HEALTH CARE
COMPLAINTS
COMMISSION

Health Care Complaints Commission

Annual Report 2012-13

Contact the Commission

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Disclaimer

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

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01 Letter of submission

HEALTH CARE COMPLAINTS COMMISSION

The Hon Jillian Skinner MP
Minister for Health
Minister for Medical Research
Level 31, Governor Macquarie Tower
1 Farrer Place
Sydney NSW 2000

Dear Minister

Report of activities for the year ended 30 June 2013

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 2013 for presentation to the NSW Parliament.

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

Yours faithfully

Kieran Pehm
Commissioner

02 About the Commission

Aims and objectives

The Commission was established by the *Health Care Complaints Act* as an independent body to protect the health and safety of the public by dealing with complaints about health service providers in NSW, including:

- registered health practitioners, such as medical practitioners, nurses and dental practitioners
- unregistered health practitioners, such as naturopaths, massage therapists and alternative health care providers
- health organisations, such as 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 or safety
- takes action in relation to unregistered health practitioners
- prosecutes serious complaints against registered health practitioners.

The Commission also informs the public and its stakeholders about its work.

Guiding principles

The *Health Care Complaints Act* provides a set of principles that require the Commission to:

- be accountable
- be open and transparent in its decision making
- maintain an acceptable balance between the rights and interests of clients and health service providers
- be effective in protecting the public from harm
- strive to improve efficiency
- be flexible and responsive.

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

Code of Practice

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

Stakeholders

The Commission's diverse stakeholders fall into three broad categories.

The first category, health consumers and the community, includes:

- 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 second category, health service providers, covers:

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

The third category, NSW government stakeholders, includes:

- the Parliament and its Committee on the Commission
- the Minister for Health
- the Ministry of Health
- Local Health Districts
- the Clinical Excellence Commission
- other public sector agencies.

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03 Commissioner's foreword

The provision of health services can be very complex. The public's expectations of health service providers, and the amount of trust placed in them, are high.

When expectations are not met, and poor outcomes are suffered, patients and their families can often be angry and frustrated.

Complaints about health service providers have increased by 35.5% over the past five years from 3,360 in 2008-09 to 4,554 this year.

The Commission uses a great part of its resources explaining to complainants why, despite their unsatisfactory experience, no disciplinary action against a health service provider can reasonably be taken. Often the Commission assists them to come to terms with their situations through various resolution processes.

Due to an injection of extra funding, the Commission has been able to improve the level of its service, which is reflected in the complainant's satisfaction with the assessment of complaints, as reported in returned satisfaction surveys, which increased from 47.2% last year to 73.7% this year. Even where the Commission's decision was to take no further action after assessing the relevant material, most complainants were satisfied with the process because Commission staff acted professionally and explained the reasons for the decisions made. The Commission's Resolution Service recorded a satisfaction rate of 78.2% from complainants.

At the same time, the Commission continued to identify, investigate and prosecute, where warranted, cases which involve significant risks to public health and safety. The system for dealing with complaints in New South Wales is unique in Australia, in that the Commission is responsible for investigating and prosecuting serious complaints. Recent legislation has strengthened the Commission's role, and provided the power to initiate its own complaints. The importance of an independent complaints body in protecting public health and safety has now been recognised in Queensland which is in the process of establishing a similar system.

In this complex and challenging complaint-handling environment, the Commission's greatest asset is its staff. The nature of the work requires Commission officers to exercise strong analytical skills, judgement, sensitivity and discretion on a daily basis. Commission staff have my thanks and gratitude for their professionalism in managing expectations and identifying significant issues requiring action to protect the public.

Kieran Pehm
Commissioner

04 Executive summary

The 2012-13 year has been a busy and successful year for the Commission.

Additional funding allowed the Commission to employ more staff to deal with the continued increase in the number of inquiries and written complaints the Commission received. While inquiries increased by 2.2% on the 2011-12 year, the number of written complaints increased by 10.3% in the same period. Since June 2012, mandatory notifications have been deemed by law to be complaints. Taking this into account the effective increase in complaints from last year was 5.9%.

All written complaints are assessed by the Commission and considerable improvement was made in the timeliness and quality of assessments during the year.

94.5% of assessments were finalised within the statutory 60-day period, which is 10% more than a couple of years ago. The average time it took to assess a complaint reduced by three days to 40 days. The performance is reported in Chapter 09 – Assessing complaints.

The Commission's Resolution Service had a 16.1% increase in complaints referred to it after the initial assessment. Despite this increase, performance remained at a high level. Chapter 10 – Resolving complaints summarises the work of that branch.

The Investigations Division closed 89.6% of its investigations within 12 months. This was a slight decrease from the previous year (2011-12: 91.0%).

The Legal Division managed increasingly complex matters and procedural complications also increased. 95.7% of Commission prosecutions were successful. The outcomes of prosecutions are reported in Chapter 12 – Prosecuting complaints.

Legal change

During the year, the *Health Care Complaints Act* was amended, broadening the circumstances under which the Commission could investigate the conduct of health services. In addition, the Commission was given an own motion power to initiate complaints against health service providers involving serious issues.

A set of guiding principles for the Commission's work was included in the Act. These principles are summarised in Chapter 02 – About the Commission.

Other amendments addressed a number of procedural issues, which will allow the Commission to provide a more efficient, responsive and effective service in future. A summary of all legal changes is included in Chapter 14 – Governance.

Financial summary

The Commission's net result before capital was a surplus of $12,000, which was $266,000 higher than budgeted. Income was higher than budgeted $236,000, which came mainly from recovered legal costs, and savings to employee-related expenses, including a long service leave actuarial adjustment of $75,000.

The full financial statements for both the Health Care Complaints Commission and the Office of the Health Care Complaints Commission are included in chapter 15 of this report.

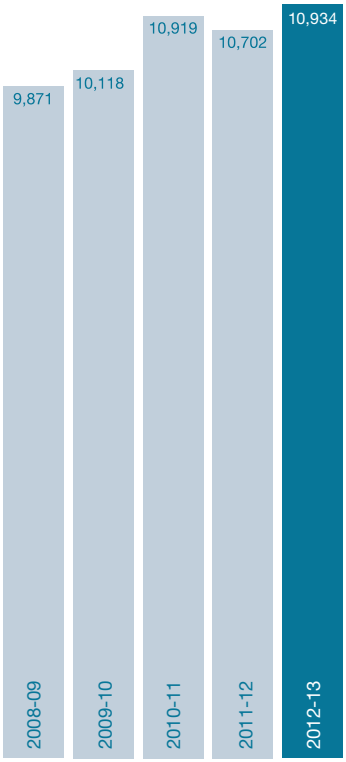
Corporate goals

The Commission's performance, measured against its corporate goals for 2012-13, is summarised in Appendix A and throughout this report:

- Comprehensive and responsive complaints handling – Chapters 9 and 10
- Investigating serious complaints – Chapter 11
- Prosecuting serious complaints – Chapter 12
- Being accountable – Chapter 5
- Continuously improving the Commission – Chapter 14.

The Commission's key complaints data over the last five years is summarised on the following pages.

Executive summary



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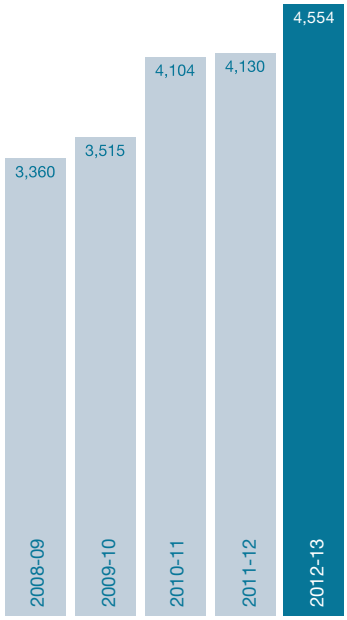

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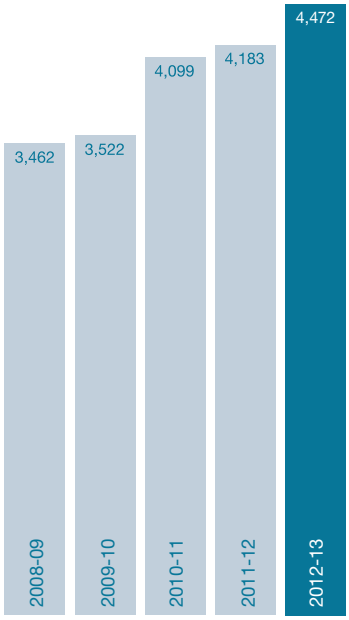


Counted by provider identified in complaint

Inquiries

Often when people are thinking about making a complaint, they contact the Commission's Inquiry Service for a confidential discussion.

Staff of the Inquiry Service can advise people how they may resolve their concerns directly with the relevant health service provider, or can assist them to put their concerns in writing.

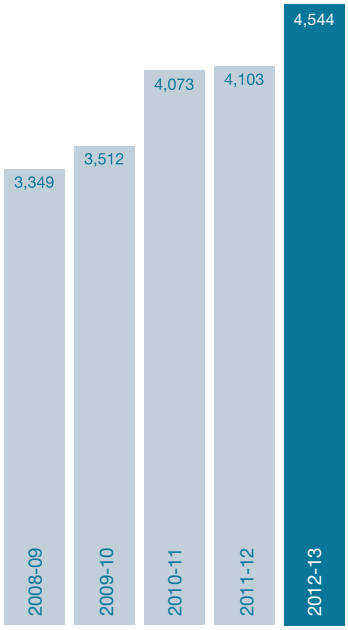
In 2012-13, the Commission received 10,934 inquiries, 2.2% more than in the previous year.

Written complaints

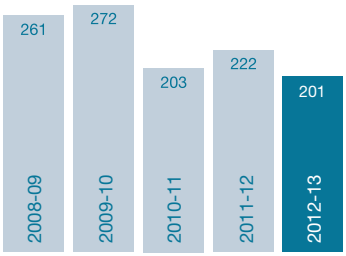
In 2012-13, the Commission saw a 10.3% increase in the number of written complaints it received, compared to last year. This can partially be attributed to the legal deeming of mandatory notifications as complaints, which came into force in June 2012.

Complaints finalised

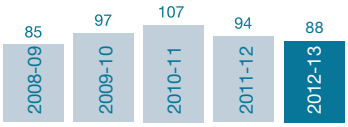
During 2012-13, the Commission finalised 4,472 complaints, which is an increase of 6.9% on last year. The number is broadly consistent with the number of incoming complaints.



Counted by provider identified in complaint



Counted by provider identified in complaint



Counted by matter

Assessments finalised

The Commission assessed 4,544 complaints in 2012-13 keeping up with the number of incoming complaints.

94.5% of complaints were assessed within the statutory 60-day period in 2012-13, compared to 88.1% in the previous year. The average days taken to assess a complaint decreased from 43 days last year to 40 days in 2012-13.

Investigations finalised

In 2012-13, 209 complaints were referred to the Investigations Division. During the same period, 201 investigations were finalised with an increasing number of registered health practitioners being referred to the relevant health professional council to take appropriate action.

Legal matters finalised

The Legal Division finalised 88 matters in 2012-13. The overall success rate of prosecutions before Professional Standards Committees and Tribunals was 95.7%.

There were an additional three matters where the disciplinary bodies made their findings, but, as at 30 June 2013, the appropriate protective orders had yet to be determined.

05 Outreach and accountability

Performance in 2012-13

CORPORATE GOAL
'to promote complaint resolution services to people across NSW'

59 presentations

Commission staff gave 59 presentations and workshops to community and health professional groups across NSW (target 60).

CORPORATE GOAL
'to report publicly about the work of the Commission'

Annual Report on time and fully compliant

The Commission's annual report for 2011-12 was tabled in both houses of Parliament on 22 November 2012. It was fully compliant with the Treasury annual report checklist.

Audited financial statements

Unqualified 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 2 October 2012.

5,485 items of information material distributed

The Commission distributed information material during its outreach presentations and provided fact sheets to parties to a complaint during the complaint process. In addition, it distributed 5,485 items (2011-12: 61,209) on request from health service providers, consumers or other organisations (target: 20,000).

In May 2012, the Commission distributed its updated material to all Local Health Districts and as a result did not receive a great number of requests for information material from public health facilities during the 2012-13 year.

Almost seven million website hits

The Commission recorded 184,045 visitors (2011-12: 145,915); 894,561 page views and 6,808,569 hits (2011-12: 5,601,709) on its website, exceeding its target of 100,000 visitors and four million hits.

100% compliant with requirement to publish disciplinary decisions

The Commission published 83 media releases, of which 75 related to decisions of disciplinary bodies, as required under its legislation.

CORPORATE GOAL
'to provide timely, accurate and relevant reporting to the Minister and the Parliamentary Committee'

Reporting on performance

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.

Response to Minister in less than six days on average

The Commission provided 51 responses to correspondence received by the Minister that were due during the year, of which 96.1% were provided within 14 days (target 90%).
On average, the requested information was provided within 5.1 days. In the previous year, 36 responses were provided, in an average of 8.4 days, and with 86.1% of these within 14 days.

Timely responses to Joint Parliamentary Committee

The Commission provided five written responses to the Joint Parliamentary Committee on the Health Care Complaints Commission, all within the requested timeframe. The Commissioner appeared at two public hearings before the Committee.

The Commission raises awareness about its role and functions, and the services it provides to gain and maintain the confidence of the public and its stakeholders.

Being accessible

On its website, the Commission offers information about its services and how to access these. The complaint form is available in 20 community languages.

Information is also available through the website of the NSW Multicultural Health Communication Service.

When dealing with inquiries and complaints, bi-lingual Commission staff can assist clients in their native language. In addition, the Commission regularly uses telephone, oral and written interpreter services.

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

People with an intellectual disability and people with low literacy levels have access to a simple illustrated fact sheet about how to make a complaint.

The Commission's information film 'What happens with health care complaints' was updated and is available in the Australian sign language AUSLAN, as well as with Arabic and Chinese subtitles. The Commission received a certificate of commendation for this resource at the 2013 NSW Multicultural Health Awards. The film was promoted to media, targeting Arabic and Chinese communities in NSW, as well as the Local Health Districts.

Raising awareness

To increase awareness of the role of the Commission among health consumers and health professionals, the Commission gave 59 presentations to community groups and health service providers about the Commission's functions and services. This included three training sessions for expert advisers who provide advice to assist the Commission's investigations of health service providers and who may be called as expert witnesses in disciplinary proceedings.

It also included six webinars for health consumers and health practitioners that cover specific topics relevant to them.

The Commission distributed information material during its outreach presentations and provided fact sheets to parties to a complaint during the complaint process. In addition, it distributed about 5,485 items on request from health service providers, consumers or other organisations. The Commission relies increasingly on its website and the promotion of its resources to relevant stakeholder groups to enhance awareness among potential and actual clients. The Commission has improved its electronic service delivery to provide easy access to complainants. In 2012-13, for the first time, the Commission received more than half of its complaints by email or people using its online complaint form.

The Commission published 83 media releases, of which 75 related to decisions of disciplinary bodies, as required under its legislation. In addition, the Commission published its decisions in relation to unregistered health practitioners where the investigation found that they breached the code of conduct for unregistered health practitioners and that they posed a risk to public health and safety.

The Commission also provided 21 articles and reports to health professional and health consumer bodies, and media. This included the Commissioner's column for the 'Australian Doctor', a publication widely read by general practitioners.

Providing better information

In 2012-13, the Commission completed an upgrade of its website to increase accessibility and make it easier to use from mobile devices.

It also reviewed and updated all website content and incorporated comments from consumer groups it had consulted.

The website has a broad range of information for health consumers and health service providers, including new fact sheets for all parties involved in a complaint. These provide relevant and targeted information about Commission's decision at certain points during the complaint process. The fact sheets are also sent with the Commission's decision letters to explain how the process works and what to expect next.

Outreach and accountability

Working together

A particular focus of the Commission's outreach activities continued to be its relationships with the Local Health Districts. The Commissioner and senior staff met with the senior Executive of all Local Health Districts and Specialty Networks between May and December 2012. These visits were often paired with a targeted half-day training program for complaint-handling staff about responding to and resolving patient complaints. The Commission delivered 16 workshops across NSW.

Building on these workshops, a series of webinars has been developed and started in February 2013. The bi-monthly webinars cover topics including the role of the Commission, responsive complaint handling, boundary issues and mandatory reporting requirements. The webinars have attracted an increasing number of participants and feedback has been overwhelmingly positive.

One Local Health District commented:

'There has been a lot of interest in the webinars; they are an excellent resource for our health professionals and having them available through our HealthTube for staff has been invaluable. It is wonderful to have access to such high calibre speakers/expertise.'

The webinars are open to any health service providers and have been promoted to health practitioners through the Local Health Districts, Specialty Networks, professional colleges and the Health Education and Training Institute (HETI).

When dealing with complaints, the Commission also regularly consults with the various professional councils, registration bodies, the Ministry of Health and the Local Health Districts.

Where the Commission made recommendations to a health service to improve systems, it also provided a copy of these to the Clinical Excellence Commission to support their work on systemic improvement. Two staff attended auditor training provided by the Clinical Excellence Commission in preparation for its own audits of recommendations that were made to health services after a formal investigation.

The Commission continued its engagement in the health literacy network together with its partner organisations, including the Clinical Excellence Commission, the Australian Commission on Quality and Safety in Health Care and the University of Sydney's School of Public Health.

The Commission works closely with other health complaints bodies. In 2012-13, the Commissioner attended a meeting of the Australian and New Zealand health complaints commissioners in Adelaide. The Director of Assessments and Resolution attended a complementary meeting of senior operational staff of complaint bodies in Canberra to discuss emerging issues and best practice approaches in complaint-handling.

During the year, the Commission was approached by the Australian Health Practitioner Regulation Agency as well as the Queensland Department of Health to discuss best practice complaint-handling. The Commission continues its work with both bodies sharing the NSW experience.

Being responsive

Understanding the concerns of health consumers and health service providers is very important for the Commission. It regularly reviews comments from people who lodged a complaint as well as health service providers who were involved in a complaint about their experience with the Commission's services. The Commission uses this feedback to train staff and set relevant priorities in the way it delivers its services. The results of its satisfaction surveys are included in Chapter 9 – Assessing complaints and Chapter 10 – Resolving complaints.

In addition, the Commission's quarterly Consumer Consultative Committee provides heath consumer organisations with the opportunity to raise current issues and provide valuable feedback on the Commission's work. Member organisations are:

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

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

Research projects

The Commission continued its support of relevant research projects, including:

- an ongoing project by the Australian National University and the University of Sydney looking at quality and safety improvements resulting from complaint investigations.
- A research project conducted by the University of Melbourne looking at whether medical practitioners with certain characteristics are more likely to be subject to complaints.
- A five-part research project comparing complaint-handling in NSW to other Australian jurisdictions. This project is run by the University of Sydney in cooperation with the Australian Health Practitioner Regulation Agency, the National Boards and the NSW Health Professional Councils.

In addition, the Commission provides ad-hoc advice and statistical data to smaller research projects, on request.

The year ahead

In 2013-14, The Commission will continue its involvement in various research studies relating to the project comparing the NSW complaint handling-system to other jurisdictions.

The Commission is also continuing its series of webinars, which are recorded to establish a library of audiovisual resources that can be accessed on the Commission's website.

The Commission will focus its outreach activities in 2013-14, on working both with people from non-English speaking backgrounds and Aboriginal health staff. More information about activities in Aboriginal outreach can be found in chapter 14 – under the heading 'Aboriginal affairs'.

06 Complaint process

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

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

All complaints are assessed to decide the most appropriate way to deal with the issues raised in the complaint.

The Commission may ask the health service provider to respond to the complaint. Where clinical issues are involved, the Commission may obtain health records and seek advice from internal medical or nursing advisers.

Where the complaint is about a registered practitioner, the Commission must consult with the relevant professional council about the most appropriate outcome.

The possible outcomes of the assessment are:

1

The Commission can **refer** a complaint about a registered practitioner to the relevant **professional council** to consider taking action such as counselling, performance assessment or action regarding impairment.

2

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 obtain relevant evidence.

3

In some cases, the Commission can refer the complaint **to another body** that is more suitable to deal with the issues of concern. For example, a complaint about conditions in a nursing home can be referred to the Commonwealth Department of Health and Ageing's Aged Care Complaints Scheme.

4

Complaints may be **resolved during the assessment process**, where the person who made the complaint is satisfied with the information and explanation that the health service provider gives in their response to the complaint, or where the Commission's Assessment Officer is able to negotiate a resolution to the complaint.

5

Complaints can also be referred to the Commission's **Resolution Service**. A Resolution Officer can assist the parties to resolve any outstanding issues. In some cases, an independent conciliator facilitates a meeting.

Complaint process

6

Some complaints about a public health organisation that do not raise serious issues of public health and safety can be referred back to the organisation to **try to resolve the matter locally** with the complainant, if the organisation agrees to this.

7

The Commission **formally investigates** complaints that raise a significant issue of public health or safety, or, if substantiated, would provide grounds for disciplinary action against a registered health practitioner.

Where the Commission investigated a complaint, it may:

8

Issue a prohibition order, public statement and/or public warning. A prohibition order can ban or limit an unregistered health practitioner from providing any or some health services. The practitioner must advise potential clients of any limitations imposed before treating them. A breach of the order is a criminal offence. The Commission usually makes a public statement about prohibition orders it issues. The Commission can also issue a public warning where it has found a treatment or health service to be unsafe.

9

Refer the complaint to a professional council to take action, including assessing the registered practitioner's performance or health, or counselling them about their conduct.

10

Refer the complaint about a registered practitioner to the Director of Proceedings who independently determines whether or not it should be prosecuted before a disciplinary body. When making this determination, the Director of Proceedings 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 decides not to prosecute a matter, it is usually referred back to the Commissioner to consider other appropriate action.

Complaints about unsatisfactory professional conduct will usually be prosecuted before a Professional Standards Committee, while complaints about professional misconduct will be prosecuted before a Tribunal.

11

Make comments. The Commission makes comments to registered health practitioners where there has been poor care or treatment, but not to an extent that would justify prosecution.

Comments can also be made to an unregistered health practitioner where there has been a breach of the Code of Conduct for Unregistered Health Practitioners, but there is no risk to public health or safety.

Comments to a health organisation are made in cases where the health care provided was inadequate, but the organisation has already taken measures to prevent a similar occurrence in the future.

12

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

13

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

14

Make recommendations to a health organisation where there has been poor health service delivery and systemic improvements should be made. The Commission also provides its recommendations to the Director-General of the Ministry of Health and the Clinical Excellence Commission, to inform their work in improving health services.

The Commission monitors whether its recommendations to a health organisation have been implemented. If the Commission is not satisfied with the implementation, it may, ultimately, make a special report to Parliament.

Where a registered health practitioner has been prosecuted:

15

A Professional Standards Committee or Tribunal that finds a complaint **proven** can reprimand, fine and/or impose conditions on the practitioner. Only a Tribunal can suspend or cancel the registration of a practitioner. The Tribunal may also issue a prohibition order that bans or limits the practitioner from practising in another area of health service – for example, a psychiatrist whose registration is cancelled can be banned from working as a counsellor.

07 Trends in complaints

The Commission classifies complaints in different ways. It records the issues that are raised by the person who makes the complaint; the type of health service provider complained about and the type of health service the complaint relates to.

Information about the issues, provider and service area, as well as information about how the Commission dealt with the complaint, are useful in identifying trends in complaints.

This information enables the Commission to provide feedback to health service providers to improve service delivery.

The Commission receives complaints about both individual health practitioners and health organisations, and some complaints involve a number of practitioners and organisations. Sometimes, a range of issues is raised about one single health service provider.

Complaint numbers in perspective

It is important to recognise that Commission data is not a comprehensive indicator of the overall standard of health care delivery in NSW. Often, complaints are addressed by the relevant health service provider directly without the Commission being involved. The number of complaints to the Commission is relatively small considering the volume of services provided.

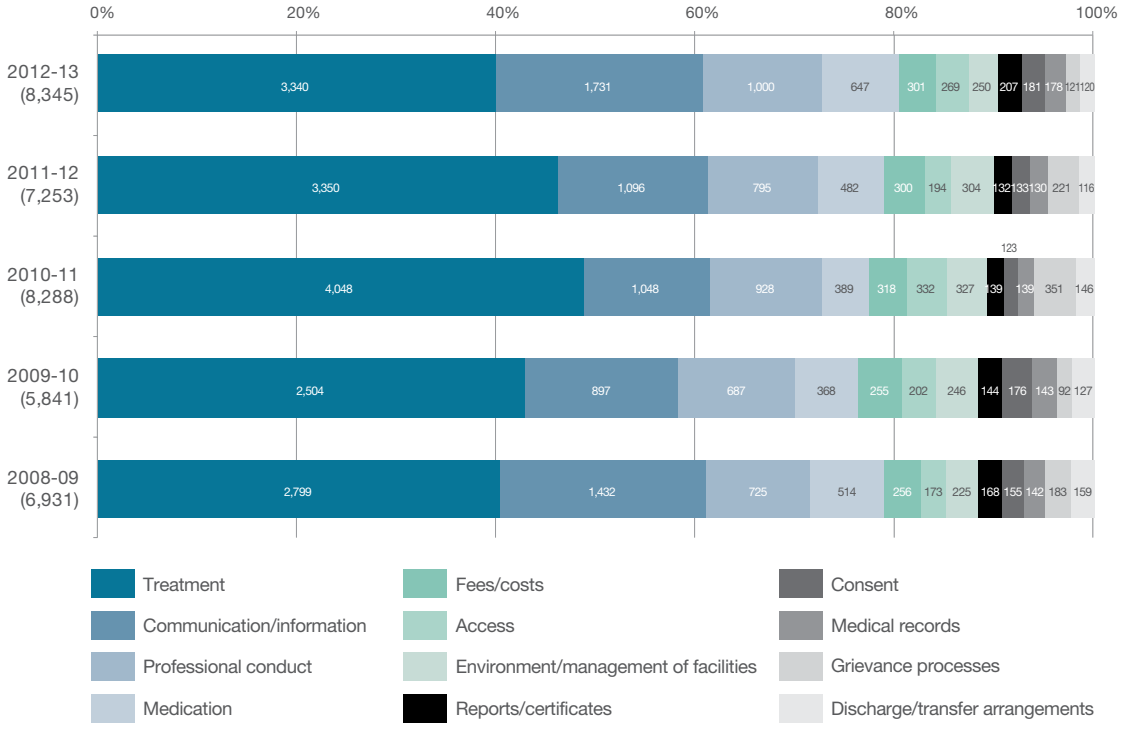
Issues raised in complaints

In 2012-13, the Commission received 4,554 complaints raising 8,345 issues – an average of 1.8 issues per complaint, the same as the year before.

