of Health where there appears to be a breach of legislation such as the *Poisons and Therapeutic Goods Act*. Some complaints about registered practitioners are referred to the relevant registration board/council to consider taking action such as counselling, an assessment of performance, or an assessment for possible impairment.

3 Often a complaint can be resolved with the assistance of a Resolution Officer. Participation in **assisted resolution** is voluntary.

4 Some complaints are suitable for **conciliation**. Conciliation is a voluntary and confidential process. A conciliator can facilitate a meeting at which the parties are assisted in trying to reach a resolution of the matter.

In 2010–11, the Commission will merge its assisted resolution and conciliation services to ensure the best use of these services.



5 The Commission can **discontinue** dealing with a complaint for many reasons – for example, the time that has passed since the incident makes it difficult to investigate the matter effectively.

6 The Commission refers complaints about individual practitioners for **formal investigation** where, if substantiated, the complaint would provide grounds for disciplinary action or involve gross negligence. Complaints about health organisations are investigated where they raise a significant issue of public health or safety or significant questions about appropriate care or treatment.

At the end of an investigation, the Commission may:

7 **Terminate** the complaint (take no further action) where the investigation has found no or insufficient evidence of inappropriate conduct, care or treatment.

8 **Make comments**. In the case of a registered health practitioner, the Commission makes comments where there was poor care or treatment, but not to an extent that would justify referring the matter to the Director of Proceedings. Comments can also be made to an unregistered health practitioner. Comments to a health organisation acknowledge that the organisation has already taken measures to prevent poor health service delivery in the future, so that there is no need for the Commission to make recommendations.

9 **Refer** the matter **to the Director of Public Prosecutions** to consider criminal charges.

10 **Make recommendations**. Recommendations are made to a health organisation where an investigation finds that there has been poor health service delivery and identifies systemic improvements that should be made. The Commission provides its recommendations to the Director-General of the Department of Health and the Clinical Excellence Commission, so that they may consider implementing the recommendations on a broader basis. The Commission follows up the implementation of its recommendations. If the Commission is not satisfied with the implementation, it may, after consultation with the Director-General, make a report to the

Minister. If the Commission is not satisfied with the Minister's response, it may make a special report to Parliament.

11 **Issue a prohibition order and/or public warning** about an unregistered health practitioner. A prohibition order can ban the provision of any health services or limit the health services that the practitioner can provide, and the practitioner must advise potential patients of the order before treating them. A breach of the order is a criminal offence. The Commission can issue a public warning where the health service poses a risk to public health or safety.

12 **Refer the complaint to a registration board/council** to take action. The registration board/council may refer the practitioner for a performance or impairment assessment or may counsel them about their conduct.

13 **Refer the complaint to the Director of Proceedings**. The Director of Proceedings determines whether a complaint against a registered health practitioner should be prosecuted before a disciplinary body. In making this determination, she must consider:

- the protection of the health and safety of the public
- the seriousness of the alleged conduct
- the likelihood of proving the alleged conduct
- and any submissions by the practitioner.

If the Director of Proceedings determines that a matter does not meet the threshold for prosecution, it is referred back to the Commissioner to consider other appropriate action.

If a decision is made to prosecute, a complaint about unsatisfactory professional conduct will usually be prosecuted before a Professional Standards Committee, while a complaint about professional misconduct will be prosecuted before a Tribunal which has the power to suspend or deregister a practitioner.

14 The disciplinary body must **dismiss the matter** where it finds that there is insufficient evidence to prove the complaint.

15 Where the disciplinary body finds the complaint proven, it can **reprimand, fine and/or impose conditions** on the practitioner.

16 Only a Tribunal can **suspend or deregister** a practitioner. The Tribunal may also issue a prohibition order banning the practitioner from practising in another area of health service – for example, a psychiatrist who is deregistered can be banned from working as a counsellor.

10

Inquiry Service

The Commission's Inquiry Service handles inquiries from people who are concerned about the health care provided to them or a family member or friend. Sometimes people call to find out more about the role of the Commission and how it handles complaints, or have questions about health care in general.

People usually call or email the Commission. In some cases, they may come to the office to speak to an Inquiry Officer in person.

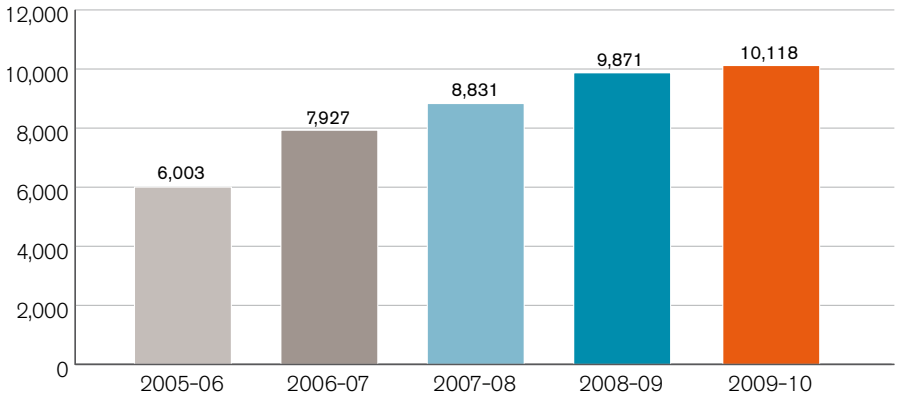
All inquiries are answered by the Commission's Inquiry Officers who are also experienced in the resolution of complaints. These officers:

- answer questions about the Commission's role and how it handles complaints
- where appropriate, refer people to other agencies and organisations that can better address their concerns
- provide practical advice on how a person can resolve their concerns directly with the health service provider without making a formal complaint to the Commission
- ask the health service provider or another agency to contact the caller to try to resolve the issue
- provide information on how to make a complaint and, where necessary, help the person to put their complaint in writing
- take down written complaints about urgent issues and refer them for immediate assessment.

Performance of the Inquiry Service

As shown in Chart 10.1, the Commission has received an increasing number of inquiries over the last five years. In 2009-10, the Inquiry Service dealt with 10,118 inquiries – a 2.5% increase on the previous year.

Chart 10.1 Number of inquiries received 2005-06 to 2009-10



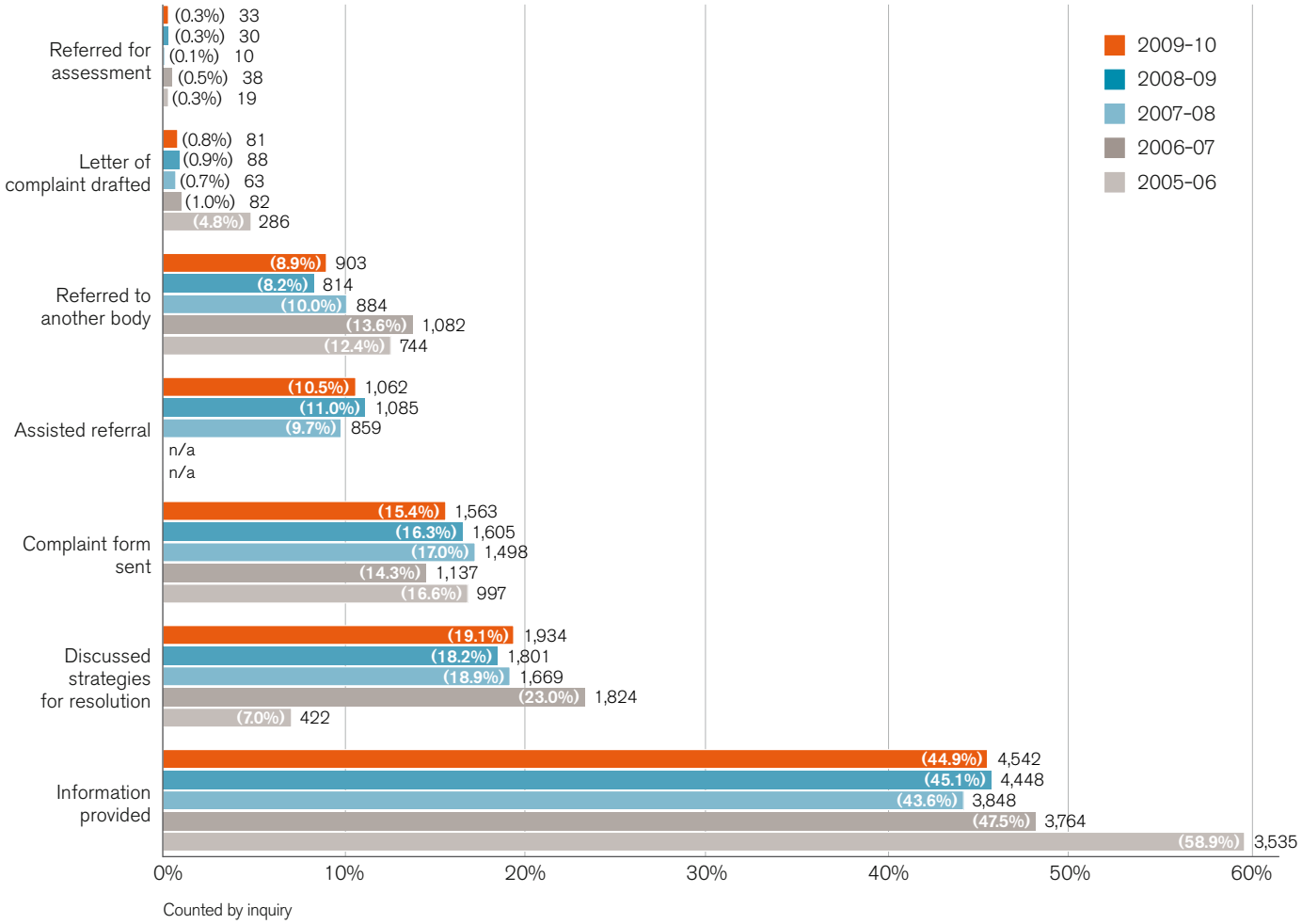
Counted by inquiry

Outcomes

Chart 10.2 shows how the Inquiry Service dealt with inquiries over the past five years. In 2009–10:

- Relevant information was provided in response to 4,542 inquiries (44.9%).
- Strategies to resolve issues directly with the health service provider were discussed in 1,934 cases (19.1%).
- Complaint forms were sent out to 1,563 people (15.4%).
- 1,062 (10.5%) of inquiries were dealt with through 'assisted referral'. This is where the officer contacts another agency that is better suited to deal with the concerns, and then provides the caller with the name and contact details of the relevant person at the other agency.
- 903 people (8.9%) were directly referred to another body.
- In 81 cases (0.8%), the officer helped the person to write a complaint.
- In 33 urgent cases (0.3%), the officer drafted a written complaint and referred it for assessment.

Chart 10.2 Outcome of inquiries 2005–06 to 2009–10



CASE STUDIES

Concerns about discharging an elderly patient from hospital

A woman rang the Inquiry Service, concerned that her elderly father, who had recently had heart surgery, was going to be discharged from a small rural hospital because the doctor was going away. She said that her father lived by himself in a remote area. She was concerned that her father could not look after himself and that the family was not available to look after him.

The Inquiry Officer asked the woman whether she had spoken to the doctor. She said that she had called a nurse at the hospital who promised that someone would call her, but nobody did.

The Inquiry Officer called the hospital and spoke to the head nurse. The nurse said that the hospital was trying to arrange an assessment by the Aged Care Team, but that this could take a long time. The doctor had said the father was fit for discharge and could perform light domestic duties. However, if the Aged Care Team could conduct a prompt assessment, the hospital might be able to keep the father there. The nurse said that she would call the woman directly to explain the situation.

The hospital subsequently advised the woman that the Aged Care Team assessment had been done and that her father was able to stay in hospital.

A cancelled hospital appointment

A man was concerned that his son, who was an inmate in a correctional centre, had a lesion on his chest which might be a melanoma, but had not received adequate treatment for it. The man called the Inquiry Service because a hospital appointment for his son had been cancelled. The man wanted information about why the appointment had been cancelled and whether alternative arrangements could be made.

The Inquiry Officer called the correctional centre clinic. The clinic explained that appointments had been secured at both Westmead Hospital and Prince of Wales Hospital. The reason for cancelling the appointment at Westmead Hospital was that it was usual practice for inmates to be treated at Prince of Wales Hospital.

The Inquiry Officer called the father and explained the situation, and also told him that the clinic manager was happy to answer his questions directly.

The man was satisfied with the explanation and was pleased that he could speak directly with the manager about any further concerns.

11

Assessing complaints

Performance in 2009–10

Corporate goal of 'efficient and timely processing and assessment of complaints and review processes'

- In 2009–10, the Commission assessed 3,512 complaints, keeping up with the 3,515 complaints received during the same period. This can be compared to the 3,349 complaints assessed in 2008–09, when 3,360 complaints were received.
- 82.3% of complaints were assessed within the statutory 60 day timeframe (target 85%), and the average time taken to assess a complaint was 46 days. This is a drop from the previous year, when 88.9% of assessments were finalised within 60 days, with an average turnaround time of 42 days.
- There were 278 requests for a review of the assessment decision (7.9% of the number of assessments). This is an improvement on 2008–09, when there were 281 review requests, representing 8.4% of complaints assessed.
- In 2009–10, 267 reviews were finalised, of which 72.4% were finalised by the review officer within 28 days (target 100%). This compares to 272 reviews finalised during the previous year.
- After making its assessment decision, the Commission notifies the parties in writing of the reasons for the decision. In 2009–10, 85.5% of decision letters were completed within 14 days of the assessment decision (target 90%). This is a slight decrease in timeliness from last year, when 90.6% of decision letters were sent within 14 days.
- 206 complaints were resolved during assessment, representing 5.9% of all complaints assessed (target 8%). This is at about the same level as the previous year, when 188 (5.6%) complaints were resolved during assessment.
- In 2009–10, it was planned to implement audits within 21 days. However, due to resourcing and staffing issues, the Commission was unable to implement these audits. It is planned to implement file audits from September 2010.

Complaints received

In 2009–10, the Commission received 3,515 complaints about health practitioners and health organisations. This is an increase of 4.6% from 2008–09.

In addition to written complaints, the Commission receives and records notifications from health professional registration boards and health service organisations such as the Area Health Services about their handling of competence and impairment issues. Although these notifications are not considered formal complaints, the Commission takes both prior complaints and notifications into account when assessing new complaints.

Performance

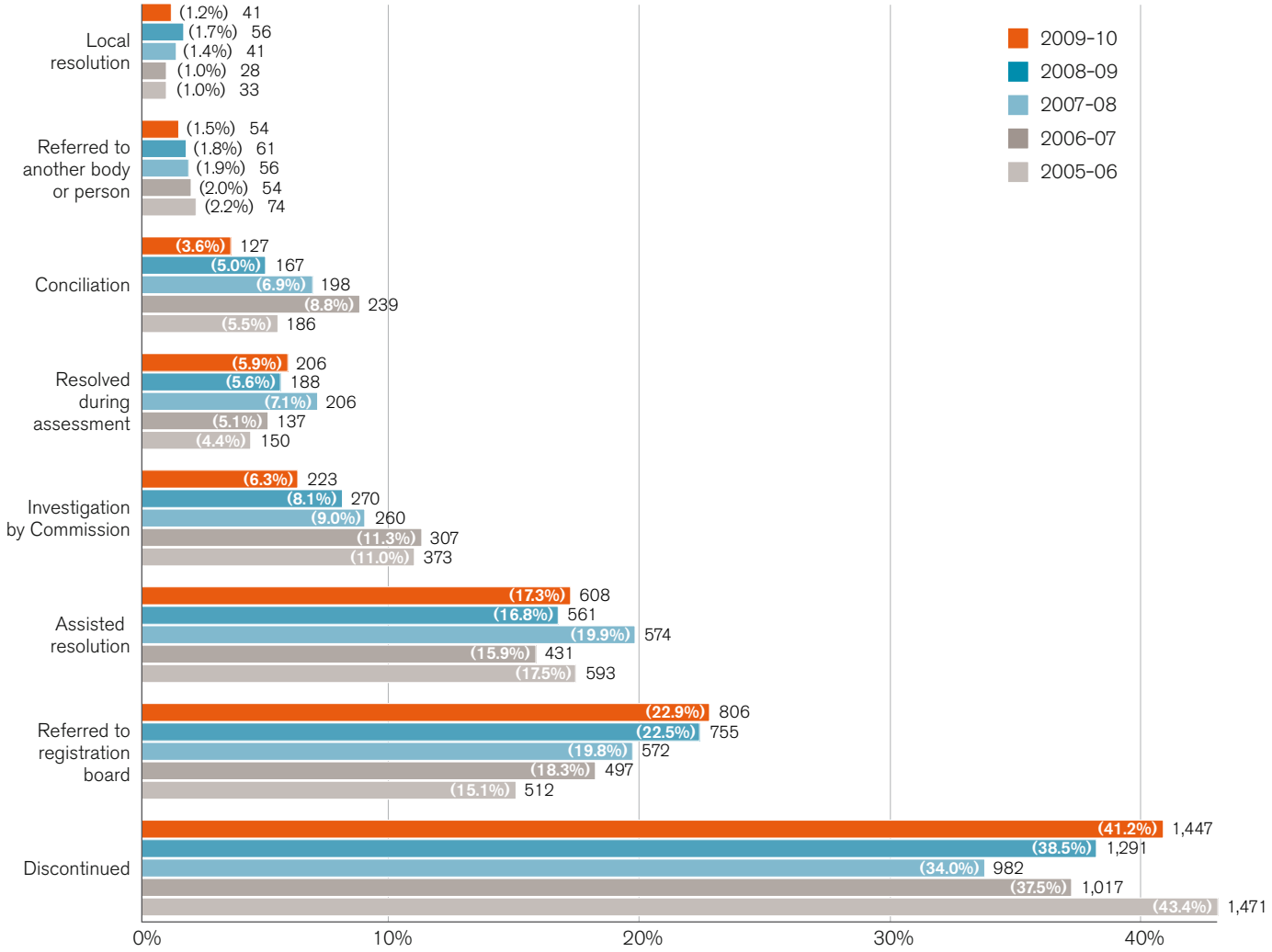
Chart 11.1 shows the outcomes of the Commission's assessment of complaints over the last five years.

Outcomes

The outcomes of assessments during 2009–10 were:

- 1,447 (41.2%) were discontinued – that is, the Commission decided to take no further action.
- 806 (22.9%) were referred to the relevant registration board for action in relation to a registered health practitioner
- 608 (17.3%) were referred to the Resolution Service
- 223 (6.3%) were referred to the Investigations Division
- 206 (5.9%) were resolved during assessment
- 127 (3.6%) were referred to the Health Conciliation Registry
- 54 (1.5%) were referred to another body for their management.
- 41 (1.2%) were referred to public health organisations for local resolution

Chart 11.1 Outcomes of assessment of complaints 2005-06 to 2009-10



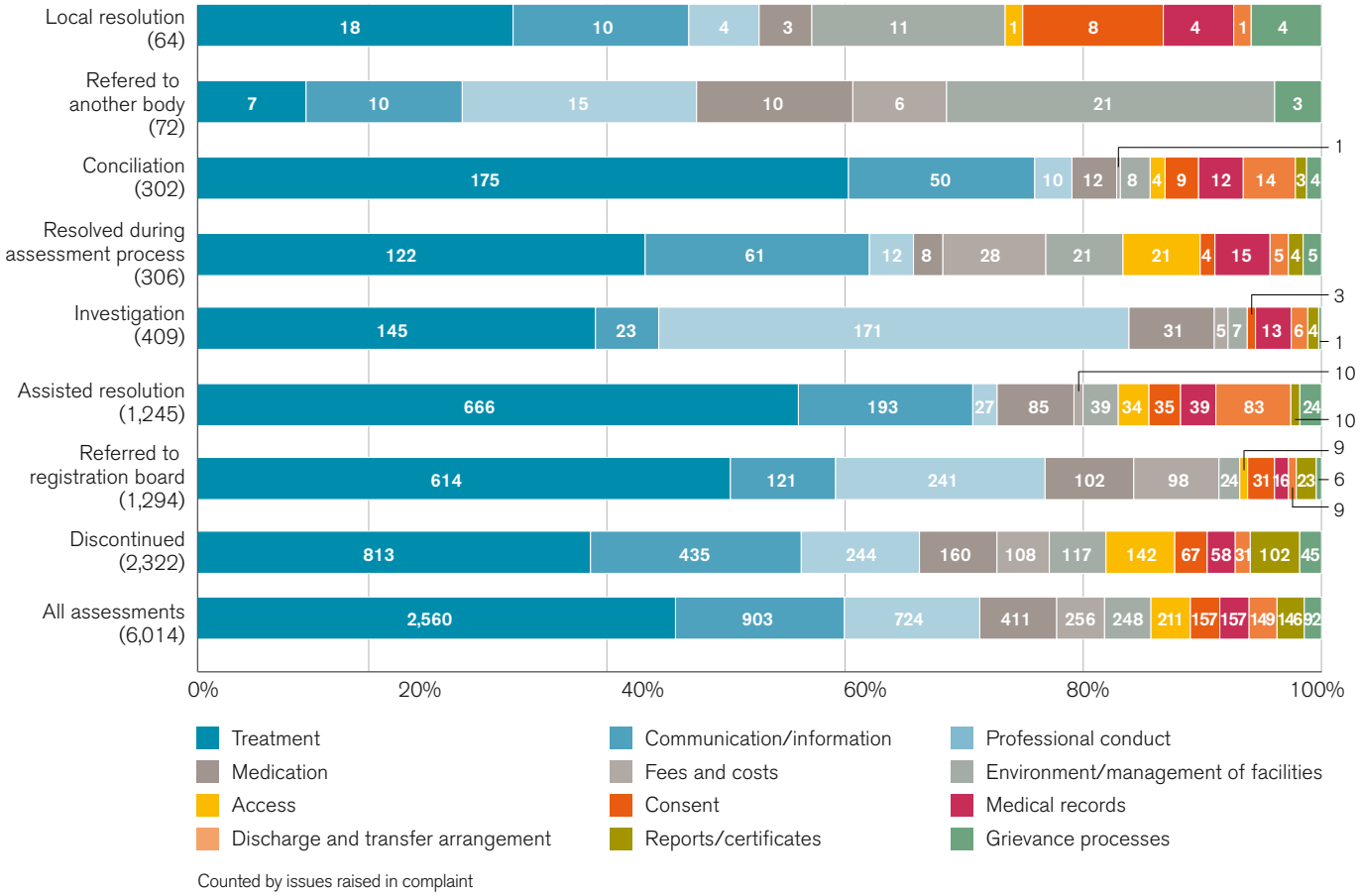
Counted by provider identified in complaint

Timeliness

In 2009-10, 82.3% of complaints were assessed within the statutory timeframe of 60 days, and the average time taken to assess a complaint was 46 days. This is a drop from the previous year, when 88.9% of assessments were finalised within 60 days, with an average turnaround time of 42 days.

After making its assessment decision, the Commission notifies the parties in writing of the reasons for the decision. In 2009-10, 85.5% of decision letters were completed within 14 days of the assessment decision. This is a slight decrease in timeliness from last year, when 90.6% of decision letters were sent within 14 days.

Chart 11.2 Issues raised in all complaints assessed 2009-10



Counted by issues raised in complaint

Outcomes by issue

Chart 11.2 shows how the Commission dealt with the various types of issues raised in the complaints in 2009-10.

Issues relating to treatment were commonly referred to one of the available resolution options – assisted resolution and conciliation.

A significant proportion of complaints raising issues of professional conduct were referred for investigation.

Issues relating to medication were more commonly referred to the Pharmaceutical Services Branch of the Department of Health, which investigates prescribing practices and can refer serious cases back to the Commission.

A large proportion of complaints about the management of a health facility were referred to the relevant facility for local resolution or to another body such as an accreditation organisation.

All of these figures continue trends identified in previous years.

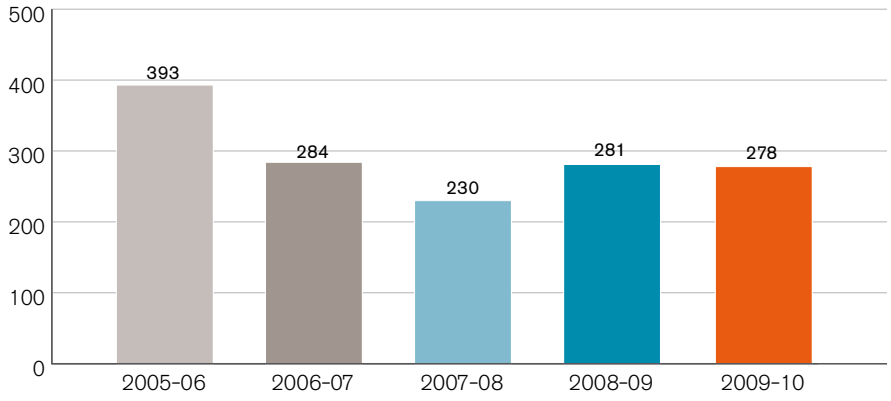
Review of assessment decisions

Complainants can seek a review of the Commission's assessment decision except where the Commission has decided to investigate the complaint.

In 2009-10, the Commission received 278 requests for a review of the assessment decision (7.9% of the total number of assessments). This is an improvement on the previous year, when 281 requests for review were received, representing 8.4% of all complaints assessed in that period.

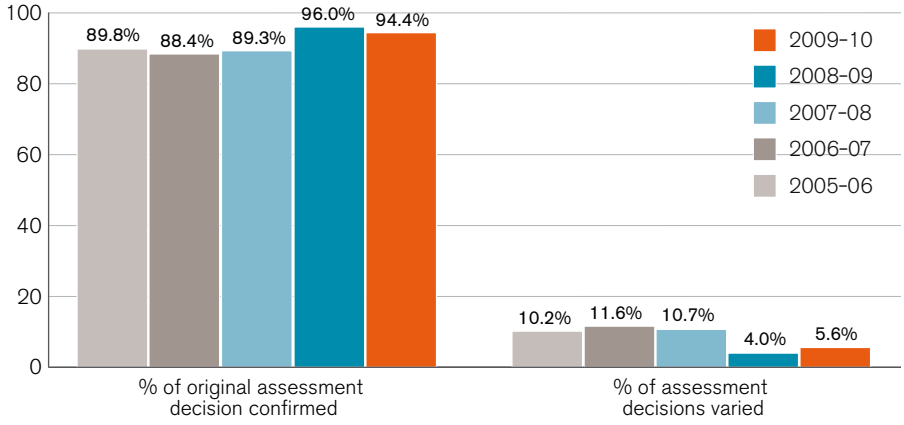
During the year, the Commission finalised 267 reviews, compared to 272 in the previous year. For 252 (94.4%) of these, the original assessment decision was confirmed, while in the remaining 15 (5.6%) the decision was changed.

Chart 11.3 Requests for review of assessment decision 2005-06 to 2009-10



Counted by provider identified in complaint

Chart 11.4 Outcome of reviews of assessment decision 2005-06 to 2009-10



Counted by provider identified in complaint

Staff development

A number of staff attended training to develop skills in using new Microsoft functions. Training for new staff concentrated on introducing them to assessment procedures and the use of the case management system.

Assessment staff also attended monthly Commission meetings to keep up to date with current developments relating to the Commission's work, as well as divisional meetings to discuss changes that were particularly relevant to the assessment of complaints.

The year ahead

In the coming year, the assessment division will have monthly divisional meetings that will include one-hour training sessions. Every quarter, this meeting will be extended to half a day to allow external and internal speakers to make presentations on specific topics, such as the collection and analysis of evidence.

In addition, teams will meet every fortnight to discuss particular cases that they are currently handling, and to receive feedback.

In 2010-11, the Director, the Manager of Assessments, team leaders and the Manager of Human Resources will meet every fortnight to discuss management and staffing issues.

Feedback

The Commission sends out client satisfaction surveys with its assessment decision letters. As a result, the Commission has received feedback that has assisted it to improve its assessment procedures and better meet client needs.

The response rate was 13.2% for complainants and 12.7% for providers who were sent a survey.

Complainants' responses

Overall, 65.6% of complainants who responded were satisfied with their interaction with the assessment officer.

- 62.3% agreed the assessment officer was impartial
- 66.1% agreed the officer's involvement was helpful
- 64.7% agreed the officer understood the issues raised in the complaint
- 63.3% agreed the officer kept them updated about progress.

Providers' responses

Overall, 72.2% of providers who responded were satisfied with their interaction with the assessment officer.

- 73.8% agreed the assessment officer was impartial
- 66.4% agreed the officer's involvement was helpful
- 73.3% agreed the officer understood the issues raised in the complaint
- 64.5% agreed the officer kept them updated about progress.

The surveys also allowed for additional comments about the Commission's services. Some examples of comments were:

Complainants

" From my first contact with the Health Care Complaints Commission, I have been impressed with the communication and assistance given. It has been a pleasant surprise to have phone calls returned and confirmation of the process in writing. Thank you. "

" [The assessment officer] was most kind and understanding, and I hope that my complaint leads to better patient services in Accident & Emergency. "

" Your response to my complaint was prompt. The woman I spoke to on the phone was appropriate and professional, polite and friendly. "

" The management of my complaint was carried out in a professional manner, and I was informed [of] progress at all times. A good service. "

Health service providers

" A very well organised process. Thank you. "

" The Assessment Officer was very helpful, courteous and impartial. She was available and approachable at all times and always willing to assist. Many thanks. "

" Our organisation has always found the Assessment Officers at the HCCC to be very professional and helpful in dealing with many complex situations. "

" The Officer was very clear and informative about the process, very helpful manner. "

" I have been very impressed with all of my dealings with the HCCC and have found them on the whole to be efficient, intelligent and professional. "

CASE STUDY

Fixing dental work

A man complained to the Commission about the dentures made by a dental practice for his grandfather.

The Commission asked the dental practice to respond to the complaint. They said that the grandfather's dentures had been correctly made and fitted, but were also prepared to make any adjustments required.

When provided with this response, the complainant said that his grandfather had already been for adjustments a number of times and that the dentures had never been properly fixed. His grandfather had lost confidence in the practice and wanted a refund so he could go to another dentist. The complainant was keen for his grandfather to get new dentures as soon as possible because they were painful and made it difficult for his grandfather to eat.

The Assessment Officer spoke to the dental practice's lawyer, and the dental practice agreed to pay for an independent dental surgeon to adjust the dentures. Initially, they suggested a dental surgeon who was located an hour's travel away from the grandfather. After further negotiations, the grandfather could see a dental surgeon located nearby. The complainant was very happy with this outcome.

12

Resolving complaints

Performance in 2009–10

Corporate goal of 'efficient and timely processing and assessment of complaints and review processes'

- In 2009–10, 61.1% of assisted resolution matters had a resolution plan approved within 21 days (target 75%). This compares to the previous year when 63.6% had a resolution plan approved within that timeframe.
- 87.2% of assisted resolution processes were completed within six months of referral to the Resolution Service (target 80%). This compares to 89.4% in the previous year.
- Where the assisted resolution process proceeded, 77.2% of matters were fully or partially resolved (target 75%) – a slight decrease from the 80.0% in 2008-09.
- Overall, 86.5% of complainants and 89.5% of health providers were satisfied with the service provided by Resolution Officers (target 80%).
- In 46.2% of cases that were referred for conciliation, both parties agreed to proceed (target 55%). This compares to 56.6% in the previous year.
- 85.0% of conciliation meetings were scheduled within three months of the matter being referred to the Conciliation Registry (target 65%).
- In 89.5% of cases, the complainant and health service providers were notified within 14 days of the arrangements for conciliation (target 100%).
- 85.3% of conciliations were finalised within six months (target 80%). This is an improvement on the previous year when 74.6% were finalised within that timeframe.
- In 60.6% of matters where conciliation proceeded, either an agreement was reached or the conciliation was helpful in clarifying the concerns raised in the complaint (target 80%). This compares to 65.9% in the previous year.

The Commission tries to resolve complaints in two ways – assisted resolution and conciliation.

Assisted resolution

The Commission's Resolution Officers assist the parties to resolve the complaint. Six Resolution Officers are located in the Sydney metropolitan area and another three are based in Newcastle, Dubbo and Lismore.

As assisted resolution is a voluntary process, the complainant and the health service provider(s) are both encouraged to participate.

Where the parties agree to participate, the Resolution Officer assists them in trying to identifying ways of resolving the complainant's concerns. If the parties are willing to meet, the officer organises an agenda and helps the parties to prepare for the meeting.

If the parties do not wish to meet, the officer can act as an intermediary. This involves obtaining responses from the health service provider(s) and discussing them with the complainant.

Conciliation

The Health Conciliation Registrar is responsible for organising conciliations and appoints a conciliator from an experienced panel to facilitate conciliation meetings.

Like assisted resolution, conciliation is voluntary. The Registrar must seek the consent of all parties to engage in the process.

Conciliation generally involves a meeting between the complainant and the health service provider(s) that is facilitated by a conciliator, whose role is to guide the parties to try to reach an agreement. The process is confidential, which means that anything said during the meeting and any document prepared for the conciliation cannot be used elsewhere, except with the consent of the parties. This confidentiality is designed to encourage frank and open discussions.

Before the meeting, the Registrar talks to the complainant about the issues to be discussed and the outcome sought, and prepares an agenda for the meeting.

Possible outcomes

There are a range of outcomes that can result from a successful assisted resolution or conciliation. The health service provider may:

- express regret for the complainant's distress, and provide an apology
- acknowledge that a mistake occurred

- provide an explanation – or better explanation – of the events in question
- recognise the need for better communication
- discuss any measures that have been taken to address the situation, so that a similar incident or mistake will not happen again
- offer to review their current practice and take steps to improve it.

Performance

Assisted resolution

In 2009-10, the Commission referred 608 (17.3%) complaints for assisted resolution, compared to 561 (16.8%) in 2008-09. The Resolution Service finalised 553 complaints, compared to 620 in 2008-09.

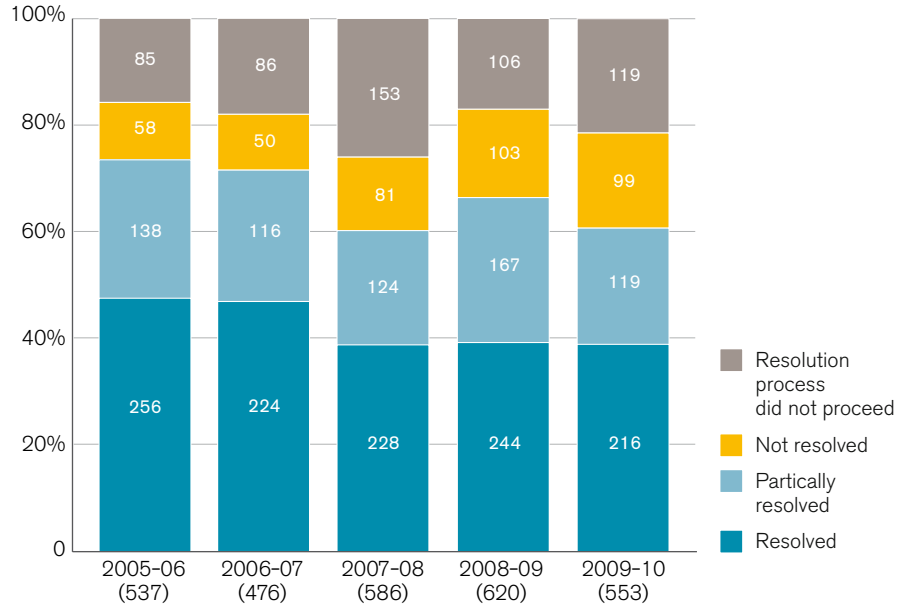
Chart 12.1 shows the outcome of assisted resolutions over the past five years.

In 2009-10, there were 119 complaints (21.5%) where the resolution process did not proceed, mainly because one of the parties was not prepared to participate. Some complainants who were dissatisfied with the decision to refer their complaint for assisted resolution sought a review.

Of the remaining 434 complaints, 335 (77.2%) were fully or partly resolved. 99 complaints (22.8%) were not resolved, mainly because the parties disagreed on what had happened, the complainant's expectations could not be met, or the offer by one side was not acceptable to the other.

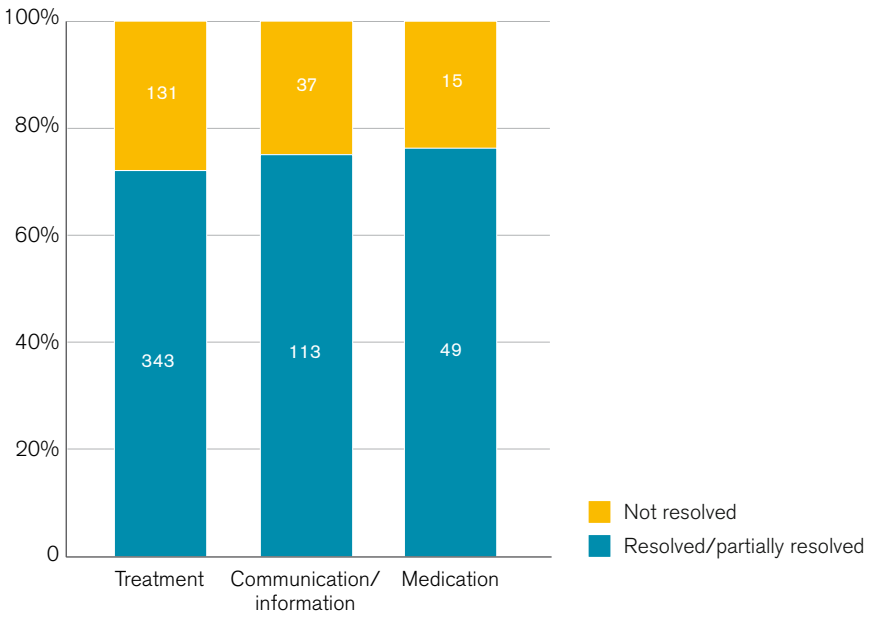
Chart 12.2 shows the outcomes for the three most common issues dealt with through assisted resolution – treatment, communication/information, and medication.

Chart 12.1 Outcome of assisted resolutions 2005-06 to 2009-10



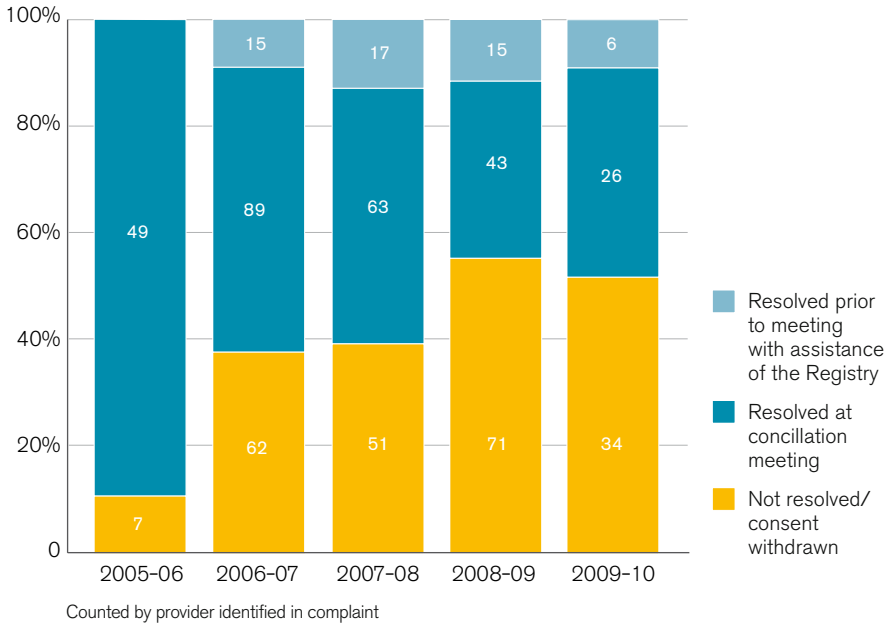
Counted by provider identified in complaint

Chart 12.2 Three most common issues and outcomes for assisted resolutions finalised 2009-10



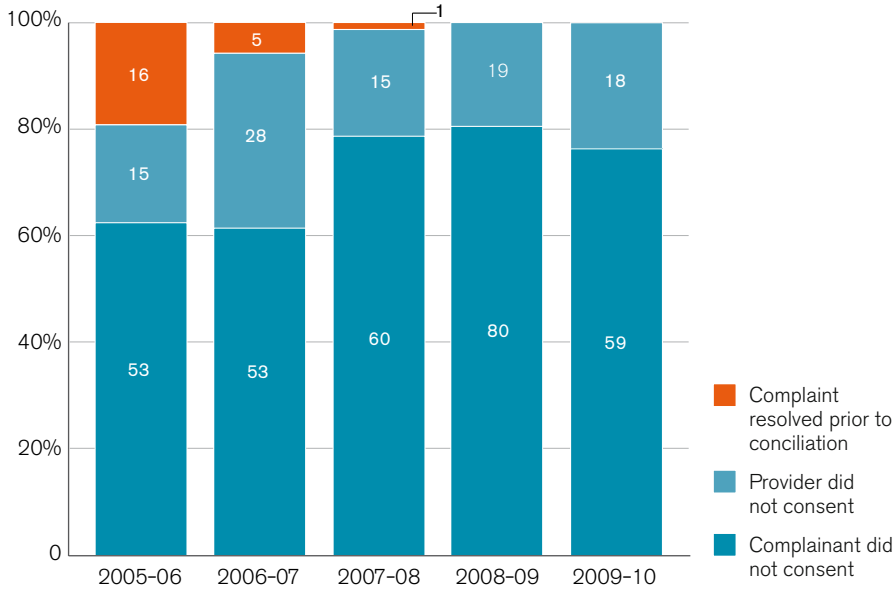
Counted by issues raised in complaint

Chart 12.3 Outcomes of conciliation that did proceed 2005-06 to 2009-10



Counted by provider identified in complaint

Chart 12.4 Reasons for conciliations not proceeding 2005-06 to 2009-10



Counted by provider identified in complaint

These three categories accounted for 75.8% of all issues dealt with in assisted resolution in 2009-10.

Conciliation

In 2009-10, the Commission referred 127 complaints for conciliation, compared to 167 in the previous year. The Health Conciliation Registry finalised 143 complaints, compared to 228 in 2008-09.

Chart 12.3 shows the outcomes of conciliations that proceeded over the past five years.

In 2009-10, of the 66 conciliations that proceeded 26 complaints (39.4%) were resolved at the conciliation meeting. In a further six cases (9.0%), the complaint was resolved before the meeting with the assistance of the Health Conciliation Registrar.

There were 34 complaints that were not resolved. In 20 cases (30.3%), this was because the complainant or the health service provider withdrew their consent to participate in conciliation. In a further eight complaints (12.1%), no final agreement could be reached at the meeting, but the parties nevertheless found the meeting helpful in clarifying the complainant's concerns. In six cases (9.0%), no agreement was reached at the meeting.

In 2009-10, as in the previous year, conciliations mainly concerned issues involving treatment and communication. These issues accounted for 72.0% of all issues dealt with through conciliation.

As shown in Chart 12.4, in 2009-10, conciliation did not proceed in 77 complaints (53.8%). Of these, there were 59 where the complainant was not prepared to participate.

Timeliness

Assisted resolution

Chart 12.5 shows how long it took to complete assisted resolutions in the past five years.

In 2009–10, 119 complaints (21.5%) were completed within one month, 349 (63.1%) within three months and 482 (87.2%) within six months. In 71 cases (12.8%), it took more than six months to finalise the complaint because of the time taken by the parties to decide when or how to proceed, the complexity of the issues, or difficulties in obtaining sufficient information.

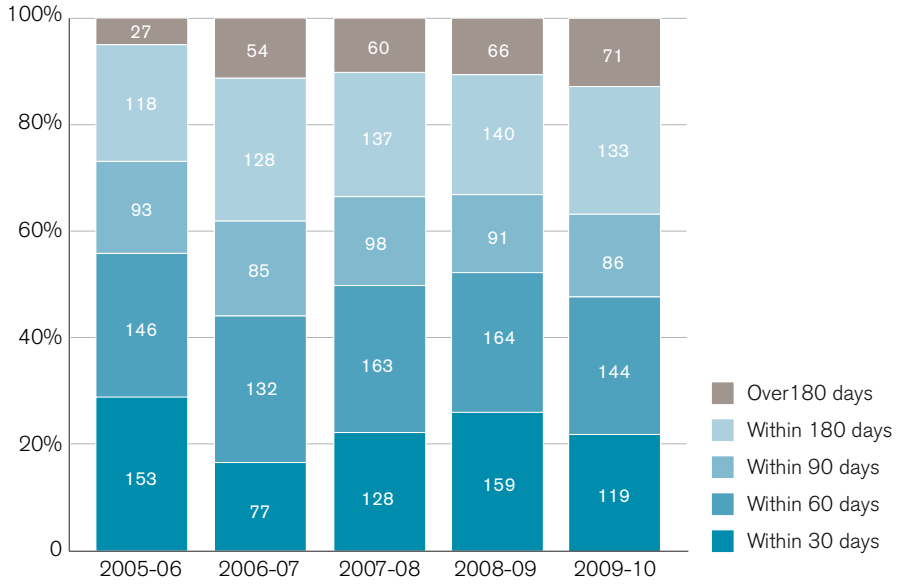
Conciliation

Chart 12.6 shows the time it took to finalise conciliations in the past five years.

In 2009–10, the Conciliation Registry finalised 18 complaints (12.6%) within one month, 77 (53.8%) within three months and 122 (85.3%) within six months.

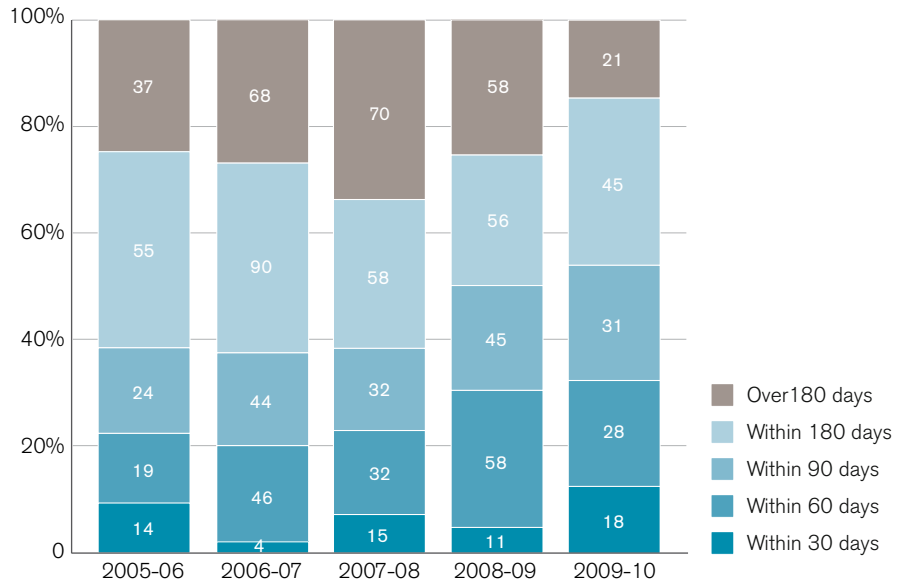
This is an improvement on the previous year, when the Registry finalised 11 (4.8%) of its complaints within a month, 114 (50.0%) within three months and 170 (74.6%) within six months.

Chart 12.5 Time taken to complete resolution process 2005–06 to 2009–10



Counted by provider identified in complaint

Chart 12.6 Time taken to complete conciliations 2005–06 to 2009–10



Counted by provider identified in complaint

Feedback

Assisted resolution

The Resolution Service seeks feedback from complainants and health service providers with whom there has been significant contact during the resolution process, by including client satisfaction surveys with the Commission's closing correspondence.

In 2009–10, the response rate was 24.3% for complainants and 26.4% for health service providers who were sent a survey.

Complainants' responses

Overall, 86.5% of complainants who responded were satisfied with their interaction with the Resolution Officer.

- 85.0% agreed the Resolution Officer was impartial
- 95.1% agreed the officer's involvement was helpful
- 91.5% agreed the officer understood the issues raised in the complaint
- 96.7% agreed that the officer kept them updated about progress.

Providers' responses

Overall, 89.5% of health service providers who responded were satisfied with their interaction with the Resolution Officer.

- 89.5% agreed the Resolution Officer was impartial
- 91.7% agreed the officer's involvement was helpful
- 89.5% agreed the officer understood the issues raised in the complaint
- 88.3% agreed the officer kept them updated about progress.

The surveys also allowed for additional comments about the Commission's resolution services. Comments from **complainants** included:

" We would like to extend our thanks to [the Resolution Officer]. She was wonderful to myself and my husband. She totally understood our case and always kept us advised as to its progress. She was extremely compassionate and empathetic and helped restore our faith in the system. "

" I found [the officer] very diligent and positively active towards my complaint. We worked as a team to try to resolve some of the issues. [The officer] was always supportive and professional when dealing with this vulnerable process. "

" Thank you, you were very caring and understanding, I am very lucky to have a nice person like you help me through my complaint. Yes, very happy with the outcome of the meeting, very relaxed, and honesty was the best policy for all concerned. "

Some **health service providers** also provided comments:

" I have to say [the facility's] Mental Health [unit] and HCCC commitment to customer care in partnership is just terrific. I value the learning experience and the collaboration. "

" [The officer] was very supportive and assisted in moving a long drawn out process forward. "

" A difficult case to resolve but well managed by HCCC. "

" I think this was the best resolution process I have been involved in. This was due to the expertise of the officer. The process I believe was very helpful for the complainant. "

CASE STUDY

Detecting eye problems in babies

A woman complained that her newborn baby had been discharged from hospital without a health examination. A congenital cataract had not been detected, and this led to a delay in diagnosis and treatment of the cataract. As a result, the baby developed a significant visual impairment.

The Commission referred this matter for assisted resolution. Both the mother and the hospital agreed to participate in the process.

The Resolution Officer discussed the hospital's response to the complaint with the mother. The hospital explained that not all babies were assessed by a doctor before discharge. Babies not assessed by a doctor are assessed by a midwife. A midwife's assessment includes an examination of the baby's eyes, but they do not perform the 'red reflex' eye test for detecting a cataract, because they are not trained to use an ophthalmoscope.

After this explanation, the mother criticised the hospital for not telling her at the time of discharge that her baby had not been examined by a doctor, and that the midwife had not carried out a full test for cataracts. She asked whether it was possible to train midwives to carry out this test.

The Resolution Officer organised a meeting between the mother and representatives of the hospital to discuss these issues.

The hospital said that, in future, midwives would provide a more detailed explanation of what tests had and had not been conducted. In addition, the standard discharge letter would be amended to make clear whether the baby had been examined by a doctor before discharge, and that a general practitioner should further examine the baby's eyes, hips and heart. The hospital also agreed to train midwives in the use of the 'red reflex' eye test, and would buy additional ophthalmoscopes for them.

The mother was pleased with this outcome.

Conciliation

In 2009–10, client satisfaction surveys were handed to everyone attending a conciliation meeting, including support persons.

Complainants' responses

Overall, 79.4% of complainants and their support persons who responded were satisfied with their interaction with the Registry staff/conciliator.

- 78.4% agreed that the conciliator was impartial
- 82.5% agreed the involvement of the Registry staff/conciliator was helpful
- 87.8% agreed the Registry staff/conciliator understood the issues raised in the complaint
- 80.5% agreed they were kept updated about progress.

Providers' responses

Overall, 87.3% of providers and their support persons who responded were satisfied with their interaction with the Registry staff/conciliator.

- 92.9% agreed that the conciliator was impartial
- 83.9% agreed the involvement of the Registry staff/conciliator was helpful
- 79.7% agreed the Registry staff/conciliator understood the issues raised in the complaint
- 83.1% agreed they were kept updated about progress.

Significant developments in 2009–10

Monitoring of agreements

The resolution of complaints may involve a health service agreeing to systemic improvements to address the issues giving rise to the complaint.

In 2009–10, the Commission started to record systemic improvements resulting from resolution processes, as well as their implementation. Stemming from assisted resolution processes, there were 113 actions agreed to by health services, of which 94 (83.2%) were implemented, one (0.9%) was not implemented and 18 (15.9%) remained outstanding at the end of the reporting year. In addition, there were 33 improvements resulting from conciliations, of which only two (6.1%) remain outstanding.

Mediation accreditation for Resolution Officers

In 2009-10, the Commission offered Resolution Officers mediation training that would lead to national accreditation by the National Alternative Disputes Resolution Advisory Council. Two Resolution Officers completed the training in 2009-10, and more Resolution Officers will complete the training in the coming year.

Closure of the Queanbeyan office

The Commission decided to close the Resolution Service's Queanbeyan office, located within the Greater Southern Area Health Service, after two attempts to fill the position in this area were unsuccessful. The position has been transferred to the Commission's Sydney office, and Resolution Officers will travel to the area to attend face-to-face meetings where required.

The year ahead

As of 1 July 2010, the Commission restructured its resolution area by merging the assisted resolution and conciliation services. Complaints are now referred for resolution without trying to predict at the outset which resolution option would be the most appropriate.

As a first step, a Resolution Officer discusses with both the complainant and the health service provider the issues involved and the ways in which the complaint might be resolved. If the parties prefer a formal meeting, an external conciliator can be appointed to facilitate a conciliation meeting. However, if the preference is to have the Resolution Officer act as an intermediary between the parties, the officer can obtain further information from the health service provider and discuss this with the complainant. The resolution process may involve face-to-face meetings, or negotiations by telephone, email, or in writing.

This approach allows for more flexibility in tailoring the resolution process to the needs and preferences of all involved. The Commission hopes that this will lead to more people agreeing to be involved in resolution processes in future, and that the use of the most suitable resolution option will also achieve a greater resolution rate.

Additional comments about the Commission's conciliation service included:

Complainants

" The conference shed new light on some issues that we felt we were left in the dark about. "

" Very necessary and appreciated. "

" Very helpful – strong conciliator. Appropriate agreement and resolutions reached. "

" I believe the process helped both sides to understand the issues involved. "

Health service providers

" I believe that the process was beneficial to all parties, for the complainant to understand the functions and internal workings of a private hospital. "

" A supportive informed family with totally reasonable complaints and concerns. It appeared to be a helpful exercise for all parties. "

" Family were engaged – process and resolution reached to allow them to move forward. Agreement is good and clear for the family. "

" The process was fair, and hopefully some issues were resolved for the family. "

" A very productive process. The mediator was very professional and at the same time welcoming and non-threatening. "

13

Investigating complaints

Performance in 2009–10

Corporate goal 'to ensure a best practice approach for the conduct of all investigations'

- The Investigations Division finalised 272 investigations during the year, as compared to the 261 investigations finalised in 2008-09.
- The Commission finalised 79.8% of investigations within 12 months. This is similar to the figure for 2008-09 when 80.8% of investigations were finalised within 12 months. Taking into consideration the period during which investigations were 'paused' pending criminal or coronial investigation, the Commission finalised 84.9% of its investigations within 12 months (target 85%).
- In 2009-10, the average time for an investigation was 278 days, which again is similar to last year's figure of 274 days.
- All investigations starting in 2009-10 had an investigation plan. The Commission has included a check in its electronic case management system to ensure that an investigation plan is completed and approved for every investigation.
- All investigations are regularly reviewed. 97.6% of these reviews (target 80%) showed that the investigation was progressing in a satisfactory manner.
- The Commission received two requests for review of the investigation outcome, representing 0.7% of all investigations finalised during the year (target: less than 5%). Both reviews confirmed the original outcome of the investigation.
- In 2009-10, 141 complaints were referred to the Director of Proceedings. This is a significant increase of 41.0% on the 100 complaints referred in 2008-09.
- The Director of Proceedings made 13 requests to the Investigations Division for additional information – that is, requisitions were made for 9.2% of all referred investigations (target 10%). This is a significant improvement on 2008-09, when there was a target of 15.0%, and 26.0% of investigations were the subject of requisitions.
- One new staff member started in the Investigations Division during the year. The officer had former qualifications in investigation, and had also worked in investigative positions before joining the Commission, and so did not require investigation training in investigative techniques. In general, staff are regularly mentored and receive on-the-job training (target 100%).

Corporate goal 'to improve health care systems through recommendations arising from investigations'

- In 2009-10, the Commission finalised 35 investigations about health organisations. Of these, 29 (82.9%) resulted in the Commission making a total of 94 recommendations. In a further four investigations, the Commission made comments. As of 30 June 2010, 72 (76.6%) recommendations made during the year had been implemented. For the 65 recommendations made in 2008-09, the implementation rate was 96.9% as at 30 June 2010 (target 80%).

The Investigations Division has three teams of investigators, each headed by a manager. The managers report to the Director of Investigations, who is responsible for the overall performance of the Division.

In November 2009, Mr Robert Wilson was appointed as the Commission's new Director of Investigations. The position had been vacant since March 2009 because the three-year secondment of the previous Director of Investigations had come to an end, and there was uncertainty about the impact of the national health practitioner registration scheme on the Commission's Investigations Division. From March to November 2009, the Commissioner supervised the Division.

Criteria for the investigation of complaints

The *Health Care Complaints Act* requires the Commission to investigate complaints about health organisations where there is a significant issue of public health or safety, or a significant question as to the appropriate care or treatment of a patient.

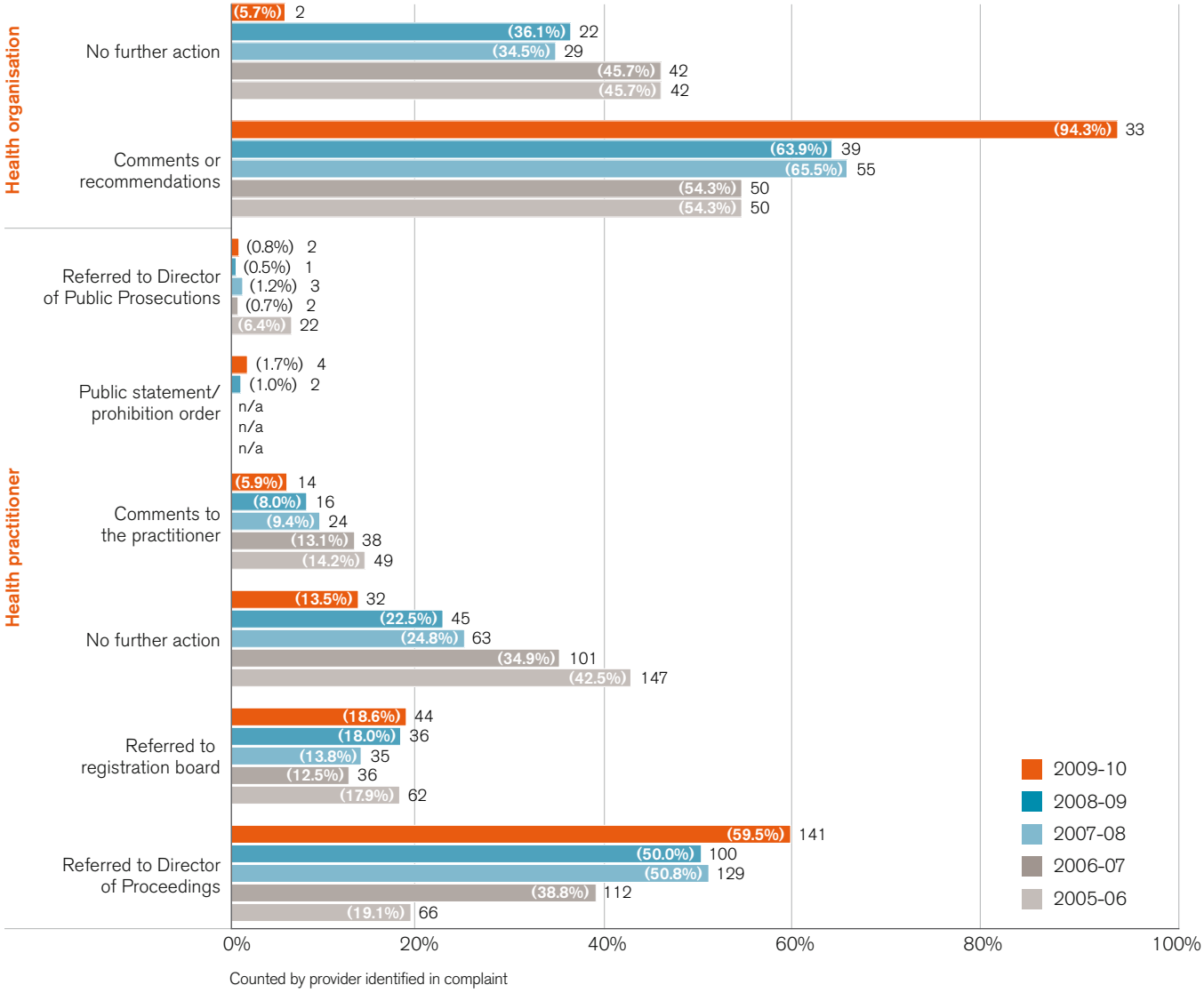
The Commission must also investigate complaints about health practitioners, which, if substantiated, would provide grounds for disciplinary action, involve gross negligence, or would reveal a breach of a prohibition order or the improper advertisement of health services.

Performance

Chart 13.1 sets out the outcomes of investigations over the past five years.

In 2009-10, the Investigations Division finalised 272 investigations, as compared to the 261 investigations finalised in 2008-09. Of the investigations finalised in 2009-10, 237 (87.1%) related to health practitioners and 35 (12.9%) to health organisations.

Chart 13.1 Outcomes of investigations into health practitioners and health organisations 2005-06 to 2009-10



Investigations of health practitioners

In 2009-10, there was a small increase in the number of investigations into health practitioners.

Of the 237 investigations into health practitioners, 141 were referred to the Director of Proceedings to consider prosecution before a professional disciplinary body, representing a 41.0% increase from the previous year. This resulted in a significant increase in the workload of the division, due to the need to prepare briefs of evidence for the Director of Proceedings.

In 2009-10, the Commission referred 44 complaints to the relevant registration board, and in another 14 cases made comments to the practitioner. In four cases, the Commission issued a public warning and/or made a prohibition order against an unregistered health practitioner. Two investigations were referred to the Director of Public Prosecutions to consider criminal charges.

There were 32 investigations into health practitioners that were terminated, because there was no evidence of unsatisfactory professional conduct by the practitioner, or no adequate basis for any further action. The proportion of investigations where the result is no action against the practitioner has progressively decreased over the past five years.

Chart 13.2 details the outcomes of investigations for the most common issues, which accounted for 87.9% of all issues investigated in 2009-10. Issues relating to the professional conduct of a practitioner are more often referred to the Director of Proceedings to consider disciplinary action. These include matters of sexual misconduct and the improper prescribing of drugs. Treatment issues are less commonly referred for prosecution. When investigating such issues, the Commission relies on expert advice. If the expert considers that there has been a departure from accepted standards, but does not consider it to be significant, the Commission makes comments or refers the matter to the relevant registration board.

Chart 13.2 Outcomes of issues raised in investigations against health practitioners 2009-10

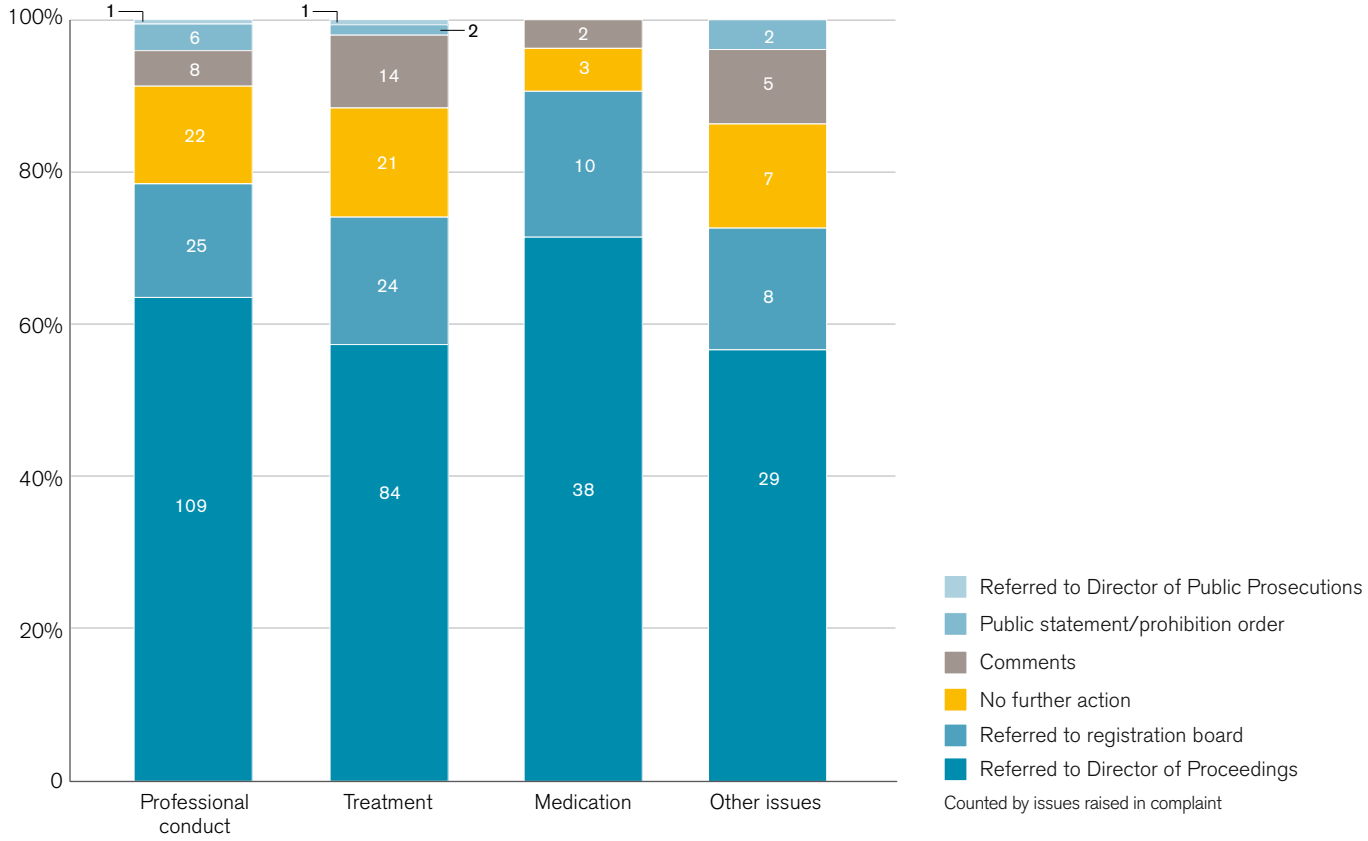
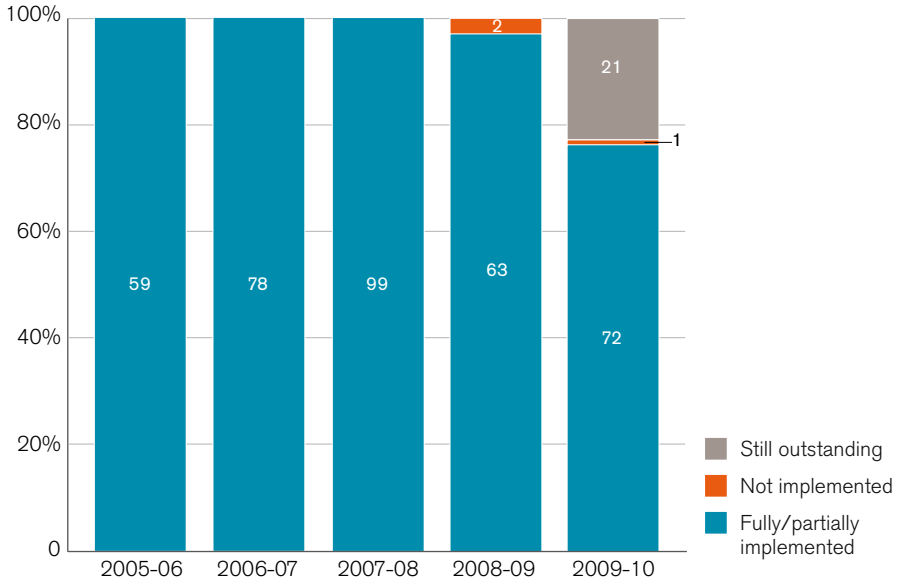
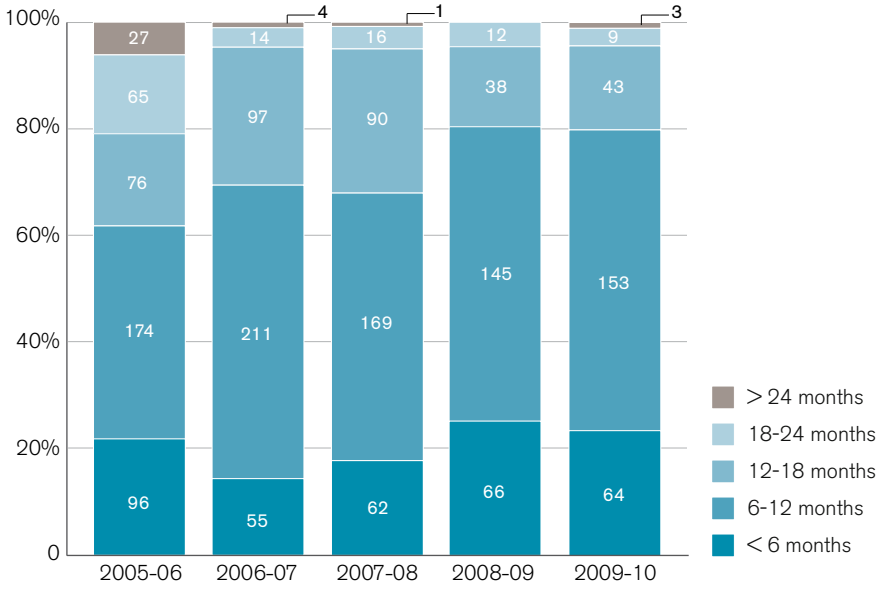


Chart 13.3 Implementation of recommendations as at 30 June 2010



Counted by recommendation

Chart 13.4 Time taken to complete investigations 2005-06 to 2009-10



Counted by provider identified in complaint

Investigations of health organisations

Of the 272 investigations finalised in 2009-10, 35 related to health organisations. This is a significant drop from the 61 investigations into health organisations in 2008-09.