Chart 6.1 shows the issues raised in complaints over the last five years. The increase in the number of issues corresponds to the increase in the number of complaints the Commission received over this period. On average, the Commission recorded between 1.7 (2009-10) and 2.1 (2008-09) issues per complaint during this five year period.

In 2012-13, the three most common issue categories were treatment (40.0%), communication (20.7%), and the professional conduct of the health service provider (12.0%). Compared to the previous year, this represents a slight fall in the proportion of treatment issues (-6.2%), and an increase in the proportions of communication (+5.6%) and professional conduct issues (+1.0%).

Chart 6.1 – Issues raised in all complaints received 2008-09 to 2012-13



Counted by issues raised in complaint

A detailed breakdown of all issues in complaints received in 2012-13 is included in table 16.2 in Appendix B of this report.

In the category treatment, the most common issues were inadequate treatment (55.3%, +8.9% from 2011-12), diagnosis (11.0%, -2.5% from 2011-12), and unexpected treatment outcomes or complications (7.9%, -1.7% from 2011-12). Other common treatment related issues were delay in treatment (5.9%), inadequate care (5.5%), and inappropriate consultation (4.6%).

The majority of communication and information related issues (58.5%, -11.8% from 2011-12) concerned the attitude and manner of the health practitioner. Other issues in this category related to incorrect (22.0%) or inadequate (18.3%) information provided by the health service provider. In a small number of cases (1.2%), the complaint was about special needs of a patient not being accommodated.

Within the third most common category of issues - professional conduct - most complaints related to a practitioner possibly suffering from an impairment (16.0%, +6.7% from 2011-12), the practitioner's competence (14.7%, +0.5% from 2011-12), or illegal practices (13.5%, -2.1% from 2011-12). Breach of a professional guideline by a health practitioner constituted 11.5% (+0.4% from 2011-12) of professional conduct issues, followed by sexual misconduct (9.6%), and inappropriate disclosure of patient information (8.1%).

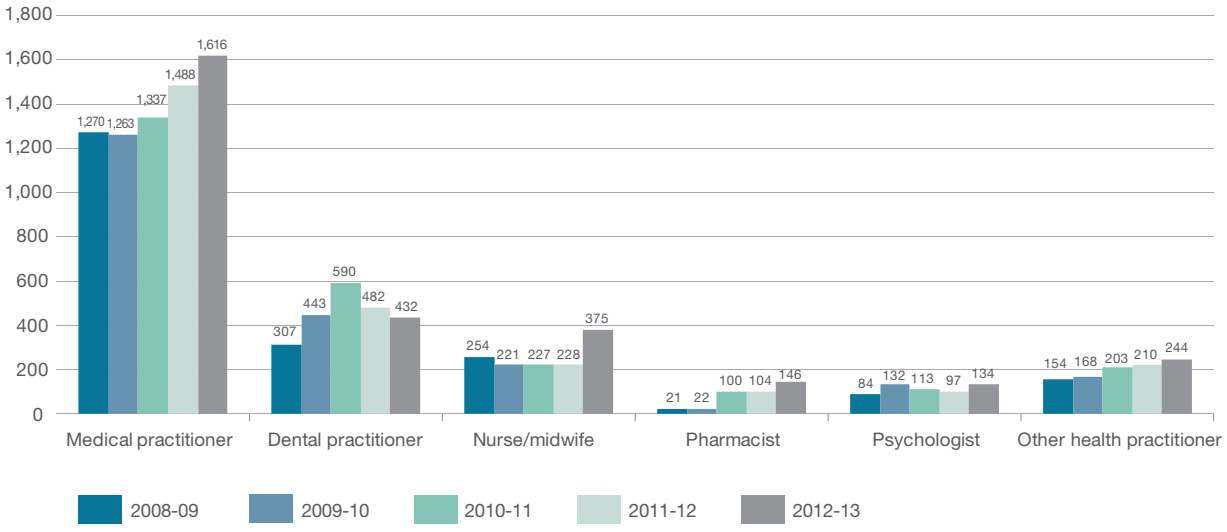
Complaints about health practitioners

Chart 6.2 shows the number of complaints about individual health practitioners received by the Commission in the past five years. For more professions, please refer to table 16.3 in Appendix B of this report.

In 2012-13, the Commission received 2,947 complaints about individual health practitioners, 13.0% more than in the previous year.

Medical practitioners, dental practitioners, nurses and midwives, pharmacists and psychologists were the health professions most commonly complained about. Complaints about these professions accounted for 91.7% of all complaints about individual practitioners in 2012-13.

Chart 6.2 – Complaints received about health practitioners 2008-09 to 2012-13



Counted by provider identified in complaint

Trends in complaints

Complaints about medical practitioners were the most common. In 2012-13, the Commission received 1,616 complaints about medical practitioners, an 8.6% increase on the 1,488 complaints received in the previous year. Complaints about medical practitioners made up 54.8% of all complaints about health practitioners in 2012-13, which is slightly less than the five year average of 56.2%.

In 2012-13, complaints about medical practitioners most commonly related to general medicine (43.7%), surgery (13.2%), medico-legal services (5.0%), mental health care (4.6%) and psychiatry (4.0%). Complaints about these areas accounted for 70.5% of all complaints about medical practitioners during the year. The high proportion of general medicine related complaints reflects the high number of patient-practitioner interactions in the primary health care sector. Surgery attracts complaints when complications or poor outcomes are suffered that can have a great impact on the patient's life.

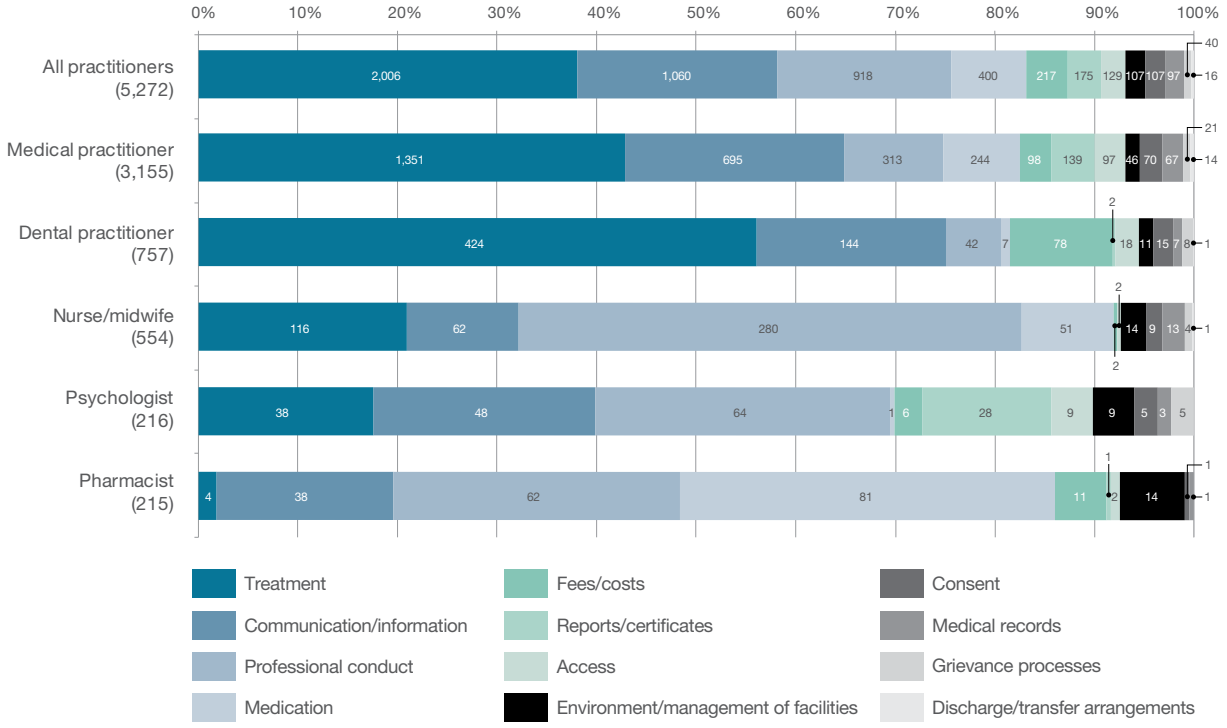
A more detailed breakdown of complaints about medical practitioners by service area over a five year period is included in table 16.4 in Appendix B of the report.

The Commission received 432 complaints about dental practitioners during the year, a 10.4% decrease from the previous year. This trend may be attributed to the end of the Medicare dental scheme in late 2012. That scheme gave people with chronic illness access to free dental treatment, and attracted a range of complaints to the Commission in the previous years.

In 2012-13, the Commission received 375 complaints about nurses and midwives, a significant increase of 64.5% from the year before. This increase was mainly driven by mandatory notifications made to the Australian Health Practitioner Regulation Agency and referred to the Commission, which are now deemed to be complaints.

The Commission received 146 complaints about pharmacists in 2012-13, a 40.4% increase from the previous year. Since 2010-11, the Commission has improved its process for identifying individual providers in pharmacy complaints, in order to be able to build a history on individual practitioners.

Chart 6.3 – Issues raised in complaints received about medical practitioners, dental practitioners, nurses and midwives, psychologists and pharmacists 2012-13



Counted by issues raised in complaint

The Commission received 134 complaints about psychologists in 2012-13, a 38.1% increase from the 97 received in the previous year. The increase in complaints about psychologists mainly came from patients and family members and most commonly related to communication issues.

Issues raised about health practitioners

Chart 6.3 sets out the types of issues raised in complaints about medical practitioners, dental practitioners, nurses and midwives, psychologists and pharmacists, compared to all practitioners in 2012-13.

Compared to all practitioners, treatment issues were more prominent in complaints about dental practitioners (56.0%) and medical practitioners (42.8%).

The proportion of treatment related complaints was relatively low for nurses and midwives (20.9%), presumably because of the nature of their interaction with patients. Nurses and midwives had the highest proportion of complaints about professional conduct among all health practitioners (50.5%). These complaints often raised issues of impairment, competence, or illegal practice. This category also includes complaints about a breach of an applicable guideline or law, or financial fraud.

Communication issues were commonly raised in complaints across all professions, but were raised less frequently in complaints about nurses and midwives.

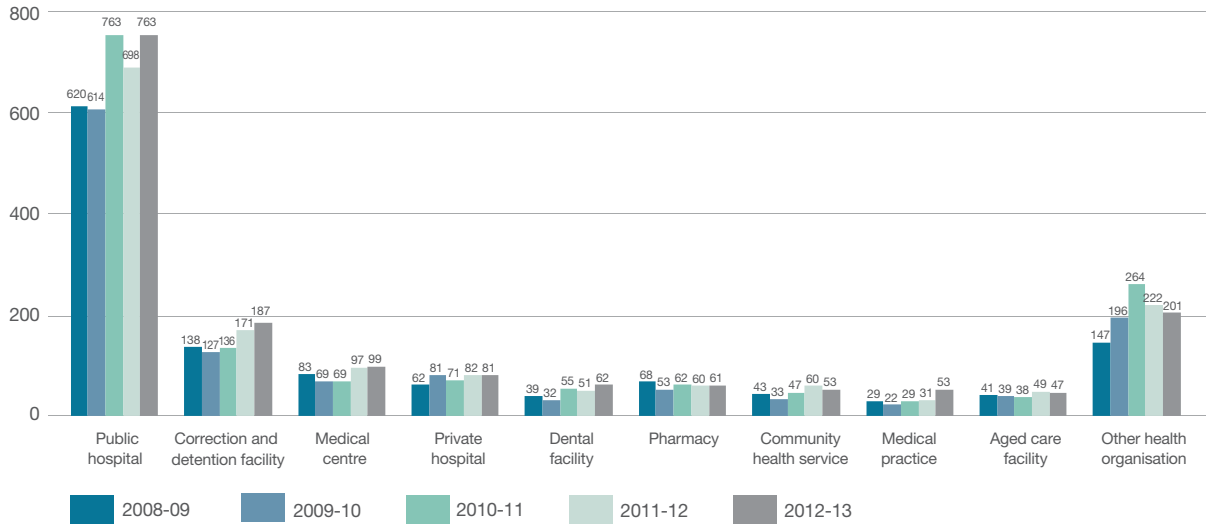
Complaints about fees and costs were more likely to be made against dental practitioners than any other profession, accounting for 10.3% of all issues raised about this health profession.

Complaints about health organisations

Chart 6.4 shows the number of complaints received about health organisations over the last five years.

In 2012-13, the Commission received 1,607 complaints about health organisations, a 5.7% increase on the previous year.

Chart 6.4 – Complaints received about health organisations 2008-09 to 2012-13



Counted by provider identified in complaint

Trends in complaints

Complaints about public hospitals increased by 9.3% in 2012-13. The high number of complaints about public hospitals is a reflection of the volume and nature of patient services provided in the public system. Complaints about public hospitals most commonly related to emergency medicine (27.1%), surgery (16.0%) and mental health care (14.5%).

Emergency medicine and surgery are higher risk areas where complications and unexpected treatment outcomes can be more prevalent.

Mental health care in public hospitals includes involuntary admissions, which are commonly the subject of complaints by patients or their family and carers.

The number of complaints about correction and detention facilities also increased by 9.4% in the 2012-13 year, while the number relating to medical centres remained stable compared to the previous year.

A five-year breakdown of complaints about other types of health organisations can be found in table 16.8 in Appendix B of this report.

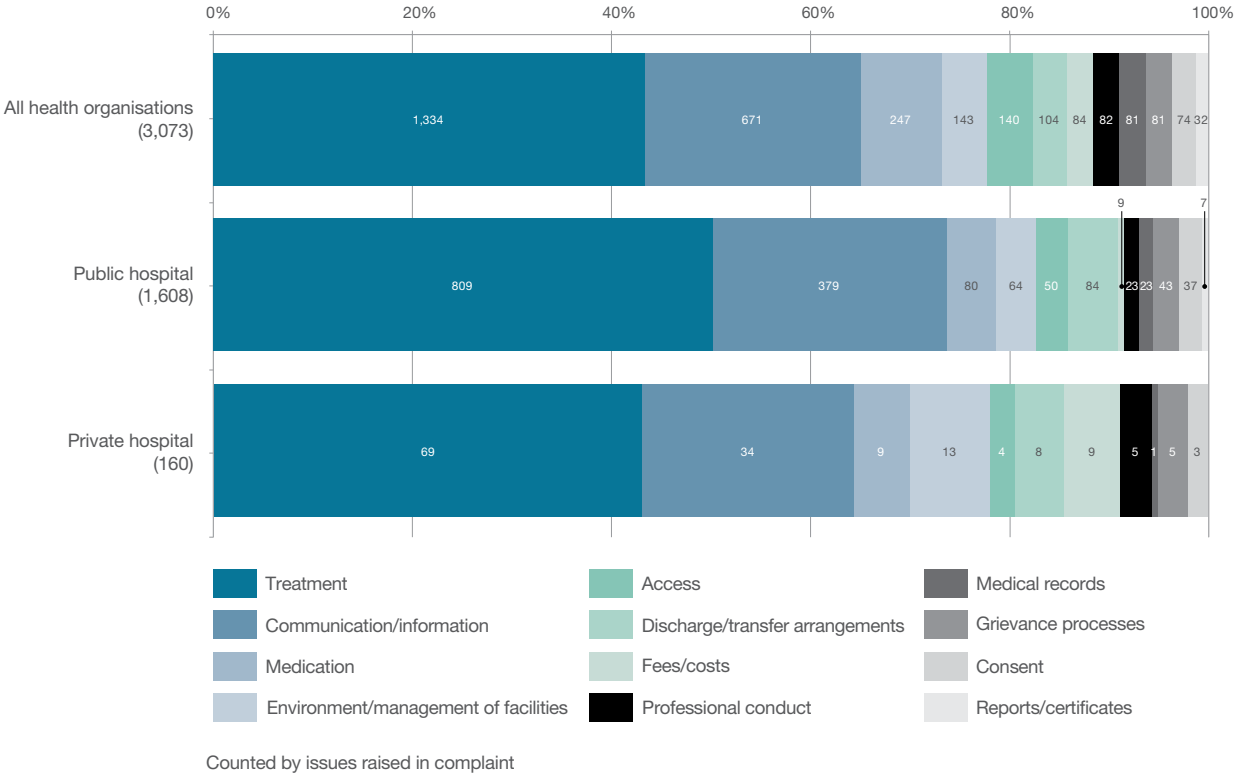
Issues raised in complaints about hospitals

Chart 6.5 shows a breakdown of the issues raised in complaints about public and private hospitals compared to all health organisations in 2012-13.

Issues relating to treatment accounted for over half of the complaints about public hospitals and 43.1% of all complaints about private hospitals.

Communication and information related issues were slightly more common in complaints about public hospitals (23.6%) compared to private hospitals (21.3%). Complaints about the environment and management of the facility were more common in relation to private hospitals (8.1%) than public hospitals (4.0%). This may reflect different expectations of private patients.

Chart 6.5 – Issues raised in complaints received about public and private hospitals 2012-13



Counted by issues raised in complaint

Complaints by service area

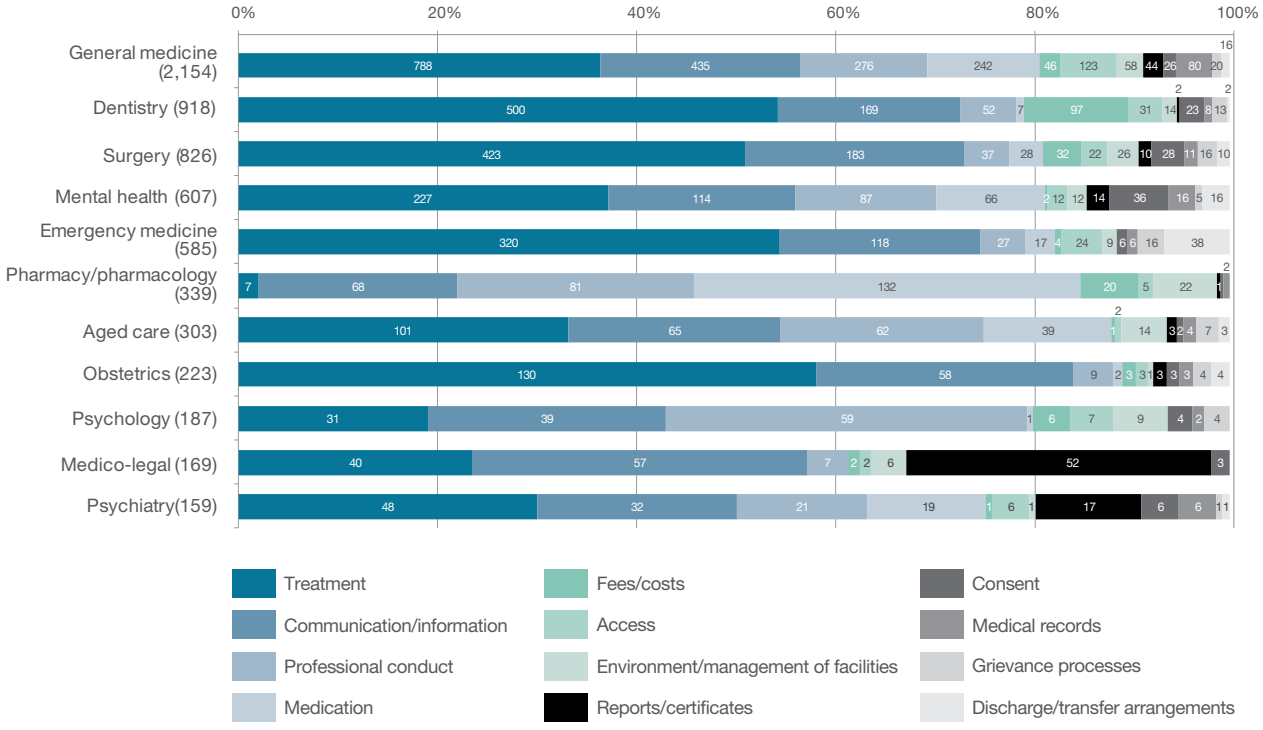
Chart 6.6 shows a breakdown of issues raised in complaints by the area in which the health service was provided.

Treatment issues, which were the most prevalent overall, were most commonly raised in complaints about obstetrics (58.3%), emergency medicine (54.7%), dentistry (54.5%) and surgery (51.2%).

Communication issues constituted the second biggest group of complaints and were most common in complaints about medico-legal services (33.7%). Medico-legal services can give rise to complaints, as the practitioner assesses the patient to form an opinion about their condition rather than to treat them. The practitioner's opinion is intended for the information of an insurer and can therefore be perceived by the patient as biased.

Complaints about professional conduct were most common in relation to psychology services (31.6%). Psychologists are often involved as expert witnesses in legal proceedings, or provide medico–legal reports for such proceedings. In such circumstances, complainants question the practitioner's competence, allege that the practitioner has inappropriately disclosed information and claim bias.

Chart 6.6 – Issues raised in complaints received by most common service area 2012-13



Counted by issues raised in complaint

How the Commission dealt with complaints

When the Commission receives a written complaint, the complaint must be assessed. If the complaint contains sufficient information, the Commission may make its assessment without further inquiries. Where more information is required, the Commission may seek a response from the relevant health service provider, and obtain internal medical or nursing advice about clinical issues.

The aim of the assessment is to determine whether a complaint raises serious issues of public health and safety warranting investigation. Where this is not the case, the Commission has a variety of other options available to address the issues raised in the complaint.

Outcome of assessment by service area

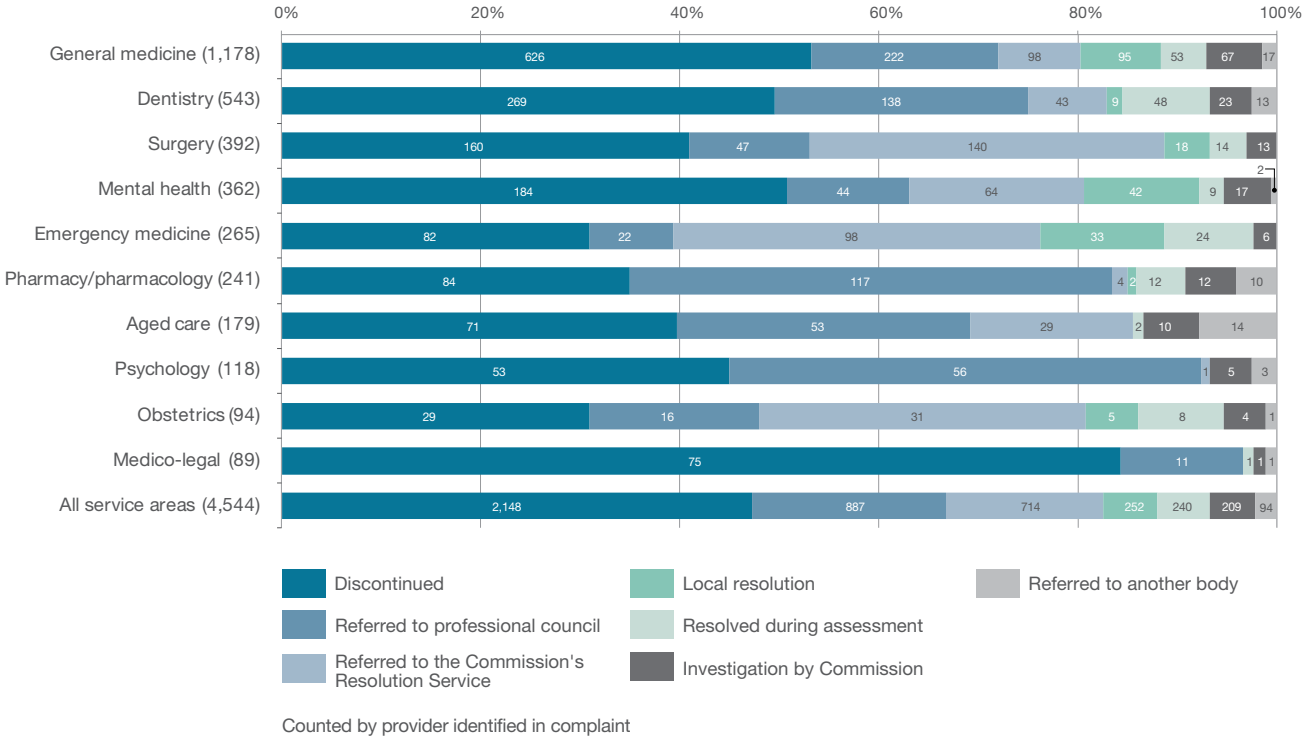
Chart 6.7 looks at the outcome of the assessment of complaints in 2012-13 by the area in which the service was provided.

Complaints about medico-legal services were often discontinued (84.3%) as the complaint assessment identified no significant issues of public health and safety.

Complaints about emergency medicine (37.0%), surgery (35.7%) and obstetrics (33.0%) were often referred to the Commission's Resolution Service. The Resolution Service can help people who have made a complaint to receive better information and explanations from the health service provider to understand what happened in their health care and why.

Complaints relating to pharmacy/ pharmacology (48.5%) and psychology (47.5%) were often referred to the relevant health professional council for appropriate action, such as counselling the practitioner, or inquiring into their performance or health.

Chart 6.7 – Outcome of assessment of complaints by service area 2012-13



Counted by provider identified in complaint

Outcome of assessment by type of health service provider

Another way to analyse how the Commission deals with complaints is to look at the outcome of the assessment of complaints by the type of health service provider, as set out in Chart 6.8.

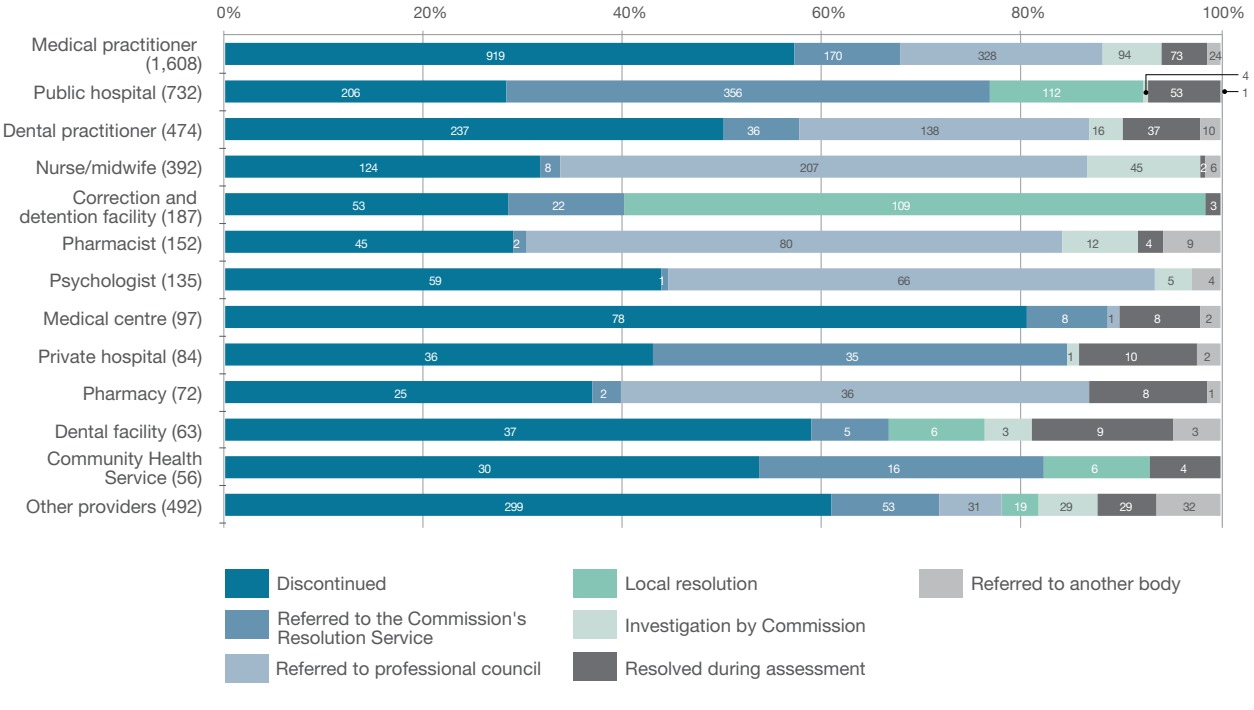
In 2012-13, medical practitioners were the most commonly complained about health service provider. The majority of complaints about medical practitioners were either discontinued (57.2%) or referred to the Medical Council of NSW for appropriate action (20.4%).

A relatively high proportion of complaints about public (48.6%) and private hospitals (41.7%) was referred to the Commission's Resolution Service, which can assist in obtaining further information and explanations to help the person who made the complaint understand the care and treatment provided. Public hospitals are often the only service provider available to the person who has made a complaint and it is important to help restore their confidence in the health service.

58.3% of complaints about medical services for prisioners in correction and detention facilities were referred for local resolution. This is often the fastest and most appropriate way to address complaints that do not raise serious issues of public health and safety, but still need to be resolved. Local resolution is not available for complaints about private health service providers.

The highest proportion of complaints referred for formal investigation was against nurses and midwives (11.5%). Many of these complaints arose from internal investigations conducted by the nurse or midwife's employer, which had identified significant concerns about the nurse or midwife's professional conduct.

Chart 6.8 – Outcome of assessment of complaints by type of health service provider 2012-13



Counted by provider identified in complaint

Trends in complaints

Outcome of assessment by the type of issue raised

Chart 6.9 summarises all assessment decisions made by the Commission in 2012-13 by the type of issue raised in the complaint.

Among the complaints referred to the Commission's Resolution Service, treatment related issues were most common (58.3%). This reflects the fact that often patients and their families do not fully understand the reasons for a particular treatment, and further information and explanation can help them resolve their concerns.

Issues relating to the professional conduct of a health practitioner were most prominent in complaints that were referred for formal investigation (49.8%), or to another body (47.0%).

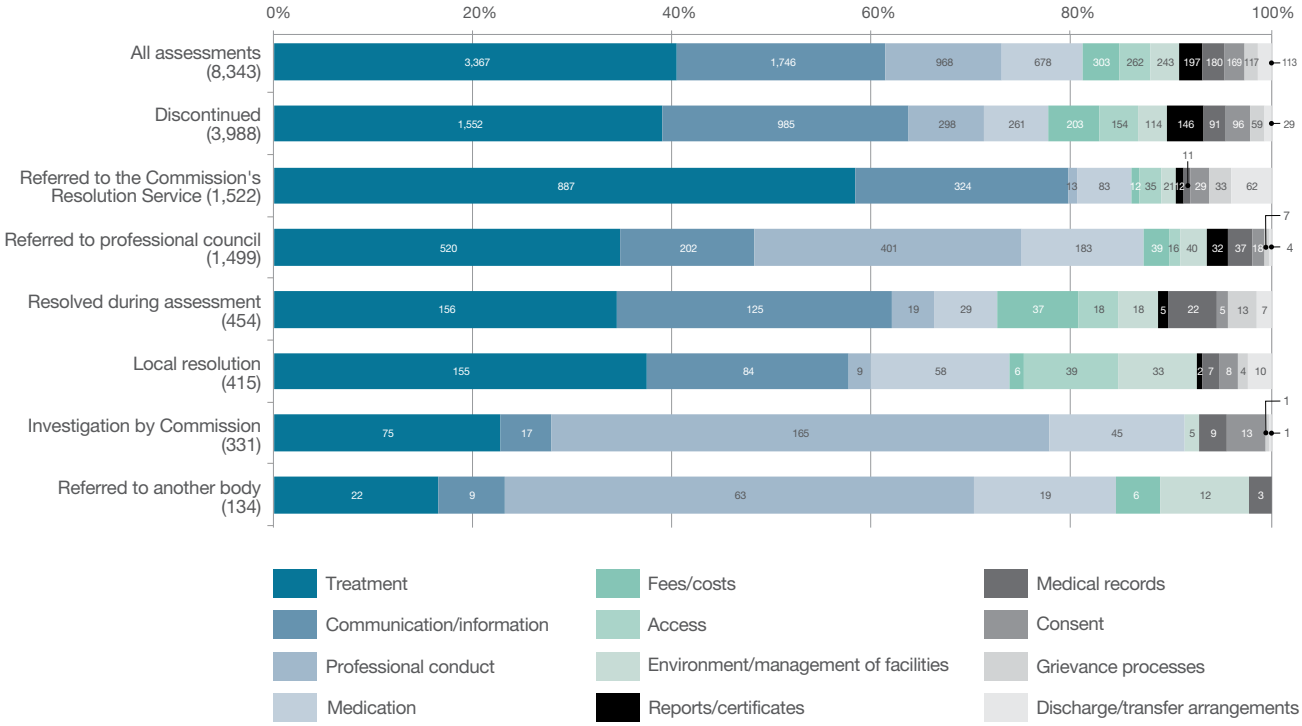
Often the alleged misconduct was relatively clear, such as the breach of a guideline or law. Breaches of registration standards are usually referred to the Australian Health Practitioner Regulation Agency as the relevant body to deal with these, which explains the high proportion of complaints about professional conduct that was referred to another body.

Communication issues were most prominent in the complaints that Commission staff were able to resolve during the assessment process (27.5%). Such complaints are often due to a lack of understanding or a misunderstanding on the part of the patient or their family about the health service they received.

Where the service provider's response contains sufficient information to satisfactorily address the complainant's concerns, the complaint can be resolved during the assessment process

Where a complaint raised significant issues of public health and safety, or where there appeared to be evidence of gross negligence or a significant departure from relevant professional standards, the Commission investigated the complaint.

Chart 6.9 – Outcomes of assessment of complaints by issues raised 2012-13



Counted by issues raised in complaint

Investigation outcomes by type of issues raised

Chart 6.10 details the outcomes of investigations in 2012-13, by the type of issue raised in complaints.

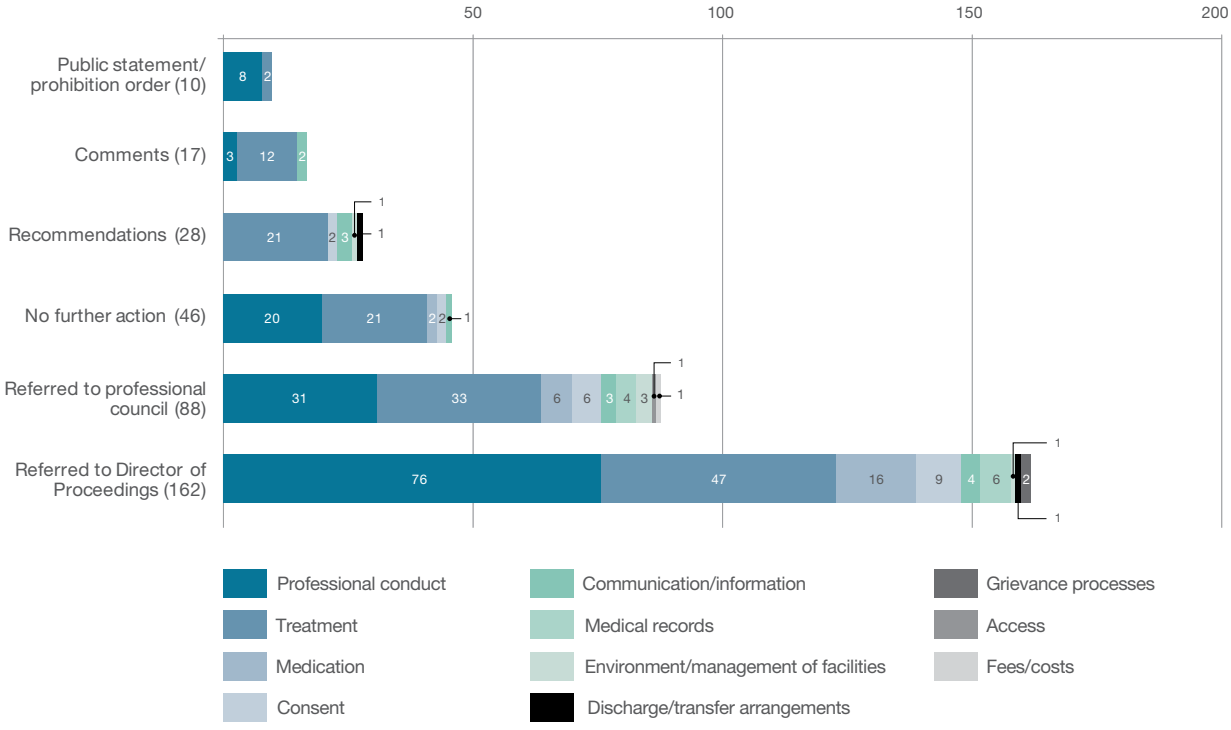
Investigations referred to the Director of Proceedings to consider prosecution, most commonly related to the professional conduct of a practitioner (46.9%). Some examples are sexual misconduct, breach of practice conditions, or prescribing medication without proper authority or therapeutic basis. The latter also explains the relatively high proportion of medication issues referred to the Director of Proceedings.

Complaints about treatment are often complex and the Commission relies on expert advice about the appropriateness of clinical decisions, care and treatment. Expert opinions may differ on the best course of treatment in a given case. Even where different experts agree that there was a departure from accepted standards, they may disagree in their evaluation of the seriousness of the departure.

Cases, in which a practitioner is found to have departed from standards, but not to a significant extent, are often referred to the relevant health professional council for their attention. In other cases, the Commission may make comments to the practitioner, based on the expert's opinion, to assist them to improve their care and treatment of patients in the future.

More information about the outcome of investigations by the type of health service provider is contained in Table 16.26 in Appendix B of this report.

Chart 6.10 – Outcome of investigation by issue category 2012-13



Counted by issues raised in complaint

08 Inquiry Service

Case studies

Assistance to clarify documentation

A woman contacted the Commission asking for assistance dealing with a documentation mix-up at her medical centre. She had vaccinated her twins on schedule at the same medical centre, but Medicare suspended a family payment following notification from the medical centre that one of the twins had not received their latest booster vaccination. The caller had contacted Medicare, the medical centre, and the doctor, but had not been able to resolve the issue.

The Inquiry Officer offered to call the Practice Manager at the medical centre to see if this was something that could be resolved. It was identified that there was conflicting information in the documentation. The Practice Manager audited the vaccination supplies for the day in question, and was able to confirm that both twins were vaccinated, as noted in their 'blue book'. Medicare payments were reinstated as a result of the information being updated on their records.

Facilitating direct contact with Local Health District

A woman called the Commission's Inquiry service to discuss her concerns about her daughter's experience at a NSW hospital. Following a normal pregnancy which continued to full-term, her daughter's baby died during childbirth. The woman had several concerns about both the treatment during the birth and the care provided to the family following the baby's death, including a lack of support and information. The woman was concerned about whether the hospital would carry out an appropriate investigation into the baby's death and whether her daughter would be consulted during the investigation so that her concerns could be taken into consideration.

The Inquiry Officer phoned the hospital and spoke to the staff in the Clinical Governance Unit. The Inquiry Officer was advised that a full investigation would be carried out and that their investigating staff would be happy to speak to the woman and the daughter directly about any concerns she might have. The Inquiry Officer passed on this information and also informed the woman about the Commission's complaint process.

The Commission's Inquiry Service is usually the first port of call for people who are seeking information about making a possible complaint and want to find out about the Commission's role and how it handles complaints.

The Inquiry Service is open 9am - 5pm, Monday to Friday. People can call, email or make inquiries online. They can also come to the office and speak to an Inquiry Officer in person. All inquiries are answered by experienced staff.

People can discuss with the Inquiry Officer how they may be able to resolve their concerns directly with the relevant health service provider, or the Inquiry Officer may sometimes contact the health service provider to facilitate contact between the caller and the service.

Where appropriate, people may be referred to other agencies and organisations that can better address their concerns.

If people wish to make a complaint, the Inquiry Service will tell them how to do so and help them to put their complaint in writing, if they require assistance. If urgent attention is required, complaints can be taken over the phone for an immediate assessment.

Performance

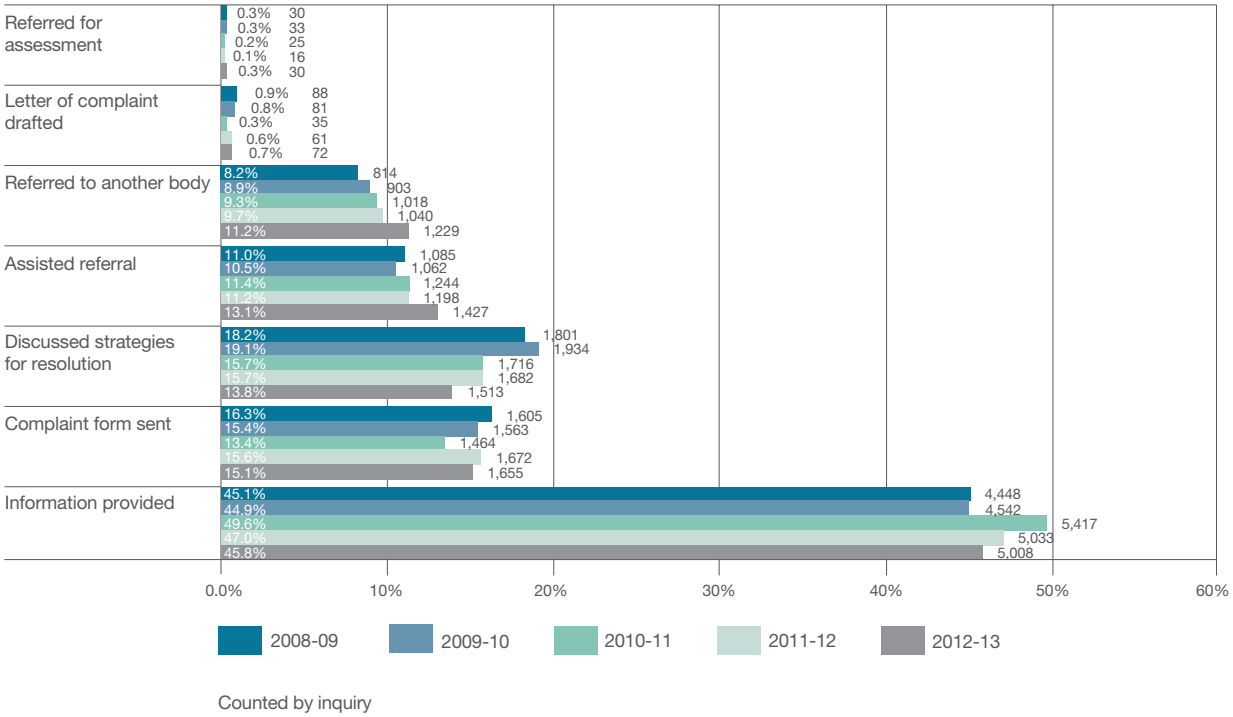
In 2012-13, the Commission received 10,934 inquiries, 2.2% more than in the previous year. The number of inquiries received over the past five years is shown in Chart 4.1 in Chapter 4 – Executive summary of this report.

Outcomes

Chart 8.1 summarises how the Commission dealt with inquiries over a five-year period. In 2012-13, the Inquiry Service:

- responded to 5,008 inquiries (45.8%) by providing relevant information
- sent out 1,655 complaint forms (15.1%)
- discussed with 1,513 people (13.8%) strategies to resolve the issues directly with the health service provider
- assisted 1,427 people (13.1%) by contacting a more relevant body to deal with their concerns and providing the contact details of the relevant staff member to the inquirer
- referred 1,229 inquiries (11.2%) to a more suitable body
- helped 72 people to write their complaint (0.7%)
- in 30 urgent cases (0.3%) drafted a complaint over the phone and referred it for immediate assessment.

Chart 8.1 – Outcome of inquiries 2008-09 to 2012-13



09 Assessing complaints

Performance in 2012-13

CORPORATE GOAL OF
‘efficient and timely processing, assessment and resolution of complaints and review processes’

94.5% of complaints assessed within 60 days

The Commission received 4,554 complaints during the year and assessed 4,544 in the same period; a significant increase in the number compared to the previous year when 4,130 complaints were received and 4,103 assessed. In 2012-13, 94.5% of complaints were assessed within the 60-day statutory timeframe. On average, complaints were assessed within 40 days. Where a complaint was not assessed within the statutory timeframe, an extension was approved in 99.2% of cases (target 100%). This is a significant improvement on the previous year, when 88.1% were assessed within the 60-day timeframe, in an average of 43 days (statutory timeframe - target 100%).

8.6% of assessment decisions where review was requested

389 requests for review of the Commission’s assessment decision were received, which represents 8.6% of all assessments finalised during the year. This compares to 292 such requests that were received in the previous year, accounting for 7.1% of all assessments finalised (target <10%).

83.5% of reviews completed within six weeks

The Commission completed 83.5% of reviews of an assessment decision within six weeks. This is an improvement on last year, when 76.1% of reviews were finalised within that timeframe (target 90%).

99.4% of decision letters sent within 14 days

When the Commission has finalised its assessment, all parties are informed in writing about the outcome and reasons for the decision. During the year, 99.4% of decision letters were sent within 14 days of the decision being made, representing a significant improvement, compared to the previous year when 86.2% of letters were sent within this timeframe (statutory timeframe - target 100%).

Assessment file audits satisfactory and on time

The Commission introduced a 7-day automatic audit to assess the recording and allocation of the file, followed by a second audit at 21 days after the complaint has been received to check the progress of the file. 96.4% of the 7 days audits showed a satisfactory result. In relation to the 21-day audits, 98.3% were completed on time and 99.0% showed satisfactory progress of the complaint (target 90%).

In 2012-13, the Commission received 4,554 complaints, an increase of 10.3% on the previous year. This coincided with mandatory notifications being deemed as complaints. Taking this into consideration, the effective increase in incoming complaints compared to the previous year is estimated to be 5.9%.

To manage the high work load while meeting the statutory requirement of assessing complaints within 60 days, the Commission continued the practice of assessing complaints that contain sufficient information without making any further inquiries.

Where it did make further inquiries, the Commission shortened the time given to a health service provider to respond to a complaint. This allows the Commission to analyse the information it receives back in greater depth and also to complete the assessment in a shorter time frame.

Assessment staff were encouraged to contact the parties to a complaint to clarify issues and to discuss the Commission's assessment decisions.

Performance

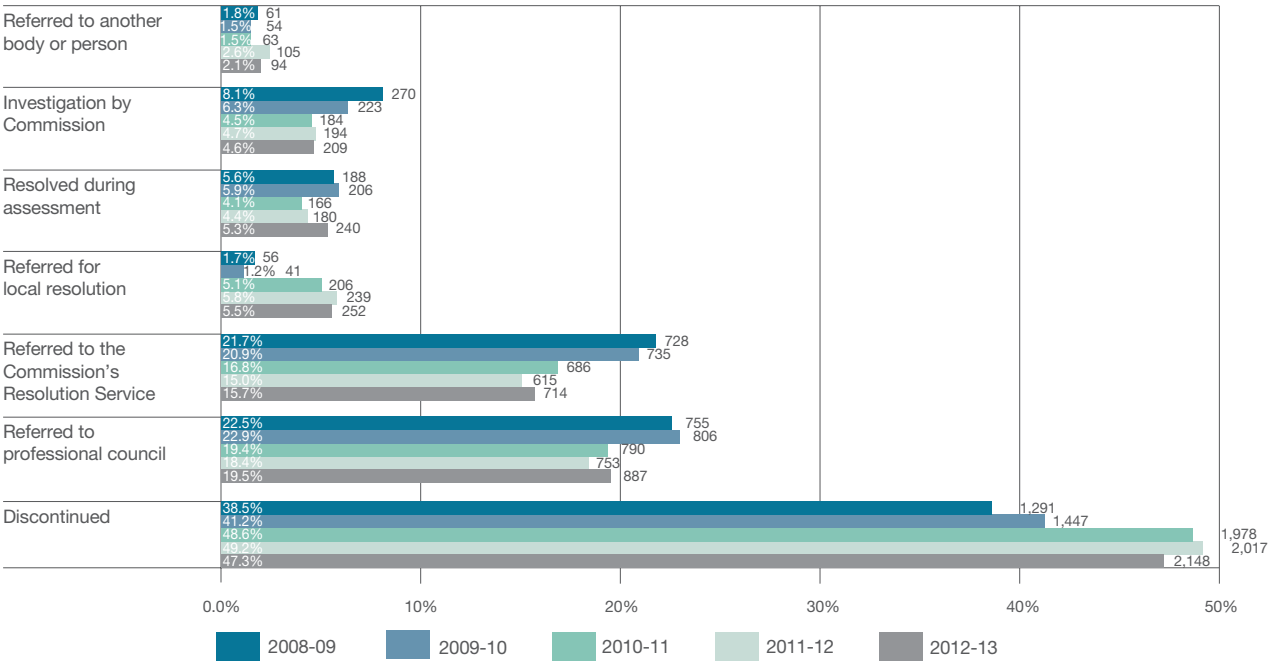
Chart 9.1 shows how the Commission assessed complaints over the past five years.

Outcomes

In 2012-13, the Commission assessed 4,544 complaints:

- 2,148 (47.3%) were discontinued – with the Commission taking no further action
- 887 (19.5%) were referred to the relevant professional council to take appropriate action regarding a registered health practitioner
- 714 (15.7%) were referred to the Commission's Resolution Service
- 252 (5.5%) were referred to the relevant public health organisations to try to resolve the complaint locally
- 240 (5.3%) were successfully resolved during the assessment process
- 209 (4.6%) were referred for formal investigation by the Commission
- 94 (2.1%) were referred to another more appropriate body for their management.

Chart 9.1 – Outcome of assessment of complaints 2008-09 to 2012-13



Counted by provider identified in complaint

Assessing complaints

Timeliness

In 2012-13, 94.5% of complaints were assessed within the 60-day statutory timeframe. On average, complaints were assessed within 40 days. This compared favourably to the previous year, when 88.1% of complaints were assessed within 60 days, on average within 43 days.

When the Commission has completed the assessment of a complaint, all parties are informed in writing about the outcome and reasons for the decision. In 2012-13, 99.4% of decision letters were sent within 14 days of the decision being made. This is an improvement from the previous year when 86.2% of letters were sent within this statutory timeframe.

Review of assessment decisions

People who made a complaint can request a review of the Commission's assessment decision except where the complaint is being investigated.

In 2012-13, 389 requests for a review of the assessment decision were received, which represents 8.6% of all assessments finalised during the year. This compares to the previous year when 292 such requests were received accounting for 7.1% of all assessments finalised.

The Commission finalised 369 reviews in 2012-13. In 344 cases (93.2%), the original assessment decision was confirmed. In 25 cases (6.8%), the initial decision was changed as result of the review.