Serious incidents are now routinely investigated by public health organisations through Root Cause Analysis processes, and the organisations engage in open disclosure with patients or their families. Where the Root Cause Analysis has recommended systems improvements, and there are no issues of individual misconduct, most of these matters are being referred for assisted resolution instead of investigation.

Although a smaller number of complaints about organisations were formally investigated, there was a significant increase in the proportion of complaints where the Commission made comments and/or recommendations to health organisations – from 63.9% in 2008-09 to 94.3% in 2009-10.

Implementation of recommendations

Of the 35 investigations about health organisations finalised in 2009-10, 29 (82.9%) resulted in the Commission making 94 recommendations. A further four investigations resulted in the Commission making comments. These were cases where the health organisation had already taken measures to address the issues of concern, and there was therefore no need for the Commission to make any recommendations.

As at 30 June 2010, 76.6% of recommendations made during the year had been implemented.

Since 2005, the Commission has made a total of 395 recommendations arising out of 163 investigations into health organisations. As at 30 June 2010, 371 of these (93.9%) had been implemented, and 21 (5.3%) are still to be implemented. Three recommendations (0.8%) were not implemented, and the Commission agreed that no further action was necessary with respect to these.

Timeliness of investigations

Of the investigations finalised in 2009-10, 79.8% were completed within 12 months – similar to the figure of 80.8% in 2008-09. The average duration of an investigation during the year was 278 days – similar to the average 274 days in 2008-09.

'Pausing' investigations

The Commission uses a 'process pause' where criminal or coronial investigations are underway. This means that the Commission puts its investigation on hold so as not to jeopardise the effective conduct of coronial or criminal proceedings.

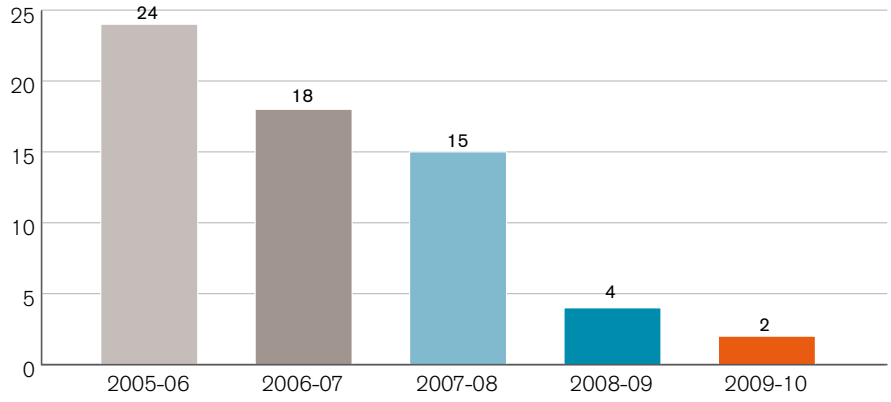
When the process pause is taken into account, the overall proportion of investigations completed within 12 months in 2009-10 (84.9%) is comparable to the figure of 84.7% in 2008-09.

Requests for review

Charts 13.5 and 13.6 set out the number of requests for review of an investigation decision over the last five years, as well as the outcome of these reviews.

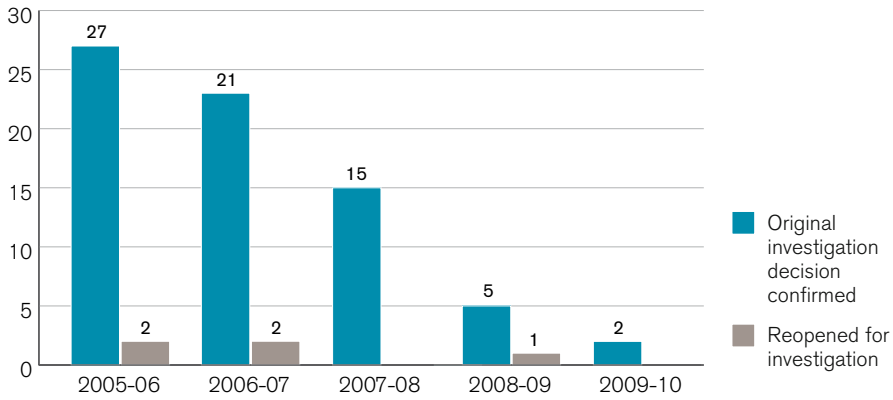
In 2009-10, there were two requests for review of investigation outcomes, and in both matters the original decision was upheld.

Chart 13.5 Requests for review of investigation decision 2005-06 to 2009-10



Counted by provider

Chart 13.6 Outcome of reviews of investigation decision 2005-06 to 2009-10



Counted by provider

Staff development

In late 2009, the Investigations Division ran a staff workshop to review all aspects of its procedures. As a result, a number of changes were implemented to ensure all relevant evidence for an investigation will be identified and obtained, and to improve the quality of briefs of evidence for the Legal Division.

The overall performance of staff is reviewed annually. Performance reviews provide an opportunity for staff to identify training and development needs.

The year ahead

The introduction of the national registration scheme for health practitioners, and the anticipated restructuring of the public health system, may lead to challenges in obtaining timely information for the Commission's investigations. In order to perform its functions effectively, the Division will need to develop effective working relationships with the new health registration councils and local hospital networks.

The Division will continue to develop staff capabilities through training programs and opportunities. This will include monthly internal training in technical skills, external training in management and supervision, and mentoring and debriefing.

Performance management will continue to focus on building the skills of investigative staff. This will include developing skills in interviewing health practitioners and witnesses who can be required to provide statements under s34A of the *Health Care Complaints Act*, executing search warrants, and the effective management of evidence.

The Division will develop models for particular types of investigations, such as those concerning prescribing and the competence of a health service provider. This is designed to ensure thorough investigations, as well as consistency.

The Division will continue to participate in training for expert advisers about how to prepare expert reports that reflect the standards stipulated in the legislation for assessing the performance and conduct of health practitioners.

Feedback

The Investigations Division seeks feedback from complainants and health service providers by including client satisfaction surveys with the Commission's closing correspondence.

In 2009–10, the response rate was 4.7% for complainants and 6.3% for health service providers who were sent a survey. Due to the low response rate, no further breakdown of the results can be given.

CASE STUDIES

Complaint about a dental technician practising dentistry

The investigation of a dental technician who was working as a dentist, although not qualified to do so, was discussed in chapter 6, under the heading 'Extended powers for the Commission'. The case illustrates how the Commission can use its search warrant powers to obtain relevant evidence.

Was there a sexual relationship?

The following case shows how the Commission can obtain and use medical records and other documents in the investigation of a complaint.

A female patient claimed that her general practitioner, whom she had been consulting for over five years, had improperly engaged in a personal relationship with her. She alleged they had met regularly for six months and had sex at the doctor's surgery and at her home.

The Commission withheld notification of the complaint to the doctor until it had obtained a detailed statement from the woman. The Commission then required the doctor to provide original copies of the woman's medical records, together with a response to her allegations.

The doctor's records revealed that, at the time the woman claimed the relationship had begun, the doctor had noted that the woman was showing signs of forming an attachment to him. He noted that he had referred her to another doctor in the practice. Records from the practice showed that she had been seen by other doctors there, and Medicare records also confirmed this.

In addition, the doctor provided evidence that he had been sick and off work for most of the period during which the woman claimed to have been seeing him. The doctor also provided evidence that, for some of that period, he was overseas on a holiday with his family.

The Commission found that the documentary evidence clearly supported the doctor's version of events, and closed the case.

14

Prosecuting complaints

Performance in 2009–10

Corporate goal of 'independent and timely determinations to prosecute'

- The Director of Proceedings considered 89.1% of matters referred to her within three months (target 80%). This is an improvement on last year, when 71.9% of matters were reviewed within three months.

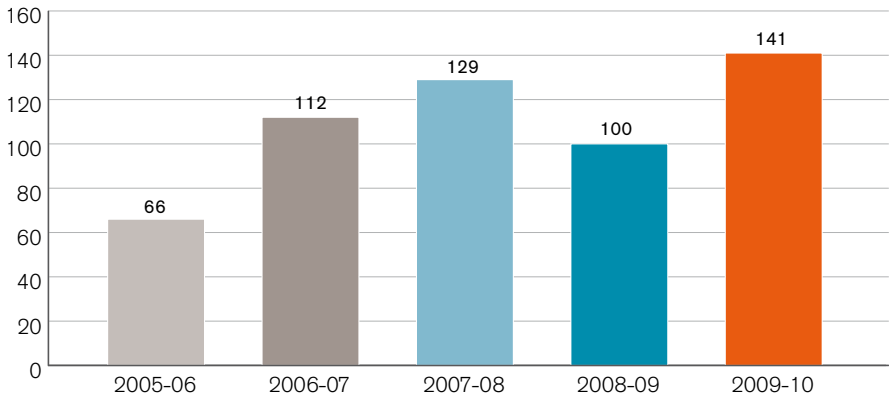
Corporate goal of 'professional and competent prosecutions of serious complaints in the public interest'

- The Commission's success rate in finalised prosecutions of health practitioners was 90.5% (target 90%).
- The Commission complied with Court and Tribunal deadlines in 70.4% of matters (target 80%).
- 52.4% of bills of costs were prepared or sent to a cost consultant for assessment within 90 days (target 80%).
- A report on the recovery of legal costs is provided every month to the Executive.
- The Legal Division aims to provide 80% of legal advice within 21 days or an agreed timeline. In 2009–10, there were no requests to the Legal Division for formal legal advice.

Chart 14.1 shows the number of complaints that were referred to the Director of Proceedings over the last five years.

In 2009–10, 141 complaints were referred to the Director of Proceedings to consider whether disciplinary proceedings were appropriate – a 41.0% increase on the 100 complaints referred in 2008–09.

Chart 14.1 Complaints referred to Director of Proceedings for prosecution before a disciplinary body 2005–06 to 2009–10



Counted by provider

Performance of the Legal Division

During 2009–10, the Legal Division finalised 97 legal proceedings. Multiple complaints about the same registered practitioner that are referred from the Investigations Division and prosecuted, are combined into a single legal matter.

The Division finalised 14.1% more legal proceedings than in the previous year, with no increase in staff numbers.

The large number of prosecutions in 2009–10 was the result of two factors. First, there were more complaints referred from the Investigations Division. Second, registration boards listed many matters for hearing before the commencement of the *Health Practitioner Regulation National Law (NSW)* on 1 July 2010. In the first six months of 2010, there was a particularly large number of hearings before Tribunals and Professional Standards Committees.

As shown in Chart 14.2, the 97 matters finalised involved 83 disciplinary proceedings, four review and re-registration applications, and ten appeals and other applications. The outcomes of these matters are set out in Table 14.1.

The Director of Proceedings decided not to prosecute 12 complaints. In four of these, the practitioner had already been deregistered (three related to the same practitioner) and in one the practitioner was no longer registered. Five complaints were referred back to the Commissioner and then referred on to the relevant registration board to counsel the practitioner. Regarding one complaint, there were issues with the evidence that meant that there was no reasonable prospect of a successful prosecution. In the remaining complaint, the complainant advised that they were unable to give evidence due to health reasons.

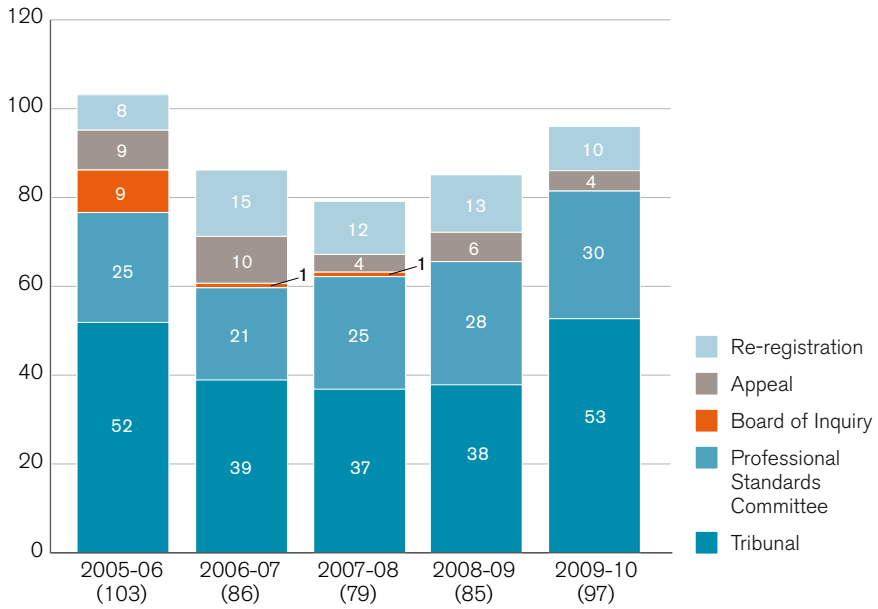
Medical Professional Standards Committees

In 2009, amendments were made to the *Medical Practice Act* to allow legal representation in hearings before Medical Professional Standards Committees (PSCs). At the same time, the Minister for Health said that the government was *'keen to ensure that proceedings for the Professional Standards Committees do not become overly legalistic and process driven'*. The amending legislation allowed for a code of conduct to be developed that would guide the use of legal practitioners in such proceedings before the amendments came into effect.

Following consultation between the NSW Medical Board, the Commission and the Australian Medical Association, a code of conduct about legal representation was agreed to. Since early 2010, parties to Medical PSCs have been entitled to legal representation, and there is now legal representation by a solicitor or barrister in most matters.

The *Health Practitioner Regulation National Law (NSW)* that came into operation on 1 July 2010 has maintained the right to legal representation before Medical PSCs and has also extended this right to proceedings before Nurses and Midwives PSCs.

Chart 14.2 Legal matters finalised 2005-06 to 2009-10*



Counted by matter

* Excludes complaints where the Director of Proceedings determined not to prosecute.

Procedures manual

The Legal Division finalised a new procedures manual in April 2010. The manual brings together a number of existing policies and procedures guiding the Division's work. In preparing the manual, all of the Legal Division's procedures were reviewed to ensure efficiency and consistency.

An internal audit of the Legal Division's processes and controls was finalised in May 2010. The audit report commended the Division's new procedures manual, on the basis that the manual:

> *… provides guidance to HCCC personnel in relation to the prosecution processes … outlines the key steps which are required to be undertaken in relation to legal determinations and prosecutions before health disciplinary tribunals … and defines the key roles and responsibilities in relation to the preparation and approval of these documents.*

Only minor changes needed to be made to the manual as a result of the audit.

14 Prosecuting complaints

Table 14.1 Outcome of legal matters in 2009–10

Professional Standards Committee		
Medical Professional Standards Committee	caution	2
	caution and conditions	1
	conditions	1
	dismissed	3
	proved – no further order	2
	reprimand	1
	reprimand and conditions	8
	withdrawn	2
	inquiry not held	1
Nurses and Midwives Professional Standards Committee	not proved	3
	referred to Tribunal*	1
	reprimand and conditions	5
	Total Professional Standards Committee	30
Tribunal		
Chiropractors Tribunal	reprimand and conditions	1
Dentists Tribunal	deregistered	1
	suspended and conditions	1
Medical Tribunal	adjourned sine die**	2
	conditions	1
	deregistered	10
	reprimand and conditions	5
	reprimand, conditions and fine	1
	suspended	1
Nurses and Midwives Tribunal	adjourned sine die**	2
	cautioned	1
	deregistered	13
	not proved	1
	reprimand	1
	reprimand and conditions	1
	suspended	1
	suspended and conditions	1
Pharmacy Board of Inquiry	deregistered	2
Physiotherapists Tribunal	deregistered	1
Psychologists Tribunal	deregistered	3
	suspended, reprimand and conditions	1
	withdrawn	2
	Total Tribunal	53

Appeals/applications		
Administrative Decisions Tribunal	appeal by respondent – dismissed	2
Court of Appeal	application regarding bias – dismissed	1
	appeal by respondent upheld and remitted to Tribunal	1
	appeal withdrawn by respondent	1
	application withdrawn	1
Medical Tribunal	appeal by respondent – dismissed	1
Nurses and Midwives Tribunal	appeal by Commission – upheld	1
Supreme Court	interlocutory order by respondent – refused	1
	application to Supreme Court by respondent withdrawn	1
	Total appeals	10
Re-registration		
Nurses and Midwives Tribunal	application rejected	3
Physiotherapists Tribunal	application withdrawn	1
	Total re-registration	4
Grand total		**97**

Counted by matter

* Matter referred to Tribunal; outcome of Tribunal hearing will be reported separately.

** Matter was adjourned indefinitely.

The year ahead

The *Health Practitioner Regulation National Law (NSW)* only operates in relation to complaints referred for prosecution after 1 July 2010. All complaints referred for prosecution before that date continue to be dealt with under the old legislation.

All registered health practitioners are now governed by a uniform disciplinary process under the *Health Practitioner Regulation National Law (NSW)*. While there has been little change to the disciplinary system for medical practitioners, there have been significant changes for disciplinary proceedings against other registered health practitioners.

The Legal Division will review all its precedents and templates to ensure that they accurately reflect the relevant provisions of the new legislation. The procedures manual will also be reviewed to ensure that it explains and reflects the relevant legal and procedural changes arising out of the new legislation.

The Legal Division's regular meetings will focus on the impact of the new legislation on the day-to-day work of the Division. Where necessary, small project teams will be established to examine specific aspects of the new legislation and to prepare advice or obtain external advice on how to apply the legislation. The procedures manual will be updated to reflect any relevant changes to the Division's procedures.

CASE STUDY

Safe births at home

The Commission prosecuted a midwife, Ms Jillian De Laile, before the Nurses and Midwives Tribunal. The Commission alleged that Ms De Laile had failed to provide safe care to two patients.

Patient A had given birth to twin boys at Ms De Laile's residence. The second twin was in very poor health immediately after his birth and died ten months later.

The Tribunal found:

- Ms De Laile should not have accepted primary antenatal care in the last stages of a high risk pregnancy – it was inappropriate to plan a home birth, and the patient should have been transferred to a medical specialist.
- Ms De Laile had inappropriately assisted the patient to discharge herself from hospital against medical advice.
- Following the delivery of the second twin, Ms De Laile had failed to contact the hospital for advice and had not brought the baby to hospital for more than five hours, although she knew that the baby was in very poor health.

Patient B gave birth to a boy at her own home. The baby died shortly after delivery. The Tribunal found that Ms De Laile:

- inadequately monitored the baby's heart rate and the mother's vital signs
- should have arranged for an ambulance at various stages of labour, particularly when this had been requested by the patient
- should have called an ambulance immediately when the baby was not responding to resuscitation
- should have had a second midwife attend the birth
- should not have left the patient on her own for almost two hours when the placenta had been retained and there was nobody with medical expertise to help.

The Tribunal found that Ms De Laile had shown a serious lack of judgment and a lack of insight into the standards expected of her as an independent homebirth midwife. On this basis, the Tribunal found her guilty of professional misconduct and ordered that she be deregistered as a midwife.

The Tribunal also said that midwives offering home birth services should have a detailed written agreement with their patients, particularly about the circumstances when the patient should be transferred to a hospital. Independent midwives should also use the methods of note-keeping and observation required of midwives working in hospitals.

15 Complaints, privacy and freedom of information

Complaints

Review requests

If a complainant is dissatisfied with the Commission's assessment of their complaint or the outcome of an investigation into a health practitioner, they are entitled to seek a review of the matter by the Commission.

Details of the requests for review in 2009-10, and of the outcomes of those requests, can be found in chapter 11 – 'Assessing complaints' and chapter 13 – 'Investigating complaints'.

Complaints about staff

The Commission received four complaints about its staff in 2009-10. Details of these complaints and their outcomes are as follows:

A witness to events that were investigated by the Commission complained that the investigating officer had been aggressive towards her and was trying to influence her evidence. The Commission looked into this complaint and the officer was counselled about their conversation with the witness. Responsibility for interviewing the witness was given to another officer.

A doctor complained that, when his patient had come to the Commission's office to lodge a complaint about the outcome of an operation, a Commission officer had inappropriately regarded the patient's concerns as an inquiry rather than a complaint, and had given medical advice although not qualified to do so. The Commission looked into this complaint and the officer's manager reinforced the need to assist people who wished to lodge complaints. The officer was also reminded not to provide advice that might be interpreted as medical advice. The Commission contacted the patient to assist her in lodging her complaint.

A woman was concerned that Commission staff were biased in the handling of her complaint. She asked the Director of Investigations to review the investigation to see whether it was being handled appropriately. The Director of Investigations found no evidence of bias, but did counsel the investigation staff about the need to provide timely advice to complainants and to record relevant information.

A complaint was made that a Commission officer threatened a person whose premises were being searched under a search warrant. The Commission's investigation found that the officer had not made a threat, but had made some inappropriate comments for which they were counselled. The Commission also notified this complaint to the ICAC, which decided that it would not take any action.

Complaints alleging breaches of the *Anti-Discrimination Act*

In last year's annual report, the Commission referred to a case where a medical practitioner had complained to the Anti-Discrimination Board of 'victimisation'. The practitioner claimed the Commission's decision to prosecute him before the Medical Tribunal was intended to victimise him for assisting other people to complain about alleged discrimination by the Commission.

The Anti-Discrimination Board referred the matter to the Administrative Decisions Tribunal.

The Commission applied for summary dismissal of the proceedings. In February 2010, the Tribunal granted this application, stating that it was satisfied that the complaint against the Commission was both 'misconceived' and 'lacking in substance'.[1]

The same practitioner also complained to the Anti-Discrimination Board that the Commission's decision to refer him to the NSW Medical Board for a possible impairment assessment was also victimisation. Again, the Board referred the matter to the Administrative Decisions Tribunal for hearing.

The hearing before the Tribunal was finalised in July 2010. The Tribunal has reserved its decision.

Compliments

The Commission maintains a file of compliments by complainants, health service providers and others about their dealings with Commission staff. The Commission passes on these compliments to the staff involved.

In addition, the Commission's client satisfaction surveys often contain compliments from complainants and health service providers about their interactions with Commission staff. Details of the results of these surveys are contained in Chapters 11-13.

Privacy

The Commission is subject to the provisions of the *Privacy and Personal Information Protection Act* and the *Health Records and Information Privacy Act*. The Commission's Privacy Management Plan sets out how the Commission manages its obligations under this legislation.

1 O'Sullivan v Health Care Complaints Commission and Ors [2010] NSW ADT 57.

Complaints alleging breach of privacy

The Commission has been advised of one complaint made to the Commonwealth Privacy Commissioner. The Privacy Commissioner sought information from the Commission to look into the matter. The Commission provided this information and has not yet been advised of any determination of the complaint.

Freedom of information

The *Freedom of Information Act* provides that the Commission is exempt from the operation of the Act in relation to the Commission's complaint-handling, investigative, complaint resolution and reporting functions.

The following information summarises how the Commission handled Freedom of Information (FOI) applications received in 2009-10.

A – New FOI applications

The Commission received four FOI applications, all of which were made by individuals – as compared to the 10 applications received in 2008-09, all of which were also made by individuals.

B – Discontinued applications

In 2009-10, as in the previous year, no applications were discontinued.

C – Completed applications

The Commission completed all four applications.

D – Applications granted or otherwise available in full

E – Applications granted or otherwise available in part

F – Applications refused

G – Exempt documents

One application was granted in part. The other three applications were dealt with on the basis that the applicant was seeking access to documents in relation to which the Commission was exempt from the operation of the *Freedom of Information Act*.

In the previous reporting period, no applications were granted, on the basis that the Commission was exempt from the operation of the *Freedom of Information Act*.

H – Ministerial certificates

No Ministerial certificates were issued in 2009-10 or in the previous reporting period.

I – Formal consultations

One application in 2009-10 required consultation. In the previous reporting period, no application required consultation.

J – Amendment of personal records

K – Notation of personal records

There were no requests for the amendment of personal records in 2009-10 or in the previous reporting period.

L – Fees and costs

M – Fee discounts

N – Fee refunds

In 2009-10, fees were provided for four applications, three of which were refunded. One request for internal review included a fee that was refunded.

In the previous reporting period, fees were provided for seven of the ten applications, all of which were refunded. Two requests for internal review also included fees that were refunded.

O – Days taken to complete request

P – Processing times (hours)

The one application that was granted in part took less than 10 hours to process within 21 days. This period includes the time taken to consult with two third parties and to finalise the consultations.

For the other three applications received in 2009-10, the Commission was exempt from the operation of the *Freedom of Information Act*. This exemption also applied to all applications received in the previous reporting period.

Q – Number of reviews

R – Results of internal reviews

There was one request for internal review in 2009-10. Because the Commission was exempt from the operation of the *Freedom of Information Act*, there was no right to an internal review.

There were three requests for internal review in the previous reporting period, but no right to an internal review, for the reason mentioned above.

The year ahead

On 1 July 2010, the *Freedom of Information Act* was repealed and replaced by the *Government Information (Public Access) Act 2010 (the GIPA Act)*.

Under the new legislation, the Commission continues to be exempt from applications for access to documents in relation to the Commission's complaint-handling functions.

16

Organisation and governance

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Performance in 2009–10

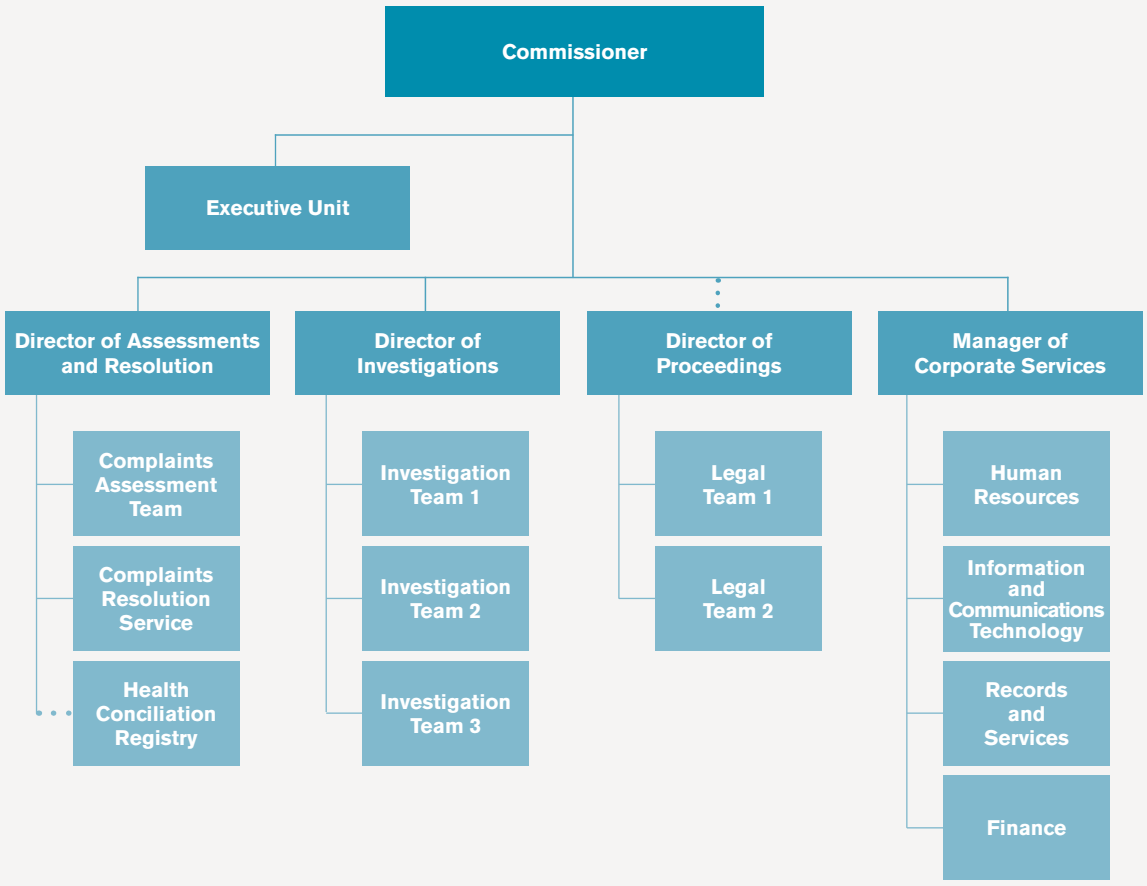
Corporate goal 'to develop as a learning organisation that embraces a culture of continuous improvement and the sharing of knowledge, and promotes a productive, safe and satisfying workplace'

- The Commission has performance agreements for its staff, which are reviewed annually. On review, 97.2% of staff were rated as competent to perform in their position (target 90%).
- Staff performance reviews are an opportunity to identify training needs that will enhance staff skills and capabilities. During the year, staff learning plans identified in performance reviews were implemented. In 2009–10, an average of two training/staff development sessions were completed per full-time equivalent employee (target minimum five sessions).
- The Commission continues to comply with relevant timeframes to develop and report on its OHS, EEO, EAPS and Disability Action Plans (target 100%).
- The Commission completed 75% of its information and communication technology development projects according to timeframes (target 100%).
- The Commission fully complied with the information security standard ISO 27001:2005 (target 100%).
- The Commission has monthly staff meetings where the Commissioner and divisional Directors update staff on recent developments and significant changes that may have an impact on the Commission's work. The meetings are also a forum for staff to seek clarification and raise issues. In addition, there are regular divisional and team meetings.
- 100% of key corporate documents were distributed to all staff and/or placed on the Intranet (target 100%). In early 2010, the Commission re-launched its Intranet. The new Intranet contains relevant Commission policies, procedures and forms. Some policies are currently being reviewed and will be added to the new Intranet shortly. In addition, each division can now include their procedure manuals, forms and template letters on the Intranet for access by other staff.

Corporate goal 'to monitor performance to ensure work quality, organisational development, good governance and effective resource management'

- Meetings were conducted according to schedule. As well as regular divisional and team meetings, there were fortnightly Executive Management meetings; quarterly OHS and Workplace Consultative Committee meetings; and a meeting of the ICT steering committee every four months.
- The Strategic Plan, Corporate Business Plan and Divisional Business Plans for the 2010–11 year were developed. The Strategic Plan 2010–13 was finalised in March 2010. The Divisional Business Plans were finalised in August 2010, and the Corporate Plan was finalised in September 2010.
- The Senior Executive Team is provided with monthly financial statements, which are reviewed and discussed as part of the regular Executive Management meetings.
- The Commission provides quarterly performance reports to both the Minister for Health and the Parliamentary Committee. There was no negative feedback about these reports.
- Commission staff have performance agreements in place, which were reviewed annually (target 100%).

Chart 16.1 Organisational chart



Corporate structure

The Commissioner, Mr Kieran Pehm, was appointed on 29 June 2005 for a five-year term. Mr Pehm's contract has been extended for a further five years to 28 June 2015.

As shown in the organisational chart, the Commission has three operational divisions, an executive unit and a small corporate services unit.