83.5% of reviews of an assessment decision were completed within six weeks.

Feedback

The Commission surveys both people who made a complaint and health service providers after the assessment of a complaint. These surveys are intended to assist the Commission to improve its assessment procedures and better meet client needs.

In 2012-13, 12.8% of complainants and 14.0% of health service providers who were sent a survey responded to the Commission.

Responses

Overall, 73.7% of people who made a complaint and responded to the survey were satisfied with their interaction with the Assessment Officer. This is a significant improvement from the result in the previous year when only 47.2% of complainants were satisfied. The results can be attributed to staff contacting people who make a complaint during the assessment process and also to the improved timeliness in the assessment of their complaints.

Overall, 87.6% of health service providers who responded to the survey were satisfied with the Commission's service. Again, this is an improvement on last year's results, when 77.6% reported that they were satisfied with their interaction with the Commission. The higher rates of satisfaction among health service providers can also be attributed to improved communication and more timely assessment of complaints.

In May 2013, the Commission sought feedback from the complaint-handling staff of the Local Health Districts and Speciality Networks who are responsible for providing responses to the Commission where complaints are made about public health facilities. The survey mirrored that used for individual providers and asked about their experience with the Commission's assessment process in the past year.

In total, 41 persons responded on behalf of 12 Local Health Districts and one Speciality Network. Overall, 87.8% of respondents were satisfied with their interaction with the Commission.

The survey also offers the opportunity to provide additional comments. Some comments this year were:

'Thank you for listening. Our complaint was handled in a very considerate and professional manner. And thank you also to [the doctor] for his sincere apology which we gratefully accept.' [Complainant]

'Since the complaint [the provider's] care of my father has been much more punctual and attentive.' [Complainant]

'I am very happy that I have been taken seriously and that education appears to have been initiated in response [...]. This is what I wanted to happen so future patients and families will not have to suffer the distress we did. It is a great relief to me to hear that these actions have been taken as a result of my complaint. I do hope you convey my appreciation to the hospital and people involved. Thank you for your thoroughness. [Complainant]

Significant developments

Implementing changes

In 2011-12, the Commission's assessment of complaints was internally audited. The audit identified three main areas for improvement: communication within the team, file allocation procedures and the accountability of team management.

In 2012-13, a number of strategies were implemented to improve these areas. Staff were encouraged to actively participate in discussions at regular meetings. The lines of reporting were clarified and Team Leaders took on a greater role in mentoring their team. Staff were encouraged to take greater ownership of their case loads.

In addition, the Commission redesigned the way complaints are received, allocated and progressed to improve the timeliness in managing complaints. Team Leaders now read all new complaints and develop an assessment plan that lists clear lines of enquiry for the Assessment Officers to follow.

The Commission also improved its data entry procedures to increase efficiency and reduce errors. For example, the assessment file now contains a barcode, which allows for automated updates and documents to be linked using barcode scanners.

The above changes, better monitoring and analysis of the timeliness of handling complaints significantly improved the branch's overall performance.

Staff upgraded

The tasks of both the Assessment Officers and Team Leaders have greatly expanded over the last few years. The Commission reviewed the relevant position descriptions, which then were independently evaluated. As a result, Assessment Officers were upgraded from grade 3/4 to 5/6 and Team Leaders from grade 5/6 to 7/8. All positions were then externally advertised for merit selection.

Training

Staff of the assessment branch participated in a number of training courses to support them to become more skilled and efficient in their work.

Staff attended external training in:

- plain English writing
- dealing with mental health complaints and patients
- writing applications and interview techniques
- dealing with dental complaints.

In addition, staff were internally trained to improve complaint handling using case studies to discuss emerging topics.

All new staff completed an in-service six-week orientation program when they started with the Assessment Branch and were assigned a 'buddy' Assessment Officer to provide additional support.

New assessment staff were also trained in how to respond to inquiries to the Commission's Inquiry Service.

The year ahead

Internal improvements

The changes that were made to the set up of complaints and data entry will continue to be monitored, evaluated and improved.

The Commission will begin to work towards a paper-less filing system.

Regular in-service training for staff will aim to improve knowledge and skills in dealing with complaints and emerging issues.

The Commission's Resolution Officers will assist assessment staff to develop and improve their dispute resolution skills. It is hoped to increase the number of complaints that can be resolved during the assessment process.

In response to the increase in the number of requests for a review of the assessment decision, the Assessment Manager and Team Leaders will work with staff to improve the quality and clarity of letters advising the parties to a complaint of the Commission's decision and its reasons.

In addition, more focus will be placed on engaging with both parties to a complaint to improve customer service.

Case study

Better care for dementia sufferers

A woman complained to the Commission about the care her husband had received at a hospital. The man suffered from dementia and had undergone an operation. The woman said that one of the nurses made some inappropriate remarks about the confused state of her husband after the surgery and also that her husband was discharged with the wrong medication. She had not received an explanation or apology from the hospital.

The Commission wrote to the hospital and the Director of Clinical Services responded outlining the treatment the man had received during his hospital stay. It became clear that the man was confused at times during his recovery process after the operation and that staff had not adequately considered his dementia as a cause for his confusion. As a result of the complaint, the hospital recognised the need to educate staff to better understand the needs of patients with dementia in acute care settings. One of the nursing staff involved in the man's care, has started a tertiary course with the aim of assisting the hospital and staff to care more effectively for people with dementia and confusion disorders.

The hospital investigated concerns that the man was discharged with incorrect medication and found that the nurse who handed the man the wrong medication package breached existing hospital policy. The nurse was made aware of the consequences this carelessness had caused and was disciplined.

The hospital apologised to the family for the distress they had experienced. The woman who had made the complaint was happy to hear about the steps the hospital had taken and considered her complaint resolved.

10 Resolving complaints

Performance in 2012-13

CORPORATE GOAL OF
‘efficient and timely processing, assessment and resolution of complaints and review processes’

90.3% of resolution plans on time

90.3% of complaints that were referred to the Resolution Service had a resolution plan in place within 28 days. This result is a significant improvement on last year, when 64.0% of plans were submitted in the required timeframe (target 90%).

64.5% of resolution processes completed within four months

64.5% of resolution and conciliation processes were completed within four months of being referred to the Resolution Service. This is a slight fall from the 69.8% in the previous year and can be attributed to a 16.1% increase in the number of complaints referred to the Resolution Service during the year (target 70%).

87.0% of complaints resolved

87.0% of complaints that proceeded to resolution and conciliation were fully or partially resolved. This compares to 87.6% of complaints being resolved in the previous year (target 80%).

86.1% of clients satisfied

Overall, 86.1% of complaint resolution/conciliation clients were satisfied with the service, compared to 87.6% in the previous year (target 80%).

Where the Commission's assessment finds no significant issues of public health and safety, but there are some outstanding issues that need to be addressed, these complaints are often referred to the Resolution Service.

How resolution works

Resolution is voluntary. A Resolution Officer contacts both parties and encourages them to be involved. If all parties want to participate, the officer helps them to find ways of resolving the complaint.

The nature of the complaint and what the parties expect influence resolution strategies. The officer develops a management plan specific to the case and sets an appropriate timeframe.

If the parties are willing to meet, the Resolution Officer organises a meeting, proposes an agenda, and assists both sides in preparing for the meeting. The Resolution Officer may also contact both parties after a meeting to follow up on any action that was agreed to.

However, if the parties do not wish to meet, other ways to assist the resolution of the complaint are explored. For example, the Resolution Officer can act as an intermediary and obtain responses from the health provider and discuss them with the person who made the complaint.

In some cases, where the parties are willing to meet, but prefer an external facilitator or the confidentiality provided by the formal conciliation process, the Resolution Officer may refer the complaint for conciliation. An independent external conciliator is appointed to facilitate a conciliation meeting. In conciliation anything said during the meeting and any document prepared for conciliation cannot be used elsewhere, for example in legal proceedings, except where both parties consent. This is intended to encourage open discussion during the conciliation.

Possible outcomes

There are various outcomes that can result from a resolution or conciliation process, such as an apology, an explanation of why something happened, or an acknowledgement that a mistake occurred. Sometimes the health service provider offers to review their current practice and take steps to improve it.

At the end of a successful conciliation, a written agreement sets out the resolution of the issues all parties have agreed on.

The Resolution Officer may follow up on agreements reached between the parties, can monitor system or policy changes.

Performance

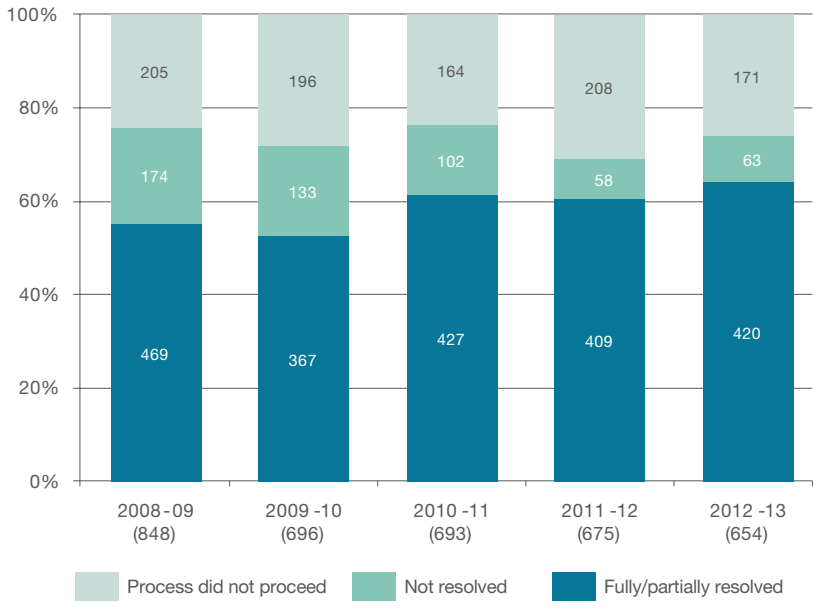
In 2012-13, 714 (15.7%) complaints were assessed to be referred to the Resolution Service, compared to 615 (15.0%) in the previous year. Although the proportion of complaints referred for resolution remained stable, the actual numbers increased by 16.1% due to the overall higher number of complaints the Commission received during the year.

In 2012-13, the Resolution Service referred 23 complaints for formal conciliation. In total, 654 resolution processes were completed, including 18 through formal conciliation. This compares to 675 resolutions, including 22 conciliations, that were completed in the previous year.

Outcomes

Chart 10.1 shows the outcomes of resolution processes over the last five years.

Chart 10.1 – Outcome of resolution processes 2008-09 to 2012-13



Counted by provider identified in complaint

Resolving complaints

In 2012-13, in 171 complaints (26.1%), one of the parties did not consent to participate in a resolution process.

Of the remaining 483 complaints, 420 (87.0%) were fully or partly resolved.

Sometimes, complaints were not resolved because the parties disagreed on what actually occurred. In other cases, the complainant's expectations could not be met, or the options for resolution offered by one side were not acceptable to the other. In 2012-13, 63 (13.0%) complaints were not resolved.

The detailed outcomes of resolution processes can be found in Tables 16.20 and 16.21 in Appendix B of this report.

Timeliness

The increased workload, due to the 16.1% increase in the number of complaints that were referred to the Resolution Service compared to the previous year, had an impact on the time it took to complete resolution processes during the year.

In 2012-13, it took 114 days on average to finalise a resolution process, compared to 102 days in the previous year. 38.1% of complaints were completed within two months (2011-12: 39.4%), 64.5% within four months (2011-12: 69.8%) and 81.3% within six months (2011-12: 84.9%). The 122 resolution cases (18.7%, 2011-12: 15.1%) that took more than six months were delayed for various reasons, including the time taken by the parties to decide when or how to proceed; the complexity of the issues; the need for further assessment, and due to illness or bereavement.

Monitoring agreements

Since July 2009, the Commission records and monitors voluntary agreements by a health service provider to change their systems, practices and policies, or provide further staff training and education.

Over the four year period, a total of 426 agreements to improve health service delivery were made, of which 407 or 95.5% have been implemented as at 30 June 2013.

A small number (17 or 4.0%) have not been implemented, while two (0.5%) agreements are still being monitored and are expected to be implemented within the next year.

Feedback

The Resolution Service seeks feedback from complainants and providers with whom there has been significant contact during the resolution or conciliation process. A satisfaction survey is posted with the Commission's closure letters. The Commission uses the feedback to improve its procedures and service to clients.

The response rate was 18.8% for people who lodged a complaint and 22.5% for health service providers who were sent a survey.

Responses

Overall, 78.2% of complainants and 92.9% of health service providers were satisfied with their interaction with the Resolution Officer.

Clients also had the opportunity to comment on the service they received from the Commission.

I wish to pass my thanks to [the officer]. She was very helpful and supportive. It was good to put the issue of the last 12 months behind us. The meeting with the staff from [the hospital] was calm and well thought out and [the Resolution Officer] brought the meeting always back to the point, slowing when she thought things were getting a little stressful for me. While the answers were not always what I expected, it did provide closure. [Complainant]

'[The Resolution Officer] has been very calm and supportive throughout the process. I have been quite unwell for much of the time of this process but [the officer has been extremely patient, (...) offering very rational, clear, helpful suggestions. I (...) feel it has been resolved to the benefit of all parties.' [Complainant]

Case study

Creating clinical pathways

A woman presented to a hospital emergency department with severe abdominal pain. She was discharged early the next day but returned shortly after again with severe abdominal pain and was admitted. Three days later, the woman had surgery for a ruptured appendix. She died five months later from cancer.

The woman's partner wanted to know why she was initially discharged despite being in so much pain and why it took so long for the ruptured appendix to be diagnosed and treated. Her partner believed that her death was hastened by the delay in recognising and treating the ruptured appendix, as this took so much energy out of her that she had little strength left to fight the cancer.

The Local Health District investigated the complaint and found that the woman's presentation was not typical for a ruptured appendix and that it had been appropriate that she was initially treated conservatively while further tests were performed.

The woman's partner complained to the Commission and the complaint was referred to the Resolution Service. A Resolution Officer organised a meeting with the hospital's Director of Medical Services who acknowledged that some mistakes had been made. Particularly, he said that greater attention to the patient's previous medical history could have seen her being operated on earlier. In hindsight, she should probably have been admitted when she first presented. The director apologised for the errors that were made and advised that a new clinical pathway for clinicians in the emergency department was developed for patients with abdominal pain.

Through the meeting, the patient's partner understood why the woman had not been admitted the first time. He accepted the apology and was glad to hear of the new clinical pathway which would be implemented in the emergency department.

Significant developments

Additional staff

Extra funding enabled the Commission to employ two additional Resolution Officers who were crucial to deal with the increased workload in that area. Three Resolution Officers are located in regional areas - Newcastle, Dubbo and Lismore.

The Commission tried to establish one position in Wollongong. However, due to major renovations at Wollongong Hospital, there was no office space available this year. The Commission will attempt to locate one of its officers at the hospital once the renovations have been completed.

Mediation accreditation

Mediation accreditation ensures that staff are skilled appropriately to assist the parties to a complaint during the resolution process. High level mediation skills are particularly important when Resolution Officers facilitate meetings between the parties.

Mediation training that leads to national accreditation under the National Alternative Disputes Resolution Advisory Council standards has been offered to Resolution Officers in the past four years. Two Resolution Officers completed the training during the year. All permanent Resolution Officers, except one who was appointed towards the end of the reporting year, are meeting the national standards.

Training

To maintain eligibility for national mediation accreditation all Resolution Officers participated in a training day at the Commission entitled 'Dealing with impasses in resolution.'

In addition, Resolution Officers attended sessions for continuing professional and personal development. Of particular importance was the Mental Health Coordinating Council's training about the difficulties mental health patients experience when they want to complain about the service provided to them.

The training aimed to improve the service that the Commission provides to people who make a complaint about mental health services.

Other training for Resolution Officers included presentations by the Opiod Treatment Line, Justice Health, Junee Correctional Centre, Cardiometabolic Care in Youth with Psychosis, and the Coronial Information and Support Program.

The year ahead

During the coming year the panel of conciliators appointed by the Minister for Health will be renewed. The appointment term of the current panel of 20 conciliators expires in December.

The recently appointed permanent Resolution Officers will receive mediation training that leads to national accreditation.

Resolution Officers who are already accredited will participate in short courses to maintain their accreditation.

Case study

Inadequate discharge information and follow up

A woman cut a tendon in her finger and presented to an emergency department. She was admitted, had surgery and was discharged without seeing the surgeon who had operated on her. The discharge summary told her to keep her arm elevated, to make an appointment with the outpatient clinic in two weeks, and that a physiotherapist would call her.

When the woman did not hear from a physiotherapist, she called the hospital and physiotherapy department herself several times, but was unable to get in contact with anyone.

After ten days, she called another hospital and made an appointment with a physiotherapist there. When the physiotherapist saw her a fortnight after surgery, he told her that it was essential that the finger be exercised soon after a tendon repair. Standard practice would be that a hand therapist sees the patient within a week after surgery.

Four months later, the woman had a second operation to free up the tendon from the adhesions that had formed after the initial surgery. She complained to the Commission that the second operation was only necessary due to the lack of physiotherapy and early movement following the first operation. She specifically complained about the lack of information before or after surgery about the importance of early movement following surgical repair of a tendon. She also complained about the fact that she was not contacted by a physiotherapist and was unsuccessful in contacting them in the days after her initial surgery.

The complaint was referred to the Resolution Service. The Resolution Officer contacted the hospital. They advised that as a result of the complaint, new procedures had been introduced whereby all patients who have hand surgery are provided with a list of contact numbers for physiotherapists and told to contact a physiotherapist directly if they do not hear from one within 48 hours. The woman suggested that patients should also be given information about exercises they can do at home themselves, but the hospital decided against this as there is a risk patients could injure themselves, if they were not shown how to do the exercise correctly. The Resolution Officer monitored the introduction of the new procedures.

11 Investigating complaints

Performance in 2012-13

CORPORATE GOAL

‘to ensure a best practice approach for the conduct of all investigations’

89.6% of investigations finalised within 12 months

The Investigations Division finalised 201 investigations during the year, compared with 222 investigations finalised in 2011-12. The Investigations Division closed 89.6% of its investigations within 12 months, on average within 244 days. This was a slight decrease from the previous year (2011-12: 91.0%, average 222 days).

All investigation plans on time

All investigations starting in 2012-13 had an investigation plan completed within 14 days of the complaint being referred to the division. This is an improvement from last year, when 82.9% of plans were in place within that timeframe (target 100%).

92.5% of investigations reviewed on time and 99.2% showing satisfactory progress

Investigations are reviewed regularly to monitor the progress and quality of the Commission’s investigation. 92.5% of reviews were completed on time and 99.2% showed satisfactory progress. This compares to 98.4% in 2011-12 that showed satisfactory progress (target 80%).

2.5% of all investigation outcomes reviewed

The Commission received five requests for a review of an investigation outcome. This represented 2.5% of all investigations finalised in 2012-13 (target <5%, 2011-12: 1.8%). During the same period, six reviews were finalised, all of which confirmed the original decision.

90.6% of investigations satisfactory for prosecution

In 2012-13, 85 complaints about health practitioners were referred to the Director of Proceedings to consider prosecution before a disciplinary body, a fall from last year when 131 complaints were referred. The Director of Proceedings was satisfied with the evidence in 90.6% of investigations referred for potential disciplinary proceedings (2011-12: 87.8%), and did not request further information (target 90%).

72.9% of briefs of evidence prepared within 28 days

A new performance measure shows that in 72.9% of cases where an investigation was referred to the Director of Proceedings to consider taking disciplinary action, the accompanying brief of evidence was prepared within 28 days after the investigation was closed (target 80%). On average, it took 24 days to complete a brief of evidence.

CORPORATE GOAL

‘to improve health care systems through recommendations arising from investigations’

All recommendations implemented

All of the nine recommendations (100%) made by the Commission to health services in 2011-12 had been implemented as of 30 June 2013. This compares to 83.6% of recommendations implemented in the previous year (target 90%).

Complaints that raise a significant issue of public health or safety, or a serious concern about the care and treatment of a patient, must be investigated by the Commission.

Performance

In 2012-13, the Investigations Division finalised 201 investigations, compared to 222 in the previous year. Of these investigations, 182 (90.5%) related to health practitioners, and 19 (9.5 %) to health organisations.

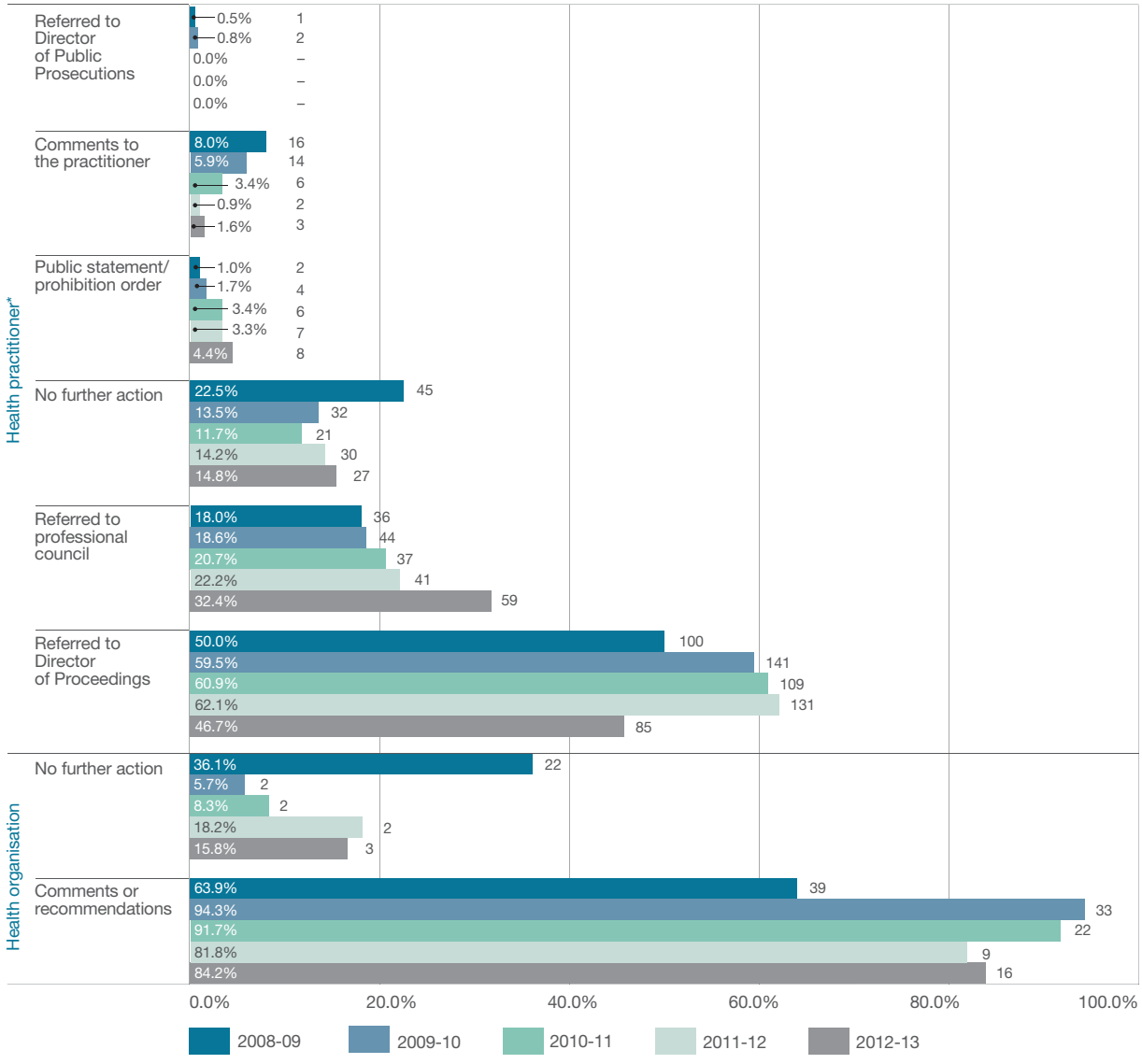
Outcomes

Registered health practitioners

Of the 182 investigations into individual health practitioners in 2012-13, 85 (46.7%) were referred to the Director of Proceedings to consider prosecution before a disciplinary body. This compares to 131 (62.1%) in 2011-12.

In total, the Commission referred 59 complaints about individual practitioners (32.4%) to the relevant professional council for further appropriate action. This compares to 41 complaints in 2011-12 (19.4%) referred to a council.

Chart 11.1 – Outcome of investigations 2008-09 to 2012-13



Counted by provider identified in complaint

* Health practitioners include both registered und unregistered health practitioners.

Investigating complaints

The Commission is required under section 20A of the *Health Care Complaints Act* to keep under review its assessment of a complaint, including during investigation. In appropriate cases, where it is clearly evident that the alleged conduct either does not meet the threshold for disciplinary proceedings or other reasons have negated the risk to the health and safety of the public, the complaint is re-assessed and referred to the relevant health professional council to consider taking appropriate actions, rather than completing a full investigation. This is an effective use of Commission resources, which enables it to focus on investigations where there are significant risks to public health and safety.

In 22 cases, the investigation into a registered practitioner was finalised without any further action being taken. In these cases, the investigation found no or insufficient evidence of wrongdoing.

Four investigations were concluded with the Commission making comments to the practitioner.

Unregistered health practitioners

Practitioners who are not required to be registered cannot be prosecuted before a disciplinary body, but the Commission has the power to issue a public statement and/or prohibition order where its investigation finds that the practitioner has breached the Code of Conduct for Unregistered Health Practitioners and poses a risk to the health or safety of the public.

A prohibition order may ban a health practitioner from providing any or specific health services.

In 2012-13, eight investigations into unregistered health practitioners resulted in the Commission issuing a public statement and making a prohibition order.

Four investigations were completed with no further action being taken. In another investigation, comments were made to the practitioner about how they could improve the treatment and care they provide in the future.

Health organisations

In 2012-13, the Commission completed 19 investigations into health organisations, an increase from the 11 completed in 2011-12. Ten of these investigations resulted in the Commission making recommendations to improve the way health services are delivered. In an additional six investigations, comments were made to the health service identifying the systems issues which caused the adverse patient outcomes and also acknowledging the steps already taken to improve health care delivery to prevent it from happening again in the future.

Implementation of recommendations

The Commission monitors the implementation of its recommendations to health organisations. In 2012-13, the Commission made 32 recommendations as a result of 10 investigations. It will monitor the implementation of these recommendations in the coming year.

As of 30 June 2013, all of the nine recommendations made in the previous year had been implemented.

Since July 2005, the Commission has made 492 recommendations as a result of 198 investigations into health services. In total, 448 (91.1%) of these recommendations had been implemented as at 30 June 2013. Fifteen recommendations (3.1%) were not implemented, and the Commission agreed that no further action was required.

Another 29 recommendations (5.9%), all of which were made during 2012-13, are still to be implemented.

Timeliness

The Commission finalised 89.6% of its investigations within 12 months. On average, it took 244 days to complete an investigation. By comparison, in 2011-12, 91.0% of investigations were finalised within 12 months, on average within 222 days.

Requests for review

In 2012-13, the Commission received five requests for a review of an investigation outcome, which represented 2.5% of all investigations finalised (2011-12: 1.8%). In the same period, the Commission finalised six reviews, all of which confirmed the original outcome.

Case study

Unqualified massage

The Commission investigated a complaint about a massage therapist, Mr Oscar Gettar, which alleged that he had engaged in sexual misconduct during a massage therapy consultation.

The investigation found that during his consultation with a female patient, Mr Gettar had removed his shirt; massaged her while she was completely naked; touched her genitals without her consent and hugged her.

At the beginning of the consultation, Mr Gettar had informed the patient that he offered three different types of massage: remedial, sensual and Tantric. He informed her that the latter would involve genital touching. The patient then told Mr Gettar that she definitely did not want the latter.

During the massage, Mr Gettar had asked the patient from time to time if she was okay. When she did not explicitly object to the things he was doing, he had believed that she was comfortable and had consented to a sexual massage.

In fact, the patient was so traumatised by her experience with Mr Gettar that she required treatment from a psychologist. That psychologist informed the Commission that a common reaction in someone who is feeling threatened and overwhelmed is to remain passive, and this should not have been interpreted as consent.

The investigation found that Mr Gettar's conduct was inappropriate and opportunistic. Despite the patient clearly saying at the outset that she did not want a sexual massage, he took it upon himself to attempt one anyway, and then failed to pick up on her level of discomfort and distress.

The investigation also found that Mr Gettar had published information on his website indicating that he was a member of the Australian Natural Therapists Association, when this was not in fact the case.

At the time of the consultation with the patient, Mr Gettar had been practising as a massage therapist for less than three months, with qualifications that were not recognised by either the Australian Natural Therapists Association or the Australian Traditional Medicine Society, and without any professional supervision.

The Commission was satisfied that Mr Gettar had breached the Code of Conduct for Unregistered Health Practitioners and posed a risk to public health and safety. The Commission made a prohibition order, banning Mr Gettar from practising, advertising or otherwise promoting himself as a massage therapist until he has completed a course recognised by a relevant professional association and is fully accredited by a professional association.

Information about this case, including the Commission's statement of decision is available on its website.

Investigating complaints

Significant developments

Restructure of the division

In 2012, the division's structure was reviewed and the existing three investigation teams merged into two. In addition, a Legal Officer is now working within the division providing advice on all stages of the investigation process. As a result, the quality of briefs of evidence sent to the Director of Proceedings in relation to complaints referred for possible prosecution has improved. Staff have also become more skilled in preparing evidence in a way that enables more efficient prosecutions of health practitioners.

Auditing recommendations to health services

For the first time, the division carried out audits of public hospitals to check ongoing compliance with recommendations the Commission had previously made. In developing the framework for these audits, the Commission worked closely with the Clinical Excellence Commission.

The audits showed that the health services had continued to comply with recommendations that were made as a result of the Commission's investigation of a complaint. It was also evident that the health services had built upon these recommendations and broadened their activities to improve health services. The Commission will continue similar audits in future.

Staff development

In 2012-13, Investigation Managers attended auditor training arranged by the Clinical Excellence Commission, as well as training in the supervision and management of people.

All Investigation Officers attended investigative interviewing workshops at the National Investigations Symposium in November 2012.

A number of staff also attended courses in innovative thinking and problem solving.

Mentors within the division attended coaching and mentoring courses.

The year ahead

In the coming year, more staff will attend the auditor training and Investigation Officers will be involved in future audits of public hospitals.

New staff will attend investigative interviewing courses and the division's Legal Officer will use relevant case studies from Commission prosecutions to provide internal training to staff.

Case study

Unclear responsibilities

An elderly man, with significant co-morbidities, was admitted to a public hospital for a total knee replacement.

The surgery was successful and he was transferred to a surgical ward for post-operative care and recovery. Over the following days, the patient's condition deteriorated. Poor oxygen saturation levels were recorded several times. The patient died four days after the surgery.

The Commission investigated a complaint from the patient's family alleging that the hospital had failed to recognise and respond appropriately to the man's deteriorating condition. The investigation found that there were deficiencies in the patient's overall care and management and missed opportunities to appropriately review and escalate his care.

The Commission identified at least five occasions when the patient's oxygen saturation dropped to a level that would have warranted a clinical review or escalation to either a 'Registrar Activating Clinical Emergency' (RACE) or 'Medical Emergency Team' (MET) call, yet nursing staff did not initiate these calls.

The Commission found the orthopaedic team, which was ultimately responsible for the patient, paid little attention to any non-orthopaedic issues. They failed to review the patient's medical record which would have alerted them to the patient's deterioration on the first day after the operation. Instead, they inappropriately relied solely on general medical registrars monitoring the patient's condition.

The hospital conducted a root cause analysis and a number of improvements were already being implemented before the Commission completed its investigation. These included mandatory training for nursing staff in DETECT - a program that helps practitioners recognise and respond earlier to clinical signs of deterioration - and a review of the way registrars are supervised.

The Commission recommended that the hospital develop a policy requiring that orthopaedic patients with several co-morbidities are assessed to determine whether they should be admitted jointly under the care of an orthopaedic and a physician consultant.

The Commission provided a copy of its investigation results to the Clinical Excellence Commission, which responded that it was considering similar issues. It also advised that the Agency for Clinical Innovation was implementing a program that should alleviate some of the issues raised by the Commission's investigation.

12 Prosecuting complaints

Performance in 2012-13

CORPORATE GOAL OF
'independent and timely prosecutions'

86.0% of determinations on time

The Director of Proceedings considered 86.0% of complaints referred to her within three months to determine whether or not to prosecute the complaint before a disciplinary body. Although the target of 80% was met, timeliness decreased compared to last year, when 92.7% of complaints were considered within three months.

62.7% of matters referred within 30 days

The Legal Division referred 62.7% of matters for prosecution within 30 days of consulting with the relevant professional council. This performance indicator was introduced in the 2012-13 reporting year (target 80%).

CORPORATE GOAL OF
'professional and competent prosecutions of serious complaints in the public interest'

95.7% success rate in prosecutions

95.7% of matters prosecuted by the Commission that were heard and finalised before Tribunals and Professional Standards Committees were found proven. This compares to 94.1% in the previous year (target 90%).

86.2% compliance with deadlines

The Commission complied with Court and Tribunal time frames in 86.2% of cases. This compares to 86.4% in the previous year (target 80%).

74.6% of bills of cost prepared on time

74.6% of bills of legal costs were prepared internally or sent to a cost consultant for assessment within 120 days (target 75%). This performance indicator was introduced in 2012-13.

Monthly reports on legal cost recovery

Monthly reports on the recovery of legal costs were provided to the executive (target: quarterly reporting).

In 2012-13, 85 complaints about registered health practitioners were referred to the Director of Proceedings to determine whether or not to prosecute them before a disciplinary body.

This compares to 131 complaints referred in 2011-12.

Performance

When a complaint is referred to the Director of Proceedings, she considers whether or not to prosecute and, if so, in which forum.

Determinations to prosecute

During the year, the Director of Proceedings made 86 determinations whether to prosecute a health practitioner before a disciplinary body. 86.0% of these were considered within three months of the complaint being referred to the Legal Division.

In 18 complaints, the Director of Proceedings decided not to prosecute the health practitioner. The reasons for this included that the practitioner was no longer registered and was not considered to pose a risk to the health and safety of the public, the practitioner had passed away or there were no reasonable prospects of a successful prosecution.

A number of these complaints were referred back to the Commissioner to consider other appropriate action.

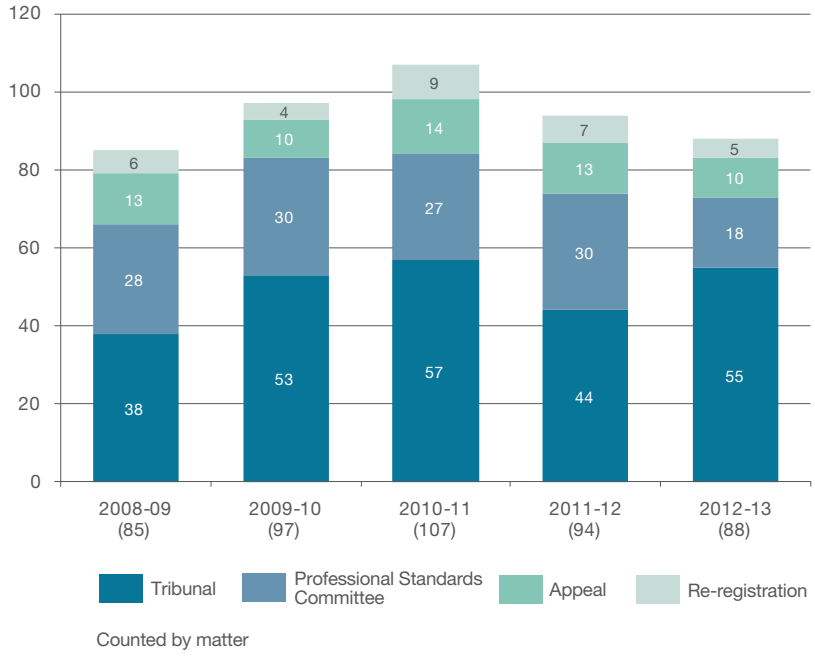
Legal proceedings

In 2012-13, the Commission's Legal Division finalised 88 matters. A matter may include multiple complaints against the same health practitioner. As shown in Chart 12.1, the 88 matters finalised, included 55 matters before Tribunals, 18 matters before Professional Standards Committees, 10 appeals and other applications and five review and restoration applications. The outcomes of these matters are detailed in Table 12.1.

In another three matters, the disciplinary body found the practitioner's conduct proven but protective orders are yet to be made. Details of these are summarised in Table 12.2

Of all matters that were heard and finalised before Tribunals and Professional Standards Committees, 95.7% were found proved, compared to 94.1% in 2011-12.

Chart 12.1 – Legal matters finalised 2008-09 to 2012-13*



Counted by matter

Prosecuting complaints

Table 12.1 - Outcome of disciplinary matters finalised 2012-13

Professional Standards Committee		No.
Medical Professional Standards Committee	reprimand and conditions	5
	reprimand	1
	caution and conditions	1
	caution	1
	withdrawn	1
	withdrawn and dismissed	1
	not proved	2
Nursing and Midwifery Professional Standards Committee	caution and conditions	1
	reprimand and conditions	2
	reprimand	1
	conditions	1
	not proved	1
Total Professional Standards Committee		**18**
Tribunal		
Chiropractic Tribunal	suspension, caution, reprimand and conditions	1
	reprimand and conditions	1
Dental Tribunal	registration cancelled	3
	suspension and conditions	1
	conditions	1
Medical Tribunal	registration cancelled	11
	suspension and conditions	1
	reprimand, conditions and fine	3
	reprimand and conditions	10
	conditions	1
	withdrawn	1
Nursing and Midwifery Tribunal	registration cancelled	8
	suspension, reprimand and conditions	1
	suspension and conditions	1
	reprimand and conditions	1
	conditions	1
	withdrawn	1
Pharmacy Tribunal	registration cancelled and reprimand	1
	registration cancelled	2
	reprimand and conditions	1
Physiotherapy Tribunal	registration cancelled	1
	suspension and conditions	1
Psychology Tribunal	registration cancelled	2
Total Tribunal		**55**
Appeals/applications		
Administrative Decisions Tribunal	application by complainant - withdrawn	1
Court of Appeal	appeal by practitioner - dismissed	2
	appeal by practitioner - withdrawn	1
Nursing and Midwifery Tribunal	appeal by Commission - dismissed	1
High Court of Australia	application by practitioner for special leave - dismissed	2
Supreme Court of NSW	appeal by practitioner - withdrawn	1
	application by practitioner - actioned	1
	appeal by practitioner - dismissed	1
Total appeals		**10**
Re-registration		
Nursing and Midwifery Tribunal	application dismissed	2
	withdrawn	1
	referred to Council for consideration	1
Psychology Tribunal	withdrawn	1
Total re-registrations		**5**
Total disciplinary cases		**88**

Counted by matter

* Excludes matters where the Director of Proceedings determined not to prosecute

Table 12.2 - Disciplinary matters proven and awaiting protective orders as at 30 June 2013

Forum	Outcome	No.
Medical Tribunal	Professional misconduct - proved	1
Nursing and Midwifery Tribunal	Impairment - proved	1
Pharmacy Tribunal	Professional misconduct - proved	1
Total matters awaiting protective orders		**3**

Counted by matter

Significant developments

Fewer matters

There has been a decrease in the number of complaints referred from the Investigations Division to the Director of Proceedings from 131 complaints in 2011-12 to 85 complaints in 2012-13.

There has also been a decrease in the number of matters the Commission prosecuted before Professional Standards Committees. In 2011-12, 30 matters were finalised before Professional Standards Committees and this number dropped to 18 matters in 2012-13.

The reason for this decrease is unclear and the Commission will continue to monitor and review these results.

Legal Officer in Investigations Division

A Legal Officer seconded to the Investigations Division to provide dedicated legal assistance from the early stage of an investigation through to the conclusion. As a result, the quality of evidence in the matters referred improved.

The Legal Officer also facilitated both divisions agreeing on a template for briefs of evidence, and further templates for more specialised matters are planned.

The Legal Officer has also been involved in training and presentations to investigations staff to reinforce principles, such as procedural fairness and the duty of disclosure.

The Legal Officer reports to the Director of Investigations to ensure that the independence of the Director of Proceedings is maintained when making determinations in matters referred from the Investigations Division.

It is anticipated the secondment of a Legal Officer to the Investigations Division will continue.

Legal change

As discussed at Chapter 14 – under the heading 'Legal changes', a number of amendments were made to the *Health Care Complaints Act* which came into effect in May 2013.

One change which is relevant to the Legal Division is that the Director of Proceedings is now able to refer complaints back to the Investigations Division for further investigation, where she is unable to determine whether the complaint should be prosecuted, or further evidence is required to prosecute the complaint.

Where further investigation identifies a new health provider or an additional allegation against the health practitioner previously referred to the Director of Proceedings, the Commission must inform the practitioner of its new findings and the proposed outcome and give them the opportunity to respond.

The changes ensure that further relevant evidence can be obtained and taken into account by the Director of Proceedings when determining whether or not to prosecute a health practitioner.

Procedures manual

A review of the legal procedures manual was completed during the year.

Past decisions of disciplinary bodies were scanned and are now available to Commission staff in a searchable, electronic format.

Copies of internal legal advices and submissions are also being added to the intranet site.

Staff development

As part of the staff performance reviews, development and training needs are regularly reviewed.

All Legal Officers undertake mandatory legal education to maintain their practising certificate. This covers a range of areas including ethics, professional responsibility, practice management, professional skills, equal employment opportunity, evidence, costs and administrative law.

During the year, new staff attended training in equal employment opportunity.

Advanced training in Microsoft Word was offered, as well as training in editing and proof reading.

The year ahead

On 26 October 2012, the Attorney General announced the establishment of the NSW Civil and Administrative Tribunal, to be known as NCAT. More than 20 of the state's existing tribunals will be integrated into NCAT, providing a single gateway for tribunal services in NSW.

It is proposed that all of the existing health tribunals will be integrated into the Occupational and Regulatory Division of NCAT and that there will be a separate list for health professional cases.

The NSW Government has established a steering committee to oversee implementation of NCAT. The committee is advised by a reference group which includes the Director of Proceedings.

Legislation to support NCAT will be introduced into Parliament in separate phases.

NCAT is due to be phased in from 1 January 2014 and will preserve existing health professional specialities.

The Legal Division will update all legal templates to ensure they comply with the new legislation and any procedural changes that flow from it. It will also revise and update its legal procedures manual.

Case study

Dangerous supply of drugs

The Health Care Complaints Commission prosecuted Mr Jonathan Fryar, a pharmacist, before the Pharmacy Tribunal of NSW. Mr Fryar admitted that he had supplied anabolic/androgenic steroids, benzodiazepines and human growth hormones outside recognised therapeutic standards. Some of these drugs were commonly abused for 'body-building' and creating greater muscle mass.

Mr Fryar's pharmacy in Sydney supplied the drugs based on prescriptions that were issued by Dr Kelvin Wong, a registered medical practitioner, who practised nearby. The Commission prosecuted Dr Wong regarding his prescribing before the Medical Tribunal, which cancelled his registration in April 2010. The amounts of medication prescribed, their combinations and the frequency of dispensing were considerable.

Although Mr Fryar was aware that the patients he supplied with the steroid medications used them for body-building, he decided it would be safer for these patients to receive them from him rather than potentially obtaining unsafe drugs from the illicit market. The Tribunal rejected his reasoning and noted that it was a paramount legal responsibility of pharmacists to appropriately challenge prescribers of medications and indeed their patients, whenever the substances were being abused for non-approved uses. It was found to be all the more necessary for pharmacists to promptly intervene when such medications were known to be abused.

Mr Fryar also admitted that he had supplied scheduled drugs to patients in breach of the *Poisons and Therapeutics Goods Act* and Regulation as the result of an agreement between him and Mr Samuel Cohen of the Institute of Hair Regrowth and Beauty ('the Institute'), that was located close by. Mr Cohen did not have any relevant health qualifications and was not a registered health practitioner.

According to the agreement, Mr Fryar supplied Mr Cohen with various medications for clients of the Institute, although he did not have any direct contact with the clients. The Tribunal found that Mr Fryar supplied certain medications to Mr Cohen in bulk without a wholesaler's licence, and supplied prescription-only medication without a prescription.

At Mr Cohen's request, Mr Fryar added to some of the medications (compounded preparations) a quantity of unknown substances that Mr Cohen provided to him referring to it as a 'confidential hair regrowth formula'. Mr Fryar did not know or ensure the quality, safety and efficacy of these substances. The Tribunal found that adding unknown substances to compounded preparations was 'repugnant' to a pharmacist's professional obligation to protect the community. The Tribunal found that Mr Fryar engaged in professional misconduct and cancelled his registration as a pharmacist for a minimum period of 18 months.

Note: The Commissions's website contains links to all public decisions about individual practitioners.

13 Consumer response, privacy and government information

Consumer response

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

The *Health Care Complaints Act* entitles complainants to a review of Commission decisions in relation to the assessment and investigation of complaints. The outcomes of such reviews are reported in Chapters 9 and 11 of this report.

The Commission also sends client satisfaction surveys to the parties to complaints after the assessment and resolution process have been completed. The feedback from those surveys is reported in Chapters 9 and 10 under the heading 'Feedback'.

Complaints about the Commission

In 2012-13, the Commission received one formal complaint about its staff. A medical practitioner complained to the Minister for Health about an error in medical advice that was provided by the Commission's internal medical adviser, which the Commission had relied on in its assessment of a complaint against the practitioner. After investigating the complaint, it became clear that the Commission's internal medical advice was based on incomplete medical records. After a review based on the complete medical records, the Commission amended the medical advice that it had relied upon and apologised to the practitioner.

Complaints to the Ombudsman

The NSW Ombudsman advised that in 2012-13, it received 23 complaints about the Commission. This compares to 17 received in the previous year.

None of the 23 complaints required formal investigation. 18 (78.3%) were declined immediately. Five were declined after the NSW Ombudsman made preliminary inquiries with the Commission. Of the remaining five complaints, the Ombudsman found no or insufficient evidence of wrong conduct on the part of the Commission in four of them. The final complaint had already been resolved by the Commission.

In addition to the 23 complaints in 2012-13, the Ombudsman recorded 36 inquiries about the Commission.

Complaints to the Information and Privacy Commission

In 2012-13, the Commission responded to one complaint to the Information and Privacy Commission. The complainant alleged that the Commission had breached her privacy by providing information that she had lodged with her complaint, including medical records, to the hospital she had complained about. After reviewing the case, the Commission found no breach of relevant privacy legislation. This was because the provision of the information to the hospital was necessary to deal with the complaint, and the Commission was exempt from the privacy legislation, with respect to information used to discharge its functions. The Information and Privacy Commission confirmed the Commission's decision and the Administrative Decisions Tribunal dismissed the complaint on 24 September 2013.

In 2011-12, the Commission reported a justified complaint that a member of staff had accessed the confidential information of a complainant with whom she was privately acquainted. The employee was not employed by the Commission at the time of the complaint. In 2012-13, the complainant made a complaint to the Administrative Decisions Tribunal about this matter. The Commission submitted evidence about the measures it takes to protect privacy. The complainant did not proceed with the matter, which was dismissed by the Tribunal.

Privacy Management Plan

During the year, the Commission reviewed and updated its Privacy Management Plan with the assistance of the Information and Privacy Commission. The Privacy Management Plan is available on the Commission's website.

Public Interest Disclosures

The *Public Interest Disclosures Act* requires the Commission to report public interest disclosures made to it.

In 2012-13, the Commission did not receive any public interest disclosures and no public interest disclosures were finalised. No public officials made public interest disclosures to the Commission.

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

Government information

The Commission has a range of information on its website that people can openly access.

In relation to its complaint-handling functions, the Commission is exempt from the *Government Information (Public Access) Act* (GIPA).

During the year, the Commission received six applications for the release of documents under the *Government Information (Public Access) Act*. Five of these were applications for documents that related to the Commission's complaint-handling functions and were therefore invalid applications. One application requested complaint-related documentation, but was partially valid with respect to the Commission's documentation of its general procedures. Partial access to the relevant documents was granted.

The following tables summarise the applications received in 2012-13 as required under the *Government Information (Public Access) Act*.

Table 13.1 - Number of applications by type of applicant and outcome

	Access granted in full	Access granted in part	Access refused in full	Information not held	Information already available	Refuse to deal with application	Refuse to confirm/deny whether information is held	Application withdrawn
Media	–	–	–	–	–	–	–	–
Members of Parliament	–	–	–	–	–	–	–	–
Private sector business	–	–	–	–	–	–	–	–
Not for profit organisations or community groups	–	–	–	–	–	–	–	–
Members of the public (application by legal representative)	–	–	–	–	–	–	–	–
Members of the public (other)	–	1	–	–	–	–	–	–

Table 13.2 - Number of applications by type of application and outcome

	Access granted in full	Access granted in part	Access refused in full	Information not held	Information already available	Refuse to deal with application	Refuse to confirm/deny whether information is held	Application withdrawn
Personal information applications	–	–	–	–	–	–	–	–
Access applications (other than personal information applications)	–	–	–	–	–	–	–	–
Access applications that are partly personal information applications and partly other	–	1	–	–	–	–	–	–

Consumer response, privacy and government information

Table 13.3 - Invalid applications

Reason for invalidity	No of applications
Application does not comply with formal requirements (section 41 of the Act)	–
Application is for excluded information of the agency (section 43 of the Act)	5
Application contravenes restraint order (section 110 of the Act)	–
Total number of invalid applications received	**5**
Invalid applications that subsequently became valid applications	–

Table 13.4 - Conclusive presumption of overriding public interest against disclosure: matters listed in Schedule 1 to Act

Number of times consideration used	
Overriding secrecy laws	–
Cabinet information	–
Executive Council information	–
Contempt	–
Legal professional privilege	–
Excluded information	–
Documents affecting law enforcement and public safety	–
Transport safety	–
Adoption	–
Care and protection of children	–
Ministerial code of conduct	–
Aboriginal and environmental heritage	–

Table 13.5 - Other public interest considerations against disclosure: matters listed in table to section 14 of Act

Number of occasions when application not successful	
Responsible and effective government	–
Law enforcement and security	–
Individual rights, judicial processes and natural justice	–
Business interests of agencies and other persons	–
Environment, culture, economy and general matters	–
Secrecy provisions	–
Exempt documents under interstate Freedom of Information legislation	–

Table 13.6 - Timeliness

Number of applications	
Decided within the statutory timeframe (20 days plus any extensions)	1
Decided after 35 days (by agreement with applicant)	–
Not decided within time (deemed refusal)	–
Total	**–**

Table 13.7 - Number of applications reviewed under Part 5 of the Act (by type of review and outcome)

	Decision varied	Decision upheld	Total
Internal review	–	–	–
Review by Information Commissioner*	–	–	–
Internal review following recommendation under section 93 of Act	–	–	–
Review by Administrative Decisions Tribunal	–	–	–
Total	**–**	**–**	**–**

* The Information Commissioner does not have the authority to vary decisions, but can make recommendations to the original decision-maker. The data in this case indicates that a recommendation to vary or uphold the original decision has been made by the Information Commissioner.