The Office of the Health Care Complaints Commission provides personnel services to the Commission. The Office of the Health Care Complaints Commission is a division of the Government Service that was established under the *Public Sector Employment and Management Act 2002*. Separate financial statements for both entities are included in chapter 17.

Senior Executive Service

In 2009-10, the Commission had a total of four senior executive service (SES) positions. These are:

- Commissioner, SES Level 6 – Kieran Pehm, Bachelor of Arts (BA) and Bachelor of Laws (LLB), Master of Laws (LLM)
- Director of Proceedings, SES Level 2 – Karen Mobbs, Bachelor of Arts (BA) and Bachelor of Laws (LLB)
- Director of Investigations, SES Level 2 – Robert Wilson, designated Queensland Police Detective 1998 and Certificate 4 in Government Investigations. Mr Wilson was appointed on 2 November 2009. He was formerly the Manager of Investigations for the Health Quality and Complaints Commission in Queensland. Prior to this, he worked for the Queensland Police Service for 19 years.

- Director of Assessments and Resolution, SES Level 1 – Ian Thurgood, Certificate in Orthopaedic Nursing, Certificate of General Nursing, Accredited Mediator

Performance of the Commissioner

The Commissioner is responsible to the Minister for Health, the Hon Carmel Tebbutt MP, for the Commission's overall management and performance.

The Commissioner's performance agreement is based on the Commission's Corporate Plan.

The Minister's assessment of the Commissioner's performance in 2009-10 was:

> *The Commissioner continues to perform to a high standard. The budgetary and corporate management processes of the Commission are sound and demonstrate the effective management of the Commission's resources. The Commission's handling of complaints appears to me to be generally effective and efficient. Overall, the Commissioner has met or exceeded the key performance criteria of his performance agreement.*

The Commissioner is renumerated at SES Level 6 with a current total renumeration package of $267,651.

Table 16.1 Senior Executive Service as at 30 June 2010

	2008-09	2009-10
Number of female executive officers	one	one
Number of executive positions occupied at each level	Level 6 – one	Level 6 – one
	Level 2 – two	Level 2 – two
	Level 1 – one	Level 1 – one

Table 16.2 Staff numbers by employment category 2006-07 to 2009-10

Employment basis	2006-07	2007-08	2008-09	2009-10
Permanent full-time	68	55	51	43
Permanent part-time	2	6	6	8
Temporary full-time	6	13	15	12
Temporary part-time	1	7	6	4
Contract – SES	4	4	3	4
Contract – non SES	–	–	–	–
Training positions	–	–	–	–
Retained staff	–	–	–	–
Casual	–	–	–	–
Total	81	85	81	71
Subtotals				
Permanent	70	61	57	51
Temporary	7	20	21	16
Contract	4	4	3	4
Full-time	78	72	69	59
Part-time	3	13	12	12

Commission staff

The Commission employed a total of 71 staff at the end of 2009-10. The Commission employed 51 permanent staff, 16 temporary staff, and four staff in SES contract positions. The majority of Commission employees (83.1%) are full-time, with 16.9% employed part-time.

The Commission had two staff seconded from other public sector agencies, one from the Department of Health and the other from the office of the NSW Ombudsman. One staff member was seconded to the NSW Ombudsman's office.

Staff attrition

In 2009–10, five permanent staff resigned, nine temporary staff completed their contracts, one officer was seconded to another agency, and the secondment of two officers ended.

Table 16.3 sets out the average full-time equivalent staffing levels for the last four years and provides a more accurate indication of staff trends. The Commission's average number of full-time equivalent employees (FTE) during 2009–10 was 69.7, a decrease of 4.4 FTEs from the previous year.

External review

In April 2010, a Commission employee took his own life. As a result of concerns arising from this tragic event, and the fact that the employee had been subject to a number of performance improvement programs, the Commissioner engaged an independent external consultant to review the Commission's management of the employee.

The consultant interviewed various staff, considered the employee's personnel file, and reviewed the Commission's policies and procedures. The consultant's report found no evidence of a culture of bullying or harassment at the Commission. However, the report made a number of recommendations to improve the general management of employees. Workcover also investigated the matter and decided to take no action under the *Occupational Health and Safety Act*.

Table 16.3 Average full time equivalent staffing 2006–07 to 2009–10

2006-07	2007-08	2008-09	2009-10
76.6	76.4	74.1	69.7

Conditions of employment and movement in salaries and allowances

Commission staff, including members of the Senior Executive Service, are appointed under the *Public Sector Employment and Management Act*.

Staff employed under the Crown Employees (Public Sector – Salaries 2007) Award received a 4% increase in salary and related allowances on 1 July 2009. They received the final increase under the current agreement in July 2010. Negotiations for a new award will start in 2010.

The Commission continues to employ a small number of medical and nursing advisers. The medical advisers are employed under the Crown Employees (Health Care Complaints Commission, Medical Advisers) Award. They received a 4% salary increase on 1 October 2009 and a further and final 4% increase will be paid from 1 October 2010.

The Commissioner and Directors are members of the Senior Executive Service. The Statutory and Other Offices Remuneration Tribunal determined a performance-based increase of 3% for the Commission's SES officers that came into effect on 1 October 2009.

Conditions of employment are principally set by the *Public Sector Employment and Management Act* and, for the majority of staff, by the Crown Employees (Public Service Conditions of Employment) Award 2009. Employees' conditions and entitlements are managed in accordance with the guidelines set by the NSW Department of Premier and Cabinet Personnel Handbook, the Commission's internal policies, and the Workplace Agreement.

Personnel policies and practices

The Commission also has a number of policies and procedures that help staff to understand their conditions of employment, as well as equal employment opportunity, occupational health and safety, security issues, and other operational requirements.

In March 2010, a new purchased leave policy was introduced. In May 2010, a new OHS training portal was released. The Code of Conduct and Code of Practice were reviewed. In addition, a new Strategic Plan for 2010–13 and a new Disability Action Plan for 2010–13 were endorsed in March 2010.

Table 16.4 Training activities 2009-10

Area	Number of participants per division						
	No. of hours	Assessments	Investigations	Legal	Corporate services	Executive	Total
Information technology	410	22	21	8	14	1	66
Organisational development	80	13	11	4	4	3	35
Risk management	28.5	8	2	3	8	–	21
Technical skills	63.5	–	–	18	–	1	19
Total	582	43	34	33	26	5	141

Staff development

The Commission provides staff with the opportunity to participate in learning and development activities and programs. These include attending seminars and conferences, performing higher duties, and undertaking internal and external training courses.

In 2009-10, staff had 582 hours of training in information technology, organisational development, risk management and technical skills. On average, each staff member attended two training sessions during the period.

The Commission also encourages staff to enhance their skills through further study. It provides assistance through study and examination leave. In 2009-10, six staff members were granted study leave.

The year ahead

In 2010, senior staff started to participate in an extensive management development program that will continue in the next financial year.

Performance management

Staff performance agreements set out performance targets for individual staff that are consistent with the Commission's corporate objectives.

97.2% of staff were rated competent or better as a result of performance reviews.

All performance agreements in 2009-10 also included a learning and development plan that is designed to help staff to enhance their competencies and assist them in performing their duties.

Industrial relations and the Workplace Consultative Committee

The Commission, its officers and the Public Service Association of NSW have maintained a strong commitment to joint consultation through Workplace Consultative Committee meetings.

The Committee meets quarterly to consider issues that have an impact on the conditions of employment and entitlements of staff. Regular topics of discussion include recruitment, training, OHS matters, and any new policies.

The Commission has a Workplace Agreement that provides for flexible working hours and work practices, dispute settlement procedures and consultation.

There were no industrial disputes involving the Commission in 2009-10.

Occupational Health and Safety (OHS)

The Commission has an Occupational Health, Safety and Risk Management Plan to assist the Commission in providing a safe and secure environment for staff and clients. The plan incorporates the five performance targets of the NSW Government's Working Together: Public Sector OHS and Injury Management Strategy 2008-10.

Measures taken under the OHS and Risk Management Plan in 2009-10 included:

- assessing the ergonomics of staff workstations. During 2009-10, an accredited occupational therapist conducted assessments for eighteen new staff. Workstations for new staff are reviewed within the first three days.
- an accredited rehabilitation provider assessed three individual workplaces in response to work-related incidents.

The Commission also:

- trained a number of first aid officers and fire wardens
- trained the Commission's OHS Committee in safety audits, and conducting quarterly workplace inspections to identify and assess potential and/or actual hazards
- continued online OHS training for new staff.

In April 2010, the Commission offered free influenza vaccinations for staff, and 21 employees chose to have the vaccination.

OHS Committee

The OHS Committee meets quarterly to review OHS policies and practices, facilitates the resolution of safety issues, and assists in mitigating reported hazards.

Equal Employment Opportunity (EEO) and diversity program

The Commission's EEO Management Plan, Disability Action Plan and Multicultural Policies and Services Program guide the Commission in meeting benchmarks set by the NSW government for the employment of people from identified EEO groups. Table 16.6 sets out the Commission's achievements in meeting these benchmarks.

Table 16.5 Occupational health and safety incidents, injuries and claims 2008-09 and 2009-10

	2008-09	2009-10
Number of new claims	3	3
Number of workers compensation claims accepted	3	3
Fall, trip, slip outside workplace	1	6
Work practice/set up related	3	2
Total injuries	**4**	**8**

Table 16.6 Trends in the representation of EEO groups 2007-2010

	% of total staff benchmark/ target	2007	2008	2009	% of total staff new benchmark/ target	2010
Women	50	70	72	68	50	**70.4**
Aboriginal people and Torres Strait Islanders	2	1.3	1.2	1.2	2.6	**1.4**
People whose first language was not English	20	19	16	23	19	**14.1**
People with a disability	12	9	18	20	12	**12.7**
People with a disability who require a work-related adjustment	7	not recorded	8.2	8.6	7	**7**

Access and equity

The Commission has a three year EEO Management Plan for 2008-11. The Plan maintains the Commission's commitment to EEO and to achieving the three key outcomes under Part 9A of the *Anti-Discrimination Act*:

- a diverse and skilled workforce
- a workplace culture displaying fair practices and behaviour
- improved employment access and participation for EEO groups.

The Commission has strategies to achieve these outcomes, and the NSW government targets for the representation of EEO groups within its workforce.

Grievance support contact officers

The Commission has two grievance support officers. In 2009-10, a new officer was appointed to the role and has undergone relevant training.

Flexible work arrangements

The Commission's policies and procedures promote flexible work practices, and allow for the balance of work and family responsibilities.

In 2009-10, eight staff had flexible work arrangements.

EEO and diversity training

EEO and diversity training is a mandatory requirement for all employees to ensure that they understand the Commission's Code of Conduct, its policies on EEO and anti-discrimination, and the prevention of bullying and harassment. Seven staff attended EEO training in 2009-10.

Employee Assistance program

The Commission has renewed its agreement with PPC Worldwide Psychological Services to provide confidential professional counselling services for staff and their families.

One employee sought counselling in 2009-10.

Disability Action Plan

The Commission initially developed a three-year Disability Action Plan in 2006 in line with the NSW Government's Disability Policy Framework and the *Disability Services Act*. The plan is intended to ensure an accessible workplace and services to people with disabilities and, where possible, to eliminate discriminatory practices.

A new Disability Action Plan has been developed for 2010-13.

The Commission's online induction program now includes a section on disability and equitable access. Other strategies include:

- undertaking workplace adjustments to support staff with disabilities
- engaging an external provider to prepare and coordinate return-to-work plans for staff with temporary disabilities and/or work-related injuries
- purchasing ergonomic equipment to assist staff in workplace adjustment.

Multicultural Policies and Services Program

The Commission recognises and upholds the NSW Government's principles of multiculturalism, as defined in the *Community Relations Commission and Principles of Multiculturalism Act*, in relation to staff and clients from culturally and linguistically diverse backgrounds.

The year ahead

In 2008-09, the Commission developed a new three-year Ethnic Affairs Priorities Statement that contains its multicultural policies and services plan. The Commission will report on the results in its annual report for 2010-11.

Aboriginal affairs

The Commission's Aboriginal Service Plan for 2009–10 addresses key areas such as staffing, and service planning and delivery.

In 2009–10, the Commission continued to employ an Aboriginal and Torres Strait Islander (ATSI) as a Resolution Officer. This position equates to 1.4% of the Commission's occupied positions.

The Commission also has a designated position for the Aboriginal Health and Medical Research Council on its Consumer Consultative Committee.

The Commission continued to be part of the 'Good Service Mob', a collaboration of the Commission and the following organisations:

- Commonwealth Ombudsman
- NSW Ombudsman
- Energy and Water Ombudsman
- Financial Services Ombudsman
- Telecommunications Industry Ombudsman
- Legal Aid NSW
- Law Access
- Anti-Discrimination Board
- Office of Fair Trading.

The 'Good Service Mob' aims to raise awareness among Indigenous people about their rights as consumers and the services available to them. The Commission contributed to all four forums run by the Good Service Mob in 2009–10.

The Commission continued to liaise with the Cooperative Legal Service Delivery Program run by Legal Aid. This aims to improve outcomes for disadvantaged people, including Aboriginal people, by building networks between legal services and community organisations in regional areas.

The year ahead

In 2010–11, the Commission will continue its involvement in the Good Service Mob and the Cooperative Legal Service Delivery Program. The Commission will also develop a dedicated Aboriginal Affairs Plan for 2010–11.

Information and Communications Technology (ICT)

The Information and Communications Technology Strategic Plan 2008–11 plans for the better use of information. Emerging technologies will help to improve efficiency in the Commission's business operations.

Major initiatives in 2009–10 included:

Enhancement of the complaint handling and case management system (Casemate)

Enhancements to Casemate included:

- better functionality to track and report on the progress of investigations
- capturing the monitoring of recommendations to health organisations, and improving the ability to find earlier recommendations relating to similar issues
- improving the recording of information relating to expert reviewers, and identifying appropriate experts who can assist in providing advice in particular cases.

New Internet website

A new website was developed and launched in September 2009. As part of this project, all content was reviewed and updated.

The website includes a content management system that allows staff to readily publish new content.

The new website complies with NSW government website design guidelines and meets accessibility requirements.

Improvements to navigation have made it easier to find relevant information. Online forms to submit complaints and inquiries are now also available on the website.

New Intranet website

A new Intranet website was developed and implemented using the Microsoft Sharepoint Contents Management System. All content was reviewed and updated. The new Intranet was released in May 2010.

The content management system allows nominated staff members to update content and has removed this responsibility from ICT staff. The new Intranet will enable integration with other applications, including Casemate, and provide a platform for improved internal communication.

ISO27001 Standard for Information Security

In January 2008, the Commission achieved accreditation to the ISO27001 Standard for Information Security. To comply with the standard, policies and procedures were reviewed and updated, and monthly internal audits were completed. In addition, two six-monthly external audits were completed in October 2009 and May 2010.

Electronic service delivery

The new Internet and Intranet websites have brought major improvement to the electronic delivery of services.

In addition, the electronic helpdesk system allows staff to lodge and monitor helpdesk requests online.

The electronic self service functionality of the Aurion human resources and payroll system permits staff to lodge leave and overtime requests online. It also allows online approval of these requests.

The Citrix system allows Commission staff in remote locations to securely access the Commission's network via the Internet.

The Trim electronic document and records management system, which is integrated with Casemate, provides a one-stop shop for creating, modifying and searching for all case-related documents.

The year ahead

The Casemate system is currently being upgraded to the .Net platform. This will provide a seamless integration with other Microsoft products and make it easier to maintain the system. The Commission plans to implement the new system in the 2010–11 year.

The new Microsoft Exchange 2010 email system will introduce a new set of features and services to support access from virtually any platform, and will improve flexibility, reliability, and security.

A new Citrix remote access system will be introduced to improve access to the Commission networks by staff in remote locations.

The Commission will continue to comply with the ISO27001 Standard for Information Security.

Records management

The Commission continued to implement its records management program in accordance with its obligations under the *State Records Act*. Major activities involved transferring more than 5,000 closed complaint files to offsite storage, and the sentencing and disposal of complaint and administration files.

The year ahead

In 2010–11, the Commission will remove a substantial number of files from onsite to offsite storage. The Commission will also identify files that are no longer required to fulfil its legal and business requirements.

Risk management and insurance activities

During the year, the Commission assessed its business risks as part of the corporate planning process. Any significant risks were identified and relevant strategies to mitigate these were implemented.

The Commission has reviewed its Business Continuity Plans, including its Information Technology and Management Disaster Recovery Plan and Crisis Management Plan. Scenarios were tested to address potential issues.

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 Allianz Australia Ltd, with GIO General Ltd providing insurance for the remaining categories.

Workers compensation premiums increased by $2,960 (10%) from the previous year, while the remaining categories decreased by $484 (3.8%).

Audit Committee and internal audit

The Audit and Risk Committee oversees business risks and governance issues such as financial practices and internal management controls, including internal audits.

During the year, the Commission appointed independent internal auditors for a four year term. The Commission also appointed an independent chair and another member to the Audit and Risk Committee to ensure full compliance with guidelines issued by the Department of Premier and Cabinet and NSW Treasury.

The internal auditors conducted a review of the Commission's expert advisers panel to evaluate whether relevant processes and controls were adequate. The audit found:

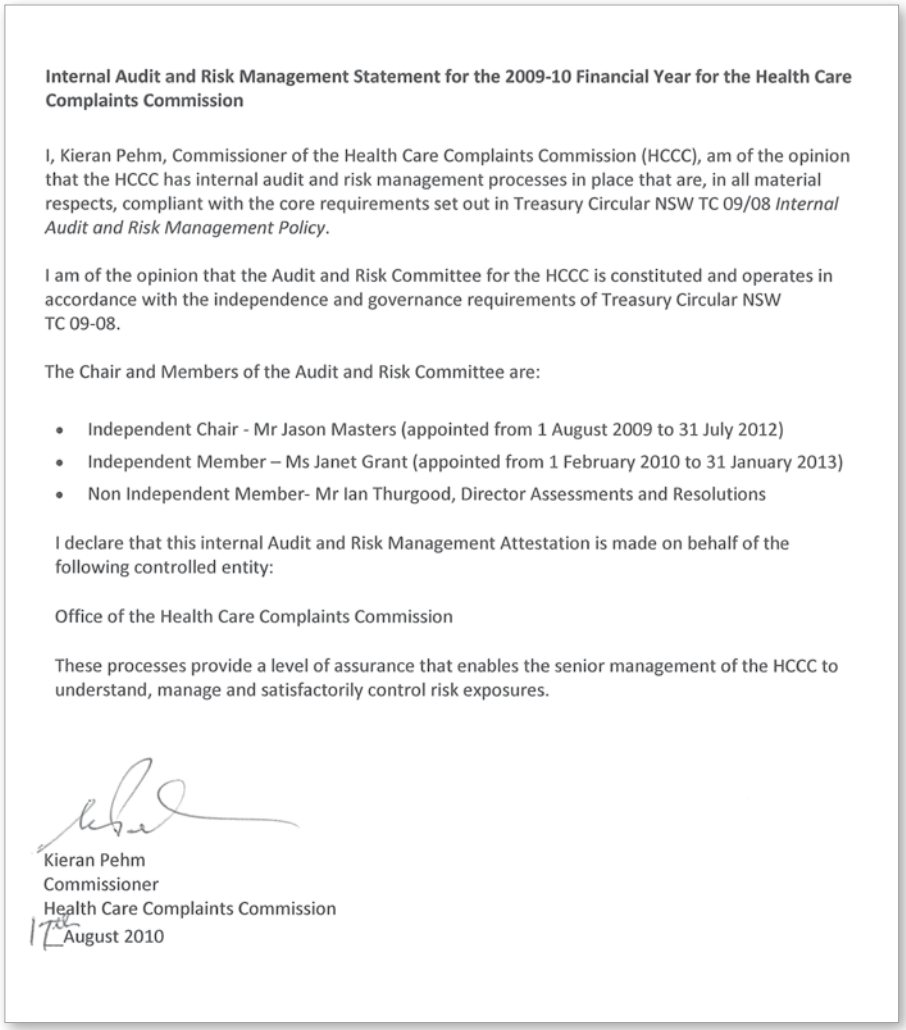
- the reasons for inconsistencies in expert payments were not adequately documented
- the need for the monitoring of expert advisor performance
- the potential to better use Casemate to manage the expert panel
- the need to strengthen current processes.

As a result, the Commission:

- amended its investigations procedures manual to ensure consistency in the reasons recorded for variations in payments
- completed a review of expert advisor performance
- is using Casemate to record performance ratings.

In addition, there was an audit of the Legal Division to examine the Commission's prosecution processes. The audit identified that monitoring the timeliness of prosecution processes needed to be improved.

As a result, the Commission has amended the Legal Division's procedures manual, and will also develop appropriate reports through Casemate to assist in monitoring the progress of legal matters.



Internal Audit and Risk Management Statement for the 2009-10 Financial Year for the Health Care Complaints Commission

I, Kieran Pehm, 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, in all material respects, compliant with the core requirements set out in Treasury Circular NSW TC 09/08 *Internal Audit and Risk Management Policy*.

I am of the opinion that the Audit and Risk Committee for the HCCC is constituted and operates in accordance with the independence and governance requirements of Treasury Circular NSW TC 09-08.

The Chair and Members of the Audit and Risk Committee are:

- Independent Chair - Mr Jason Masters (appointed from 1 August 2009 to 31 July 2012)
- Independent Member – Ms Janet Grant (appointed from 1 February 2010 to 31 January 2013)
- Non Independent Member- Mr Ian Thurgood, Director Assessments and Resolutions

I declare that this internal Audit and Risk Management Attestation is made on behalf of the following controlled entity:

Office of the Health Care Complaints Commission

These processes provide a level of assurance that enables the senior management of the HCCC to understand, manage and satisfactorily control risk exposures.

Kieran Pehm
Commissioner
Health Care Complaints Commission
17th August 2010

Consultants

In 2009-10, there were 278 engagements of health practitioners to provide clinical advice on health care complaints at a total cost of $181,449. A human resources consultant was engaged at a cost of $15,000.

Credit card certification

The Commissioner certifies that there were no irregularities in the use of corporate credit cards. This certification has been made in accordance with the Premier's Memoranda and Treasurer's Directions.

17

Finance

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Office of the Health Care Complaints Commission

17 Finance

HEALTH CARE COMPLAINTS COMMISSION

Preamble

The greatest proportion of the Commission's operating expenses are employee related. In 2009-10, the Commission had an employee related expense budget of $7.48M – which was unchanged from the previous year.

Between 2005-06 and 2009-10, there has been an actual budget increase of 5.6%. In the same period, the average salary of Commission staff increased by 21.7% due to CPI indexation of 4% annually. As a result, the Commission has decreased its staff numbers to operate within its budget, while having to deal with an increased number of complaints and inquiries. The Commission managed to finish the year with only a small deficit of $61,000 in its net cost of services.

Chart 17.1 Employee related expenses budget and full time equivalent staff number comparison 2005-06 to 2009-10

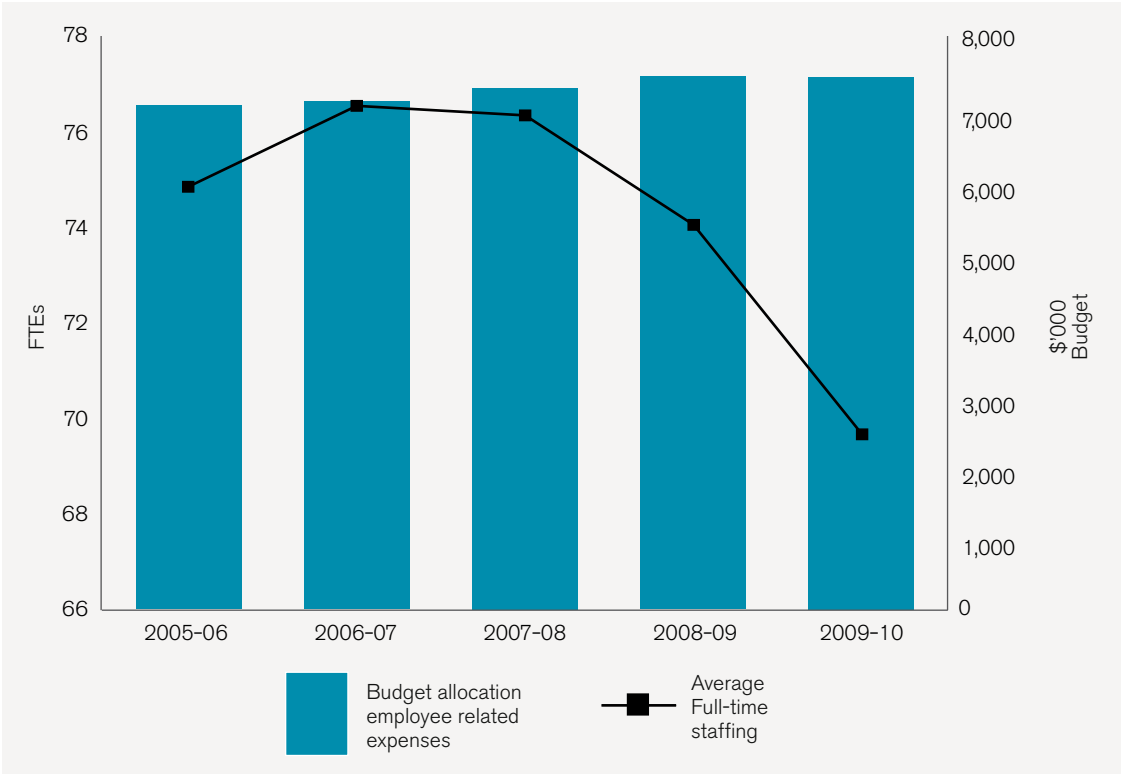

Table 17.1 Comparison of finances 2005-06 to 2009-10

Actual	2005-06 $'000	2006-07 $'000	2007-08 $'000	2008-09 $'000	2009-10 $'000
Total expenses	10,306	10,436	10,798	11,409	10,803
Total retained revenue	323	750	590	402	450
Gain/(Loss) on sale of non-current assets	(24)	(1)	0	(7)	2
Net cost of services	**10,007**	**9,687**	**10,208**	**11,014**	**10,355**

Table 17.2 Outline budget for 2010–11 financial year

Operating Statement	$'000
Expenses	
Employee related	7,550
Operating expenses	3,085
Depreciation and amortisation	229
Total expenses	10,864
Less	
Retained revenue	
Sale of goods and services	–
Investment income	46
Other revenue	331
Total retained revenue	377
Net cost of services	10,487

Account Payment Performance

The processing of accounts for payment and the recording of the Commission financial data is incorporated into the Sun financial system which is maintained by the Independent Commission Against Corruption as part of the Commission's new shared corporate service arrangement.

The payment performance analysis is as follows:

Table 17.3 Aged analysis at end of each quarter 2009–10

Quarter	Current (i.e.) within due date $	Less than 30 days overdue $	Between 30 and 60 days overdue $	Between 60 and 90 days overdue $	More than 90 days overdue $
September	788,472	68,680	43,128	5,659	171
December	960,732	68,224	6,944	515	21,688
March	540,881	58,490	2,497	14,829	3,795
June	1,245,646	89,689	30,981	4,943	7,427

Table 17.4 Accounts paid on time within each quarter 2009–10

Quarter	Total accounts paid on time			Total amount Paid $
	Target %	Actual %	$	
September	85	87	788,472	906,109
December	85	91	960,732	1,058,104
March	85	87	540,881	620,492
June	85	90	1,252,250	1,377,863

The format is in accordance with the requirements of Treasury Circular TC 06/26.
No interest was paid on overdue amounts.

HEALTH CARE COMPLAINTS COMMISSION

HEALTH CARE COMPLAINTS COMMISSION

HEALTH CARE COMPLAINTS COMMISSION

Statement by Commissioner

In accordance with section 45F of the *Public Finance and Audit Act, 1983*, I state that:

(a) the accompanying financial statements in respect of the year ended 30 June 2010 have been prepared in accordance with applicable Australian Accounting Standards (which include Australian Accounting Interpretations), the requirements of the *Public Finance and Audit Act 1983* (the Act), and Regulation 2010, and the Financial Reporting Directions published in the Financial Reporting Code for Budget Dependent General Government Sector Agencies or issued by the Treasurer under section 9(2) of the Act;

(b) the financial statements exhibit a true and fair view of the financial position and transactions of the Health Care Complaints Commission; and

(c) there are no circumstances which would render any particulars included in the financial statements to be misleading or inaccurate.

Kieran Pehm
Commissioner

19 October 2010

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HEALTH CARE COMPLAINTS COMMISSION

GPO BOX 12
Sydney NSW 2001

INDEPENDENT AUDITOR'S REPORT

Health Care Complaints Commission and its Controlled Entity

To Members of the New South Wales Parliament

I have audited the accompanying financial statements of the Health Care Complaints Commission & its controlled entity (the Commission), which comprises the statement of financial position as at 30 June 2010, the statement of comprehensive income, statement of changes in equity and statement of cash flows, service group statements and a summary of compliance with financial directives for the year then ended, a summary of significant accounting policies and other explanatory notes.

Auditor's Opinion

In my opinion, the financial statements:

- present fairly, in all material respects, the financial position of the Commission as at 30 June 2010, and its financial performance for the year then ended in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations)
- are in accordance with section 41B of the *Public Finance and Audit Act 1983* (the PF&A Act) and the Public Finance and Audit Regulation 2010.

My opinion should be read in conjunction with the rest of this report.

The Commissioner's Responsibility for the Financial Statements

The Commissioner is responsible for the preparation and fair presentation of the financial statements in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations) and the PF&A Act. This responsibility includes establishing and maintaining internal controls relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error; selecting and applying appropriate accounting policies; and making accounting estimates that are reasonable in the circumstances.

Auditor's Responsibility

My responsibility is to express an opinion on the financial statements based on my audit. I conducted my audit in accordance with Australian Auditing Standards. These Auditing Standards require that I comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal controls relevant to the Commission's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Commission's internal controls. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the Commissioner, as well as evaluating the overall presentation of the financial statements.

HEALTH CARE COMPLAINTS COMMISSION

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

My opinion does *not* provide assurance:

- about the future viability of the Commission
- that it has carried out its activities effectively, efficiently and economically
- about the effectiveness of its internal controls
- about the assumptions used in formulating the budget figures disclosed in the financial statements.

Independence

In conducting this audit, the Audit Office of New South Wales has complied with the independence requirements of the Australian Auditing Standards and other relevant ethical requirements. The PF&A Act further promotes independence by:

- providing that only Parliament, and not the executive government, can remove an Auditor-General
- mandating the Auditor-General as auditor of public sector agencies but precluding the provision of non-audit services, thus ensuring the Auditor-General and the Audit Office of New South Wales are not compromised in their role by the possibility of losing clients or income.

Peter Barnes
Director, Financial Audit Services

20 October 2010
SYDNEY

HEALTH CARE COMPLAINTS COMMISSION

Statement of comprehensive income for the year ended 30 June 2010

	Notes	Parent			Consolidated		
		Actual 2010 $'000	Budget 2010 $'000	Actual 2009 $'000	Actual 2010 $'000	Budget 2010 $'000	Actual 2009 $'000
Expenses excluding losses							
Operating expenses							
Employee related	2(a)	–	–	–	7,415	7,484	7,662
Personnel services	2(a)	7,415	7,484	7,662	–	–	–
Other operating expenses	2(b)	2,993	2,948	3,371	2,993	2,948	3,371
Depreciation and amortisation	2(c)	404	255	376	404	255	376
Total expenses excluding losses		10,812	10,687	11,409	10,812	10,687	11,409
Revenue							
Sale of goods and services	3(a)	3	2	–	3	2	–
Investment revenue	3(b)	42	82	81	42	82	81
Other revenue	3(c)	384	290	321	384	290	321
Total revenue		429	374	402	429	374	402
Gain/(loss) on disposal	4	9	–	(7)	9	–	(7)
Net Cost of Services		10,374	10,313	11,014	10,374	10,313	11,014
Government contributions							
Recurrent appropriation	5	9,487	9,593	9,469	9,487	9,593	9,469
Capital appropriation	5	–	–	191	–	–	191
Acceptance by the Crown Entity of employee benefits and other liabilities	6	431	347	383	431	347	383
Total government contributions		9,918	9,940	10,043	9,918	9,940	10,043
(DEFICIT) FOR THE YEAR		(456)	(373)	(971)	(456)	(373)	(971)
Other comprehensive income							
Net increase/(decrease) in property, plant and equipment asset revaluation reserve		–	–	–	–	–	–
Other comprehensive income for the year		–	–	–	–	–	–
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		(456)	(373)	(971)	(456)	(373)	(971)

The accompanying notes form part of these financial statements.

HEALTH CARE COMPLAINTS COMMISSION

Statement of financial position as at 30 June 2010

	Notes	Parent			Consolidated		
		Actual 2010 $'000	Budget 2010 $'000	Actual 2009 $'000	Actual 2010 $'000	Budget 2010 $'000	Actual 2009 $'000
ASSETS							
Current assets							
Cash and cash equivalents	8	715	633	809	715	633	809
Receivables	9	296	312	312	296	312	312
Other		–	–	–	–	–	–
Total current assets		1,011	945	1,121	1,011	945	1,121
Non-current assets							
Property, plant and equipment	10						
Leasehold improvements		48	63	112	48	63	112
Plant and equipment		345	570	550	345	570	550
Intangible assets	11	245	209	295	245	209	295
Total non-current assets		638	842	957	638	842	957
Total assets		1,649	1,787	2,078	1,649	1,787	2,078
LIABILITIES							
Current liabilities							
Payables	12	215	242	221	215	242	221
Provisions	13	815	782	782	815	782	782
Total current liabilities		1,030	1,024	1,003	1,030	1,024	1,003
Non-current liabilities							
Provisions	13	8	8	8	8	8	8
Total non-current liabilities		8	8	8	8	8	8
Total liabilities		1,038	1,032	1,011	1,038	1,032	1,011
Net assets		611	755	1,067	611	755	1,067
EQUITY							
Accumulated funds		611	755	1,067	611	755	1,067
Total equity		611	755	1,067	611	755	1,067

The accompanying notes form part of these financial statements.

HEALTH CARE COMPLAINTS COMMISSION

Statement of changes in equity for the year ended 30 June 2010

	Notes	Parent		Consolidated	
		Accumulated Funds $'000	Total $'000	Accumulated Funds $'000	Total $'000
Balance at 1 July 2009		1,067	1,067	1,067	1,067
Surplus/(deficit) for the year		(456)	(456)	(456)	(456)
Other comprehensive income:		–	–	–	–
Total other comprehensive income		–	–	–	–
Total comprehensive income for the year		(456)	(456)	(456)	(456)
Transactions with owners in their capacity as owners					
Increase/(decrease) in net assets from equity transfers		–	–	–	–
Balance at 30 June 2010		611	611	611	611
Balance at 1 July 2008		2,038	2,038	2,038	2,038
Surplus/(deficit) for the year		(971)	(971)	(971)	(971)
Other comprehensive income:					
Total other comprehensive income		–	–	–	–
Total comprehensive income for the year		(971)	(971)	(971)	(971)
Transactions with owners in their capacity as owners		–	–	–	–
Increase/(decrease) in net assets from equity transfers		–	–	–	–
Balance at 30 June 2009		1,067	1,067	1,067	1,067

The accompanying notes form part of these financial statements.

HEALTH CARE COMPLAINTS COMMISSION

Statement of cash flows for the year ended 30 June 2010

	Notes	Parent			Consolidated		
		Actual 2010 $'000	Budget 2010 $'000	Actual 2009 $'000	Actual 2010 $'000	Budget 2010 $'000	Actual 2009 $'000
CASH FLOWS FROM OPERATING ACTIVITIES							
Payments							
Employee Related		–	–	–	(6,992)	(7,511)	(7,131)
Personnel Services		(6,992)	(7,511)	(7,131)	–	–	–
Fees – barristers/reviews		(809)	(604)	(986)	(809)	(604)	(986)
Fees – shared corporate services		(333)	(333)	(429)	(333)	(333)	(429)
Fees – rental charges		(862)	(858)	(834)	(862)	(858)	(834)
Other		(1,276)	(1,465)	(1,961)	(1,276)	(1,465)	(1,961)
Total payments		(10,272)	(10,771)	(11,341)	(10,272)	(10,771)	(11,341)
Receipts							
Sale of goods and services		111	2	60	111	2	60
Interest received		41	82	126	41	82	126
Legal cost recoveries		359	270	293	359	270	293
Other		267	318	347	267	318	347
Total receipts		778	672	826	778	672	826
Cash Flows from Government							
Recurrent appropriation	5	9,487	9,683	9,469	9,487	9,683	9,469
Capital appropriation	5	–	–	191	–	–	191
Cash reimbursements from Crown Entity		–	–	–	–	–	–
Net Cash Flows from Government		9,487	9,683	9,660	9,487	9,683	9,660
NET CASH FLOWS FROM OPERATING ACTIVITIES	18	7	(416)	(855)	7	(416)	(855)
Cash Flows from Investing Activities							
Proceeds from sale of plant and equipment		–	–	–	–	–	–
Purchase of plant and equipment		(87)	(140)	(474)	(87)	(140)	(474)
NET CASH FLOWS FROM INVESTING ACTIVITIES		(111)	(140)	(474)	(111)	(140)	(474)
Cash Flows from Financing Activities							
Other		–	–	–	–	–	–
NET CASH FLOWS FROM FINANCING ACTIVITIES		–	–	–	–	–	–
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		(94)	(556)	(1,329)	(94)	(556)	(1,329)
Opening cash and cash equivalents		809	1,189	2,138	809	1,189	2,138
CLOSING CASH AND CASH EQUIVALENTS	8	715	633	809	715	633	809

The accompanying notes form part of these financial statements.

HEALTH CARE COMPLAINTS COMMISSION

Service group statements for the year ended 30 June 2010

AGENCY'S EXPENSES & INCOME	Service Group 1*		Service Group 2*		Not Attributable		Total	
	2010 $'000	2009 $'000	2010 $'000	2009 $'000	2010 $'000	2009 $'000	2010 $'000	2009 $'000
Expenses excluding losses								
Operating expenses								
Employee related	3,038	4,214	4,377	3,448			7,415	7,662
Other operating expenses	1,227	1,854	1,766	1,517			2,993	3,371
Depreciation and amortisation	165	207	239	169			404	376
Total expenses excluding losses	4,430	6,275	6,382	5,134	–	–	10,812	11,409
Revenue								
Sale of goods and services	1	–	2	–			3	–
Investment revenue	17	45	25	36			42	81
Other revenue	157	177	227	144			384	321
Total revenue	175	222	254	180	–	–	450	402
Gain/(loss) on disposal	4	(4)	5	(3)			9	(7)
Net Cost of Services	4,251	6,057	6,123	4,957	–	–	10,374	11,014
Government contributions**					9,918	10,043	9,918	10,043
SURPLUS/(DEFICIT) FOR THE YEAR							456	(971)
Other comprehensive income								
Net increase/(decrease) in asset revaluation reserve	–	–	–	–	–	–	–	–
Total other comprehensive income	–	–	–	–	–	–	–	–
TOTAL COMPREHENSIVE INCOME							456	(971)

* The names and purposes of each service group are summarised in Note 7.

** Appropriations are made on an agency basis and not to individual service groups. Consequently, government contributions must be included in the "Not Attributable" column.

HEALTH CARE COMPLAINTS COMMISSION

Service group statements for the year ended 30 June 2010

AGENCY'S ASSETS & LIABILITIES	Service Group 1*		Service Group 2*		Not Attributable		Total	
	2010 $'000	2009 $'000	2010 $'000	2009 $'000	2010 $'000	2009 $'000	2010 $'000	2009 $'000
Current assets								
Cash and cash equivalents	293	402	422	407			715	809
Receivables	121	155	175	157			296	312
Other	–	–	–	–			–	–
Total current assets	414	557	597	564	–	–	1,011	1,121
Non-current assets								
Property, plant and equipment								
Leasehold improvements	20	54	28	59			48	113
Plant and equipment	141	275	204	274			345	549
Intangible assets	100	147	145	148			245	295
Total non-current assets	261	476	377	481	–	–	638	957
TOTAL ASSETS	675	1,033	974	1,045	–	–	1,649	2,078
Current liabilities								
Payables	88	110	127	111			215	221
Provisions	334	388	481	394			815	782
Other							–	–
Total current liabilities	422	498	608	505	–	–	1,030	1,003
Non-current liabilities								
Provisions	4	4	4	4			8	8
Total non-current liabilities	4	4	4	4	–	–	8	8
TOTAL LIABILITIES	426	502	612	509	–	–	1,038	1,011
NET ASSETS	249	531	362	536	–	–	611	1,067

* The names and purposes of each service group are summarised in Note 7.

HEALTH CARE COMPLAINTS COMMISSION

Summary of compliance with financial directives

	2010				2009			
	Recurrent Appropriation	Expenditure/ Net Claim on Consolidated Fund	Capital Appropriation	Expenditure/ Net Claim on Consolidated Fund	Recurrent Appropriation	Expenditure/ Net Claim on Consolidated Fund	Capital Appropriation	Expenditure/ Net Claim on Consolidated Fund
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
ORIGINAL BUDGET APPROPRIATION/ EXPENDITURE								
Appropriation Act	9,873	9,487	–	–	9,743	9,469	191	191
Additional Appropriations								
▶ s 21A PF&AA – special appropriation								
▶ s 24 PF&AA – transfers of functions between departments								
▶ s 26 PF&AA – Commonwealth specific purpose payments								
▶ Other								
	9,873	9,487	–	–	9,743	9,469	191	191
OTHER APPROPRIATIONS/ EXPENDITURE								
Treasurer's Advance								
▶ Section 22 – expenditure for certain works and services								
– Protected item (legal costs)								
▶ Transfers to/from another agency (s28 of the Appropriations Act)								
– Revised TMF Benchmark funding					2			
▶ Other	(386)				(85)			
	(386)	–	–	–	(83)	–	–	–
Total Appropriations	9,487							
Expenditure/Net Claim on Consolidated Fund (includes transfer payments)		9,487	–	–	9,660	9,469	191	191
Amount drawn down against Appropriation		9,487		–		9,469		191
Liability to Consolidated Fund*		–		–		–		–

* The Summary of Compliance is based on the assumption that Consolidated Fund moneys are spent first (except where otherwise identified or prescribed).

The accompanying notes form part of these financial statements.

HEALTH CARE COMPLAINTS COMMISSION

Notes to and forming part of the financial statements for the year ended 30 June 2010

1. Summary of Significant Accounting Policies

(a) Reporting Entity

The Health Care Complaints Commission (HCCC), as a reporting entity, comprises all the entities under its control, namely the Health Care Complaints Commission and the Office of the Health Care Complaints Commission.

In the process of preparing the consolidated financial statements for the economic entity consisting of the controlling and controlled entities, all inter-entity transactions and balances have been eliminated.

The Health Care Complaints Commission is a NSW Government statutory body that protects the public health and safety by dealing with complaints about health service providers. The HCCC is a not-for-profit entity (as profit is not its principal objective) and it has no cash generating units. The reporting entity is consolidated as part of NSW Total State Sector Accounts.

The HCCC was established as a body corporate under Section 75 of the *Health Care Complaints Act 1993* and is a separate reporting entity under Schedule 2 of the *Public Finance and Audit Act 1983*, outside the control of the NSW Department of Health.

These consolidated financial statements for the year ended 30 June 2010 have been authorised for issue by the Commissioner on 19 October 2010.

(b) Basis of Preparation

The HCCC's financial statements are general purpose financial statements which have been prepared in accordance with:

- applicable Australian Accounting Standards (which include Australian Accounting Interpretations)
- the requirements of the *Public Finance and Audit Act 1983* and Regulation
- the Financial Reporting Directions published in the Code for Budget Dependent General Government Sector Agencies or issued by the Treasurer.

Plant and equipment are measured at fair value. Other financial statement items are prepared in accordance with the historical cost convention.

Judgement, key assumptions and estimations that management has made are disclosed in the relevant notes to the financial statements.

All amounts are rounded to the nearest one thousand dollars and are expressed in Australian currency.

(c) Statement of Compliance

The consolidated and parent entity financial statements and notes comply with Australian Accounting Standards, which include Australian Accounting Interpretations.

(d) Insurance

The HCCC's insurance activities are conducted through the NSW Treasury Managed Fund Scheme of self insurance for Government agencies. The expense (premium) is determined by Fund Managers based on past claim experience.

(e) Accounting for the Goods and Services Tax (GST)

Income, expenses and assets are recognised net of the amount of GST, except that:

- the amount of GST incurred by the HCCC as a purchaser that is not recoverable from the Australian Taxation Office is recognised as part of the cost of acquisition of an asset or as part of an item of expense, and
- receivables and payables are stated with the amount of GST included.

Cash flows are included in the statement of cash flows on a gross basis. However, the GST components of cash flows arising from investing and financing activities which is recoverable from, or payable to, the Australian Taxation Office are classified as operating cash flows.

(f) Income Recognition

Income is measured at the fair value of the consideration or contribution received or receivable. Additional comments regarding the accounting policies for the recognition of income are discussed below.

(i) Parliamentary Appropriation and Contributions

Except as specified below, parliamentary appropriations and contributions from other bodies (including grants and donations) are generally recognised as income when HCCC obtains control over the assets comprising the appropriations/contributions. Control over appropriations and contributions is normally obtained upon receipt of cash.

Unspent appropriations are recognised as liabilities rather than income, as the authority to spend the money lapses and the unspent amount must be repaid to the Consolidated Fund.

(ii) Rendering of Services

Revenue is recognised when the service is provided.

(iii) Investment Revenue

Interest revenue is recognised using the effective interest method as set out in AASB139 *Financial Instruments: Recognition and Measurement.*

(iv) Legal Cost Recoveries

Legal costs awarded in favour of the HCCC arising from the prosecution of health practitioners, where the respondent has been found to be negligent, are recognised as revenue when agreement is reached with the respondent on settlement of the amount of legal cost recovered.

(g) Assets

(i) Acquisitions of assets

The cost method of accounting is used for the initial recording of all acquisition of assets controlled by the HCCC. Cost is the amount of cash or cash equivalents paid or the fair value of the other consideration given to acquire the asset at the time of this acquisition or construction or, where applicable the amount attributed to that asset when initially recognised in accordance with the requirements of other Australian Accounting Standards.

Assets acquired at no cost, or for nominal consideration, are initially recognised at their fair value at the date of acquisition.

Fair value is the amount for which an asset could be exchanged between knowledgeable, willing parties in an arm's length transaction.

Where payment for an asset is deferred beyond normal credit terms, its cost is the cash price equivalent, i.e. deferred payment amount is effectively discounted at an asset-specific rate.

(ii) Capitalisation thresholds

Property, plant and equipment and intangible assets costing $5,000 and above individually (or forming part of a network costing more than $5,000) are capitalised.

HEALTH CARE COMPLAINTS COMMISSION

Notes to and forming part of the financial statements for the year ended 30 June 2010

(iii) Revaluation of property, plant and equipment

Physical non-current assets are valued in accordance with the Valuation of Physical Non-Current Assets at Fair Value (TPP 07-1). This policy adopts fair value in accordance with AASB 116 *Property, Plant and Equipment.*

Plant and equipment is measured on an existing use basis where there are no feasible alternative users in the existing natural, legal, financial and socio-political environment. However, in the limited circumstances where there are feasible alternative uses, assets are valued at their highest and best use.

Fair value of property, plant and equipment is determined based on the best available market evidence, including current market selling prices for the same or similar assets. Where there is no available market evidence, the asset's fair value is measured at its market buying price, the best indicator of which is depreciated replacement cost.

The HCCC holds non-specialised assets with short useful lives and these are measured at depreciated historical cost as a surrogate for fair value.

(iv) Impairment of property, plant and equipment

As a not-for-profit entity with no cash generating units, the HCCC is effectively exempted from AASB 136 *Impairment of Assets* and impairment testing. This is because AASB 136 modifies the recoverable amount test to the higher of fair value less costs to sell and depreciated replacement cost. This means that, for an asset already measured at fair value, impairment can only arise if selling costs are material. Selling costs are regarded as immaterial.

(v) Depreciation of property, plant and equipment

Depreciation is provided for on a straight line basis for all depreciable assets so as to write off the depreciable amount of each asset as it is consumed over its useful life to the HCCC. The depreciation rate for computer equipment was reviewed and a revised useful life estimate of four years was applied to purchases from 2008-09 onwards. The depreciation rate for plant and equipment was also reviewed and a revised useful life estimate of five years was applied for new purchases from 2008-09 onwards. All material separately identifiable components of assets are depreciated over their shorter useful lives.

The useful life of the various categories of non-current assets is as follows:

	Depreciation life in years	Depreciation life in years
Asset category	**2009-10**	**2008-09**
Computer Hardware	4	4
Computer Software	4	4
Plant and Equipment	5	5
Leasehold Improvements	5	5

Leasehold improvement assets are amortised at the lesser of five years or the lease term.

(vi) Maintenance

Day-to-day servicing costs or maintenance are charged as expenses as incurred, except where they relate to the replacement of a component of an asset, in which case the costs are capitalised and depreciated.

(vii) Leased Assets

Operating lease payments are charged to the statement of comprehensive income in the periods in which they are incurred.

(viii) Intangible Assets

The HCCC recognises intangible assets only if it is probable that future economic benefits will flow to the HCCC and the costs of the asset can be measured reliably. Intangible assets are measured initially at cost. Where an asset is acquired at no or nominal cost, the cost is its fair value as at the date of acquisition.

All research costs are expensed. Development costs are only capitalised when certain criteria are met.

The useful lives of intangible assets are assessed to be finite.

Intangible assets are subsequently measured at fair value only if there is an active market. As there is no active market for the HCCC's intangible assets, the assets are carried at cost less any accumulated amortisation. The HCCC's intangible assets, computer software, are amortised using the straight-line method over a period of four years.

In general, intangible assets are tested for impairment where an indicator of impairment exists. However, as a not-for-profit entity with no cash generating units, the HCCC is effectively exempted from impairment testing (refer paragraph (g)(iv)).

(ix) Loans and Receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. These financial assets are recognised initially at fair value, usually based on the transaction cost or face value. Subsequent measurement is at amortised cost using the effective interest method, less an allowance for any impairment of receivables. Any changes are recognised in the surplus/(deficit) for the year when impaired, de-recognised or through the amortisation process.

Short-term receivables with no stated interest rate are measured at the original invoice amount where the effect of discounting is immaterial.

(x) Impairment of financial assets

All financial assets, except those measured at fair value through profit and loss, are subject to an annual review for impairment. An allowance for impairment is established when there is objective evidence that the entity will not be able to collect all amounts due.

For financial assets carried at amortised cost, the amount of the allowance is the difference between the asset's carrying amount and the present value of estimated future cash flows, discounted at the effective interest rate. The amount of the impairment loss is recognised in the surplus/(deficit) for the year.

Any reversals of impairment losses are reversed through the surplus/(deficit) for the year, where there is objective evidence, except reversals of impairment losses on an investment in an equity instrument classified as "available for sale" which must be made through the reserve. Reversals of impairment losses of financial assets carried at amortised cost cannot result in a carrying amount that exceed what the carrying amount would have been had there not been an impairment loss.

HEALTH CARE COMPLAINTS COMMISSION

Notes to and forming part of the financial statements for the year ended 30 June 2010

(xi) De-recognition of financial assets and financial liabilities

A financial asset is derecognised when the contractual rights to the cash flows from the financial assets expire or if the HCCC transfers the financial asset:

- where substantially all the risks and rewards have been transferred; or
- where HCCC has not transferred substantially all the risks and rewards, if the entity has not retained control.

Where the HCCC has neither transferred nor retained substantially all the risks and rewards or transferred control, the asset is recognised to the extent of the HCCC's continuing involvement in the asset.

A financial liability is de-recognised when the obligation specified in the contract is discharged or cancelled or expires.

(h) Liabilities

(i) Payables

These amounts represent liabilities for goods and services provided to the HCCC and other amounts. Payables are recognised initially at fair value, usually based on the transaction cost or face value. Subsequent measurement is at amortised cost using the effective interest method. Short-term payables with no stated interest rate are measured at the original invoice amount where the effect of discounting is immaterial.

(ii) Employee Benefits and Other Provisions

(a) Salaries and Wages, Annual Leave, Sick Leave and On-Costs

Liabilities for salaries and wages (including non-monetary benefits), annual leave paid and paid sick leave that are due to be settled within 12 months after the end of the period in which the employees render the service are recognised and measured in respect of employees' services up to the reporting date at undiscounted amounts based on the amounts expected to be paid when the liabilities are settled. There is no liability for long-term annual leave i.e. greater than 12 months.

Unused non-vesting sick leave does not give rise to a liability as it is not considered probable that sick leave taken in the future will be greater than the benefits accrued in the future.

The outstanding amounts of payroll tax, workers compensation insurance premiums and fringe benefits tax, which are consequential to employment, are recognised as liabilities and expenses where the employee benefits to which they relate have been recognised.

(b) Long Service Leave and Superannuation

The HCCC's liabilities for long service leave and defined benefit superannuation are assumed by the Crown Entity. The HCCC accounts for the liability as having been extinguished; resulting in the amount assumed being shown as part of the non-monetary revenue item described as 'Acceptance by the Crown Entity of Employee Benefits and other Liabilities'.

Long service leave is measured at present value in accordance with AASB 119 *Employee Benefits*. This is based on the application of the certain factors (specified in NSWTC 09/04) to employees with five or more years of service using current rates of pay. These factors were determined based on an actuarial review to approximate present value.

Long service leave on-costs are not assumed by the Crown Entity and are the responsibility of the HCCC, except for the related superannuation on-costs and long service leave accruing while on long service leave.

The superannuation expense for the financial year is determined by using the formulae specified in the Treasurer's Directions. The expense for certain superannuation schemes (i.e. Basic Benefit and First State Super) is calculated as a percentage of the employees' salary. For other superannuation schemes (i.e. State Superannuation Scheme and State Authorities Superannuation Scheme), the expense is calculated as a multiple of the employees' superannuation contributions.

(i) Budgeted Amounts

The budgeted amounts are drawn from the budgets as formulated at the beginning of the financial year and with any adjustments for the effects of additional appropriations under s21A, s24 and/or s26 of the *Public Finance and Audit Act 1983*.

The budgeted amounts in the statement of comprehensive income and the statement of cash flows are generally based on the amounts disclosed in the NSW Budget Papers (as adjusted above). However, in the statement of financial position, the amounts vary from the Budget Papers, as the opening balances of the budgeted amounts are based on carried forward actual amounts i.e. per the audited financial statements (rather than carried forward estimates).

(j) Comparative information

Except where an Australian Accounting Standard permits or requires otherwise, comparative information is disclosed in respect of the previous period for all amounts reported in the financial statements.

(k) New Australian Accounting Standards/Interpretations issued but not effective

The following new Accounting Standards/Interpretations have not been applied and are not yet effective (NSW TC10/08). However, the Commission is not able to reliably measure the impact of the initial application of these standards on the financial results of the Commission.

AASB 9 and AASB 2009-11 regarding financial instruments

AASB 2009-5 regarding annual improvements

AASB 2009-9 regarding first time adoption

AASB 2009-10 regarding classification of rights

AASB 2009-14 regarding prepayments of a minimum funding requirement

AASB 2010-1 regarding AASB 7 for comparatives for first time adopters.

HEALTH CARE COMPLAINTS COMMISSION

Notes to and forming part of the financial statements for the year ended 30 June 2010

2. Expenses excluding losses

	Parent		Consolidated	
	2010 $'000	2009 $'000	2010 $'000	2009 $'000
(a) Employee related expenses				
Salaries and wages (including recreation leave)		–	6,124	6,502
Superannuation – defined benefits plans		–	169	197
Superannuation – defined contributions plans		–	400	390
Workers' compensation insurance		–	41	33
Long service leave		–	252	151
Payroll tax and fringe benefits tax		–	429	389
Personnel services	7,415	7,662	–	–
	7,415	**7,662**	**7,415**	**7,662**
(b) Other operating expenses				
Auditors remuneration				
– Audit of the financial statements	12	11	12	11
Bad and doubtful debts	–	–	–	–
Consultancy	16	16	16	16
Equipment and plant	18	15	18	15
Equipment leasing	–	1	–	1
Fees for services rendered	451	631	451	631
Legal fees and adverse costs	659	850	659	850
Maintenance	(2)	1	(2)	1
Fees – legal witness	110	101	110	101
Fees – translators	18	36	18	36
Transcript fees	40	44	40	44
Fees – peer review reports	158	195	158	195
Training	44	49	44	49
Printing	40	25	40	25
Rental expenses relating to operating leases	889	863	889	863
Stores	170	153	170	153
Telephone, postal and internet	122	100	122	100
Travelling	55	90	55	90
Other	193	190	193	190
	2,993	**3,371**	**2,993**	**3,371**
(c) Depreciation and amortisation expense				
Plant and equipment – depreciation	243	246	243	246
Intangible assets – amortisation	161	130	161	130
	404	**376**	**404**	**376**

HEALTH CARE COMPLAINTS COMMISSION

Notes to and forming part of the financial statements for the year ended 30 June 2010

3. Revenue

	Parent		Consolidated	
	2010 $'000	2009 $'000	2010 $'000	2009 $'000
(a) Sale of goods and services	3	–	–	–
(b) Investment revenue				
Interest	42	81	42	81
	42	**81**	**42**	**81**
(c) Other revenue				
Legal cost recoveries	359	293	359	293
Other	25	28	25	28
	384	**321**	**384**	**321**

4. Gain/(Loss) on Disposal

	Parent		Consolidated	
	2010 $'000	2009 $'000	2010 $'000	2009 $'000
Gain/(loss) on disposal of plant and equipment	9	(7)	9	(7)
Proceeds from sale	–	–	–	–
Written down value of assets disposed	–	–	–	–
Net gain/(loss) on disposal of plant and equipment	9	(7)	9	(7)

5. Appropriations

	Parent		Consolidated	
	2010 $'000	2009 $'000	2010 $'000	2009 $'000
Recurrent appropriations				
Total recurrent draw-downs from NSW Treasury (per Summary of Compliance)	9,487	9,469	9,487	9,469
Comprising:				
Recurrent appropriations (per Statement of comprehensive income)	9,487	9,469	9,487	9,469
Capital Appropriations				
Total capital draw-downs from NSW Treasury (per Summary of Compliance)	–	191	–	191
Comprising:				
Capital appropriations (per Statement of comprehensive income)	–	191	–	191

HEALTH CARE COMPLAINTS COMMISSION

Notes to and forming part of the financial statements for the year ended 30 June 2010

6. Acceptance by the Crown Entity of Employee Benefits and Other Liabilities

	Parent		Consolidated	
	2010 $'000	2009 $'000	2010 $'000	2009 $'000
Superannuation – defined benefit	169	197	169	197
Long service leave	252	151	252	151
Payroll tax	10	35	10	35
	431	383	431	383

7. Service Groups of the Health Care Complaints Commission

(a) Service Group 1 – Complaints Assessment and Resolution

This service group covers processing, assessment and resolution of complaints about health care which are dealt with by assisted resolution, facilitated conciliation or referral for investigation.

This service group contributes towards the improved protection of the health and safety of the public by working towards a range of intermediate results that include the following:

- confidence that health care complaints are being properly assessed and
- consumers have an active role in health care complaint outcomes.

(b) Service Group 2 – Investigation and Prosecution of Serious Cases

This service group covers investigation and prosecution of serious cases of inappropriate health care, including recommendations to health organisations to address systemic health care issues.

This service group contributes to the improved protection of the health and safety of the public by working towards a range of intermediate results that include the following:

- confidence that complaints are being properly investigated
- systemic health care issues are addressed through recommendations to health care organisations
- the community regards the HCCC as the most effective means to prosecute serious complaints against health practitioners.

8. Current Assets – Cash and Cash Equivalents

	Parent		Consolidated	
	2010 $'000	2009 $'000	2010 $'000	2009 $'000
Cash at bank and on hand	715	809	715	809
	715	809	715	809
For the purpose of the statement of cash flows, cash and cash equivalents include cash on hand and cash at bank. Cash and cash equivalent assets recognised in the statement of financial position are reconciled at the end of the financial year to the statement of cash flows as follows:				
Cash and cash equivalents (per statement of financial position)	715	809	715	809
Closing cash and cash equivalents (per statement of cash flows)	715	809	715	809

Refer Note 19 for details regarding credit risk, liquidity risk and market risk arising from financial instruments.

HEALTH CARE COMPLAINTS COMMISSION

Notes to and forming part of the financial statements for the year ended 30 June 2010

9. Current Assets – Receivables

	Parent		Consolidated	
	2010 $'000	2009 $'000	2010 $'000	2009 $'000
Other revenue	334	434	334	434
Less allowance for impairment	(38)	(122)	(38)	(122)
	296	**312**	**296**	**312**
Movement in the allowance for impairment				
Balance at 1 July	(122)	(122)	(122)	(122)
Amounts written off during the year	84	–	84	–
Amounts recovered during the year	–	–	–	–
Balance at 30 June	(38)	(122)	(38)	(122)

Details regarding credit risk, liquidity risk and market risk, including financial assets that are either past due or impaired, are disclosed in Note 19.

10. Non-current Assets – Plant and Equipment

	Parent					Consolidated
	$'000					$'000
	Leasehold Improvements	Computer Equipment	Plant and Equipment	Work in Progress	Total	Total
At 1 July 2009 – fair value						
Gross carrying amount	646	465	168	332	1,611	1,611
Accumulated depreciation and impairment	(533)	(334)	(82)	–	(949)	(949)
Net carrying amount	**113**	**131**	**86**	**332**	**662**	**662**
At 30 June 2010 – fair value						
Gross carrying amount	646	607	170	–	1,423	1,423
Accumulated depreciation and impairment	(598)	(323)	(109)	–	(1,030)	(1,030)
Net carrying amount	**48**	**284**	**61**	**–**	**393**	**393**

HEALTH CARE COMPLAINTS COMMISSION

Notes to and forming part of the financial statements for the year ended 30 June 2010

Reconciliation

A reconciliation of the carrying amount of each class of property, plant and equipment at the beginning and end of the current reporting period is set out below:

	Parent					Consolidated
	$'000					$'000
	Leasehold Improvements	Computer Equipment	Plant and Equipment	Work in Progress	Total	Total
Year ended 30 June 2010						
Net carrying amount at start of year	113	131	86	332	662	662
Additions	–	–	2	–	2	2
Transfer	–	332	–	(332)	–	–
Disposals	–	(190)	–	–	(190)	(190)
Depreciation/amortisation written back on disposal	–	162	–	–	162	162
Depreciation expense	(65)	(151)	(27)	–	(242)	(242)
Net carrying amount at end of year	**48**	**284**	**61**	**–**	**393**	**393**
At 1 July 2008 – fair value						
Gross carrying amount	635	481	149	–	1,265	1,265
Accumulated depreciation and impairment	(406)	(266)	(58)	–	(730)	(730)
Net carrying amount	**229**	**215**	**91**	**–**	**535**	**535**
At 30 June 2009 – fair value						
Gross carrying amount	646	799	168	–	1,611	1,611
Accumulated depreciation and impairment	(533)	(334)	(82)	–	(949)	(949)
Net carrying amount	**113**	**465**	**86**	**–**	**662**	**662**

A reconciliation of the carrying amount of plant and equipment at the beginning and end of the previous reporting period is set out below:

	Parent					Consolidated
	$'000					$'000
	Leasehold Improvements	Computer Equipment	Plant and Equipment	Work in Progress	Total	Total
Year ended 30 June 2009						
Net carrying amount at start of year	229	215	91	–	535	535
Additions	10	353	18	–	380	380
Disposals	–	–	(7)	–	(7)	(7)
Depreciation expense	(127)	(103)	(16)	–	(246)	(246)
Net carrying amount at end of year	**113**	**465**	**86**	**–**	**662**	**662**

HEALTH CARE COMPLAINTS COMMISSION

Notes to and forming part of the financial statements for the year ended 30 June 2010

11. Intangible Assets – Computer software

	Parent		Consolidated
	Software $'000	Work in Progress $'000	$'000
At 1 July 2009			
Cost (gross carrying amount)	688	53	741
Accumulated amortisation and impairment	(446)	–	(446)
Net carrying amount	242	53	295
At 30 June 2010			
Cost (gross carrying amount)	776	76	852
Accumulated amortisation and impairment	(607)	–	(607)
Net carrying amount	169	76	245
Year ended 30 June 2010			
Net carrying amount at start of year	242	53	295
Additions	88	23	111
Amortisation (recognised in 'depreciation and amortisation')	(161)	–	(161)
Net carrying amount at end of year	169	76	245
At 1 July 2008			
Cost (gross carrying amount)	647	–	647
Accumulated amortisation and impairment	(316)	–	(316)
Net carrying amount	331	–	331
At 30 June 2009			
Cost (gross carrying amount)	741	–	741
Accumulated amortisation and impairment	(446)	–	(446)
Net carrying amount	295	–	295
Year ended 30 June 2009			
Net carrying amount at start of year	331	–	331
Additions	41	53	94
Amortisation (recognised in 'depreciation and amortisation')	(130)	–	(130)
Net carrying amount at end of year	242	53	295

HEALTH CARE COMPLAINTS COMMISSION

Notes to and forming part of the financial statements for the year ended 30 June 2010

12. Current Liabilities – Payables

	Parent		Consolidated	
	2010 $'000	2009 $'000	2010 $'000	2009 $'000
Accrued salaries, wages and on costs	–	–	88	111
Payable for personnel services	88	111	–	–
Creditors	126	94	126	94
Other	1	16	1	16
	215	**221**	**215**	**221**

13. Current/Non-current Liabilities – Provisions

	Parent		Consolidated	
	2010 $'000	2009 $'000	2010 $'000	2009 $'000
Employee benefit and related on-costs – Current				
Recreation leave		–	615	636
Payroll tax on recreation leave		–	34	–
Payroll tax on long service leave		–	87	73
Long service leave on-costs		–	83	77
Provision for personnel services	819	786		–
Total	**819**	**786**	**819**	**786**
Employee benefit and related on-costs – Non-current				
Payroll tax on long service leave	–	–	4	4
Provision for personnel services	4	4	–	–
Total	**4**	**4**	**4**	**4**
Aggregate employee benefits and related on-costs				
Provisions – current	–	–	819	786
Provisions – non-current	–	–	4	4
Provision for personnel services – current	819	786	–	–
Provision for personnel services – non-current	4	4	–	–
Accrued salaries, wages and on-costs (Note 12)	–	–	88	111
Payable for personnel services	88	111	–	–
	911	**901**	**911**	**901**

HEALTH CARE COMPLAINTS COMMISSION

Notes to and forming part of the financial statements for the year ended 30 June 2010

14. Commitments for Expenditure

	Parent		Consolidated	
	2010 $'000	2009 $'000	2010 $'000	2009 $'000
(a) Operating Lease Commitments Future non-cancellable operating lease rentals not provided for and payable:				
Not later than one year	1,015	994	1,015	994
Later than one year and not later than 5 years	4,163	811	4,163	811
Later than five years	–	–	–	–
Total (including GST)	5,178	1,805	5,178	1,805

Total Commitments above included input tax creditors of $470,739 (2008-09 $163,073) that are expected to be recovered from the Australian Taxation Office.

15. Contingent Assets

These are legal costs awarded in favour of the HCCC arising from prosecution of health practitioners where the respondents have been found to be negligent. The amounts are subject to negotiation and determination and total $335,846 (2008-09 $901,057).