Table 13.8 - Applications for review under Part 5 of the Act (by type of applicant)

Number of applications or review	
Applications by access applicants	–
Applications by persons to whom information the subject of access application relates	–

14 Organisation and Governance

Performance in 2012-13

CORPORATE GOAL

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

Staff training

Annual staff performance reviews are an opportunity to identify training needs to enhance staff skills and capabilities. In 2012-13, on average, each full time equivalent staff member attended 3.8 days of training.

Up to date reporting

The Commission continues to develop and report on its Work Health Safety (WHS), Equal Employment Opportunity (EEO), Multicultural Plan and Disability Action Plans.

Staff regularly updated

The Commission holds monthly staff meetings where the Commissioner and divisional directors inform staff about recent developments and significant changes that have an impact on the Commission's work.

All key information on intranet

All relevant corporate documents were distributed to staff and/or placed on the Commission's intranet site (target 100%).

CORPORATE GOAL

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

Internal meeting to schedule

Internal management meetings were held according to schedule, including fortnightly meetings of the Executive Management Group, monthly staff and Investigations Review Group meetings, and quarterly meetings of the Information and Communication Technology Steering Committee, Audit and Risk Committee, Workplace Consultative Committee and Work Health and Safety Committee.

Information security compliance

The Commission fully complied with the information security standard ISO 27001:2005 (target 100%).

Internal planning on time

All corporate and divisional plans were delivered according to the planning cycle.

Regular management reviews

The Executive Management Group reviews and discusses financial statements and staffing reports on a monthly basis. Senior Executive were also provided with quarterly reports on the Commission's performance.

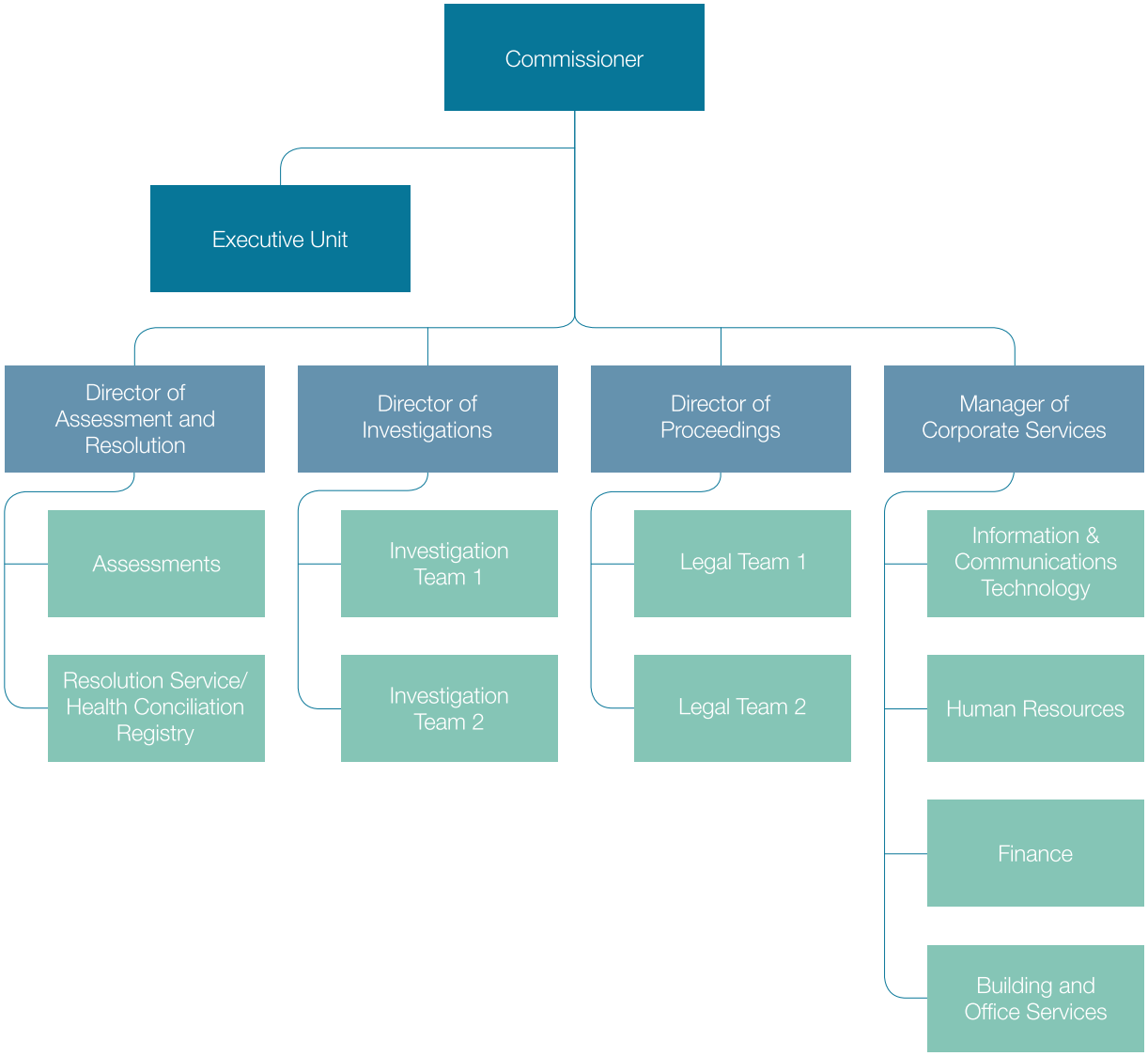
Staff performance reviewed

All staff have performance agreements in place that are regularly reviewed (target 100%).

All staff rated competent

97.4% of staff were considered competent or better at their last annual performance review (target 90%).

Chart 14.1 – Organisational structure



Corporate structure

As shown on the organisational chart, the Commission has three operational divisions headed by a director, an executive unit and a corporate services unit. The Commissioner, Mr Kieran Pehm, was appointed on 28 June 2010 for a second five-year term.

Personnel services are provided by the Office of the Health Care Complaints Commission which is a division of the Government Service that was established under the *Public Sector Employment and Management Act*. Separate financial statements for both entities are included in Chapter 15.

Senior Executive Service

In 2012-13, the Commission had four Senior Executive Service (SES) positions:

- 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 – Tony Kofkin, Bachelor of Arts (BA), former Detective Chief Inspector at Kent Police (UK)
- Director of Assessment and Resolution, SES Level 1 – Ian Thurgood, Certificate in Orthopaedic Nursing, Certificate of General Nursing, accredited mediator.

Table 14.1 - Senior Executive Service as at 30 June

	2012	2013
Number of female executive officers	One	One
Number of executive positions occupied at each level	Level 6 – one Level 2 – two Level 1 – one	Level 6 – one Level 2 – two Level 1 – one

Performance of the Commissioner

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

The Commission's Corporate Plan is the basis for the evaluation of the Commissioner's performance. In relation to the Commissioner's performance in 2012-13, the Minister noted:

> *On the basis of the Commission's quarterly reports and the Commissioner's annual performance report, I have reviewed the performance of the Commissioner as satisfactory. In noting the increase in the levels of satisfaction expressed by complainants with assessment decisions compared to last year, the Commissioner's performance is satisfactory.*

The Commissioner is remunerated at SES Level 6 with a current total remuneration package of $292,451.

Commission staff

The Commission employed a total of 86 staff as at 30 June 2013. This included 57 permanent staff, 22 temporary staff, and four staff in SES contract positions. The majority of Commission employees (64) are working full-time, with 15 employed part-time.

Table 14.2 - Staff numbers by employment category 2010 to 2013 (as at 30 June)

Employment basis	2010	2011	2012	2013
Permanent full-time	43	46	48	50
Permanent part-time	8	9	9	7
Temporary full-time	12	17	15	14
Temporary part-time	4	2	8	8
Contract - SES	4	3	4	4
Contract - non SES	–	–	–	–
Training positions	–	–	–	–
Retained staff	–	–	–	–
Casual	–	–	–	3
Total	**71**	**77**	**84**	**86**
Subtotals				
Permanent	51	55	57	57
Temporary	16	19	23	22
Contract	4	3	4	4
Full-time	63	66	67	64
Part-time	8	11	17	15

During the year, two staff members were seconded to the Commission: one from the Department of Public Prosecutions and one from the Long Service Corporation (Workcover). One of the Commission's staff members was on secondment to the NSW Department of Education and Training.

Table 14.3 shows the average full-time equivalent staffing levels for the last four years. The Commission's average number of full-time equivalent employees (FTE) during 2012-13 was 76.2, an increase of 5.4 FTE from the previous year. The increase was the result of additional funding to the Commission.

Table 14.3 - Average full-time equivalent staffing 2009-10 to 2012-13

2009-10	2010-11	2011-12	2012-13
69.7	72.8	70.8	76.2

Organisation and governance

Staff attrition

In 2012-13, ten staff members resigned, one staff member was seconded to another agency and one staff member retired.

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 Service Conditions of Employment) Award 2009 received a 2.5% increase in salary and related allowances on 1 July 2012. The planned increase of staff salaries as at 1 July 2013 had not been implemented on that date due to an ongoing appeal by the NSW Government before the High Court regarding the question whether or not the 2.5 % increase incorporates a mandated 0.25% increase in superannuation. The Commission will pay any increase retrospectively after the decision has been finalised.

The Commission employs medical and nursing advisers under the Crown Employees (Health Care Complaints Commission, Medical Advisers) Award. From 1 October 2012, these experts received a 2.5% annual increase under the current award.

The Commissioner and directors are members of the Senior Executive Service. The Statutory and Other Offices Remuneration Tribunal determined a performance-based increase of 2.5% annually for these officers starting on 1 October 2012.

Personnel policies and practices

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 policies and directions of the Public Service Commission of NSW and the Commission's own workplace agreement and internal policies.

The Commission has a number of policies and procedures regarding conditions of employment, as well as polices on equal employment opportunity, work health and safety, security issues, and other operational requirements. In 2012-13, nine human resources related policies were reviewed and updated. This includes the Commission's Privacy Plan, Equal Employement Opportunity and Discrimination Policy, Grievance Policy, and Training and Development Policy. All policies were approved by both the Workers Consultative Committee and the Senior Executive and are available on the Commission's intranet.

Staff development

Commission staff are encouraged to participate in learning and development activities, such as attending seminars and conferences, performing higher duties, and undertaking internal and external training courses.

In 2012-13, staff attended a total of 287 days of training in the areas of information technology, organisational development, risk management and technical skills. On average, each full time equivalent staff member attended 3.8 days of training during the period.

The Commission also offers study and examination leave to staff to encourage them to enhance their skills. In 2012-13, three staff members had access to study leave.

Overseas travel

The Commission's Director of Proceedings attended the International Association of Medical Regulatory Authorities' conference in Ottawa, Canada, in October 2012. The conference fee was paid for by the Commission, with the Minister's consent, while the Director paid privately for accommodation and travel.

Performance management

Each staff member has a performance agreement that includes individual targets derived from the Commission's corporate and business plans. These performance agreements also include a learning and development plan designed to help staff to enhance their competencies and assist them in performing their duties. Performance plans and training needs are reviewed annually.

Governance

People matter survey results

The Public Service Commission conducted the 2012 People Matter Survey to capture public service employees' perceptions of how well they thought the public sector values are applied across the public service and their views on their workplace.

The Health Care Complaints Commission received very positive results in the survey with 100% of the Commission staff who responded agreeing that:

- they are proud to work for the NSW Public Sector
- they have the skills to do their job effectively
- they understand how their work contributes to the Commission's objectives
- their team strives to achieve customer satisfaction
- their team treats customers and clients with respect.

None of the participating staff members had experienced or witnessed any bullying or harassment in the workplace in the past 12 months.

Staff wellbeing

The Commission supports staff wellbeing with a range of activities.

Employee Assistance Program

The Commission has an established Employee Assistance Program and has engaged PPC Worldwide to provide to employees free confidential, professional counselling in relation to any work-related or personal concerns of an employee or their immediate family members.

Grievance Officer

The Commission has appointed a Grievance Officer who is trained to provide staff with confidential information and support to address any work-related issues they may have. Issues may relate to discrimination, harassment, bullying or other workplace concerns.

Flexible work arrangements

The Commission offers flexible work arrangement to allow its employees to balance their work with other commitments, including caring for children or elderly parents.

Staying healthy

Staff participated in on-site Pilates classes at their own expense.

Charitable work

The Work Place Giving program that allows staff to make donations to nominated charities from their pre-taxable salary was introduced in June 2013. Staff nominated ten charities of their choice to donate to.

In addition, the Commission gives staff the opportunity to raise funds for charitable projects in their own time. Staff participated in the Cancer Council Biggest Morning Tea and each year a Christmas fund raiser collects donations for a charity of choice.

Industrial relations and the Workplace Consultative Committee

The Commission, its officers and the Public Service Association of NSW meet quarterly at the Workplace Consultative Committee. The Committee discusses issues relating to the conditions of employment and entitlements of staff, including recruitment, training, Work Health and Safety (WHS) matters, and any new policies.

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

There were no industrial disputes involving the Commission in 2012-13.

Work Health and Safety (WHS)

The Commission has a Work Health and Safety and Risk Management Plan to ensure the Commission is a safe and secure environment for its staff and clients. The Commission reports on its activities on a triennial basis. The next full report will be included in the annual report 2013-14.

Equal Employment Opportunity (EEO) and diversity program

The Commission's EEO Management Plan aims to meet benchmarks set by the NSW Government. The Commission reports on its activities on a triennial basis. The next full report will be included in the annual report 2013-14.

Disability Action Plan

The Commission has in place a Disability Action Plan for 2010–13. The plan is intended to ensure an accessible workplace and services to people with disabilities and, where possible, to eliminate discriminatory practices. The Commission reports on its activities on a triennial basis with the next full report due in 2013-14.

Multicultural Policies and Services Program

The Commission recognises and upholds the NSW Government's principles of multiculturalism in relation to staff and clients from culturally and linguistically diverse backgrounds. The Commission reports on its activities on a triennial basis. The next full report will be included in the annual report 2013-14.

Aboriginal affairs

The Commission's engagement with Aboriginal people, including employment and development, service planning and delivery, is summarised below.

Outreach to consumers

The Aboriginal Health and Medical Research Council is a member of the Commission's Consumer Consultative Committee. The Committee is an important forum that assists the Commission in better understanding health consumers' concerns.

During the year, the Commission continued to contribute to the curriculum of the Aboriginal Health Workers College in Little Bay and presented to students as part of their degrees.

Employment and development

In 2012-13, the Commission continued to employ an Aboriginal and Torres Strait Islander (ATSI) Resolution Officer. This position equates to 1.3% of the Commission's average full-time equivalent employees.

The year ahead

The Commission will work with selected Aboriginal Medical Centres delivering a complaint-management workshop that will be evaluated and may be offered to more centres in the future.

In addition, the Commission is in the process of establishing working relationships with Aboriginal health staff in the public health sector to work with them on preventing and responding to concerns and complaints from Aboriginal people.

Legislative change

Last year, the Commission reported on recommendations by the Joint Parliamentary Committee on the Health Care Complaints Commission to amend the *Health Care Complaints Act 1993* (the Act). It also reported on a Supreme Court decision to the effect that the Commission could not investigate the conduct of a health service unless it related to the treatment of an actual individual client.

On 14 May 2013, amendments to the Act came into force generally adopting the recommendations of the Joint Parliamentary Committee on the Commission and broadening the circumstances under which the Commission could investigate the conduct of health services.

The amendments provide that the Commission may now investigate a complaint concerning a health service which affects, 'or is likely to affect', the clinical management or care of an individual client. This means that complaints may be made about a health service even though they do not concern the treatment of specific patients or clients but where the treatment of clients generally is likely to be affected by the practice of the health service.

Following the recommendations of the Committee, the Act was amended to include:

- the power for the Commission to initiate its own complaints in serious matters
- a set of principles requiring the Commission to:
  - be accountable
  - be open and transparent in its decision making
  - maintain an acceptable balance between the rights and interests of clients and health service providers
  - be effective in protecting the public from harm
  - strive to improve efficiency
  - be flexible and responsive.

Other amendments require the Commission to notify current employers of a health practitioner about complaints against the health practitioner where it is necessary to protect the public health and safety. The Commission is also required to give reasons for its decisions, which it already did in the past although not explicitly required by legislation.

The amendments to the Act also rationalise a number of procedural requirements in the legislation which will allow the Commission to be more effective and efficient. The impact of these legislative changes on the work of the Legal Division are summarised in Chapter 12 – Prosecuting complaints.

Information and Communications Technology (ICT)

The Information and Communications Technology Strategic Plan 2011–14, outlines relevant emerging technologies that have the potential to improve the efficiency of the Commission's operations.

Major initiatives under this plan that were implemented in 2012-13 are detailed below.

Enhancements to Casemate

A number of enhancements to the Commission's case management system (Casemate) were made, including:

- further improvements to reporting functionality
- automated data validation reports
- improvements to the usability of the system resulting in improved productivity for users
- system stability and performance improvements
- automated scanning of forms.

Internet enhancements

As part of the internet project referred to in Chapter 5, the technical functionality of the Commission's website was enhanced, user accessibility and the online complaint form were improved.

ISO27001 Standard for Information Security

In January 2008, the Commission achieved accreditation to the ISO27001:2005 Standard for Information Security. The Commission has actively operated and maintained its Information Security Management System since then. It has taken steps to maintain its accreditation, including reviewing and updating relevant policies and procedures, and conducting regular internal audits. In addition, two six-monthly independent external audits were successfully completed in November 2012 and May 2013.

ICT infrastructure review and upgrade

The Commission conducted a detailed review of its ICT infrastructure and developed a plan to adopt emerging technologies to operate more efficiently. A business case outlining the required funding was submitted to the Ministry of Health and as a result, $753,100, over the 2012-14 financial years, was approved.

Major works in progress

The upgrade project started in July 2012 and progress has been in line with project timelines and budget. So far, the ageing network cabling has been replaced to improve data access speeds. New network printers, portable printers and laptop computers were purchased. Multifunction copiers, as well as new servers and operating systems, backup devices and software, and other network-related equipment were installed. A total of $441,000 was spent in 2012-13 and the project is scheduled to be completed during 2013-14 at an additional cost of $278,000.

Relevant staff were equipped with mobile communication devices that allow faster and easier access to documents and systems from outside the office.

In 2013-14, a virtualised server environment will be introduced.

Documents and records management

In 2012-13, the Commission undertook a number of records-related projects, including:

- completing a review of its Functional Retention and Disposal Authority (FRDA) in consultation with Recordkeeping Innovation Pty Ltd and State Records. The FRDA was submitted to the State Records Board in August 2013.
- identifying records for future transfer to the state archives
- completing a case file audit in July 2012 and updating the entry of barcodes in the records management system - TRIM
- designing and implementing new electronic case folders to make it easier to print them and related documents from the Commission's electronic records and case management systems
- setting up a search for legal decisions in TRIM.

The year ahead

The approved FRDA for records will allow the Commission to automatically identify all case file retention periods and required disposals. This will enable it to decrease off-site storage.

The electronic records management and case management systems will be further developed to simplify the management and archiving of relevant hardcopy and electronic records.

The Commission will continue to improve its records filing procedures and practice, moving towards an electronic records environment.

Organisation and governance

Risk management and insurance activities

The Commission reviewed its business risks as part of the corporate planning process. Risks were identified and relevant strategies developed and implemented to mitigate these risks.

The Commission has also reviewed its Business Continuity Plans, including its Information Technology and Management Disaster Recovery Plan and Crisis Management Plan. Desktop testing was conducted 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 QBE Ltd, with GIO General Ltd providing insurance for the remaining categories.

Workers compensation premiums increased by $24,421 from the previous year because of increased wages and an increase in the benchmark rate for the Commission's industry classification. The remaining insurance categories increased by $572.

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.

The internal auditors reviewed the Investigations Management and Fraud Prevention Framework and Controls, to establish whether it is effective and whether sufficient controls are in place to manage the risks associated with the investigation process. As a result of the audit, some minor administrative changes were made and the investigations procedures manual was updated to amend the timing of reviews of investigations.

The Commission's Fraud Prevention Framework and Controls assist it in assessing its fraud risk in accordance with the principles of the Australian and New Zealand Standard on Risk Management (AS/NZS 4360:2004) and Risk Management – Guidelines and Principles (ISO 31000:2009). The assessment identified potential 60 fraud risk scenarios. Following an evaluation of the relevant internal controls and procedures, the Commission was able to lower its risks, ranging from low to medium level.

Consultants

In 2012–13, there were 231 engagements of health practitioners to provide clinical advice on health care complaints at a total cost of $181,544.

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.

Waste Reduction and Purchasing Policy (WRAPP)

The Commission is required to report on progress under WRAPP on a triannual basis. The next report will be included in the annual report 2013-14.

Internal Audit and Risk Management Statement for the 2012-2013 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 Chair- Mr Raymond Petty (appointed from 1 September 2012 to 31 August 2015)
- Independent Member – Ms Janet Grant (appointed from 1 February 2010 to 31 January 2013)
- Independent Member- Ms Claudia Bels (appointed from 1 February 2013 to 31 January 2016)
- 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

23 JUL 2013

15 Finance

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Preamble

The Commission's net result before capital was a surplus of $12,000, which was $266,000 higher than budgeted. A higher than budgeted other income of $236,000, which mainly related to recovered legal costs, and savings to employee related expenses, including a long service leave actuarial adjustment of $75,000, had a significant impact on the overall result.

PAYMENT PERFORMANCE INDICATORS

Table 15.1 - Aged analysis for each quarter 2012-13

Quarter	Current (i.e.) within due date $'000	Less than 30 days overdue $'000	Between 30 and 60 days overdue $'000	Between 60 and 90 days overdue $'000	More than 90 days overdue $'000
All suppliers					
September	1,498	56	–	–	–
December	1,371	50	–	–	–
March	1,332	22	–	–	–
June	1,796	45	–	–	–
Small business suppliers					
September	27	–	–	–	–
December	60	–	–	–	–
March	33	–	–	–	–
June	49	–	–	–	–

Table 15.2 - Accounts due or paid within each quarter 2012-13

Measure	September	December	March	June
All suppliers				
Number of accounts due for payment	731	713	544	725
Number of accounts paid on time	722	681	512	690
Actual percentage of accounts due for payment	98.7%	95.1%	99.6%	95.2%
Dollar amount of accounts due for payment	1,553,721	1,421,126	1,354,055	1,841,296
Dollar amount of accounts paid on time	1,498,480	1,371,544	1,331,718	1,796,447
Actual percentage of accounts paid on time (based on $)	96.4%	96.5%	98.5%	97.6%
Number of payments for interest on overdue accounts	–	–	–	–
Interest paid on overdue accounts	–	–	–	–
Small business suppliers				
Number of accounts due for payment	22	39	29	30
Number of accounts paid on time	21	38	29	30
Actual percentage of accounts due for payment	95.4%	97.4%	100%	100%
Dollar amount of accounts due for payment	27,277	59,971	33,663	49,427
Dollar amount of accounts paid on time	27,277	59,971	33,663	49,427
Actual percentage of accounts paid on time (based on $)	100%	100%	100%	100%
Number of payments for interest on overdue accounts	–	–	–	–
Interest paid on overdue accounts	–	–	–	–

The Commission did not make any interest payments for late payment of accounts. Where there were delays in the payment of accounts, the reasons can be attributed to inaccuracies/incompleteness of the original invoices and/or minor disputes requiring the adjustment of invoice details prior to eventual payment.

All small business number of accounts were paid on time during the reporting period.

INDEPENDENT AUDITOR'S REPORT

Health Care Complaints Commission

To Members of the New South Wales Parliament

I have audited the accompanying financial statements of the Health Care Complaints Commission (the Commission), which comprise the statement of financial position as at 30 June 2013, the statement of comprehensive income, the statement of changes in equity and the statement of cash flows for the year then ended, notes comprising a summary of significant accounting policies and other explanatory information of the Commission and the consolidated entity. The consolidated entity comprises the Commission and the entities it controlled at the year's end or from time to time during the financial year.

Opinion

In my opinion, the financial statements:

- give a true and fair view of the financial position of the Commission and the consolidated entity as at 30 June 2013, and of their financial performance and cash flows for the year then ended in accordance with Australian Accounting Standards
- are in accordance with section 41B of *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 of the financial statements that give a true and fair view in accordance with Australian Accounting Standards and the PF&A, and for such internal control as the Commissioner determines is necessary to enable the preparation of the financial statements that give a true and fair view and that are free from material misstatement, whether due to fraud or error.

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. Those standards require that I comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance about 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 control relevant to the entity's preparation of the financial statements that give a true and fair view 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 entity's internal control. 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.

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

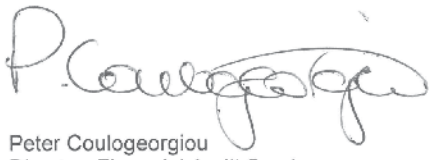
My opinion does *not* provide assurance:

- about the future viability of the Commission or consolidated entity
- that they have carried out their activities effectively, efficiently and economically
- about the effectiveness of internal control
- about the assumptions used in formulating the budget figures disclosed in the financial statements
- about the security and controls over the electronic publication of the audited financial statements on any website where they may be presented
- about any other information, that may have been hyperlinked to/from the financial statements.

Independence

In conducting my audit, I have complied with the independence requirements of the Australian Auditing Standards and other relevant ethical pronouncements. 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 Coulogeorgiou
Director, Financial Audit Services

20 September 2013
SYDNEY

Health Care Complaints Commission

Statement by Commissioner

In accordance with section 41C(1B) of the *Public Finance and Audit Act 1983* ("the Act"), I state that:

(a) the accompanying financial statements in respect of the year ended 30 June 2013 have been prepared in accordance with applicable Australian Accounting Standards (which include Australian Accounting Interpretations), the requirements of the Act, and Regulation 2010, and the Financial Reporting Directions published in the Financial Reporting Code for NSW General Government Sector Entities 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 financial performance of the Health Care Complaints Commission

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

Kieran Pehm
Commissioner
20th September 2013

Start of audited financial statement

Statement of comprehensive income for the year ended 30 June 2013

	Notes	Parent Actual 2013 $'000	Parent Actual 2012 $'000	Consolidated Actual 2013 $'000	Consolidated Budget 2013 $'000	Consolidated Actual 2012 $'000
Expenses excluding losses						
Operating expenses						
Employee related	2(a)	–	–	8,154	8,473	7,586
Personnel services	2(a)	8,154	7,586	–	–	–
Other operating expenses	2(b)	3,286	3,303	3,286	3,205	3,303
Depreciation and amortisation	2(c)	240	280	240	219	280
Total expenses excluding losses		**11,680**	**11,169**	**11,680**	**11,897**	**11,169**
Revenue						
Sale of goods and services	3(a)	–	–	–	–	–
Interest revenue	3(b)	42	50	42	45	50
Grants and contributions	3(c)	11,458	10,181	11,458	11,485	10,181
Acceptance by the Crown Entity of employee benefits and other liabilities	3(d)	58	218	58	216	218
Other revenue	3(e)	612	490	612	372	490
Total revenue		**12,170**	**10,939**	**12,170**	**12,118**	**10,939**
Net result		**490**	**(231)**	**490**	**221**	**(231)**
Total other comprehensive income		**–**	**–**	**–**	**–**	**–**
TOTAL COMPREHENSIVE INCOME		**490**	**(231)**	**490**	**221**	**(231)**

The accompanying notes form part of these financial statements.

Statement of financial position as at 30 June 2013

		Parent		Consolidated		
	Notes	Actual 2013 $'000	Actual 2012 $'000	Actual 2013 $'000	Budget 2013 $'000	Actual 2012 $'000
ASSETS						
Current assets						
Cash and cash equivalents	5	731	846	731	524	846
Receivables	6	388	214	388	258	214
Total current assets		**1,119**	**1,060**	**1,119**	**782**	**1,060**
Non-current assets						
Property, plant and equipment	7					
Leasehold improvements		110	172	110	–	172
Plant and equipment		355	113	355	422	113
Total property, plant and equipment		**465**	**285**	**465**	**422**	**285**
Intangible assets	8	129	119	129	70	119
Total non-current assets		**594**	**404**	**594**	**492**	**404**
Total assets		**1,713**	**1,464**	**1,713**	**1,274**	**1,464**
LIABILITIES						
Current liabilities						
Payables	9	282	488	282	275	488
Provisions	10	768	816	768	802	816
Total current liabilities		**1,050**	**1,304**	**1,050**	**1,077**	**1,304**
Non-current liabilities						
Provisions	10	260	248	260	–	248
Total non-current liabilities		**260**	**248**	**260**	**–**	**248**
Total liabilities		**1,310**	**1,552**	**1,310**	**1,077**	**1,552**
Net assets		**403**	**(87)**	**403**	**197**	**(87)**
EQUITY						
Accumulated funds		403	(87)	403	197	(87)
Total equity		**403**	**(87)**	**403**	**197**	**(87)**

The accompanying notes form part of these financial statements.

Statement of changes in equity for the year ended 30 June 2013

		Parent		Consolidated	
	Notes	Accumulated Funds $'000	Total $'000	Accumulated Funds $'000	Total $'000
Balance at 1 July 2012		**(87)**	**(87)**	**(87)**	**(87)**
Net result for the year		490	490	490	490
Total other comprehensive income		–	–	–	–
Total comprehensive income for the year		490	490	490	490
Balance at 30 June 2013		**403**	**403**	**403**	**403**
Balance at 1 July 2011		144	144	144	144
Net result for the year		(231)	(231)	(231)	(231)
Total other comprehensive income		–	–	–	–
Total comprehensive income for the year		(231)	(231)	(231)	(231)
Balance at 30 June 2012		**(87)**	**(87)**	**(87)**	**(87)**

The accompanying notes form part of these financial statements.

Statement of cash flows for the year ended 30 June 2013

		Parent		Consolidated		
	Notes	Actual 2013 $'000	Actual 2012 $'000	Actual 2013 $'000	Budget 2013 $'000	Actual 2012 $'000
Cash flows from operating activities						
Payments						
Employee related		–	–	(7,860)	(8,250)	(7,565)
Personnel services		(7,860)	(7,565)	–	–	–
Other payments		(4,026)	(3,050)	(4,026)	(3,504)	(3,050)
Total payments		**(11,886)**	**(10,615)**	**(11,886)**	**(11,754)**	**(10,615)**
Receipts						
Sale of goods and services		–	21	–	–	21
Interest received		47	50	47	45	50
GST		94	–	94	–	–
Grants and contributions	3(c)	11,458	10,181	11,458	11,485	10,181
Legal cost recoveries		601	425	601	525	425
Other receipts		–	93	–	146	93
Total receipts		**12,200**	**10,770**	**12,200**	**12,201**	**10,770**
Net cash flows from operating activities		**314**	**155**	**314**	**447**	**155**
Cash flows from investing activities						
Proceeds from sale of plant and equipment		–	–	–	–	–
Purchases of plant and equipment		(429)	(9)	(429)	(445)	(9)
Other		–	–	–	(30)	–
Net cash flows from investing activities		**(429)**	**(9)**	**(429)**	**(475)**	**(9)**
Net increase/(decrease) in cash and cash equivalents		**(115)**	**146**	**(115)**	**(28)**	**146**
Opening cash and cash equivalents		846	700	846	552	700
Closing cash and cash equivalents	5	**731**	**846**	**731**	**524**	**846**

The accompanying notes form part of these financial statements.

Notes to and forming part of the financial statements for the year ended 30 June 2013

1. Summary of significant accounting policies

(a) Reporting entity

The Health Care Complaints Commission is a NSW Government statutory body, responsible for protecting the health and safety of the public by dealing with complaints about sub-standard health services and incompetent and unethical health practitioners.

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

The HCCC is an agency within the NSW Ministry of Health cluster and received grant funding directly from the Ministry. These consolidated financial statements for the year ended 30 June 2013 have been authorised for issue by the Commissioner on 20 September 2013.

(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 Financial Reporting Code for NSW General Government Sector Entities 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) Insurance

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

(d) 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 are recoverable from, or payable to, the Australian Taxation Office are classified as operating cash flows.

Notes to and forming part of the financial statements for the year ended 30 June 2013

1. Summary of significant accounting policies (continued)

(e) 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) Grants and contributions

Grants and contributions from other bodies (including grants from the NSW Ministry of Health) are generally recognised as income when the HCCC obtains control over the assets comprising the contributions. Control over contributions is normally obtained upon the receipt of cash.

(ii) Rendering of services

Revenue is recognised when the service is provided.

(ii) Interest 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 guilty of unsatisfactory professional conduct or professional misconduct, are recognised as revenue when agreement is reached with the respondent on settlement of the amount of legal cost recovered.

(f) 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, that is 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.

(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' Policy and Guidelines Paper (TPP 07-1) (as amended by NSWTC12/05 and NSWTC 10/07). This policy adopts fair value in accordance with AASB 116 *Property, Plant and Equipment* and AASB 140 *Investment Property*.

Property, plant and equipment is measured on an existing use basis, where there are no feasible alternative uses 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.

Notes to and forming part of the financial statements for the year ended 30 June 2013

1. Summary of significant accounting policies (continued)

(iv) Impairment of property, plant and equipment

As a not-for-profit entity with no cash generating units, AASB 136 Impairment of Assets effectively is not applicable to the HCCC. AASB 136 modifies the recoverable amount test to the higher of fair value less costs to sell and depreciated replacement cost. This means that, where an asset is already measured at fair value, impairment can only arise if selling costs are material. Selling costs for the HCCC 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 useful life of the various categories of non-current assets is as follows:

Asset category	Depreciation life in years 2012-13	Depreciation life in years 2011-12
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 part or component of an asset, in which case the costs are capitalised and depreciated.

(vii) Leased assets

A distinction is made between finance leases which effectively transfer from the lessor to the lessee substantially all the risks and benefits incidental to ownership of the leased assets, and operating leases under which the lessor does not transfer substantially all the risks and benefits. The HCCC does not have any finance leases.

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 cost 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. 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.

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 to paragraph (f)(iv)).

(ix) Receivables

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 net result 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.

Notes to and forming part of the financial statements for the year ended 30 June 2013

1. Summary of significant accounting policies (continued)

(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 net result for the year. Any reversals of impairment losses are reversed through the net result for the year, where there is objective evidence.

Reversals of impairment losses of financial assets carried at amortised cost cannot result in a carrying amount that exceeds what the carrying amount would have been had there not been an impairment loss.

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

A financial asset is de-recognised 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.

(g) 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 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. >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 12/06) 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 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.

Notes to and forming part of the financial statements for the year ended 30 June 2013

1. Summary of significant accounting policies (continued)

(iii) Other provisions

The HCCC has a present legal obligation to make good its current accommodation premises when the current lease agreement terminates on the 30 April 2015. This liability was recognised for the first time in the 2011-12 financial year as the lease – make good provision (Note 10). This is because it is probable that an outflow of resources will be required to settle the obligation; and a reliable estimate can be made of the amount ofthe obligation.

As the effect of the time value of money is material, provisions are discounted at 5.5%, which is a pre-tax rate that reflects the current market assessments of the time value of money and the risks specific to the liability.

(h) Equity and reserves

(i) Revaluation surplus

The revaluation surplus is used to record increments and decrements on the revaluation of non-current assets. This accords with the HCCC's policy on the revaluation of property, plant and equipment as discussed in Note 1(f)(iii).

(ii) Accumulated funds

The category 'Accumulated funds' includes all current and prior period retained funds

(iii) Separate reserve accounts are recognised in the financial statements only if such accounts are required by specific legislation or Australian Accounting Standards (e.g. Revaluation surplus and foreign currency translation reserve).

(i) Budgeted amounts

The budgeted amounts are drawn from the original budgeted financial statements presented to Parliament in respect of the reporting period, as adjusted for section 24 of the *Public Finance and Audit Act* where there has been a transfer of functions between departments. Other amendments made to the budget are not reflected in the budgeted amounts.

(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

NSW public sector entities are not permitted to early adopt new Australian Accounting Standards, unless Treasury determines otherwise. The following new Australian Accounting Standards have not been applied and are not yet effective. The possible impact of these Standards in the period of initial application includes:

AASB 9 and AASB 2010-7, Financial Instruments have mandatory application from 1 July 2015 and comprise changes to improve and simplify the approach for classification and measurement of financial assets. AASB 2011-8 and AASB 2012-6 are updates of AASB 9 for amendments to other accounting standards. The change is not expected to materially impact the financial statements.

AASB 10, Consolidated Financial Statements has mandatory application from 1 July 2013 and provides replacement criteria for the assessment of control in lieu of the provisions of AASB 127. Changes to the reporting of consolidated entities is not expected as a result of this amendment.

AASB 13, AASB 2011-8 and AASB 2012-1, Fair Value Measurement have mandatory application from 1 July 2013 and address, inter alia, the assumption that market participants would use when pricing the asset of liability. Future impact is assessed as minimal.

AASB 119, AASB 2011-10 and AASB 2011-11, regarding employee entitlements, have mandatory application from 1 July 2013 and cover the recognition and measurement of short term and long term employee benefits. Any changes to the 2012/13 financial statements will be dependent on the policy of the NSW Treasury.

AASB 1053 and AASB 2010-2, Application of Tiers of Australian Accounting Standards, have application from 1 July 2013 and may result in a lessening of reporting requirements, dependent on the mandate of Treasury.

AASB 1055, Budgetary Reporting, has application from 1 July 2013. Any changes in future disclosures will be determined by the policies adopted by NSW Treasury for whole of government reporting.

AASB 2010-10 regarding removal of fixed dates for first time adopters has mandatory application from 1 July 2013 and based on current activities, is assessed as having no impact on the HCCC.

AASB 2011-2, Trans Tasman Convergence Project - Reduced Disclosure Requirements, has mandatory application from 1 July 2013 and may result in a lessening of reporting requirements, dependent on the mandate of Treasury.

AASB 2011-6, Amendments to Australian Accounting Standards - Extending Relief from Consolidation, the Equity Method and Proportionate Consolidation - Reduced Disclosure Requirements (AASB 127, AASB 128 and AASB 131),applies from 1 July 2013. The exemption is not expected to have a material impact.

Notes to and forming part of the financial statements for the year ended 30 June 2013

2. Expenses including losses

	Parent		Consolidated	
	2013 $'000	2012 $'000	2013 $'000	2012 $'000
(a) Employee related expenses				
Salaries and wages (including annual leave)	–	–	7,103	6,477
Superannuation - defined benefits plans	–	–	87	114
Superannuation - defined contributions plans	–	–	499	456
Long service leave	–	–	(33)	98
Workers' compensation insurance	–	–	56	34
Payroll tax and fringe benefits tax	–	–	442	407
Personnel services	8,154	7,586	–	–
	8,154	**7,586**	**8,154**	**7,586**
(b) Other operating expenses include the following:				
Auditors remuneration				
- audit of the financial statements	18	12	18	12
Consultancy	15	13	15	13
Contractors	–	–	–	–
Equipment and plant	25	18	25	18
Fees for services rendered	459	495	459	495
Fees - legal witness	84	78	84	78
Fees - peer review reports	175	134	175	134
Fees - translators	12	16	12	16
Insurance	14	16	14	16
Legal fees and adverse costs	828	928	828	928
Maintenance*	–	–	–	–
Operating lease rental expense				
- minimum lease payments	942	914	942	914
Printing	21	12	21	12
Stores	146	177	146	177
Telephone, postal and internet	129	129	129	129
Training	64	71	64	71
Transcript fees	60	39	60	39
Travelling	51	62	51	62
Other operating expenses	243	189	243	189
	3,286	**3,303**	**3,286**	**3,303**
* Reconciliation - Total maintenance				
Maintenance expense - contracted labour and other (non-employee related), as above	–	–	–	–
Employee related maintenance expense included in Note 2(a)	–	–	–	–
Total maintenance expenses included in Note 2(a) + 2(b)	**–**	**–**	**–**	**–**

Notes to and forming part of the financial statements for the year ended 30 June 2013

2. Expenses including losses (continued)

	Parent		Consolidated	
	2013 $'000	2012 $'000	2013 $'000	2012 $'000
(c) Depreciation and amortisation expense				
Depreciation				
Leasehold improvements	62	80	61	80
Computer equipment	82	95	83	95
Plant equipment	21	22	21	22
Total depreciation	**165**	**197**	**165**	**197**
Amortisation - Intangible assets	75	83	75	83
Total depreciation and amortisation	**240**	**280**	**240**	**280**

3. Revenue

	Parent		Consolidated	
	2013 $'000	2012 $'000	2013 $'000	2012 $'000
(a) Sale of goods and services	**–**	**–**	**–**	**–**
(b) Interest revenue	**42**	**50**	**42**	**50**
(c) Grants and contributions				
Recurrent - (NSW Ministry of Health)	10,983	10,156	10,983	10,156
Capital - (NSW Ministry of Health)	475	25	475	25
	11,458	**10,181**	**11,458**	**10,181**
(d) Acceptance by the Crown Entity of employee benefits and other liabilities				
The following liabilities and/or expenses have been assumed by the Crown Entity:				
Superannuation - defined benefit	87	114	87	114
Long service leave	(34)	98	(34)	98
Payroll tax	5	6	5	6
	58	**218**	**58**	**218**
(e) Other revenue				
Legal cost recoveries	601	426	601	426
Other	11	64	11	64
	612	**490**	**612**	**490**

Notes to and forming part of the financial statements for the year ended 30 June 2013

4. Service group of the Health Care Complaints Commission

Complaints handling

The HCCC has one service group - complaint handling. This service group covers the processing, assessment and management of health care complaints, which can be dealt with through assisted resolution, facilitated conciliation or referral for investigation. Serious cases of inappropriate health care, are investigated and prosecuted, and recommendations made to health organisations to address systemic health care issues.

5. Current assets - cash and cash equivalents

	Parent		Consolidated	
	2013 $'000	2012 $'000	2013 $'000	2012 $'000
Cash at bank and on hand	**731**	**846**	**731**	**846**
For the purpose of the statement of cash flows, cash and cash equivalents include cash at bankand cash on hand. 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)	731	846	731	846
Closing cash and cash equivalents (per statement of cash flows)	**731**	**846**	**731**	**846**

Refer to Note 16 for details regarding credit risk, liquidity risk and market risk arising from financial instruments.

6. Current assets - receivables

Legal cost recoveries	216	148	216	148
Prepayment	30	32	30	32
GST Receivables	110	-	110	-
Other	32	35	32	35
Less allowance for impairment	-	-	-	-
	388	**214**	**388**	**214**
Movement in the allowance for impairment				
Balance at 1 July 2012	-	(21)	-	(21)
Amounts written off during the year	-	-	-	-
Amounts recovered during the year	-	21	-	21
Increase/(decrease) in allowance recognised in profit or loss	-	-	-	-
Balance at 30 June 2013	**-**	**-**	**-**	**-**

Details regarding credit risk, liquidity risk and market risk, including financial assets that are either past due or impaired, are disclosed in Note 16.

Notes to and forming part of the financial statements for the year ended 30 June 2013

7. Non-current assets - plant and equipment

	Consolidated and parent				
	Leasehold improvements $'000	Computer equipment $'000	Plant and equipment $'000	Work in progress $'000	Total $'000
At 30 June 2012 - fair value					
Gross carrying amount	882	602	172	11	1,667
Accumulated depreciation and impairment	(710)	(518)	(154)	–	(1,382)
Net carrying amount	**172**	**84**	**18**	**11**	**285**
At 30 June 2013 - fair value					
Gross carrying amount	882	771	283	75	2,011
Accumulated depreciation and impairment	(772)	(600)	(174)	–	(1,546)
Net carrying amount	**110**	**171**	**109**	**75**	**465**

Reconciliation

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

	Consolidated and parent				
	Leasehold improvements $'000	Computer equipment $'000	Plant and equipment $'000	Work in progress $'000	Total $'000
Year ended 30 June 2013					
Net carrying amount at start of year	172	84	18	11	285
Additions	–	169	99	77	345
Transfers to/(from) other asset classes	–	–	13	(13)	–
Depreciation expense	(62)	(82)	(21)	–	(165)
Net carrying amount at end of year	**110**	**171**	**109**	**75**	**466**
At 1 July 2011 - fair value					
Gross carrying amount	646	610	172	–	1,428
Accumulated depreciation and impairment	(631)	(434)	(131)	–	(1,196)
Net carrying amount	**15**	**176**	**41**	**–**	**232**
At 30 June 2012 - fair value					
Gross carrying amount	882	602	172	11	1,667
Accumulated depreciation and impairment	(710)	(518)	(154)	–	(1,382)
Net carrying amount	**172**	**84**	**18**	**11**	**285**

Notes to and forming part of the financial statements for the year ended 30 June 2013

7. Non-current assets - plant and equipment (continued)

Reconciliation

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

	Consolidated and parent				
	Leasehold improvements $'000	Computer equipment $'000	Plant and equipment $'000	Work in progress $'000	Total $'000
Year ended 30 June 2012					
Net carrying amount at start of year	15	176	41	–	232
Additions	237	3	–	11	251
Depreciation expense	(80)	(95)	(23)	–	(198)
Net carrying amount at end of year	**172**	**84**	**18**	**11**	**285**

8. Intangible assets - computer software

	Consolidated and parent
	Software $'000
At 1 July 2012	
Cost (gross carrying amount)	880
Accumulated amortisation and impairment	(761)
Net carrying amount	**119**
At 30 June 2013	
Cost (gross carrying amount)	965
Accumulated amortisation and impairment	(836)
Net carrying amount	**129**
Year ended 30 June 2013	
Net carrying amount at start of year	119
Additions	85
Amortisation (recognised in 'depreciation and amortisation')	(75)
Net carrying amount at end of year	**129**
At 1 July 2011	
Cost (gross carrying amount)	871
Accumulated amortisation and impairment	(678)
Net carrying amount	**193**

Notes to and forming part of the financial statements for the year ended 30 June 2013

8. Intangible assets - computer software (continued)

	Consolidated and parent
	Software $'000
At 30 June 2012	
Cost (gross carrying amount)	880
Accumulated amortisation and impairment	(761)
Net carrying amount	**119**
Year ended 30 June 2012	
Net carrying amount at start of year	193
Additions	9
Amortisation (recognised in 'depreciation and amortisation')	(83)
Net carrying amount at end of year	**119**

9. Current liabilities - payables

	Parent		Consolidated	
	2013 $'000	2012 $'000	2013 $'000	2012 $'000
Accrued salaries, wages and on costs	–	–	161	165
Payable for personnel services	161	165	–	–
Creditors	–	4	–	4
GST payable	–	165	–	165
Accrued expenses	121	154	121	154
	282	**488**	**282**	**488**

Details regarding credit risk, liquidity risk and market risk are disclosed in Note 16.

10. Current/non-current liabilities - provisions

	Parent		Consolidated	
	2013 $'000	2012 $'000	2013 $'000	2012 $'000
Employee benefits and related on-costs - current				
Annual leave	–	–	507	537
Payroll tax on recreation leave	–	–	25	30
Payroll tax on long service leave	–	–	82	86
Long service leave on-costs	–	–	119	124
Annual leave on-costs	–	–	35	39
Provision for personnel services	768	816	–	–
Total current provisions	**768**	**816**	**768**	**816**

Annual leave expected to be settled in the next 12 months is $382K.

Notes to and forming part of the financial statements for the year ended 30 June 2013

10. Current/non-current liabilities - provisions (continued)

	Parent		Consolidated	
	2013 $'000	2012 $'000	2013 $'000	2012 $'000
Employee benefit and related on-costs - non-current				
Payroll tax on long service leave	–	–	11	11
Long service leave on-costs	–	–	–	–
Provision for personnel services	11	11	–	–
Total	**11**	**11**	**11**	**11**
Other provisions - non-current				
Lease - make good provision	249	237	249	237
Total non-current provisions	**249**	**237**	**249**	**237**
Total employee benefit and related on-costs non-current	**260**	**248**	**260**	**248**

2013	'Make good' provision $'000
Carrying amount at the beginning of financial year	237
Unwinding of the discount rate	12
Carrying amount at end of financial year	**249**

Aggregate employee benefits and related on costs				
Provisions - current		–	768	816
Provisions - non-current		–	11	11
Provision for personnel services - current	768	816	–	–
Provision for personnel services - non-current	11	11	–	–
Accrued salaries, wages and on-costs (Note 9)	–	–	161	165
Payable for personnel services	161	165	–	–
	940	**992**	**940**	**992**

11. Commitments for expenditure

	Parent		Consolidated	
	2013 $'000	2012 $'000	2013 $'000	2012 $'000
(a) Capital commitments				
Aggregate other expenditure for the acquisition of ICT Infrastructure Upgrade hardware contracted for at balance date and not provided for:				
Not later than one year	53	–	53	–
Later than one year and not later than five years	–	–	–	–
Later than five years	–	–	–	–
Total (including GST)	**53**	**–**	**53**	**–**

Total capital commitments included input tax credits of $4,818 (2011-12: $nil)

Notes to and forming part of the financial statements for the year ended 30 June 2013

11. Commitments for expenditure (continued)

	Parent		Consolidated	
	2013 $'000	2012 $'000	2013 $'000	2012 $'000
(b) Operating Lease Commitments				
Future non-cancellable operating lease rentals not provided for and payable:				
Not later than one year	1,110	1,053	1,110	1,053
Later than one year and not later than five years	1,001	2,008	1,001	2,008
Later than five years	–	–	–	–
Total (including GST)	**2,111**	**3,061**	**2,111**	**3,061**

Total commitments above included input tax credits of $191,887 (2011-12: $278,325) that are expected to be recovered from the Australian Taxation Office. Total commitments include the HCCC's premises lease at Levels 12 and 13, 323 Castlereagh Street, Sydney. The lease terminates on the 30 April 2015 and lease conditions included a market rent review on 1 May 2013 and 1 May 2014.

12. Contingent assets

There are legal costs awarded in favour of the HCCC arising from prosecution of serious cases of complaints of health care where the respondents have been found to be guilty of unsatisfactory professional conduct and/or professional misconduct. The amounts are subject to negotiation and determination and total $1,305,411 (2011-12: $772,607).

13. Contingent liabilities

Adverse costs awarded against the HCCC, across a range of cases, and are estimated to be $nil at 30 June 2013 (2011-12: $nil).

The HCCC has contingent liabilities estimated at $268,100 representing potential legal expenses for which the Crown Solicitor is acting on behalfof the HCCC as at 30 June 2013 (2012: $162,000). The total amount of $232,100 will be reimbursed by the Treasury Managed Fund if the liabilities are realised.

14. Budget review

Net result

The HCCC's favourable net result of $490,000 is higher than budget net result by $269,000. The positive variance can be explained by the unanticipated increase of revenues received from legal cost recovered during 2012-13 of $240,000 and general under-expenditure for employee related expenses.

Assets and Liabilities

The HCCC upgraded its ICT Infrastructure during 2012-13 with a capital expenditure outlay of approximately $445,000. Cash and cash equivalents assets slightly increased compared to budget while provisions and payables maintained its budget levels.

Cash flows

Closing cash balance is slightly higher than budgeted due to higher revenue than anticipated and lower expenditure than budget.

15. Reconciliation of cash flows from operating activities to net result

	Parent		Consolidated	
	2013 $'000	2012 $'000	2013 $'000	2012 $'000
Net cash used on operating activities	314	155	314	155
Depreciation	(240)	(280)	(240)	(280)
Decrease/(increase) in provisions	36	(140)	36	(140)
Increase/(decrease) in receivables and other assets	174	(49)	174	(49)
Decrease/(increase) in creditors	206	83	206	83
Net result	**490**	**(231)**	**490**	**(231)**

Notes to and forming part of the financial statements for the year ended 30 June 2013

16. 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 Commissioner 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.