16. Contingent Liabilities

Adverse costs awarded against the HCCC, across a range of cases, and estimated to be $Nil at 30 June 2010 (2008-09 $Nil).

17. Budget Review

Net Cost of Services

The Net Cost of Services was higher than Budget by $61,000. The variance is largely due to over expenditure for legal costs being offset by under-expenditure for protected expenditure for adverse costs and employee related expenses.

At the same time, higher than budgeted revenue from legal cost recoveries of $115,000 also reduced the deficit.

Assets and Liabilities

Current assets were $66,000 over budget. This mainly reflects the additional cash received for legal cost recoveries.

Cash flows

Cash flows from operating activities were higher than budget by $423,000 as a result of under-expenditure for adverse costs and employee related expenses and higher than budgeted revenue from legal cost recoveries.

HEALTH CARE COMPLAINTS COMMISSION

Notes to and forming part of the financial statements for the year ended 30 June 2010

18. Reconciliation of Net Cash Flows from Operating Activities to Net Cost of Services

	Parent		Consolidated	
	2010 $'000	2009 $'000	2010 $'000	2009 $'000
Net cash used on operating activities	7	(855)	7	(855)
Depreciation	(404)	(376)	(404)	(376)
Decrease/(increase) in provisions	(33)	(81)	(33)	(81)
Acceptance by the Crown Entity of employee benefits and other liabilities	(431)	(383)	(431)	(383)
Cash flows from Government/Appropriations	(9,487)	(9,660)	(9,487)	(9,660)
Increase/(decrease) in receivables and other assets	(41)	(16)	(41)	(16)
Decrease/(increase) in creditors	6	364	6	364
Net gain/(loss) on sale of plant and equipment	9	(7)	9	(7)
Net cost of services	(10,374)	(11,014)	(10,374)	(11,014)

19. Financial Instruments

The HCCC's principal financial instruments are outlined below. These financial instruments arise directly from the HCCC's operations or are required to finance the HCCC's operations. The HCCC does not enter into or trade financial instruments, including derivative financial instruments, for speculative purposes.

The HCCC's main risks arising from financial instruments are outlined below, together with the HCCC's objectives, policies and processes for measuring and managing risks. Further quantitative and qualitative disclosures are included throughout these financial statements.

The Manager Corporate Services has overall responsibility for the establishment and oversight of risk management and reviews and agrees policies for managing each of these risks. Risk management policies are established to identify and analyse the risks faced by the HCCC, to set risk limits and controls and to monitor risks.

Compliance with policies is reviewed by the HCCC's Audit and Risk Committee on a continuous basis.

(a) Financial instrument categories

			Parent		Consolidated	
			2010 $'000	2009 $'000	2010 $'000	2009 $'000
Financial Assets	**Note**	**Category**	**Carrying Amount**	**Carrying Amount**	**Carrying Amount**	**Carrying Amount**
Class:						
Cash and cash equivalents	8	N/A	715	809	715	809
Receivables[1]	9	Loans and receivables at amortised cost	111	312	111	312
Financial Liabilities	**Note**	**Category**	**Carrying Amount**	**Carrying Amount**	**Carrying Amount**	**Carrying Amount**
Class:						
Payables[2]	12	Financial liabilities measured at amortised cost	212	221	212	221

Notes:
1. Excludes statutory receivables and prepayments (not within scope of AASB 7).
2. Excludes statutory payables and unearned revenue (not within scope of AASB 7).

HEALTH CARE COMPLAINTS COMMISSION

Notes to and forming part of the financial statements for the year ended 30 June 2010

(b) Credit risk

Credit risk arises when there is the possibility of the HCCC's debtors defaulting on their contractual obligations, resulting in a financial loss to the HCCC. The maximum exposure to credit risk is generally represented by the carrying amount of the financial assets (net of any allowance for impairment).

Credit risk arises from the financial assets of the HCCC, including cash and receivables. No collateral is held by the HCCC. The HCCC has not granted any financial guarantees.

Cash

Cash comprises cash on hand and bank balances within the NSW Treasury Banking System. Interest is earned on daily bank balances at the monthly average NSW Treasury Corporation (Tcorp) 11 am unofficial cash rate adjusted for a management fee to Treasury. The average interest rate during the period was 3.60%. The average rate for the year ended 2008-09 was 4.52%.

Receivables – trade debtors

All trade debtors are recognised as amounts receivable at balance date. Collectability of trade debtors is reviewed on an ongoing basis. Procedures as established in the Treasurer's Directions are followed to recover outstanding amounts, including letters of demand. Debts which are known to be uncollectible are written off. An allowance for impairment is raised when there is objective evidence that the entity will not be able to collect all amounts due. This evidence includes past experience, and current and expected changes in economic conditions and debtor credit ratings. No interest is earned on trade debtors. Sales are made on 30 day terms.

The HCCC is exposed to concentrations of credit risk to a single trade debtor but as the HCCC is the OHCCC's single debtor, this exposure is considered immaterial. Based on past experience, debtors that are not past due (2010:$nil; 2009:$nil) and not less than 12 months past due (2010:$nil; 2009:$nil) are not considered impaired.

Debtors which are currently past due (2010: $74,060; 2009: $176,419) represent 99% of the total debtors. These debtors comprise debts arising from tribunal ordered costs against health care practitioners. All of the debts reported in the financial statements are being settled by agreed regular instalments and are not considered to be impaired.

	Parent		Consolidated	
	$'000	$'000	$'000	$'000
	Past due but not impaired[1, 2]	Considered impaired[1, 2]	Past due but not impaired[1, 2]	Considered impaired[1, 2]
2010				
< 3 months overdue				
3 months – 6 months overdue				
> 6 months overdue	74	–	74	–
2009				
< 3 months overdue				
3 months – 6 months overdue				
> 6 months overdue	176	–	176	–

Notes
1. Each column in the table reports "gross receivables".
2. The ageing analysis excludes statutory receivables, as these are not within the scope of AASB7 and excludes receivables that are not past due and not impaired. Therefore, the "total" will not reconcile to the receivables total recognised in the statement of financial position.

(c) Liquidity risk

Liquidity risk is the risk that the HCCC will be unable to meet its payment obligations when they fall due. The HCCC continuously manages risk through monitoring future cash flows to ensure adequate holding of liquid assets.

During the year no assets have been pledged as collateral. The HCCC's exposure to liquidity risk is deemed insignificant based on prior periods' data and other current assessment of risk.

The liabilities are recognised for amounts due to be paid in the future for goods or services received, whether or not invoiced. Amounts owing to suppliers (which are unsecured) are settled in accordance with the policy set out in Treasurer's Direction 219.01. If trade terms are not specified, payment is made no later than the end of the month following the month in which an invoice or a statement is received. Treasurer's Direction 219.01 allows the Minister to award interest for late payment.

HEALTH CARE COMPLAINTS COMMISSION

Notes to and forming part of the financial statements for the year ended 30 June 2010

(d) Market risk

Market risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices. The HCCC has no exposure to market risk as it does not have borrowings or investments. The HCCC has no exposure to foreign currency risk and does not enter into commodity contracts.

Interest rate risk

Exposure to interest rate risk arises primarily through the HCCC's interest bearing liabilities. This risk is minimised by undertaking mainly fixed rate borrowings, primarily with the NSW Tcorp. The HCCC does not account for any fixed rate financial instruments at fair value through profit or loss or as available-for-sale. Therefore, for these financial instruments, a change in interest rates would not affect surplus/deficit or equity. A reasonably possible change of +/-% is used, consistent with current trends in interest rates. The basis will be reviewed annually and amended where there is a structural change in the level of interest rate volatility. The HCCC's exposure to interest rate risk is set out below.

	$'000				
	Carrying Amount	-1%		1%	
		Result	Equity	Result	Equity
2010 Financial assets					
Cash and cash equivalents	715	(7)	(7)	7	7
Receivables	296	(3)	(3)	3	3
Total financial assets	1,011	(10)	(10)	10	10
Financial liabilities					
Payables	215	(2)	(2)	2	2
Borrowings	–	–	–	–	–
Total financial liabilities	215	(2)	(2)	2	2
2009 Financial assets					
Cash and cash equivalents	809	(8)	(8)	8	8
Receivables	312	(3)	(3)	3	3
Total financial assets	1,121	(11)	(11)	11	11
Financial liabilities					
Payables	221	(2)	(2)	2	2
Borrowings	–	–	–	–	–
Total financial liabilities	221	(2)	(2)	2	2

(e) Fair value compared to carrying amount

Financial instruments are generally recognised at cost, with the exception of the Tcorp Hour-Glass facilities, which are measured at fair value.

As discussed, the value of the Hour-Glass Investments is based on the Department's share of the value of the underlying assets of the facility, based on the market value. All of the Hour Glass facilities are valued using 'redemption' pricing.

The amortised cost of financial instruments recognised in the statement of financial position approximates the fair value, because of the short-term nature of the HCCC's financial instruments. The HCCC does not have any financial instruments where the fair value differs from the carrying amount.

20. After balance date events

There were no after balance date events (2009: None).

End of Audited Financial Statement

OFFICE OF THE HEALTH CARE COMPLAINTS COMMISSION

HEALTH CARE COMPLAINTS COMMISSION

OFFICE OF THE HEALTH CARE COMPLAINTS COMMISSION

Statement by Commissioner

In accordance with section 45F of the *Public Finance and Audit Act, 1983*, I state that:

(a) the accompanying financial statements in respect of the year ended 30 June 2010 have been prepared in accordance with applicable Australian Accounting Standards (which include Australian Accounting Interpretations), the requirements of the *Public Finance and Audit Act 1983* (the Act), and Regulation 2010, and the Financial Reporting Directions published in the Financial Reporting Code for Budget Dependent General Government Sector Agencies or issued by the Treasurer under section 9(2) of the Act;

(b) the financial statements exhibit a true and fair view of the financial position and transactions of the Office of the Health Care Complaints Commission; and

(c) there are no circumstances which would render any particulars included in the financial statements to be misleading or inaccurate.

Kieran Pehm
Commissioner

19 October 2010

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OFFICE OF THE HEALTH CARE COMPLAINTS COMMISSION

GPO BOX 12
Sydney NSW 2001

INDEPENDENT AUDITOR'S REPORT

Office of the Health Care Complaints Commission

To Members of the New South Wales Parliament

I have audited the accompanying financial statements of the Office of the Health Care Complaints Commission (the Office), which comprises the statement of financial position as at 30 June 2010, the statement of comprehensive income, statement of changes in equity, statement of cash flows and a summary of compliance with financial directives for the year then ended, a summary of significant accounting policies and other explanatory notes.

Auditor's Opinion

In my opinion, the financial statements:

- present fairly, in all material respects, the financial position of the Office as at 30 June 2010, and its financial performance for the year then ended in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations)
- are in accordance with section 41B of the *Public Finance and Audit Act 1983* (the PF&A Act) and the Public Finance and Audit Regulation 2010.

My opinion should be read in conjunction with the rest of this report.

The Commissioner's Responsibility for the Financial Statements

The Commissioner is responsible for the preparation and fair presentation of the financial statements in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations) and the PF&A Act. This responsibility includes establishing and maintaining internal controls relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error; selecting and applying appropriate accounting policies; and making accounting estimates that are reasonable in the circumstances.

Auditor's Responsibility

My responsibility is to express an opinion on the financial statements based on my audit. I conducted my audit in accordance with Australian Auditing Standards. These Auditing Standards require that I comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal controls relevant to the Office's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Office's internal controls. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the Commissioner, as well as evaluating the overall presentation of the financial statements.

OFFICE OF THE HEALTH CARE COMPLAINTS COMMISSION

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

My opinion does *not* provide assurance:

- about the future viability of the Office
- that it has carried out its activities effectively, efficiently and economically
- about the effectiveness of its internal controls.

Independence

In conducting this audit, the Audit Office of New South Wales has complied with the independence requirements of the Australian Auditing Standards and other relevant ethical requirements. The PF&A Act further promotes independence by:

- providing that only Parliament, and not the executive government, can remove an Auditor-General
- mandating the Auditor-General as auditor of public sector agencies but precluding the provision of non-audit services, thus ensuring the Auditor-General and the Audit Office of New South Wales are not compromised in their role by the possibility of losing clients or income.

Peter Barnes
Director, Financial Audit Services

20 October 2010
SYDNEY

OFFICE OF THE HEALTH CARE COMPLAINTS COMMISSION

Statement of comprehensive income for the year ended 30 June 2010

	Notes	Actual 2010 $'000	Actual 2009 $'000
EXPENSES EXCLUDING LOSSES			
Operating expenses			
Employee related	2	7,415	7,662
Total expenses excluding losses		7,415	7,662
Less:			
Revenue			
Personnel services	3	7,415	7,662
Total revenue		7,415	7,662
SURPLUS/(DEFICIT) FOR THE YEAR		–	–
Other comprehensive income			
Net increase/(decrease) in property, plant and equipment asset revaluation reserve		–	–
Other comprehensive income for the year		–	–
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		–	–

The accompanying notes form part of these financial statements.

Statement of financial position as at 30 June 2010

	Notes	Actual 2010 $'000	Actual 2009 $'000
ASSETS			
Current assets			
Receivables	4	907	897
Total current assets		907	897
Non-current assets			
Receivables	4	4	4
Total non-current assets		4	4
Total assets		911	901
LIABILITIES			
Current liabilities			
Payables	5	88	111
Provisions	6	819	786
Total current liabilities		907	897
Non-current liabilities			
Provisions	6	4	4
Total non-current liabilities		4	4
Total liabilities		911	901
Net assets		–	–
EQUITY			
Accumulated funds		–	–
Total equity		–	–

The accompanying notes form part of these financial statements.

OFFICE OF THE HEALTH CARE COMPLAINTS COMMISSION

Statement of changes in equity for the year ended 30 June 2010

	Notes	Parent		Consolidated	
		Accumulated Funds $'000	Total $'000	Accumulated Funds $'000	Total $'000
Balance at 1 July 2009		–	–	–	–
Surplus/(deficit) for the year		–	–	–	–
Other comprehensive income:		–	–	–	–
Total other comprehensive income		–	–	–	–
Total comprehensive income for the year		–	–	–	–
Transactions with owners in their capacity as owners					
Increase/(decrease) in net assets from equity transfers		–	–	–	–
Balance at 30 June 2010		–	–	–	–
Balance at 1 July 2008		–	–	–	–
Surplus/(deficit) for the year		–	–	–	–
Other comprehensive income:					
Total other comprehensive income		–	–	–	–
Total comprehensive income for the year		–	–	–	–
Transactions with owners in their capacity as owners		–	–	–	–
Increase/(decrease) in net assets from equity transfers		–	–	–	–
Balance at 30 June 2009		–	–	–	–

The accompanying notes form part of these financial statements.

OFFICE OF THE HEALTH CARE COMPLAINTS COMMISSION

Statement of cash flows for the year ended 30 June 2010

	Notes	Actual 2010 $'000	Actual 2009 $'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee related		–	–
Other		–	–
Total payments		–	–
Receipts			
Sale of goods and services		–	–
Interest received		–	–
Other		–	–
Total receipts		–	–
Cash flows from government			
Recurrent appropriation		–	–
Capital appropriation		–	–
Cash reimbursements from Crown Entity		–	–
Net Cash Flows from Government		–	–
NET CASH FLOWS FROM OPERATING ACTIVITIES		–	–
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of plant and equipment			–
NET CASH FLOWS FROM INVESTING ACTIVITIES		–	–
CASH FLOWS FROM FINANCING ACTIVITIES			
Other		–	–
NET CASH FLOWS FROM FINANCING ACTIVITIES		–	–
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		–	–
Opening cash and cash equivalents		–	–
CLOSING CASH AND CASH EQUIVALENTS		–	–

The accompanying notes form part of these financial statements.

OFFICE OF THE HEALTH CARE COMPLAINTS COMMISSION

Summary of compliance with financial directives

	2010				2009			
	Recurrent Appropriation	Expenditure/ Net Claim on Consolidated Fund	Capital Appropriation	Expenditure/ Net Claim on Consolidated Fund	Recurrent Appropriation	Expenditure/ Net Claim on Consolidated Fund	Capital Appropriation	Expenditure/ Net Claim on Consolidated Fund
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
ORIGINAL BUDGET APPROPRIATION/ EXPENDITURE								
▶ Appropriation Act								
▶ Additional Appropriations								
▶ S21A PF&AA – special appropriation								
▶ S24 PF&AA – transfer of functions between departments								
▶ S26 PF&AA – Commonwealth specific purpose payments								
	–	–	–	–	–	–	–	–
OTHER APPROPRIATIONS/ EXPENDITURE								
▶ Treasurer's Advance								
▶ Under expenditure on protected items								
▶ Section 22 – expenditure for certain works and services								
▶ Transfers from another agency (Section 28 of the Appropriation Act)								
	–	–	–	–	–	–	–	–
Total Appropriations								
Expenditure/Net Claim on Consolidated Fund (includes transfer payments)								
Amount drawn down against Appropriation		–		–		–		–
Liability to Consolidated Fund*		–		–		–		–

The Summary of Compliance is based on the assumption that Consolidated Fund moneys are spent first (except where otherwise identified or prescribed).

* The "Liability to Consolidated Fund" represents the difference between the "Amount drawn down against Appropriation" and the "Total Expenditure/Net Claim on Consolidated Fund.

The accompanying notes form part of these statements.

OFFICE OF THE HEALTH CARE COMPLAINTS COMMISSION

Notes to and forming part of the financial statements for the year ended 30 June 2010

1. Summary of Significant Accounting Policies

(a) Reporting entity

The Office of the Health Care Complaints Commission (OHCCC) is a Division of the Government Service, established pursuant to Part 1 of Schedule 1 to the Public Sector Employment and Management Act 2002. It is a not-for-profit entity as profit is not its principal objective. It is consolidated as part of the NSW State Sector Accounts. The OHCCC is a controlled entity of the Health Care Complaints Commission.

The OHCCC's objective is to provide personnel services to the Health Care Complaints Commission.

The financial statements for the year ended 30 June 2010 have been authorised for issue by the Commissioner on 19 October 2010.

(b) Basis of preparation

The OHCCC's financial statements are general purpose financial statements which have been prepared in accordance with:

- applicable Australian Accounting Standards (which include Australian Accounting Interpretations)
- the requirements of the *Public Finance and Audit Act* and Regulations, and
- the Financial Reporting Directions published in the Financial Reporting Code for Budget Dependent General Government Sector Agencies or issued by the Treasurer.

Judgement, key assumptions and estimations management has made are disclosed in the relevant notes to the financial statements.

The financial statements are prepared in accordance with the historical cost convention. All amounts are rounded to the nearest one thousand dollars and are expressed in Australian currency.

(c) Statement of compliance

The financial statements and notes comply with Australian Accounting Standards which include Australian Accounting Interpretations.

(d) Insurance

The OHCCC's insurance activities are conducted through the NSW Treasury Managed Fund Scheme of self insurance for Government agencies. The expense (premium) is determined by Fund Managers based on past claim experience.

(e) Income recognition

Income is measured at the fair value of the consideration or contribution received or receivable. Revenue from rendering of personnel services is recognised when the service is provided and only to the extent that the associated recoverable expenses are recognised.

(f) Liabilities

(i) Employee benefits and other provisions

(a) Salaries and wages, annual leave, sick leave and on-costs

Liabilities for salaries and wages (including non-monetary benefits), annual leave and paid sick leave that are due to be settled within 12 months after the end of the period in which the employees render the service are recognised and measured in respect of employees' services up to the reporting date at undiscounted amounts based on the amounts expected to be paid when the liabilities are settled.

Unused non-vesting sick leave does not give rise to a liability as it is not considered probable that sick leave taken in the future will be greater than the benefits accrued in the future.

The outstanding amounts of payroll tax, workers' compensation insurance premiums and fringe benefit tax, which are consequential to employment, are recognised as liabilities and expenses where the employee benefits to which they relate have been recognised.

(b) Long service leave and superannuation

The OHCCC's liabilities for long service leave and defined benefit superannuation are assumed by the Crown Entity. The OHCCC accounts for the liability as having been extinguished, resulting in the amount assumed being shown as part of the non-monetary revenue item described as "Acceptance by the Crown Entity of employee benefits and other liabilities".

Long service leave is measured at present value in accordance with AASB 119 *Employee Benefits*. This is based on the application of certain factors (specified in NSWTC 09-04) to employees with five or more years of service, using current rates of pay. These factors were determined based on an actuarial review to approximate present value.

The superannuation expense for the financial year is determined by using the formulae specified in the Treasurers' Directions. The expense for certain superannuation schemes (i.e. Basic Benefit and First State Super) is calculated as a percentage of the employees's salary. For other superannuation schemes (i.e. State Superannuation Scheme and State Authorities Superannuation Scheme), the expense is calculated as a multiple of the employees' superannuation contributions.

(ii) Payables

These amounts represent liabilities for accrued wages, salaries and related on costs (such as payroll tax, fringe benefits tax and workers compensation insurance) where there is certainty as to the amount and timing of settlement.

(g) Assets

(i) Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. These financial assets are recognised initially at fair value, usually based on the transaction cost using the effective interest method, less an allowance for any impairment of receivables. Any changes are recognised in the surplus/(deficit) for the year when impaired, derecognised or through the amortisation process.

Short term receivables with no stated interest rate are measured at the original invoice amount where the effect of discounting is immaterial.

(h) Comparative information

Except where an Australian Accounting Standard permits or requires otherwise, comparative information is disclosed in respect of the previous period for all amounts reported in the financial statements.

(i) New Australian Accounting Standards/Interpretations issued but not effective

The following new Accounting Standards/Interpretations have not been applied and are not effective (NSW TC10/08). However, the OHCCC is not able to reliably measure the impact of the initial application of these standards on the financial results of the OHCCC.

- AASB 9 and AASB 2009-11 regarding financial instruments
- AASB 2009-5 regarding annual improvements
- AASB 2009-9 regarding classification of rights
- AASB 2009-14 regarding prepayments of a minimum funding requirement
- AASB 2010-1 regarding AASB 7 for comparatives for first time adopters

OFFICE OF THE HEALTH CARE COMPLAINTS COMMISSION

Notes to and forming part of the financial statements for the year ended 30 June 2010

2. Expenses Excluding Losses

	2010 $'000	2009 $'000
Employee related expenses		
Salaries and wages (including recreation leave)	6,124	6,502
Superannuation – defined benefits plans	169	197
Superannuation – defined contributions plans	400	390
Workers' compensation insurance	41	33
Long service leave	252	151
Payroll tax and fringe benefits tax	429	389
	7,415	7,662

3. Revenue

	2010 $'000	2009 $'000
Rendering of personnel services	7,415	7,662
	7,415	7,662

4. Current/Non-current Assets – Receivables

	2010 $'000	2009 $'000
Personnel Services – current	907	897
Personnel Services – non-current	4	4
	911	901

5. Current Liabilities – Payables

	2010 $'000	2009 $'000
Accrued salaries, wages and on-costs	88	111
	88	111

OFFICE OF THE HEALTH CARE COMPLAINTS COMMISSION

Notes to and forming part of the financial statements for the year ended 30 June 2010

6. Current/Non-current Liabilities – Provisions

	2010 $'000	2009 $'000
Employee benefit and related on-costs		
Recreation leave	615	636
Payroll tax on recreational leave	34	–
Payroll tax on long service leave	87	73
Long service leave on-costs	83	77
Total	**819**	**786**
Aggregate employee benefits and related on-costs		
Provisions – current	819	786
Provisions – non-current	4	4
Accrued salaries, wages and on-costs	88	111
	911	**901**

7. Contingent Liabilities and Contingent Assets

The OHCCC has no contingent liabilities or contingent assets as at 30 June 2010 (30 June 2009: Nil).

8. Financial Instruments

The OHCCC's principal financial instruments are outlined below. These financial instruments arise directly from the OHCCC's operations or are required to finance the OHCCC's operations. The OHCCC does not enter into or trade financial instruments, including derivative financial instruments, for speculative purposes.

The OHCCC's main risks arising from financial instruments are outlined below, together with the OHCCC's objectives, policies and processes for measuring and managing risks. Further quantitative and qualitative disclosures are included throughout this financial report.

The Manager Corporate Services has overall responsibility for the establishment and oversight of risk management and reviews and agrees policies for managing each of these risks. Risk management policies are established to identify and analyse the risks faced by the OHCCC, to set risk limits and controls and to monitor risks. Compliance with policies is reviewed by the OHCCC's Audit and Risk Committee on a continuous basis.

(a) Financial instrument categories

			2010 $'000	2009 $'000
Financial Assets	**Note**	**Category**	**Carrying Amount**	**Carrying Amount**
Class:				
Receivables[1]	4	Receivables	911	901
Financial Liabilities	**Note**	**Category**	**Carrying Amount**	**Carrying Amount**
Class:				
Payables[2]	5	Financial liabilities measured at amortised cost	–	–

Notes:
1. Excludes statutory receivables and prepayments (not within scope of AASB 7).
2. Excludes statutory payables and unearned revenue (not within scope of AASB 7).

(b) Credit risk

Credit risk arises when there is the possibility of the OHCCC's debtors defaulting on their contractual obligations, resulting in a financial loss to the OHCCC. The maximum exposure to credit risk is generally represented by the carrying amount of the financial assets (net of any allowance for impairment).

Credit risk arises from the financial assets of the HCCC, including cash and receivables. No collateral is held by the OHCCC. The OHCCC has not granted any financial guarantees.

OFFICE OF THE HEALTH CARE COMPLAINTS COMMISSION

Notes to and forming part of the financial statements for the year ended 30 June 2010

Receivables – debtors

All receivables are for personnel services receivable and are recognised as amounts receivable at balance date. Review of the collectability of debtors is not required as the only debtor is the HCCC.

The OHCCC is exposed to concentrations of credit risk to a single debtor but as the HCCC is the OHCCC's single debtor this exposure is not considered material. Based on past experience, debtors that are not past due (2010:$911,000; 2009:$901,000) and not less than 12 months past due (2010:$nil; 2009:$nil) are not considered impaired.

	Total	Past due but not impaired	Considered impaired
2010			
< 3 months overdue	–	–	–
3 months – 6 months overdue	–	–	–
> 6 months overdue	–	–	–
2009			
< 3 months overdue	–	–	–
3 months – 6 months overdue	–	–	–
> 6 months overdue	–	–	–

The ageing analysis excludes statutory receivables, as these are not within the scope of AASB 7.

(c) Liquidity risk

Liquidity risk is the risk that the OHCCC will be unable to meet its payment obligations when they fall due. The OHCCC continuously manages risk through monitoring future cash flows to ensure adequate holding of liquid assets.

During the current and prior years, there were no defaults or breaches on any loans payable. No assets have been pledged as collateral.

The OHCCC's exposure to liquidity risk is deemed insignificant based on prior periods' data and other current assessment of risk.

The liabilities are recognised for amounts due to be paid in the future for goods or services received, whether or not invoiced. Amounts owing to suppliers (which are unsecured) are settled in accordance with the policy set out in Treasurer's Direction 219.01.

If trade terms are not specified, payment is made no later than the end of the month following the month in which an invoice is received.

Treasurer's Direction 219.01 allows the Minister to award interest for late payment.

(d) Market risk

Market risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices.

The OHCCC has no exposure to market risk as it does not have borrowings or investments. The OHCCC has no exposure to foreign currency risk and does not enter into commodity contracts.

(e) Fair value compared to carrying amount

Financial instruments are generally recognised at cost, with the exception of the Tcorp Hour-Glass facilities, which are measured at fair value. As discussed, the value of the Hour-Glass Investments is based on the OHCCC's share of the value of the underlying assets of the facility, based on the market value. All of the Hour Glass facilities are valued using 'redemption' pricing.

The amortised cost of financial instruments recognised in the statement of financial position approximates the fair value, because of the short-term nature of the HCCC's financial instruments. The HCCC does not have any financial instruments where the fair value differs from the carrying amount.

9. After balance date events

There were no after balance date events (2009: Nil).

10. Commitments

There were no commitments (2009: Nil).

End of Audited Financial Report

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Appendices

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Appendix A – Complaints statistics

Table 18.1 Complaints received by issue category 2005-06 to 2009-10

Issue category	2005-06		2006-07		2007-08	
	No.	%	No.	%	No.	%
Treatment	1,924	56.7%	1,813	55.7%	2,245	50.9%
Communication	265	7.8%	366	11.2%	642	14.6%
Professional conduct	595	17.5%	590	18.1%	597	13.5%
Access	224	6.6%	210	6.4%	401	9.1%
Cost	178	5.3%	106	3.3%	153	3.5%
Privacy/ discrimination	115	3.4%	68	2.1%	132	3.0%
Consent	56	1.7%	52	1.6%	94	2.1%
Grievances	11	0.3%	17	0.5%	79	1.8%
Corporate services	24	0.7%	36	1.1%	66	1.5%
Total	3,392	100.0%	3,258	100.0%	4,409	100.0%

Issue category	2008-09		2009-10	
	No.	%	No.	%
Treatment	2,799	40.4%	2,504	42.9%
Communication/ information	1,432	20.7%	897	15.4%
Professional conduct	725	10.5%	687	11.8%
Medication	514	7.4%	368	6.3%
Fees/costs	256	3.7%	255	4.4%
Environment/ management of facilities	225	3.2%	246	4.2%
Access	173	2.5%	202	3.5%
Consent	155	2.2%	176	3.0%
Reports/certificates	168	2.4%	144	2.5%
Medical records	142	2.0%	143	2.4%
Discharge/transfer arrangements	159	2.3%	127	2.2%
Grievance processes	183	2.6%	92	1.6%
Total	6,931	100.0%	5,841	100.0%

Counted by issues raised in complaint

Table 18.2 Breakdown of category of complaints received 2009–10

Issue category	Issue name	No.	%
Treatment	Inadequate treatment	962	16.5%
	Diagnosis	404	6.9%
	Unexpected treatment outcome/complications	254	4.3%
	Delay in treatment	178	3.0%
	Inadequate care	135	2.3%
	Inadequate/inappropriate consultation	135	2.3%
	Inadequate prosthetic equipment	127	2.2%
	Rough and painful treatment	87	1.5%
	Coordination of treatment/results follow-up	50	0.9%
	Infection control	49	0.8%
	No/inappropriate referral	43	0.7%
	Excessive treatment	34	0.6%
	Wrong/inappropriate treatment	13	0.2%
	Public/private election	12	0.2%
	Attendance	10	0.2%
	Withdrawal of treatment	9	0.2%
	Experimental treatment	2	0.0%
Treatment total		2,504	42.9%
Communication/information	Attitude/manner	605	10.4%
	Inadequate information provided	271	4.6%
	Incorrect/misleading information provided	18	0.3%
	Special needs not accommodated	3	0.1%
Communication/information total		897	15.4%
Professional conduct	Competence	143	2.4%
	Sexual misconduct	120	2.1%
	Illegal practice	92	1.6%
	Inappropriate disclosure of information	82	1.4%
	Misrepresentation of qualifications	57	1.0%
	Impairment	46	0.8%
	Boundary violation	45	0.8%
	Assault	31	0.5%
	Financial fraud	21	0.4%
	Breach of condition	18	0.3%
	Discriminatory conduct	18	0.3%
	Annual declaration not lodged/incomplete/wrong or misleading	9	0.2%
	Emergency treatment not provided	3	0.1%
	Scientific fraud	2	0.0%
Professional conduct total		687	11.8%
Medication	Prescribing medication	223	3.8%
	Administering medication	77	1.3%
	Dispensing medication	60	1.0%
	Supply/security/storage of medication	8	0.1%
Medication total		368	6.3%

Table continued on next page

Table 18.2 Breakdown of category of complaints received 2009-10 (continued)

Issue category	Issue name	No.	%
Fees/costs	Billing practices	189	3.2%
	Financial consent	64	1.1%
	Cost of treatment	2	0.0%
Fees/costs total		255	4.4%
Environment/management of facilities	Administrative processes	156	2.7%
	Staffing and rostering	31	0.5%
	Cleanliness/hygiene of facility	30	0.5%
	Physical environment of facility	21	0.4%
	Statutory obligations/accreditation standards not met	8	0.1%
Environment/management of facilities total		246	4.2%
Access	Refusal to admit or treat	135	2.3%
	Waiting lists	53	0.9%
	Service availability	12	0.2%
	Access to subsidies	1	0.0%
	Access to facility	1	0.0%
Access total		202	3.5%
Consent	Consent not obtained or inadequate	68	1.2%
	Involuntary admission or treatment	67	1.1%
	Uninformed consent	41	0.7%
Consent total		176	3.0%
Reports/certificates	Accuracy of report/certificate	125	2.1%
	Refusal to provide report/certificate	12	0.2%
	Report written with inadequate or no consultation	4	0.1%
	Cost of report/certificate	2	0.0%
	Timeliness of report/certificate	1	0.0%
Reports/certificates total		144	2.5%
Medical records	Record keeping	77	1.3%
	Access to/transfer of records	57	1.0%
	Records management	9	0.2%
Medical records total		143	2.4%
Discharge/transfer arrangements	Inadequate discharge	105	1.8%
	Delay	10	0.2%
	Patient not reviewed	7	0.1%
	Mode of transport	5	0.1%
Discharge/transfer arrangements total		127	2.2%
Grievance processes	Inadequate/no response to complaint	81	1.4%
	Reprisal/retaliation as result of complaint lodged	7	0.1%
	Information about complaints procedures not provided	4	0.1%
Grievance processes total		92	1.6%
Grand total		5,841	100.0%

Counted by issues raised in complaint

Table 18.3 Complaints received about registered and unregistered health practitioners 2005-06 to 2009-10

	2005-06		2006-07		2007-08		2008-09		2009-10	
Health practitioner	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Registered health practitioner										
Medical practitioner	1,227	68.6%	1,104	66.6%	1,145	64.7%	1,270	60.8%	1,263	56.2%
Dentist	165	9.2%	173	10.4%	177	10.0%	292	14.0%	410	18.2%
Nurse/midwife	154	8.6%	177	10.7%	224	12.6%	254	12.2%	221	9.8%
Psychologist	70	3.9%	81	4.9%	77	4.3%	84	4.0%	132	5.9%
Dental technician and prosthetist	24	1.3%	8	0.5%	21	1.2%	17	0.8%	42	1.9%
Chiropractor	17	1.0%	18	1.1%	15	0.8%	30	1.4%	24	1.1%
Physiotherapist	19	1.1%	15	0.9%	15	0.8%	25	1.2%	23	1.0%
Pharmacist	17	1.0%	21	1.3%	9	0.5%	21	1.0%	22	1.0%
Optometrist	6	0.3%	10	0.6%	5	0.3%	18	0.9%	15	0.7%
Podiatrist	10	0.6%	13	0.8%	8	0.5%	9	0.4%	14	0.6%
Osteopath	1	0.1%	4	0.2%	2	0.1%	1	0.0%	3	0.1%
Optical dispenser	–	0.0%	1	0.0%	–	0.0%	1	0.0%	1	0.0%
Total registered health practitioners	1,710	95.6%	1,625	98.0%	1,698	95.9%	2,022	96.7%	2,170	96.5%
Unregistered health practitioner										
Administration/clerical staff	2	0.1%	2	0.1%	1	0.1%	7	0.3%	15	0.7%
Other/unknown	30	1.7%	7	0.4%	1	0.1%	8	0.4%	9	0.4%
Massage therapist	n/a	0.0%	n/a	0.0%	n/a	0.0%	4	0.2%	8	0.4%
Social worker	1	0.1%	–	0.0%	2	0.1%	6	0.3%	8	0.4%
Alternative health provider	17	1.0%	5	0.3%	10	0.6%	1	0.0%	6	0.3%
Counsellor/therapist	7	0.4%	2	0.1%	1	0.1%	8	0.4%	6	0.3%
Previously registered health practitioner	1	0.1%	3	0.2%	44	2.5%	18	0.9%	5	0.2%
Naturopath	2	0.1%	1	0.1%	2	0.1%	2	0.1%	3	0.1%
Occupational therapist	1	0.1%	1	0.1%	–	0.0%	1	0.0%	3	0.1%
Acupuncturist	1	0.1%	–	0.0%	2	0.1%	–	0.0%	2	0.1%
Dietitian/nutritionist	–	0.0%	1	0.1%	1	0.1%	1	0.0%	2	0.1%
Psychotherapist	2	0.1%	1	0.1%	3	0.2%	–	0.0%	2	0.1%
Radiographer	–	0.0%	1	0.1%	3	0.2%	3	0.1%	2	0.1%
Traditional Chinese medicine practitioner	8	0.4%	2	0.1%	–	0.0%	2	0.1%	2	0.1%
Assistant in nursing	2	0.1%	2	0.1%	–	0.0%	1	0.0%	1	0.0%
Homeopath	n/a	0.0%	n/a	0.0%	n/a	0.0%	2	0.1%	1	0.0%
Hypnotherapist	n/a	0.0%	n/a	0.0%	n/a	0.0%	–	0.0%	1	0.0%
Natural therapist	4	0.2%	2	0.1%	–	0.0%	2	0.1%	1	0.0%
Reflexologist	n/a	0.0%	n/a	0.0%	n/a	0.0%	–	0.0%	1	0.0%
Residential care worker	–	0.0%	–	0.0%	3	0.2%	–	0.0%	1	0.0%
Ambulance personnel	–	0.0%	2	0.1%	–	0.0%	–	0.0%	–	0.0%
Speech therapist	–	0.0%	–	0.0%	–	0.0%	2	0.1%	–	0.0%
Total unregistered health practitioners	78	4.4%	32	2.0%	73	4.1%	68	3.3%	79	3.5%
Grand total	1,788	100.0%	1,657	100.0%	1,771	100.0%	2,090	100.0%	2,249	100.0%

Counted by provider identified in complaint

Table 18.4 Complaints received about registered health practitioners by issue category 2009-10

Issue Category	Registered health practitioner												Total	
	Medical practitioner	Dentist	Nurse/midwife	Psychologist	Dental technician and prosthetist	Chiropractor	Physiotherapist	Pharmacist	Optometrist	Podiatrist	Osteopath	Optical dispenser	No.	%
Treatment	908	444	69	27	40	13	11	–	13	8	1	–	1,534	42.8%
Professional conduct	294	23	143	64	9	15	11	5	4	6	2	–	576	16.1%
Communication/ information	419	50	48	28	9	3	3	4	5	4	1	1	575	16.1%
Medication	159	1	27	1	1	–	–	17	–	–	–	–	206	5.8%
Fees/costs	63	94	–	10	8	1	1	3	2	1	–	–	183	5.1%
Reports/ certificates	83	1	1	38	–	–	3	–	1	1	–	–	128	3.6%
Consent	66	25	1	1	–	1	1	–	1	–	1	–	97	2.7%
Environment/ management of facilities	37	3	18	10	2	2	1	3	–	–	–	–	76	2.1%
Access	65	5	2	4	–	–	–	–	–	–	–	–	76	2.1%
Medical records	48	8	12	–	1	2	2	–	1	1	–	–	75	2.1%
Discharge/transfer arrangements	27	–	1	–	–	–	–	–	1	–	–	–	29	0.8%
Grievance processes	14	4	3	1	1	–	–	–	–	2	–	–	25	0.7%
Total	2,183	658	325	184	71	37	33	32	28	23	5	1	3,580	100.0%
No. of practitioners registered in NSW as at 30.6.2010	31,420	5,599	121,000	10,776	1,333	1,543	7,074	8,532	1,764	937	574	1,545	192,097	

Counted by issues raised in complaint

Table 18.5 Complaints received about unregistered health practitioners by issue category 2009–10

Issue category	Un-registered health practitioner																				Total	
	Administration/clerical staff	Social worker	Counsellor/therapist	Other/unknown	Massage therapist	Previously registered practitioner	Alternative health provider	Occupational therapist	Naturopath	Psychotherapist	Natural therapist	Acupuncturist	Dietitian/nutritionist	Traditional Chinese medicine practitioner	Assistant in nursing	Radiographer	Reflexologist	Homeopath	Residential care worker	Hypnotherapist	No.	%
Professional conduct	8	5	5	2	9	3	6	–	2	2	–	1	–	2	2	1	1	–	1	–	50	47.2%
Treatment	–	3	2	1	–	4	–	–	–	1	1	1	1	–	–	1	–	1	–	1	17	16.0%
Communication/ information	1	5	3	1	–	1	1	2	1	–	–	–	2	–	–	–	–	–	–	–	17	16.0%
Environment/ management of facilities	3	–	–	3	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	6	5.7%
Fees/costs	–	–	–	1	–	1	–	–	–	–	2	1	–	–	–	–	–	–	–	–	5	4.7%
Reports/certificates	–	–	–	1	–	–	–	2	–	–	–	–	–	–	–	–	–	–	–	–	3	2.8%
Grievance processes	3	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	3	2.8%
Medical records	2	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2	1.9%
Access	1	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	1	0.9%
Medication	–	–	–	–	–	–	–	–	1	–	–	–	–	–	–	–	–	–	–	–	1	0.9%
Consent	–	1	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	1	0.9%
Total	18	14	10	9	9	9	7	4	4	3	3	3	3	2	2	2	1	1	1	1	106	100.0%

Counted by issues raised in complaint

Table 18.6 Complaints received about health organisations 2005-06 to 2009-10

Organisation	2005-06		2006-07		2007-08		2008-09		2009-10	
	No.	%	No.	%	No.	%	No.	%	No.	%
Public hospital	540	43.7%	512	48.1%	763	56.2%	620	48.8%	614	48.5%
Correction and detention facility	131	10.6%	93	8.7%	106	7.8%	138	10.9%	127	10.0%
Private hospital	71	5.7%	70	6.6%	55	4.1%	62	4.9%	81	6.4%
Medical centre	61	4.9%	47	4.4%	70	5.2%	83	6.5%	69	5.5%
Pharmacy	63	5.1%	51	4.8%	59	4.3%	68	5.4%	53	4.2%
Aged care facility	70	5.7%	53	5.0%	48	3.5%	41	3.2%	39	3.1%
Area Health Service	61	4.9%	29	2.7%	27	2.0%	37	2.9%	37	2.9%
Community health service	40	3.2%	49	4.6%	43	3.2%	43	3.4%	33	2.6%
Dental facility	42	3.4%	30	2.8%	22	1.6%	39	3.1%	32	2.5%
Ambulance service	22	1.8%	21	2.0%	24	1.8%	23	1.8%	30	2.4%
Radiology practice	24	1.9%	18	1.7%	10	0.7%	12	0.9%	27	2.1%
Medical practice	19	1.5%	20	1.9%	24	1.8%	29	2.3%	22	1.7%
Pathology centre/lab	18	1.5%	12	1.1%	17	1.3%	10	0.8%	16	1.3%
Other/unknown	39	3.2%	17	1.6%	1	0.1%	10	0.8%	14	1.1%
Alternative health service	1	0.1%	8	0.8%	5	0.4%	1	0.1%	12	0.9%
Psychiatric hospital	8	0.6%	5	0.5%	26	1.9%	26	2.0%	8	0.6%
Day procedure centre	2	0.2%	5	0.5%	4	0.3%	5	0.4%	7	0.6%
Health fund	1	0.1%	4	0.4%	5	0.4%	1	0.1%	7	0.6%
Drug and alcohol service	3	0.2%	6	0.6%	4	0.3%	6	0.5%	6	0.5%
Government department	–	0.0%	–	0.0%	4	0.3%	8	0.6%	5	0.4%
Rehabilitation facility	n/a	0.0%	n/a	0.0%	10	0.7%	2	0.2%	5	0.4%
Aboriginal health centre	n/a	0.0%	n/a	0.0%	n/a	0.0%	n/a	0.0%	4	0.3%
Optometrist practice	8	0.6%	4	0.4%	7	0.5%	3	0.2%	4	0.3%
Physiotherapy clinic	5	0.4%	3	0.3%	2	0.1%	1	0.1%	4	0.3%
Supported accommodation services	5	0.4%	4	0.4%	9	0.7%	2	0.2%	4	0.3%
Multi purpose service	–	0.0%	–	0.0%	4	0.3%	–	0.0%	3	0.2%
Blood bank	–	0.0%	1	0.1%	1	0.1%	–	0.0%	1	0.1%
Chiropractic practice	1	0.1%	2	0.2%	2	0.1%	–	0.0%	1	0.1%
Nursing agency	–	0.0%	1	0.1%	4	0.3%	–	0.0%	1	0.1%
Optical laboratory	–	0.0%	–	0.0%	1	0.1%	n/a	0.0%	n/a	0.0%
Total	1,235	100.0%	1,065	100.0%	1,357	100.0%	1,270	100.0%	1,266	100.0%

Counted by provider identified in complaint

Table 18.7 Complaints received about public and private hospitals by most common service areas 2009–10

Service area	Public		Private		Total	
	No.	%	No.	%	No.	%
Emergency medicine	192	31.3%	4	4.9%	196	28.2%
Surgery	102	16.6%	35	43.2%	137	19.7%
Mental health	90	14.7%	2	2.5%	92	13.2%
Obstetrics	53	8.6%	6	7.4%	59	8.5%
General medicine	32	5.2%	6	7.4%	38	5.5%
Rehabilitation medicine	8	1.3%	8	9.9%	16	2.3%
Administration	10	1.6%	4	4.9%	14	2.0%
Neurology	10	1.6%	2	2.5%	12	1.7%
Aged care	11	1.8%	–	0.0%	11	1.6%
Cardiology	9	1.5%	2	2.5%	11	1.6%
Palliative care	9	1.5%	1	1.2%	10	1.4%
Paediatric medicine	9	1.5%	–	0.0%	9	1.3%
Non-health related	8	1.3%	–	0.0%	8	1.2%
Urology	5	0.8%	2	2.5%	7	1.0%
Other service areas	66	10.7%	9	11.1%	75	10.8%
Total	614	100.0%	81	100.0%	695	100.0%

Counted by provider identified in complaint

Table 18.8 Complaints received about public hospitals by Area Health Service 2005–06 to 2009–10

Area Health Service	2005-06		2006-07		2007-08		2008-09		2009-10	
	No.	%	No.	%	No.	%	No.	%	No.	%
South Eastern Sydney/Illawarra	98	18.1%	106	20.7%	137	18.0%	115	18.5%	130	21.2%
Sydney South West	106	19.6%	96	18.8%	104	13.6%	122	19.7%	124	20.2%
Sydney West	96	17.8%	90	17.6%	106	13.9%	97	15.6%	88	14.3%
Hunter/New England	60	11.1%	59	11.5%	102	13.4%	84	13.5%	77	12.5%
Northern Sydney/Central Coast	72	13.3%	73	14.3%	121	15.9%	84	13.5%	72	11.7%
North Coast	49	9.1%	36	7.0%	81	10.6%	38	6.1%	51	8.3%
Greater Southern	21	3.9%	28	5.5%	47	6.2%	45	7.3%	41	6.7%
Greater Western	37	6.9%	24	4.7%	63	8.3%	35	5.6%	31	5.0%
Interstate/unknown	1	0.2%	–	0.0%	2	0.3%	–	0.0%	–	0.0%
Total	540	100.0%	512	100.0%	763	100.0%	620	100.0%	614	100.0%

Area Health Service	2009-10		
	Separations	Non-admitted patient services	Emergency department attendances
South Eastern Sydney/Illawarra	296,366	4,987,739	392,790
Sydney South West	319,180	4,425,895	359,741
Sydney West	248,964	3,673,136	295,441
Hunter/New England	193,936	2,651,582	369,009
Northern Sydney/Central Coast	185,400	2,570,864	266,308
North Coast	156,375	1,812,062	309,258
Greater Southern	108,036	1,383,360	223,733
Greater Western	88,398	1,189,025	226,702
Total	1,596,655	22,693,932	2,442,982

Counted by provider identified in complaint

Notes:
Excludes psychiatric hospitals.
Sydney West includes Westmead Children's Hospital.
Greater Southern includes Albury Wodonga Health.

Table 18.9 Issues raised in all complaints received about health organisations by organisation type 2009–10

Organisation type	Issue category												Total	
	Treatment	Communication / information	Environment / management of facilities	Medication	Access	Discharge/transfer arrangements	Consent	Fees/costs	Medical records	Grievance processes	Professional conduct	Reports/certificates	No.	%
Public														
Hospital	629	181	68	51	59	84	55	3	34	32	20	4	1,220	56.6%
Correction and detention facility	83	8	8	40	29	–	–	1	4	1	2	2	178	8.3%
Community health service	18	9	2	3	3	–	13	–	2	–	1	2	53	2.5%
Area Health Service	7	4	10	2	5	3	2	–	1	8	1	–	43	2.0%
Ambulance service	20	7	2	–	2	2	–	1	1	1	1	–	37	1.7%
Psychiatric hospital/unit	4	1	1	–	–	–	3	–	–	–	1	–	10	0.5%
Dental facility	6	2	–	–	1	–	–	–	–	–	–	–	9	0.4%
Supported accommodation services	3	1	–	2	–	–	1	–	–	–	–	–	7	0.3%
Aboriginal health centre	1	1	–	1	2	–	–	–	–	–	1	–	6	0.3%
Aged care facility	2	1	2	1	–	–	–	–	–	–	–	–	6	0.3%
Government department	–	–	3	–	–	–	–	–	–	–	2	–	5	0.2%
Other/unknown	–	1	3	–	–	–	–	–	–	–	–	–	4	0.2%
Rehabilitation facility	–	1	–	–	1	–	–	–	–	–	1	–	3	0.1%
Drug and alcohol service	–	1	–	–	–	–	–	–	–	–	–	–	1	0.0%
Health fund	–	–	1	–	–	–	–	–	–	–	–	–	1	0.0%
Public total	773	218	100	100	102	89	74	5	42	42	30	8	1,583	73.5%

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Table 18.9 Issues raised in all complaints received about health organisations by organisation type 2009-10 (continued)

Organisation type	Issue category												Total	
	Treatment	Communication/ information	Environment/ management of facilities	Medication	Access	Discharge/transfer arrangements	Consent	Fees/costs	Medical records	Grievance processes	Professional conduct	Reports/certificates	No.	%
Private														
Hospital	60	28	21	12	3	8	3	11	1	7	2	–	156	7.2%
Medical centre	23	13	8	2	11	–	–	10	14	5	7	1	94	4.4%
Aged care facility	28	11	16	1	1	–	–	1	3	4	3	1	69	3.2%
Pharmacy	–	4	3	43	2	–	–	3	–	–	3	–	58	2.7%
Dental facility	18	3	–	–	1	–	–	12	1	–	–	–	35	1.6%
Radiology practice	15	4	2	–	2	–	1	4	1	2	1	1	33	1.5%
Medical practice	8	4	4	2	1	–	–	2	3	–	1	–	25	1.2%
Pathology centre/lab	5	3	1	–	–	–	–	9	–	1	–	–	19	0.9%
Other/unknown	1	5	–	–	–	–	–	–	–	–	4	1	11	0.5%
Alternative health centre	5	2	–	–	–	–	–	–	–	–	3	–	10	0.5%
Day procedure centre	2	1	2	–	–	–	–	3	–	2	–	–	10	0.5%
Drug and alcohol service	4	–	–	1	1	–	–	1	–	–	2	–	9	0.4%
Health fund	1	1	3	–	1	–	–	2	–	–	–	–	8	0.4%
Alternative health practice	3	1	–	–	–	–	–	2	–	–	2	–	8	0.4%
Physiotherapy clinic	1	2	–	–	–	–	–	1	–	1	2	–	7	0.3%
Optometrist practice	2	1	1	–	–	–	–	–	1	–	–	–	5	0.2%
Multi purpose service	1	2	–	–	–	–	–	1	–	–	–	–	4	0.2%
Rehabilitation facility	1	1	2	–	–	–	–	–	–	–	–	–	4	0.2%
Chiropractic practice	1	–	–	–	–	–	–	–	–	–	1	–	2	0.1%
Supported accommodation services	–	–	1	–	–	–	–	–	–	–	–	–	1	0.0%
Nursing agency	–	–	–	–	–	–	–	–	–	–	–	1	1	0.0%
Blood Bank	–	1	–	–	–	–	–	–	–	–	–	–	1	0.0%
Psychiatric hospital/unit	–	–	–	–	–	1	–	–	–	–	–	–	1	0.0%
Ambulance service	1	–	–	–	–	–	–	–	–	–	–	–	1	0.0%
Private total	180	87	64	61	23	9	4	62	24	22	31	5	572	26.5%
Grand total	953	305	164	161	125	98	78	67	66	64	61	13	2,155	100.0%

Counted by issues raised in complaint

Table 18.10 Issues raised in all complaints received by service area 2009–10

Service area	Issue category												Total	
	Treatment	Communication/ information	Professional conduct	Medication	Fees/costs	Environment/ management of facilities	Access	Consent	Reports/ certificates	Medical records	Discharge/transfer arrangements	Grievance processes	No.	%
General medicine	499	225	211	153	37	39	85	4	35	53	6	16	1,363	23.3%
Dentistry	501	58	30	3	112	6	12	25	1	9	–	5	762	13.0%
Surgery	306	95	52	18	17	26	22	28	2	11	22	10	609	10.4%
Emergency medicine	323	93	26	12	1	18	23	9	2	19	42	13	581	9.9%
Mental health	115	51	35	36	–	14	13	62	4	9	20	4	363	6.2%
Obstetrics	125	42	7	5	3	11	4	8	–	2	6	7	220	3.8%
Aged care	65	26	25	14	1	24	1	6	3	6	6	6	183	3.1%
Psychology	22	20	54	1	9	10	4	–	25	–	–	–	145	2.5%
Medico-Legal	18	36	10	–	2	1	–	–	36	–	–	2	105	1.8%
Administration	–	7	30	–	6	26	2	–	4	7	–	10	92	1.6%
Psychiatry	29	13	19	7	2	–	5	1	9	4	1	1	91	1.6%
Pharmacy/pharmacology	–	8	8	60	6	6	2	–	–	–	–	–	90	1.5%
Cardiology	32	13	2	2	1	3	4	2	–	3	5	1	68	1.2%
Dermatology	27	15	3	1	5	3	4	1	–	1	–	–	60	1.0%
Paediatric medicine	29	8	4	3	1	2	–	2	2	3	1	3	58	1.0%
Non-health related	7	8	23	1	–	15	–	–	1	–	–	–	55	0.9%
Rehabilitation medicine	26	6	3	4	–	7	2	–	3	–	2	1	54	0.9%
Palliative care	22	6	2	12	–	3	–	3	1	2	1	–	52	0.9%
Radiology	25	7	4	2	6	1	1	1	1	1	–	2	51	0.9%
Cosmetic services	22	5	8	1	6	1	–	3	1	1	–	–	48	0.8%
Gynaecology	15	16	3	1	2	1	3	4	–	–	3	–	48	0.8%
Neurology	27	11	2	2	–	2	–	–	2	–	–	1	47	0.8%
Midwifery	16	13	12	–	–	1	–	2	–	–	–	–	44	0.8%
Drug and alcohol	12	6	4	7	1	8	1	–	–	–	1	–	40	0.7%
Ambulance service	21	7	3	–	1	1	2	–	–	1	2	1	39	0.7%
Chiropractice	14	3	15	–	1	2	–	1	–	2	–	–	38	0.7%
Optometry	15	8	6	–	2	1	–	1	1	2	1	–	37	0.6%
Physiotherapy	8	4	15	–	2	3	–	1	1	1	–	1	36	0.6%
Oncology	13	5	–	3	1	1	2	–	1	1	1	–	28	0.5%
Anaesthesia	8	4	5	4	2	–	–	3	–	–	–	1	27	0.5%
Ophthalmology	11	7	1	–	5	–	–	2	–	–	–	–	26	0.4%
Geriatrics/gerontology	13	5	–	2	–	2	–	–	–	–	2	1	25	0.4%
Pathology	5	3	–	–	13	1	–	–	2	–	–	1	25	0.4%
Intensive care	14	2	3	2	–	–	–	1	–	–	1	1	24	0.4%
Radiography	12	4	2	–	–	2	1	1	–	–	1	–	23	0.4%
Alternative health	3	9	7	1	3	–	–	–	–	–	–	–	23	0.4%
Podiatry	8	4	6	–	1	–	–	–	1	1	–	2	23	0.4%

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Table 18.10 Issues raised in all complaints received by service area 2009–10 (continued)

Service area	Issue category												Total	
	Treatment	Communication/ information	Professional conduct	Medication	Fees/costs	Environment/ management of facilities	Access	Consent	Reports/ certificates	Medical records	Discharge/transfer arrangements	Grievance processes	No.	%
Gastroenterology	12	5	–	2	–	–	1	1	–	–	1	–	22	0.4%
Prosthetics and orthotics	12	4	3	–	2	–	–	–	–	–	–	–	21	0.4%
Respiratory/thoracic medicine	13	3	–	–	1	1	–	–	1	–	1	–	20	0.3%
Urology	7	4	–	–	2	1	3	2	–	–	–	–	19	0.3%
Pain management	9	1	–	4	–	1	1	–	–	1	–	1	18	0.3%
Other/unknown	2	1	9	–	–	–	1	–	–	–	–	–	13	0.2%
Renal medicine	4	3	–	1	–	1	–	–	1	1	1	–	12	0.2%
Reproductive medicine	5	4	–	–	–	–	–	1	–	–	–	1	11	0.2%
Infectious diseases	6	3	–	1	–	–	–	–	–	–	–	–	10	0.2%
Counselling	3	1	5	–	–	–	1	–	–	–	–	–	10	0.2%
Massage therapy	1	–	8	–	–	–	–	–	–	–	–	–	9	0.2%
Osteopathy	2	2	4	–	–	–	–	1	–	–	–	–	9	0.2%
Rheumatology	4	1	1	3	–	–	–	–	–	–	–	–	9	0.2%
Psychotherapy	4	1	4	–	–	–	–	–	–	–	–	–	9	0.2%
Haematology	3	2	–	–	–	1	–	–	–	1	–	–	7	0.1%
Early childhood	1	1	4	–	–	–	–	–	–	–	–	–	6	0.1%
Endocrinology	3	–	–	–	–	–	2	–	–	–	–	–	5	0.1%
Natural therapy	–	2	3	–	–	–	–	–	–	–	–	–	5	0.1%
Developmental disability	1	2	–	–	–	–	–	–	–	1	–	–	4	0.1%
Acupuncture	1	1	–	–	1	–	–	–	1	–	–	–	4	0.1%
Occupational therapy	–	2	–	–	–	–	–	–	1	–	–	–	3	0.1%
Traditional Chinese medicine	1	–	2	–	–	–	–	–	–	–	–	–	3	0.1%
Aviation medicine	1	1	–	–	–	–	–	–	1	–	–	–	3	0.1%
Forensic medicine	–	–	1	–	–	–	–	–	1	–	–	–	2	0.0%
Sexual assault service	–	–	1	–	–	–	–	–	–	–	–	–	1	0.0%
Occupational health	–	–	1	–	–	–	–	–	–	–	–	–	1	0.0%
Hypnotherapy	1	–	–	–	–	–	–	–	–	–	–	–	1	0.0%
Hydrotherapy	–	–	1	–	–	–	–	–	–	–	–	–	1	0.0%
Grand total	2,504	897	687	368	255	246	202	176	144	143	127	92	5,841	100.0%

Counted by issues raised in complaint

Table 18.11 Source of complaints 2005-06 to 2009-10

Source	2005-06		2006-07		2007-08		2008-09		2009-10	
	No.	%	No.	%	No.	%	No.	%	No.	%
Consumer	1,256	48.8%	901	39.1%	1,073	39.3%	1,242	43.7%	1,484	48.2%
Registration board	486	18.9%	697	30.3%	666	24.4%	828	29.2%	850	27.6%
Family or friend	563	21.9%	491	21.3%	627	23.0%	580	20.4%	585	19.0%
Health professional	66	2.6%	18	0.8%	25	0.9%	24	0.8%	35	1.1%
Parliament/Minister	39	1.5%	42	1.8%	40	1.5%	27	1.0%	35	1.1%
Government department	25	1.0%	19	0.8%	198	7.3%	46	1.6%	31	1.0%
Department of Health (State and Commonwealth)	42	1.6%	22	1.0%	18	0.7%	30	1.1%	26	0.8%
Legal representative	30	1.2%	37	1.6%	29	1.1%	20	0.7%	20	0.7%
Court	15	0.6%	8	0.3%	11	0.4%	8	0.3%	5	0.2%
Non-government organisation	2	0.1%	3	0.1%	1	0.0%	–	0.0%	5	0.0%
Other	23	0.9%	9	0.4%	13	0.5%	22	0.8%	–	0.0%
Consumer organisation	19	0.7%	54	2.3%	28	1.0%	12	0.4%	–	0.0%
Professional association	7	0.3%	1	0.0%	1	0.0%	–	0.0%	–	0.0%
Total	2,573	100.0%	2,302	100.0%	2,730	100.0%	2,839	100.0%	3,076	100.0%

Counted by complainant

Table 18.12 Outcome of assessment of complaints 2005-06 to 2009-10

Assessment decision	2005-06		2006-07		2007-08		2008-09		2009-10	
	No.	%	No.	%	No.	%	No.	%	No.	%
Discontinued	1,471	43.4%	1,017	37.5%	982	34.0%	1,291	38.5%	1,447	41.2%
Referred to registration board	512	15.1%	497	18.3%	572	19.8%	755	22.5%	806	22.9%
Assisted resolution	593	17.5%	431	15.9%	574	19.9%	561	16.8%	608	17.3%
Investigation by Commission	373	11.0%	307	11.3%	260	9.0%	270	8.1%	223	6.3%
Resolved during assessment	150	4.4%	137	5.1%	206	7.1%	188	5.6%	206	5.9%
Referred for conciliation	186	5.5%	239	8.8%	198	6.9%	167	5.0%	127	3.6%
Referred to another body or person	74	2.2%	54	2.0%	56	1.9%	61	1.8%	54	1.5%
Local resolution	33	1.0%	28	1.0%	41	1.4%	56	1.7%	41	1.2%
Total	3,392	100.0%	2,710	100.0%	2,889	100.0%	3,349	100.0%	3,512	100.0%

Counted by provider identified in complaint

Table 18.13 Outcome of assessment of complaints by issues identified in complaint 2009-10

Issue category	Issue name	Outcome								Total	
		Discontinued	Referred to registration board	Assisted resolution	Investigation	Resolved during assessment process	Conciliation	Referred to another body	Local resolution	No.	%
Treatment	Inadequate treatment	288	288	259	56	45	55	3	5	999	16.6%
	Diagnosis	172	58	126	26	13	28	–	4	427	7.1%
	Unexpected treatment outcome/ complications	68	54	65	13	4	38	–	1	243	4.0%
	Delay in treatment	64	14	71	9	25	25	–	4	212	3.5%
	Inadequate/inappropriate consultation	78	37	8	9	10	2	–	1	145	2.4%
	Inadequate care	28	5	61	6	4	8	2	1	115	1.9%
	Inadequate prosthetic equipment	8	84	6	–	7	–	–	–	105	1.7%
	Rough and painful treatment	30	21	28	2	2	7	–	1	91	1.5%
	Infection control	13	10	15	6	4	4	1	–	53	0.9%
	Coordination of treatment/ results follow-up	13	9	15	7	2	3	–	–	49	0.8%
	No/inappropriate referral	24	9	6	1	2	2	–	–	44	0.7%
	Excessive treatment	10	15	2	2	–	–	1	1	31	0.5%
	Wrong/inappropriate treatment	6	3	1	5	–	–	–	–	15	0.2%
	Public/private election	6	–	1	2	2	1	–	–	12	0.2%
	Attendance	2	5	–	–	2	–	–	–	9	0.1%
	Withdrawal of treatment	3	1	2	–	–	2	–	–	8	0.1%
	Experimental treatment	–	1	–	1	–	–	–	–	2	0.0%
Treatment total		813	614	666	145	122	175	7	18	2,560	42.6%
Communication/ information	Attitude/manner	321	100	94	15	40	19	3	8	600	10.0%
	Inadequate information provided	106	19	95	8	19	30	1	1	279	4.6%
	Incorrect/misleading information provided	8	2	2	–	2	–	6	1	21	0.3%
	Special needs not accommodated	–	–	2	–	–	1	–	–	3	0.0%
Communication/ information total		435	121	193	23	61	50	10	10	903	15.0%

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Table 18.13 Outcome of assessment of complaints by issues identified in complaint 2009–10 (continued)

Issue category	Issue name	Outcome								Total	
		Discontinued	Referred to registration board	Assisted resolution	Investigation	Resolved during assessment process	Conciliation	Referred to another body	Local resolution	No.	%
Professional conduct	Competence	43	61	14	38	1	7	–	–	164	2.7%
	Sexual misconduct	37	25	–	56	–	–	–	–	118	2.0%
	Illegal practice	39	25	4	20	4	1	6	2	101	1.7%
	Inappropriate disclosure of information	56	17	8	4	5	1	1	1	93	1.5%
	Misrepresentation of qualifications	12	41	–	7	–	–	–	–	60	1.0%
	Impairment	5	25	–	11	–	–	2	–	43	0.7%
	Boundary violation	13	15	–	12	–	1	–	–	41	0.7%
	Assault	17	8	1	3	1	–	3	1	34	0.6%
	Financial fraud	3	9	–	5	1	–	3	–	21	0.3%
	Discriminatory conduct	17	3	–	–	–	–	–	–	20	0.3%
	Breach of conditions	–	4	–	12	–	–	–	–	16	0.3%
	Annual declaration not lodged/ incomplete/wrong or misleading	1	4	–	3	–	–	–	–	8	0.1%
	Emergency treatment not provided	1	2	–	–	–	–	–	–	3	0.0%
	Scientific fraud	–	2	–	–	–	–	–	–	2	0.0%
Professional conduct total		**244**	**241**	**27**	**171**	**12**	**10**	**15**	**4**	**724**	**12.0%**
Medication	Prescribing medication	122	38	49	19	4	5	7	2	246	4.1%
	Administering medication	29	12	34	8	4	7	1	1	96	1.6%
	Dispensing medication	6	49	1	2	–	–	2	–	60	1.0%
	Supply/security/storage of medication	3	3	1	2	–	–	–	–	9	0.1%
Medication total		**160**	**102**	**85**	**31**	**8**	**12**	**10**	**3**	**411**	**6.8%**
Fees/costs	Billing practices	74	78	7	5	16	–	5	–	185	3.1%
	Financial consent	34	19	2	–	12	1	1	–	69	1.1%
	Cost of treatment	–	1	1	–	–	–	–	–	2	0.0%
Fees/costs total		**108**	**98**	**10**	**5**	**28**	**1**	**6**	**–**	**256**	**4.3%**
Environment/management of facilities	Administrative processes	88	20	17	3	12	–	11	7	158	2.6%
	Staffing and rostering	11	1	10	3	2	4	2	–	33	0.5%
	Cleanliness/hygiene of facility	11	1	7	1	4	2	4	–	30	0.5%
	Physical environment of facility	4	2	5	–	2	–	–	3	16	0.3%
	Statutory obligations/ accreditation standards not met	3	–	–	–	1	2	4	1	11	0.2%
Environment/management of facilities total		**117**	**24**	**39**	**7**	**21**	**8**	**21**	**11**	**248**	**4.1%**

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Table 18.13 Outcome of assessment of complaints by issues identified in complaint 2009-10 (continued)

Issue category	Issue name	Outcome								Total	
		Discontinued	Referred to registration board	Assisted resolution	Investigation	Resolved during assessment process	Conciliation	Referred to another body	Local resolution	No.	%
Access	Refusal to admit or treat	92	9	15	–	8	4	–	1	129	2.1%
	Waiting lists	39	–	16	–	12	–	–	–	67	1.1%
	Service availability	9	–	3	–	1	–	–	–	13	0.2%
	Access to subsidies	1	–	–	–	–	–	–	–	1	0.0%
	Access to facility	1	–	–	–	–	–	–	–	1	0.0%
Access total		**142**	**9**	**34**	**–**	**21**	**4**	**–**	**1**	**211**	**3.5%**
Consent	Consent not obtained or inadequate	24	25	10	1	1	3	–	–	64	1.1%
	Involuntary admission or treatment	38	–	13	–	1	1	–	8	61	1.0%
	Uninformed consent	5	6	12	2	2	5	–	–	32	0.5%
Consent total		**67**	**31**	**35**	**3**	**4**	**9**	**–**	**8**	**157**	**2.6%**
Medical records	Record keeping	28	8	26	13	3	11	–	1	90	1.5%
	Access to/transfer of records	26	4	12	–	9	1	–	3	55	0.9%
	Records management	4	4	1	–	3	–	–	–	12	0.2%
Medical records total		**58**	**16**	**39**	**13**	**15**	**12**	**–**	**4**	**157**	**2.6%**
Discharge/transfer arrangements	Inadequate discharge	24	7	65	6	4	11	–	1	118	2.0%
	Delay	4	1	12	–	–	1	–	–	18	0.3%
	Patient not reviewed	1	1	4	–	1	2	–	–	9	0.1%
	Mode of transport	2	–	2	–	–	–	–	–	4	0.1%
Discharge/transfer arrangements total		**31**	**9**	**83**	**6**	**5**	**14**	**–**	**1**	**149**	**2.5%**
Reports/certificates	Accuracy of report/certificate	89	20	8	4	–	2	–	–	123	2.0%
	Refusal to provide report/certificate	9	1	1	–	3	1	–	–	15	0.2%
	Report written with inadequate or no consultation	–	2	1	–	1	–	–	–	4	0.1%
	Timeliness of report/certificate	2	–	–	–	–	–	–	–	2	0.0%
	Cost of report/certificate	2	–	–	–	–	–	–	–	2	0.0%
Reports/certificates total		**102**	**23**	**10**	**4**	**4**	**3**	**–**	**–**	**146**	**2.4%**
Grievance processes	Inadequate/no response to complaint	36	6	23	1	3	4	2	3	78	1.3%
	Reprisal/retaliation as result of complaint lodged	8	–	1	–	–	–	1	–	10	0.2%
	Information about complaints procedures not provided	1	–	–	–	2	–	–	1	4	0.1%
Grievance processes total		**45**	**6**	**24**	**1**	**5**	**4**	**3**	**4**	**92**	**1.5%**
Grand total		**2,322**	**1,294**	**1,245**	**409**	**306**	**302**	**72**	**64**	**6,014**	**100.0%**

Counted by issues raised in complaint

Table 18.14 Outcome of assessment of complaints by service area 2009–10

Service area	Outcome								Total	
	Discontinued	Referred to registration board	Assisted resolution	Investigation	Resolved during assessment process	Conciliation	Referred to another body	Local resolution	No.	%
General medicine	464	151	95	83	58	9	15	5	880	25.1%
Dentistry	55	339	15	4	21	–	–	–	434	12.4%
Emergency medicine	94	19	108	27	30	27	–	11	316	9.0%
Surgery	85	24	103	15	22	30	1	3	283	8.1%
Mental health	125	10	61	11	8	6	1	11	233	6.6%
Aged care	47	24	21	4	2	3	12	–	113	3.2%
Psychology	49	43	2	8	2	–	–	–	104	3.0%
Obstetrics	24	8	38	1	8	14	–	–	93	2.6%
Pharmacy/pharmacology	7	59	–	3	3	–	2	–	74	2.1%
Medico-legal	58	12	–	1	–	–	–	–	71	2.0%
Administration	31	10	3	10	1	1	8	3	67	1.9%
Psychiatry	45	5	6	4	1	3	1	–	65	1.9%
Non-health related	19	10	1	4	3	–	2	1	40	1.1%
Drug and alcohol	23	1	3	2	4	1	4	–	38	1.1%
Cardiology	11	2	15	1	3	4	–	–	36	1.0%
Ambulance service	18	1	11	–	4	1	–	–	35	1.0%
Paediatric medicine	16	7	4	3	–	3	–	1	34	1.0%
Rehabilitation medicine	12	2	15	–	–	2	–	–	31	0.9%
Cosmetic services	25	–	1	1	1	3	–	–	31	0.9%
Radiology	21	2	5	2	–	–	–	–	30	0.9%
Dermatology	24	3	1	2	–	–	–	–	30	0.9%
Midwifery	7	12	5	3	–	2	–	–	29	0.8%
Gynaecology	20	3	1	–	2	2	–	–	28	0.8%
Chiropractice	10	11	–	6	–	1	–	–	28	0.8%
Neurology	7	1	11	2	1	3	–	–	25	0.7%
Physiotherapy	8	11	3	2	–	–	–	–	24	0.7%
Palliative care	6	2	12	–	–	3	–	–	23	0.7%
Optometry	12	4	3	–	4	–	–	–	23	0.7%
Anaesthesia	12	–	4	2	2	2	–	–	22	0.6%
Pathology	8	2	–	–	8	1	–	–	19	0.5%
Prosthetics and orthotics	5	7	2	1	3	–	–	–	18	0.5%
Radiography	9	–	4	–	5	–	–	–	18	0.5%
Geriatrics/gerontology	7	–	8	–	1	–	–	–	16	0.5%
Ophthalmology	10	–	4	–	1	–	–	–	15	0.4%
Intensive care	–	4	8	1	–	1	–	–	14	0.4%
Other/unknown	4	7	–	1	–	–	1	1	14	0.4%

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Table 18.14 Outcome of assessment of complaints by service area 2009-10 (continued)

Service area	Outcome								Total	
	Discontinued	Referred to registration board	Assisted resolution	Investigation	Resolved during assessment process	Conciliation	Referred to another body	Local resolution	No.	%
Urology	6	–	7	–	–	–	–	1	14	0.4%
Alternative health	4	1	–	2	1	–	5	–	13	0.4%
Oncology	5	–	7	–	–	1	–	–	13	0.4%
Pain management	6	–	2	–	1	–	–	1	10	0.3%
Respiratory/thoracic medicine	4	–	4	–	–	1	–	–	9	0.3%
Massage therapy	8	–	–	1	–	–	–	–	9	0.3%
Counselling	7	1	–	–	–	–	–	–	8	0.2%
Early childhood	2	–	2	4	–	–	–	–	8	0.2%
Podiatry	1	5	–	1	1	–	–	–	8	0.2%
Gastroenterology	3	–	2	1	1	–	–	1	8	0.2%
Infectious diseases	1	–	3	–	1	2	–	–	7	0.2%
Renal medicine	0	–	4	–	1	–	–	1	6	0.2%
Natural therapy	2	–	–	1	–	–	2	–	5	0.1%
Psychotherapy	2	1	–	2	–	–	–	–	5	0.1%
Traditional Chinese medicine	3	–	–	2	–	–	–	–	5	0.1%
Haematology	0	–	1	–	2	1	–	1	5	0.1%
Rheumatology	2	1	1	–	–	–	–	–	4	0.1%
Reproductive medicine	3	1	–	–	–	–	–	–	4	0.1%
Osteopathy	0	–	1	3	–	–	–	–	4	0.1%
Acupuncture	2	–	–	1	–	–	–	–	3	0.1%
Aviation medicine	1	–	–	1	–	–	–	–	2	0.1%
Endocrinology	1	–	1	–	–	–	–	–	2	0.1%
Forensic medicine	1	–	–	–	–	–	–	–	1	0.0%
Immunology	1	–	–	–	–	–	–	–	1	0.0%
Hydrotherapy	1	–	–	–	–	–	–	–	1	0.0%
Hypnotherapy	1	–	–	–	–	–	–	–	1	0.0%
Occupational health	1	–	–	–	–	–	–	–	1	0.0%
Sexual assault service	1	–	–	–	–	–	–	–	1	0.0%
Grand total	1,447	806	608	223	206	127	54	41	3,512	100.0%

Counted by provider identified in complaint

Table 18.15 Time taken to assess complaints 2005-06 to 2009-10

	2005-06	2006-07	2007-08	2008-09	2009-10
Percentage of complaints assessed within 60 days	55.6%	83.7%	88.2%	88.9%	82.3%
Average days to assess complaints	61	39	39	42	46

Counted by provider identified in complaint

Table 18.16 Requests for review of assessment decision 2005-06 to 2009-10

	2005-06 No.	2006-07 No.	2007-08 No.	2008-09 No.	2009-10 No.
Requests for review of assessment decision	393	284	230	281	278
Percentage of assessments finalised	11.6%	10.5%	8.0%	8.4%	7.9%

Counted by provider identified in complaint

Table 18.17 Outcome of reviews of assessment decision 2005-06 to 2009-10

	2005-06		2006-07		2007-08		2008-09		2009-10	
Review result	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Original assessment decision confirmed	345	89.8%	297	88.4%	216	89.3%	261	96.0%	252	94.4%
Assessment decision varied	39	10.2%	39	11.6%	26	10.7%	11	4.0%	15	5.6%
Total	**384**	100.0%	**336**	100.0%	**242**	100.0%	**272**	100.0%	**267**	100.0%

Counted by provider identified in complaint

Table 18.18 Outcome of assisted resolutions 2005-06 to 2009-10

		2005-06		2006-07		2007-08		2008-09		2009-10	
Outcome		**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Resolution did proceed											
Resolved	Resolved	256	47.7%	224	47.1%	228	38.9%	244	39.4%	216	39.1%
	Partially resolved	138	25.7%	116	24.4%	124	21.2%	167	26.9%	119	21.5%
Not Resolved	Not resolved	58	10.8%	50	10.5%	81	13.8%	103	16.6%	99	17.9%
Resolution did proceed total		**452**	**84.2%**	**390**	**81.9%**	**433**	**73.9%**	**514**	**82.9%**	**434**	**78.5%**
Resolution did not proceed		85	15.8%	86	18.1%	153	26.1%	106	17.1%	119	21.5%
Grand total		**537**	100.0%	**476**	100.0%	**586**	100.0%	**620**	100.0%	**553**	100.0%

Counted by provider identified in complaint

Table 18.19 Time taken to complete resolution process 2005-06 to 2009-10

Time taken to complete	2005-06		2006-07		2007-08		2008-09		2009-10	
	No.	%	No.	%	No.	%	No.	%	No.	%
1-30 days	153	28.5%	77	16.1%	128	21.8%	159	25.6%	119	21.5%
1-2 months	146	27.2%	132	27.7%	163	27.8%	164	26.5%	144	26.0%
2-3 months	93	17.3%	85	17.8%	98	16.7%	91	14.7%	86	15.6%
3-4 months	62	11.5%	59	12.4%	62	10.6%	62	10.0%	62	11.2%
4-5 months	34	6.3%	40	8.4%	53	9.0%	44	7.1%	37	6.7%
5-6 months	22	4.1%	29	6.1%	22	3.8%	34	5.5%	34	6.1%
6-7 months	9	1.7%	16	3.4%	16	2.7%	25	4.0%	31	5.6%
7-9 months	10	1.9%	15	3.2%	24	4.1%	23	3.7%	21	3.8%
9-12 months	8	1.5%	17	3.6%	18	3.1%	11	1.8%	15	2.7%
>12 months	–	0.0%	6	1.3%	2	0.3%	7	1.1%	4	0.7%
Total	537	100.0%	476	100.0%	586	100.0%	620	100.0%	553	100.0%

Counted by provider identified in complaint

Table 18.20 Outcome of conciliations 2005-06 to 2009-10

Outcome	Reason	2005-06		2006-07		2007-08		2008-09		2009-10	
		No.	%	No.	%	No.	%	No.	%	No.	%
Conciliation process did proceed											
Resolved	Agreement reached at conciliation meeting	49	32.9%	89	35.3%	63	30.4%	43	18.9%	26	18.2%
	Complaint resolved with the assistance of the Registry	–	0.0%	15	6.0%	17	8.2%	15	6.6%	6	4.2%
Not Resolved	Consent withdrawn	3	2.0%	30	11.9%	25	12.1%	34	14.9%	20	14.0%
	The conciliation was helpful in clarifying concerns	n/a	0.0%	n/a	0.0%	10	4.8%	27	11.8%	8	5.6%
	Parties did not reach agreement at conciliation meeting	4	2.7%	32	12.7%	16	7.7%	10	4.4%	6	4.2%
Total conciliation process did proceed		56	37.6%	166	65.9%	131	63.3%	129	56.6%	66	46.2%
Conciliation process did not proceed											
	Conciliation did not proceed	77	51.7%	81	32.1%	75	36.2%	99	43.4%	77	53.8%
	Complaint resolved prior to conciliation	16	10.7%	5	2.0%	1	0.5%	–	0.0%	–	0.0%
Total conciliation process did not proceed		93	62.4%	86	34.1%	76	36.7%	99	43.4%	77	53.8%
Grand total		149	100.0%	252	100.0%	207	100.0%	228	100.0%	143	100.0%

Counted by provider identified in complaint

Table 18.21 Time taken to complete conciliation process 2005-06 to 2009-10

Time taken to complete	2005-06		2006-07		2007-08		2008-09		2009-10	
	No.	%	No.	%	No.	%	No.	%	No.	%
1-30 days	14	9.4%	4	1.6%	15	7.2%	11	4.8%	18	12.6%
1-2 months	19	12.8%	46	18.3%	32	15.5%	58	25.4%	28	19.6%
2-3 months	24	16.1%	44	17.5%	32	15.5%	45	19.7%	31	21.7%
3-4 months	25	16.8%	42	16.7%	29	14.0%	26	11.4%	27	18.9%
4-5 months	18	12.1%	32	12.7%	16	7.7%	11	4.8%	10	7.0%
5-6 months	12	8.1%	16	6.3%	13	6.3%	19	8.3%	8	5.6%
6-7 months	12	8.1%	18	7.1%	13	6.3%	7	3.1%	5	3.5%
7-9 months	8	5.4%	28	11.1%	12	5.8%	6	2.6%	4	2.8%
9-12 months	7	4.7%	10	4.0%	18	8.7%	23	10.1%	4	2.8%
>12 months	10	6.7%	12	4.8%	27	13.0%	22	9.6%	8	5.6%
Total	149	100.0%	252	100.0%	207	100.0%	228	100.0%	143	100.0%

Counted by provider identified in complaint

Table 18.22 Outcome of investigations 2005-06 to 2009-10

Investigation result		2005-06		2006-07		2007-08		2008-09		2009-10	
		No.	%	No.	%	No.	%	No.	%	No.	%
Health organisation	Comments or recommendations	50	54.3%	50	54.3%	55	65.5%	39	63.9%	33	94.3%
	No further action	42	45.7%	42	45.7%	29	34.5%	22	36.1%	2	5.7%
Health organisation total		92	100.0%	92	100.0%	84	100.0%	61	100.0%	35	100.0%
Health practitioner	Referred to Director of Proceedings	66	19.1%	112	38.8%	129	50.8%	100	50.0%	141	59.5%
	Referred to registration board	62	17.9%	36	12.5%	35	13.8%	36	18.0%	44	18.6%
	No further action	147	42.5%	101	34.9%	63	24.8%	45	22.5%	32	13.5%
	Comments to practitioner	49	14.2%	38	13.1%	24	9.4%	16	8.0%	14	5.9%
	Public statement/ prohibition order	n/a	0.0%	n/a	0.0%	n/a	0.0%	2	1.0%	4	1.7%
	Referred to Director of Public Prosecutions	22	6.4%	2	0.7%	3	1.2%	1	0.5%	2	0.8%
Health practitioner total		346	100.0%	289	100.0%	254	100.0%	200	100.0%	237	100.0%
Grand total		438	100.0%	381	100.0%	338	100.0%	261	100.0%	272	100.0%

Counted by provider identified in complaint

Table 18.23 Investigations into health organisations and health practitioners finalised 2005-06 to 2009-10

		2005-06		2006-07		2007-08		2008-09		2009-10	
	Description	No.	%	No.	%	No.	%	No.	%	No.	%
Health organisations	Public hospital	65	70.7%	63	68.5%	63	75.0%	46	75.4%	30	85.7%
	Private hospital	10	10.9%	7	7.6%	6	7.1%	4	6.6%	2	5.7%
	Area health service	1	1.1%	–	0.0%	3	3.6%	3	4.9%	2	5.7%
	Aged care facility	5	5.4%	8	8.7%	4	4.8%	2	3.3%	1	2.9%
	Pathology centre/lab	–	0.0%	–	0.0%	1	1.2%	2	3.3%	–	0.0%
	Dental facility	–	0.0%	–	0.0%	–	0.0%	1	1.6%	–	0.0%
	Drug and alcohol service	2	2.2%	2	2.2%	–	0.0%	1	1.6%	–	0.0%
	Medical centre	4	4.3%	1	1.1%	1	1.2%	1	1.6%	–	0.0%
	Radiology practice	1	1.1%	1	1.1%	1	1.2%	1	1.6%	–	0.0%
	Ambulance service	1	1.1%	2	2.2%	–	0.0%	–	0.0%	–	0.0%
	Other/unknown	–	0.0%	–	0.0%	2	2.4%	–	0.0%	–	0.0%
	Community health service	1	1.1%	2	2.2%	1	1.2%	–	0.0%	–	0.0%
	Correction and detention facility	2	2.2%	–	0.0%	2	2.4%	–	0.0%	–	0.0%
	Supported accommodation services	–	0.0%	1	1.1%	–	0.0%	–	0.0%	–	0.0%
	Medical practice	–	0.0%	5	5.4%	–	0.0%	–	0.0%	–	0.0%
	Health organisation total	**92**	**100.0%**	**92**	**100.0%**	**84**	**100.0%**	**61**	**100.0%**	**35**	**100.0%**
Health practitioners	Medical practitioner	191	55.2%	175	60.6%	150	59.1%	112	56.0%	149	62.9%
	Nurse/midwife	113	32.7%	68	23.5%	75	29.5%	69	34.5%	53	22.4%
	Pharmacist	2	0.6%	2	0.7%	2	0.8%	–	0.0%	12	5.1%
	Chiropractor	3	0.9%	3	1.0%	3	1.2%	1	0.5%	6	2.5%
	Dentist	2	0.6%	11	3.8%	2	0.8%	1	0.5%	3	1.3%
	Physiotherapist	2	0.6%	2	0.7%	2	0.8%	1	0.5%	3	1.3%
	Psychologist	9	2.6%	17	5.9%	9	3.5%	6	3.0%	3	1.3%
	Dental technician and prosthetist	1	0.3%	–	0.0%	–	0.0%	–	0.0%	2	0.8%
	Administration/clerical staff	–	0.0%	–	0.0%	–	0.0%	–	0.0%	1	0.4%
	Alternative health provider	17	4.9%	–	0.0%	6	2.4%	1	0.5%	1	0.4%
	Massage therapist	n/a	0.0%	n/a	0.0%	–	0.0%	1	0.5%	1	0.4%
	Natural therapist	–	0.0%	2	0.7%	–	0.0%	–	0.0%	1	0.4%
	Psychotherapist	–	0.0%	1	0.3%	–	0.0%	1	0.5%	1	0.4%
	Traditional Chinese medicine practitioner	–	0.0%	7	2.4%	–	0.0%	–	0.0%	1	0.4%
	Acupuncturist	1	0.3%	–	0.0%	–	0.0%	–	0.0%	–	0.0%
	Ambulance personnel	–	0.0%	–	0.0%	2	0.8%	–	0.0%	–	0.0%
	Assistant in nursing	1	0.3%	–	0.0%	–	0.0%	–	0.0%	–	0.0%
	Homeopath	n/a	0.0%	n/a	0.0%	n/a	0.0%	1	0.5%	–	0.0%
	Naturopath	–	0.0%	–	0.0%	2	0.8%	–	0.0%	–	0.0%
	Optometrist	1	0.3%	–	0.0%	–	0.0%	1	0.5%	–	0.0%
	Osteopath	–	0.0%	–	0.0%	–	0.0%	1	0.5%	–	0.0%
	Podiatrist	2	0.6%	–	0.0%	1	0.4%	2	1.0%	–	0.0%
	Radiographer	–	0.0%	–	0.0%	–	0.0%	2	1.0%	–	0.0%
	Social worker	1	0.3%	1	0.3%	–	0.0%	–	0.0%	–	0.0%
	Health practitioner total	**346**	**100.0%**	**289**	**100.0%**	**254**	**100.0%**	**200**	**100.0%**	**237**	**100.0%**
	Grand total	**438**	**100.0%**	**381**	**100.0%**	**338**	**100.0%**	**261**	**100.0%**	**272**	**100.0%**

Counted by provider identified in complaint

Table 18.24 Investigations finalised by issue category 2005-06 to 2009-10

Category	2005-06		2006-07		2007-08	
	No.	%	No.	%	No.	%
Treatment	297	52.5%	271	60.8%	237	57.2%
Professional conduct	203	35.9%	129	28.9%	141	34.1%
Communication	15	2.7%	23	5.2%	19	4.6%
Access	22	3.9%	5	1.1%	10	2.4%
Consent	4	0.7%	4	0.9%	6	1.4%
Privacy/discrimination	4	0.7%	4	0.9%	1	0.2%
Costs	6	1.1%	5	1.1%	–	0.0%
Corporate services	8	1.4%	4	0.9%	–	0.0%
Grievances	2	0.4%	1	0.2%	–	0.0%
Miscellaneous	5	0.9%	–	0.0%	–	0.0%
Total	566	100.0%	446	100.0%	414	100.0%

	2008-09		2009-10	
	No.	%	No.	%
Treatment	196	45.6%	223	41.4%
Professional conduct	148	34.4%	171	31.7%
Medication	28	6.5%	57	10.6%
Communication/ information	23	5.3%	41	7.6%
Medical records	7	1.6%	16	3.0%
Discharge/transfer arrangements	6	1.4%	12	2.2%
Consent	4	0.9%	7	1.3%
Environment/ management of facilities	9	2.1%	6	1.1%
Grievance processes	8	1.9%	3	0.6%
Fees/costs	–	0.0%	2	0.4%
Reports/certificates	–	0.0%	1	0.2%
Access	1	0.2%	–	0.0%
Total	430	100.0%	539	100.0%

Counted by issues raised in complaint

Table 18.25 Outcome of investigations finalised by profession and organisation type 2009–10

Health practitioner															Total	
Outcome	Medical practitioner	Nurse/midwife	Pharmacist	Chiropractor	Dentist	Physiotherapist	Psychologist	Dental technician and prosthetist	Administration/ clerical staff	Alternative health practitioner	Massage therapist	Natural therapist	Psychotherapist	Traditional Chinese medicine practitioner	No.	%
Referred to Director of Proceedings	91	32	7	4	2	2	3	–	–	–	–	–	–	–	141	59.5%
Referred to registration board	26	12	3	2	–	1	–	–	–	–	–	–	–	–	44	18.6%
No further action	20	8	1	–	1	–	–	–	1	–	–	–	–	1	32	13.5%
Comments to practitioner	10	1	1	–	–	–	–	–	–	–	–	1	1	–	14	5.9%
Prohibition order/public statement	–	–	–	–	–	–	–	2	–	1	1	–	–	–	4	1.7%
Referred to Director of Public Prosecutions	2	–	–	–	–	–	–	–	–	–	–	–	–	–	2	0.8%
Total	149	53	12	6	3	3	3	2	1	1	1	1	1	1	237	100.0%

Health organisation				Total	
Outcome	Hospital	Area Health Service	Aged care facility	No.	%
Recommendations	27	1	1	29	82.9%
Comments	4	–	–	4	11.4%
No further action	1	1		2	5.7%
Total	32	2	1	35	100.0%

Counted by provider identified in complaint

Table 18.26 Requests for review of investigation decision 2005–06 to 2009–10

	2005-06 No.	2006-07 No.	2007-08 No.	2008-09 No.	2009-10 No.
Review requests of investigations received	24	18	15	4	2
Percentage of investigations finalised	5.5%	4.7%	4.4%	1.5%	0.7%

Counted by provider identified in complaint

Table 18.27 Outcome of reviews of investigation decision 2005-06 to 2009-10

Outcome	2005-06		2006-07		2007-08		2008-09		2009-10	
	No.	%	No.	%	No.	%	No.	%	No.	%
Original investigation decision confirmed	27	93.1%	21	91.3%	15	100.0%	5	83.3%	2	100.0%
Reopened for investigation	2	6.9%	2	8.7%	–	0.0%	1	16.7%	–	0.0%
Total	29	100.0%	23	100.0%	15	100.0%	6	100.0%	2	100.0%

Counted by provider identified in complaint

Table 18.28 Time taken to complete investigations 2005-06 to 2009-10

Time taken to complete	2005-06		2006-07		2007-08		2008-09		2009-10	
	No.	%	No.	%	No.	%	No.	%	No.	%
< 6 months	96	21.9%	55	14.4%	62	18.3%	66	25.3%	64	23.5%
6-12 months	174	39.7%	211	55.4%	169	50.0%	145	55.6%	153	56.3%
12-18 months	76	17.4%	97	25.5%	90	26.6%	38	14.6%	43	15.8%
18-24 months	65	14.8%	14	3.7%	16	4.7%	12	4.6%	9	3.3%
24-30 months	18	4.1%	3	0.8%	1	0.3%	–	0.0%	2	0.7%
30-36 months	7	1.6%	–	0.0%	–	0.0%	–	0.0%	1	0.4%
>36 months	2	0.5%	1	0.3%	–	0.0%	–	0.0%	–	0.0%
Total	438	100.0%	381	100.0%	338	100.0%	261	100.0%	272	100.0%
Average days	352		318		309		274		278	

Counted by provider identified in complaint

Table 18.29 Open complaints as at 30 June 2010

Category	2005-06		2006-07		2007-08		2008-09		2009-10	
	No.	%	No.	%	No.	%	No.	%	No.	%
Open assessments	334	28.5%	342	33.2%	583	45.7%	597	58.4%	566	49.4%
Open investigations	322	27.5%	286	27.8%	215	16.9%	165	16.1%	184	15.6%
Open resolutions	155	13.3%	137	13.3%	152	11.9%	78	7.6%	169	14.8%
Open complaints in legal	171	14.6%	129	12.5%	209	16.4%	114	11.2%	160	14.0%
Open assessment reviews	82	7.0%	28	2.7%	18	1.4%	25	2.4%	35	3.1%
Open conciliations	98	8.4%	105	10.2%	95	7.5%	42	4.1%	30	2.6%
Open investigation reviews	8	0.7%	3	0.3%	3	0.2%	1	0.1%	1	0.1%
	1,170	100.0%	1,030	100.0%	1,275	100.0%	1,022	100.0%	1,145	100.0%

Counted by provider identified in complaint

Appendix B – List of expert advisers

The Commission would like to thank its expert advisers below. In addition, the Commission would also like to thank those experts who provided phone advice throughout the year that helped to clarify clinical issues during the assessment of complaints.

Dr Richard **Abbott**
Dr Ion **Alexander**
Dr Roger **Allan**
Dr Stephen **Allnutt**
Ms Deborah **Armitage**
Dr Mark **Arnold**
Mr John **Baker**
Dr Michael **Baldwin**
Dr Gary **Banks**
Professor David **Barnes**
Dr Hani **Bittar**
Dr Peter **Bland**
Professor Elie Leslie **Bokey**
Mr Sam **Borenstein**
Dr David **Bowers**
Professor Bruce **Brew**
Dr Geoffrey **Brodie**
Dr Andrew **Brooks**
Dr Jeremy **Bunker**
Dr Richard **Burns**
Dr Andrew **Byrne**
Mrs Janice **Caldwell**
Ms Jann **Capizzi**
Mr William **Cearns**
Dr Daniel **Challis**
Dr Harry **Champion**
Professor Richard **Chard**
Miss Kate **Chellew**
Dr Andrew **Child**
Dr Ian **Chung**
Mr Peter **Cleasby**
Ms Vanessa **Clements**
Professor Paul **Colditz**
Mr Albert **Coleiro**
Mrs Helen **Cooke**
Ms Anne **Cooper**
Dr Marcela **Cox**
Ms Allison **Cummins**
Dr John **Curotta**
Mr Eric **Daniels**
Professor David **Davies**
Dr Robert **Day**
Dr Michael **Delaney**
Mr Christopher **Derkenne**
Professor Hugh **Dickson**
Dr Glenys **Dore**
Ms Jasmin **Douglas**
Dr Iain **Dunlop**
Ms Maureen **Edgtton-Winn**
Dr Frederick **Ehrlich**
Dr David **Eizenberg**
Ms Jeanette **Eldridge**
Dr Jeannie **Ellis**
Mr Roger **Engel**
Dr John **England**
Dr David **Farlow**
Dr Diana **Farlow**
Professor Glen **Farrow**
Mr John **Ferguson**
Professor John **Fletcher**
Ms Vikki **Fogarty**
Dr Anthony **Freeman**
Professor Gordian **Fulde**
Dr Paul **Gaudry**
Mrs Marianne **Gaul**
Dr Mark **Gianoutsos**
Dr Margaret **Gibbons**
Dr Michael **Giblin**
Dr Jonathan **Gillis**
Mrs Alison **Goodfellow**
Ms Maxine **Goodman**
Ms Amanda **Gordon**
Professor James **Greenwood**
Mrs Sue **Greig**
Ms Kathrine **Grover**
Professor David **Handelsman**
Dr John **Harkness**
Mr Steven **Harris**
Ms Bethne **Hart**
Dr Keith **Hartman**
Dr Ray **Hayek**
Mr Antony **Heath**
Dr Paul **Hendel**
Dr Ralph **Higgins**
Dr Peter **Holman**
Dr Herbert **Hooi**
Dr Craig **Hore**
Mr Allan **Hudson**
Dr Carole **Hungerford**
Mrs Sarah **Hunstead**
Ms Lee-Ann **Jackson**
Dr Walid **Jammal**
Ms Andrea **Jordan**
Ms Blanche **Kairies**
Dr Jeffrey **Keir**
Dr Adrian **Keller**
Professor Dianna **Kenny**
Dr Timothy **Keogh**
Dr Emery **Kertesz**
Dr Suresh **Khatri**
Mr Raymond **Khoury**
Mr David **Kitching**
Professor Leon **Kleinman**
Dr Peter **Klug**
Ms Diana **Knagge**
Dr Mary **Langcake**
Ms Janine **Learmont**
Dr Vinoo **Lele**
Dr Michael **Levitt**
Dr Edward **Loughman**
Mr Ashton **Lucas**
Dr Sara **Lucas**
Mr Stuart **Ludington**
Dr Peter **Lye**
Dr Kenneth **Mackey**
Dr Colin **Macleod**
Professor Guy **Maddern**
Mr Philip **Major**
Dr Linda **Mann**
Ms Carol **Martin**
Dr Hugh **Martin**
Ms Kerri **Masters**
Ms Toni **McCallum Pardey**
Dr Sally **McCarthy**
Dr Sallyann **McCarthy**
Professor William **McCarthy**
Dr Michael **McGlynn**
Mr John **McGuire**
Mr Bernard **McNair**
Dr Alan **Meagher**
Ms Rebekkah **Middleton**
Dr Geoffrey **Mifsud**
Ms Helen **Miller**
Dr Janelle **Miller**
Dr Peter **Morse**
Dr Muniswami **Mudaliar**
Ms Christine **Muller**
Dr Raymond **Mullins**
Ms Donna **Muscardin**
Dr Gregory **Nelson**
Dr Harry **Nespolon**
Ms Robin **Norton**
Professor Lynne **Oliver**
Mr Brendan **O'Loughlin**
Dr Matthew **O'Meara**
Ms Sonya **Otte**
Ms Michelle **Parker**
Dr Julian **Parmegiani**
Dr Martyn **Patfield**
Mr Francis **Payne**
Professor Roger **Pepperell**
Dr Jeffrey **Post**
Dr Jennifer **Prowse**
Professor Carolyn **Quadrio**
Dr John **Quinn**
Dr Geoffrey **Ramin**
Ms Patricia **Reynolds**
Ms Jenifer **Richardson**
Dr Adam **Rish**
Dr Wendy **Roberts**
Dr Patricia (Patsy) **Robertson**
Ms Janette **Robinson**
Dr Tuly **Rosenfeld**
Dr William **Ross**
Ms Nadime **Roumieh**
Ms Robyn **Rudner**
Professor Richard **Ruffin**
Dr Anthony **Samuels**
Ms Suzanne **Samuels**
Dr Raymond **Seidler**
Dr Diana **Semmonds**
Mr Stephen **Seymour**
Dr Gabriel **Shannon**
Ms Nerralie **Shaw**
Ms Rosalee **Shaw**
Mr Warren **Shaw**
Dr John **Sippe**
Dr George **Skowronski**
Dr John **Slaughter**
Dr Graydon **Smith**
Dr Oscar **Stanley**
Dr Michael **Steiner**
Ms Helen **Stevens**
Dr Janine **Stevenson**
Dr Michael **Suranyi**
Dr Joanna **Sutherland**
Ms Sally **Sutherland-Fraser**
Dr Deniz **Tek**
Dr Kenneth **Tiver**
Dr Tom **Tseng**
Dr Christopher **Vickers**
Dr Martine **Walker**
Dr Bernard **Walsh**
Dr James **Walter**
Mrs Rachel **Weeks**
Ms Elvina **Weissel**
Mr Adam **Whitby**
Mr Lawrence **Whitman**
Professor Ian **Wilcox**
Dr Cholmondeley **Williams**
Mr Michael **Williamson**
Dr Deborah **Yates**
Dr Simon **Young**
Dr Rasiah **Yuvarajan**
Mr Shijing **Zhang**
Ms Jennifer **Zwart**

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Appendix D – List of charts

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