From time to time, compliance with policies is reviewed by the Audit and Risk Committee.

(a) Financial instrument categories

			Parent		Consolidated	
	Note	Category	2013 $'000 Carrying Amount	2012 $'000 Carrying Amount	2013 $'000 Carrying Amount	2012 $'000 Carrying Amount
Financial assets						
Class:						
Cash and cash equivalents	5	N/A	731	846	731	846
Receivables[1]	6	Receivables at amortised cost	248	176	248	176
Financial liabilities						
Class:						
Payables[2]	9	Financial liabilities measured at amortised cost	121	154	121	154

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 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 4.23%. The average rate for the year ended 2011-12 was 3.27%.

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.

Notes to and forming part of the financial statements for the year ended 30 June 2013

Receivables - trade debtors (continued)

The HCCC is not exposed to concentrations of credit risk to trade debtors as they are mainly other government departments. Based on past experience, debtors that are not past due (2013: $nil; 2012:$nil) and not less than 12 months past due 2013: $nil; (2012: $nil) are not considered impaired.

Debtors (legal cost recoveries) which are currently past due (2013: $55,408; 2012: $129,791) represent 100% of the total debtors overdue. 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	
	Past due but not impaired [1,2] $'000	Considered impaired [1,2] $'000	Past due but not impaired [1,2] $'000	Considered impaired [1,2] $'000
2013				
< 3 months overdue	10	–	10	–
3 months - 6 months overdue	20	–	20	–
> 6 months overdue	25	–	25	–
2012				
< 3 months overdue	29	–	29	–
3 months - 6 months overdue	–	–	–	–
> 6 months overdue	100	–	100	–

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 current and prior years, there were no defaults on any loans payable. 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 TC11/12. For small business suppliers, where terms are not specified, payment is made not later than 30 days from date of receipt of a correctly rendered invoice. For other suppliers, 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. For small business suppliers, where payment is not made within the specified time period, simple interest must be paid automatically, unless an existing contract specifies otherwise. For payments to other suppliers, the Manager Corporate Services may authorise the automatic payment of simple interest to the supplier.

(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. The HCCC does not have any interest bearing liabilities.

(e) Fair value compared to carrying amount

Financial instruments are generally recognised at cost. The amortised cost of financial instruments recognised in the statement of financial position approximates the fair value, because of the short term nature of many of the financial instruments.

17. Events after the reporting period

There were no after reporting period events.

End of audited financial statement

AUDITOR-GENERAL NEW SOUTH WALES

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 comprise the statement of financial position as at 30 June 2013, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes comprising a summary of significant accounting policies and other explanatory information.

Opinion

In my opinion the financial statements:

- give a true and fair view of the financial position of the Office as at 30 June 2013, and of its financial performance and its cash flows for the year then ended in accordance with Australian Accounting Standards
- are in accordance with section 45E 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.

Commissioner's Responsibility for the Financial Statements

The Commissioner is responsible for the preparation of the financial statements that give a true and fair view in accordance with Australian Accounting Standards and the PF&A Act, and for such internal control as the Commissioner determines is necessary to enable the preparation of the financial statements that give a true and fair view and that are free from material misstatement, whether due to fraud or error.

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. Those standards require that I comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance about 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 control relevant to the Office's preparation of the financial statements that give a true and fair view 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 control. 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.

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

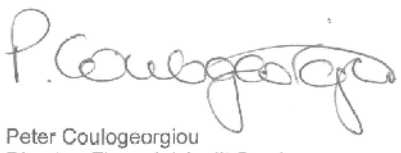
My opinion does *not* provide assurance:

- about the future viability of the Office
- that it has carried out its activities effectively, efficiently and economically
- about the effectiveness of its internal control
- about the security and controls over the electronic publication of the audited financial statements on any website where they may be presented
- about other information that may have been hyperlinked to/from the financial statements.

Independence

In conducting my audit, I have complied with the independence requirements of the Australian Auditing Standards and relevant ethical pronouncements. 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 roles by the possibility of losing clients or income.



Peter Coulogeorgiou
Director, Financial Audit Services

20 September 2013
SYDNEY

Office of the Health Care Complaints Commission

Statement by Commissioner

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

(a) the accompanying financial statements in respect of the year ended 30 June 2013 have been prepared in accordance with applicable Australian Accounting Standards (which include Australian Accounting Interpretations), the requirements of the Act, and Regulation 2010, and the Treasurer's Directions

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

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

Kieran Pehm
Commissioner

20 September 2013

Start of audited financial statement

Statement of comprehensive income for the year ended 30 June 2013

	Notes	Actual 2013 $'000	Actual 2012 $'000
Expenses excluding losses			
Operating expenses			
Employee related	2	8,154	7,586
Total expenses excluding losses		**8,154**	**7,586**
Revenue			
Personnel services	3	8,154	7,586
Total revenue		**8,154**	**7,586**
Net result		**–**	**–**
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**–**	**–**

The accompanying notes form part of these financial statements.

Statement of financial position as at 30 June 2013

	Notes	Actual 2013 $'000	Actual 2012 $'000
ASSETS			
Current assets			
Receivables	4	929	981
Total current assets		**929**	**981**
Non-current assets			
Receivables	4	11	11
Total non-current assets		**11**	**11**
Total assets		**940**	**992**
LIABILITIES			
Current liabilities			
Payables	5	161	165
Provisions	6	768	815
Total current liabilities		**929**	**981**
Non-current liabilities			
Provisions	6	11	11
Total non-current liabilities		**11**	**11**
Total liabilities		**940**	**992**
Net assets		**–**	**–**
Accumulated funds		–	–
Total equity		**–**	**–**

The accompanying notes form part of these financial statements.

Statement of cash flows for the year ended 30 June 2013

	Notes	Actual 2013 $'000	Actual 2012 $'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee related		–	–
Personnel services		–	–
Other		–	–
Total payments		**–**	**–**
Receipts			
Sale of goods and services		–	–
Interest received		–	–
GST		–	–
Grants and contributions		–	–
Legal cost recoveries		–	–
Other		–	–
Total receipts		**–**	**–**
NET CASH FLOWS FROM OPERATING ACTIVITIES		**–**	**–**
CASH FLOWS FROM INVESTING ACTIVITIES			
Proceeds from sale of plant and equipment		–	–
Purchase of plant and equipment		–	–
NET CASH FLOWS FROM INVESTING ACTIVITIES		**–**	**–**
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**–**	**–**
Opening cash and cash equivalents		–	–
CLOSING CASH AND CASH EQUIVALENTS		**–**	**–**

Statement of changes in equity for the year ended 30 June 2013

		Parent	
	Notes	Accumulated funds $'000	Total $'000
Balance at 1 July 2013		–	–
Net result for the year		–	–
Total other comprehensive income			
Total comprehensive income for the year		**–**	**–**
Balance at 30 June 2013		**–**	**–**
Balance at 1 July 2012		–	–
Net result for the year		–	–
Total other comprehensive income			
Total comprehensive income for the year		**–**	**–**
Balance at 30 June 2012		**–**	**–**

The accompanying notes form part of these financial statements.

Notes to and forming part of the financial statements for the year ended 30 June 2013

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's objective is to provide personnel services to the Health Care Complaints Commission.

The financial statements for the year ended 30 June 2013 have been authorised for issue by the Commissioner on 20 September 2013.

(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 1983* and Regulation
- the Treasurer's Directions.

Judgement, key assumptions and estimations that management have 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 consolidated and parent entity 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 the fund manager 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) Assets

Receivables

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 net result 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.

Notes to and forming part of the financial statements for the year ended 30 June 2013

1. Summary of significant accounting policies (continued)

(g) 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 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 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 12/06) 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 formula 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' 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.

(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 OHCCC has not early adopted any new Australian Accounting Standards/Interpretations issued but not yet effective. The OHCCC believes the impact of the standards issued but not yet effective would be immaterial on its financial statements.

Notes to and forming part of the financial statements for the year ended 30 June 2013

2. Expenses excluding losses

	2013 $'000	2012 $'000
Employee related expenses		
Salaries and wages (including recreation leave)	7,103	6,477
Superannuation - defined benefits plans	87	114
Superannuation - defined contributions plans	499	456
Long service leave	(33)	98
Workers' compensation Insurance	56	34
Payroll tax and fringe benefits tax	442	408
	8,154	**7,586**

3. Revenue

	2013 $'000	2012 $'000
Rendering of personnel services	**8,154**	**7,586**

4. Current/non-current assets - receivables

	2013 $'000	2012 $'000
Personnel services - current	929	981
Personnel services - non-current	11	11
	940	**992**

5. Current liabilities - payables

	2013 $'000	2012 $'000
Accrued salaries, wages and on costs	**161**	**165**

6. Current/non-current liabilities - provisions

	2013 $'000	2012 $'000
CURRENT		
Employee benefit and related on-costs		
Annual leave	507	537
Payroll tax on recreation leave	25	30
Payroll tax on long service leave	82	86
Long service leave on-costs	119	124
Annual leave on-costs	35	39
Total	**768**	**816**

Notes to and forming part of the financial statements for the year ended 30 June 2013

6. Current/non-current liabilities - provisions (continued)

	2013 $'000	2012 $'000
Aggregate employee benefits and related on costs		
Provisions - current	768	816
Provisions - non current		
Payroll tax on long service leave	4	4
Long service leave on-costs	7	7
Accrued salaries, wages and on-costs	161	165
Total	**940**	**992**

Annual leave expected to be settled in the next 12 months is $382K.

7. Contingent liabilities and contingent assets

The OHCCC has no contingent liabilities or contingent assets as at 30 June 2013 (2012 - $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. From time to time, compliance with policies is reviewed by the Audit and Risk Committee.

(a) Financial instrument categories

	Notes	Category	2013 $'000 Carrying amount	2012 $'000 Carrying amount
Financial assets				
Receivables[1]	4	Receivables	940	992
Financial liabilities				
Payables[2]	5	Financial liabilities measured at amortised cost	–	–

Notes

1. Excludes statutory receivables and prepayment (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 OHCCC, including cash and receivables. No collateral is held by the OHCCC. The OHCCC has not granted any financial guarantees.

Notes to and forming part of the financial statements for the year ended 30 June 2013

8. Financial instruments (continued)

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 (2013: $940,000; 2012: $991,000) and not less than 12 months past due (2013: $nil; 2012: $nil) are not considered impaired.

(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 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 TC11/12. For small business suppliers, where terms are not specified, payment is made no later than 30 days from date of receipt of a correctly rendered invoice. For other suppliers, 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. For small business suppliers, where payment is not made within the specified time period, simple interest must be paid automatically, unless an existing contract specifies otherwise. For payments to other suppliers, the Manager Corporate Services may authorise the automatic payment of simple interest to the supplier.

(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. The amortised cost of financial instruments recognised in the statement of financial position approximates the fair value, because of the short term nature of many of the financial instruments.

9. Commitments

The OHCCC did not have any expenditure commitments as at 30 June 2013 (2012: $nil).

10. Events after the reporting period

There were no events after the reporting period.

End of audited financial statement

16 Appendices

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Appendix A - Complaint statistics

Table 16.1 - Complaints received by issue category 2008-09 to 2011-12

	2008-09		2009-10		2010-11		2011-12		**2012-13**	
Issue category	No.	%	No.	%	No.	%	No.	%	**No.**	**%**
Treatment	2,799	40.4%	2,504	42.9%	4,048	48.8%	3,350	46.2%	**3,340**	**40.0%**
Communication/information	1,432	20.7%	897	15.4%	1,048	12.6%	1,096	15.1%	**1,731**	**20.7%**
Professional conduct	725	10.5%	687	11.8%	928	11.2%	795	11.0%	**1,000**	**12.0%**
Medication	514	7.4%	368	6.3%	389	4.7%	482	6.6%	**647**	**7.8%**
Fees/costs	256	3.7%	255	4.4%	318	3.8%	300	4.1%	**301**	**3.6%**
Access	173	2.5%	202	3.5%	332	4.0%	194	2.7%	**269**	**3.2%**
Environment/management of facilities	225	3.2%	246	4.2%	327	3.9%	304	4.2%	**250**	**3.0%**
Reports/certificates	168	2.4%	144	2.5%	139	1.7%	132	1.8%	**207**	**2.5%**
Consent	155	2.2%	176	3.0%	123	1.5%	133	1.8%	**181**	**2.2%**
Medical records	142	2.0%	143	2.4%	139	1.7%	130	1.8%	**178**	**2.1%**
Grievance processes	183	2.6%	92	1.6%	351	4.2%	221	3.0%	**121**	**1.4%**
Discharge/transfer arrangements	159	2.3%	127	2.2%	146	1.8%	116	1.6%	**120**	**1.4%**
Total	**6,931**	**100.0%**	**5,841**	**100.0%**	**8,288**	**100.0%**	**7,253**	**100.0%**	8,345	100.0%

Counted by issues raised in complaint

Appendices

Table 16.2 - Breakdown of complaints received 2012-13

Issue category	Issue name	No.	%
Treatment	Inadequate treatment	1,846	22.1%
	Diagnosis	366	4.4%
	Unexpected treatment outcome/complications	264	3.2%
	Delay in treatment	198	2.4%
	Inadequate care	185	2.2%
	Inadequate/inappropriate consultation	152	1.8%
	Rough and painful treatment	60	0.7%
	Wrong/inappropriate treatment	56	0.7%
	Inadequate prosthetic equipment	53	0.6%
	No/inappropriate referral	46	0.6%
	Coordination of treatment/results follow-up	38	0.5%
	Infection control	35	0.4%
	Excessive treatment	26	0.3%
	Withdrawal of treatment	10	0.1%
	Experimental treatment	2	0.0%
	Public/private election	2	0.0%
	Attendance	1	0.0%
Treatment total		**3,340**	**40.0%**
Communication/information	Attitude/manner	1,013	12.1%
	Incorrect/misleading information provided	381	4.6%
	Inadequate information provided	316	3.8%
	Special needs not accommodated	21	0.3%
Communication/information total		**1,731**	**20.7%**
Professional conduct	Impairment	160	1.9%
	Competence	147	1.8%
	Illegal practice	135	1.6%
	Breach of guideline/law	115	1.4%
	Sexual misconduct	96	1.2%
	Inappropriate disclosure of information	81	1.0%
	Boundary violation	62	0.7%
	Misrepresentation of qualifications	58	0.7%
	Assault	56	0.7%
	Breach of condition	36	0.4%
	Financial fraud	27	0.3%
	Discriminatory conduct	22	0.3%
	Annual declaration not lodged/incomplete/wrong or misleading	4	0.0%
	Scientific fraud	1	0.0%
Professional conduct total		**1,000**	**12.0%**
Medication	Prescribing medication	353	4.2%
	Administering medication	142	1.7%
	Dispensing medication	137	1.6%
	Supply/security/storage of medication	15	0.2%
Medication total		**647**	**7.8%**

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Table 16.2 - Breakdown of complaints received 2012-13 (continued)

Issue category	Issue name	No.	%
Fees/costs	Billing practices	262	3.1%
	Cost of treatment	22	0.3%
	Financial consent	17	0.2%
Fees/costs total		**301**	**3.6%**
Access	Refusal to admit or treat	192	2.3%
	Waiting lists	41	0.5%
	Service availability	29	0.3%
	Access to facility	4	0.0%
	Access to subsidies	2	0.0%
	Remoteness of service	1	0.0%
Access total		**269**	**3.2%**
Environment/management of facilities	Administrative processes	164	2.0%
	Cleanliness/hygiene of facility	49	0.6%
	Physical environment of facility	27	0.3%
	Staffing and rostering	8	0.1%
	Statutory obligations/accreditation standards not met	2	0.0%
Environment/Management of facilities total		**250**	**3.0%**
Reports/certificates	Accuracy of report/certificate	160	1.9%
	Refusal to provide report/certificate	22	0.3%
	Report written with inadequate or no consultation	13	0.2%
	Timeliness of report/certificate	11	0.1%
	Cost of report/certificate	1	0.0%
Reports/certificates total		**207**	**2.5%**
Consent	Consent not obtained or inadequate	147	1.8%
	Involuntary admission or treatment	25	0.3%
	Uninformed consent	9	0.1%
Consent total		**181**	**2.2%**
Medical records	Record keeping	85	1.0%
	Access to/transfer of records	80	1.0%
	Records management	13	0.2%
Medical records total		**178**	**2.1%**
Grievance processes	Inadequate/no response to complaint	114	1.4%
	Information about complaints procedures not provided	4	0.0%
	Reprisal/retaliation as result of complaint lodged	3	0.0%
Grievance processes total		**121**	**1.4%**
Discharge/transfer arrangements	Inadequate discharge	104	1.2%
	Delay	9	0.1%
	Mode of transport	6	0.1%
	Patient not reviewed	1	0.0%
Discharge/transfer arrangements total		**120**	**1.4%**
Grand total		**8,345**	**100.0%**

Counted by issues raised in complaint

Table 16.3 - Complaints received about health care practitioners 2008-09 to 2012-13

		2008-09		2009-10		2010-11		2011-12		2012-13	
	Health practitioner	No.	%	No.	%	No.	%	No.	%	**No.**	**%**
Registered health practitioner	Medical practitioner	1,270	60.8%	1,263	56.2%	1,337	52.0%	1,488	57.0%	**1,616**	**54.8%**
	Dental practitioner	307	14.7%	443	19.7%	590	23.0%	482	18.5%	**432**	**14.7%**
	Nurse/midwife	254	12.2%	221	9.8%	227	8.8%	228	8.7%	**375**	**12.7%**
	Pharmacist	21	1.0%	22	1.0%	100	3.9%	104	4.0%	**146**	**5.0%**
	Psychologist	84	4.0%	132	5.9%	113	4.4%	97	3.7%	**134**	**4.5%**
	Physiotherapist	25	1.2%	23	1.0%	20	0.8%	19	0.7%	**22**	**0.7%**
	Chiropractor	29	1.4%	24	1.1%	26	1.0%	27	1.0%	**20**	**0.7%**
	Chinese medicine practitioner***	2	0.1%	4	0.2%	-	0.0%	6	0.2%	**15**	**0.5%**
	Optometrist	18	0.9%	15	0.7%	21	0.8%	27	1.0%	**12**	**0.4%**
	Podiatrist	9	0.4%	14	0.6%	10	0.4%	16	0.6%	**12**	**0.4%**
	Occupational therapist*	1	0.0%	3	0.1%	3	0.1%	4	0.2%	**7**	**0.2%**
	Osteopath	1	0.0%	3	0.1%	5	0.2%	8	0.3%	**6**	**0.2%**
	Medical radiation practitioner**	3	0.1%	2	0.1%	2	0.1%	2	0.1%	**4**	**0.1%**
Total registered health practitioners		**2,024**	**96.8%**	**2,169**	**96.4%**	**2,454**	**95.5%**	**2,508**	**96.1%**	2,801	95.0%
Previously registered health practitioner	Medical practitioner	14	0.7%	2	0.1%	6	0.2%	8	0.3%	**8**	**0.3%**
	Dental practitioner	-	0.0%	1	0.0%	-	0.0%	-	0.0%	**3**	**0.1%**
	Nurse/midwife	2	0.1%	-	0.0%	-	0.0%	-	0.0%	**3**	**0.1%**
	Pharmacist	-	0.0%	-	0.0%	-	0.0%	-	0.0%	**3**	**0.1%**
	Psychologist	-	0.0%	-	0.0%	-	0.0%	-	0.0%	**3**	**0.1%**
	Podiatrist	1	0.0%	-	0.0%	1	0.0%	-	0.0%	**-**	**0.0%**
Total previously registered health practitioners		**17**	**0.8%**	**3**	**0.1%**	**7**	**0.3%**	**8**	**0.3%**	20	0.7%
Unregistered health practitioner	Administration/ clerical staff	7	0.3%	16	0.7%	13	0.5%	12	0.5%	**24**	**0.8%**
	Assistant in nursing	1	0.0%	2	0.1%	14	0.5%	9	0.3%	**21**	**0.7%**
	Alternative health provider	2	0.1%	6	0.3%	19	0.7%	12	0.5%	**19**	**0.6%**
	Counsellor/ therapist	8	0.4%	6	0.3%	8	0.3%	10	0.4%	**9**	**0.3%**
	Social worker	6	0.3%	8	0.4%	12	0.5%	11	0.4%	**9**	**0.3%**
	Massage therapist	4	0.2%	8	0.4%	6	0.2%	3	0.1%	**6**	**0.2%**
	Naturopath	2	0.1%	3	0.1%	1	0.0%	1	0.0%	**6**	**0.2%**
	Dental technician	2	0.1%	10	0.4%	8	0.3%	1	0.0%	**4**	**0.1%**
	Cosmetic therapist	-	0.0%	-	0.0%	1	0.0%	4	0.2%	**3**	**0.1%**
	Psychotherapist	1	0.0%	2	0.1%	4	0.2%	2	0.1%	**3**	**0.1%**
	Hypnotherapist	-	0.0%	1	0.0%	3	0.1%	-	0.0%	**2**	**0.1%**
	Residential care worker	-	0.0%	1	0.0%	5	0.2%	6	0.2%	**2**	**0.1%**
	Speech therapist	2	0.1%	-	0.0%	-	0.0%	2	0.1%	**2**	**0.1%**
	Ambulance personnel	-	0.0%	-	0.0%	1	0.0%	-	0.0%	**1**	**0.0%**

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Table 16.3 - Complaints received about health care practitioners 2008-09 to 2012-13 (continued)

		2008-09		2009-10		2010-11		2011-12		2012-13	
	Health practitioner	No.	%	No.	%	No.	%	No.	%	**No.**	**%**
	Dietitian/ nutritionist	1	0.0%	2	0.1%	-	0.0%	1	0.0%	**1**	**0.0%**
	Homeopath	2	0.1%	1	0.0%	-	0.0%	-	0.0%	**1**	**0.0%**
	Optical dispenser	1	0.0%	3	0.1%	-	0.0%	-	0.0%	**1**	**0.0%**
	Audiologist	n/a	0.0%	n/a	0.0%	1	0.0%	1	0.0%	**-**	**0.0%**
	Doula	-	0.0%	-	0.0%	-	0.0%	1	0.0%	**-**	**0.0%**
	Herbalist	-	0.0%	-	0.0%	2	0.1%	-	0.0%	**-**	**0.0%**
	Natural therapist	2	0.1%	1	0.0%	1	0.0%	-	0.0%	**-**	**0.0%**
	Reflexologist	-	0.0%	1	0.0%	-	0.0%	-	0.0%	**-**	**0.0%**
Total unregistered health practitioners		**41**	**2.0%**	**71**	**3.2%**	**99**	**3.9%**	**76**	**2.9%**	**114**	**3.9%**
Unknown health practitioner		8	0.4%	6	0.3%	10	0.4%	17	0.7%	**12**	**0.4%**
Grand total		**2,090**	**100.0%**	**2,249**	**100.0%**	**2,570**	**100.0%**	**2,609**	**100.0%**	**2,947**	**100.0%**

Counted by provider identified in complaint
* Occupational therapist registered from 1 July 2012
** Medical radiation practitioner registered from 1 July 2012
*** Chinese medical practitioner registered from 1 July 2012

Table 16.4 - Complaints received about medical practitioners by service area 2008-09 to 2012-13

	2008-09		2009-10		2010-11		2011-12		2012-13	
Service Area	No.	%	No.	%	No.	%	No.	%	**No.**	**%**
General medicine	560	44.7%	559	45.1%	662	49.7%	622	41.8%	**706**	**43.7%**
Surgery	156	12.5%	153	12.3%	163	12.2%	217	14.6%	**213**	**13.2%**
Medico-legal	61	4.9%	58	4.7%	59	4.4%	74	5.0%	**81**	**5.0%**
Mental health	29	2.3%	49	4.0%	18	1.4%	42	2.8%	**74**	**4.6%**
Psychiatry	61	4.9%	46	3.7%	57	4.3%	85	5.7%	**65**	**4.0%**
Emergency medicine	70	5.5%	72	5.8%	51	3.8%	56	3.8%	**38**	**2.4%**
Gynaecology	39	3.1%	22	1.8%	28	2.1%	29	1.9%	**35**	**2.2%**
Obstetrics	48	3.8%	47	3.8%	27	2.0%	36	2.4%	**35**	**2.2%**
Paediatric medicine	17	1.4%	16	1.3%	25	1.9%	22	1.5%	**33**	**2.0%**
Anaesthesia	23	1.8%	15	1.2%	20	1.5%	23	1.5%	**32**	**2.0%**
Aged care	14	1.1%	17	1.3%	17	1.3%	14	0.9%	**29**	**1.8%**
Ophthalmology	12	1.0%	9	0.7%	24	1.8%	28	1.9%	**26**	**1.6%**
Dermatology	13	1.0%	25	2.0%	20	1.5%	28	1.9%	**23**	**1.4%**
Gastroenterology	8	0.6%	10	0.8%	21	1.6%	25	1.7%	**22**	**1.4%**
Oncology	20	1.6%	5	0.4%	5	0.4%	12	0.8%	**22**	**1.4%**
Drug and alcohol	4	0.3%	13	1.0%	7	0.5%	8	0.5%	**21**	**1.3%**
Cosmetic services	22	1.8%	18	1.4%	17	1.3%	43	2.9%	**19**	**1.2%**
Cardiology	15	1.2%	17	1.4%	12	0.9%	18	1.2%	**18**	**1.1%**
Other service area	98	7.7%	112	8.9%	104	7.8%	106	7.1%	**124**	**7.7%**
Total	**1,270**	**100.0%**	**1,263**	**100.0%**	**1,337**	**100.0%**	**1,488**	**100.0%**	**1,616**	**100.0%**

Counted by provider identified in complaint

Table 16.5 - Complaints received about registered and previously registered health practitioners by issue category 2012-13

	Registered health practitioner														Total	
Issue category	Medical practitioner	Dental practitioner	Nurse/midwife	Pharmacist	Psychologist	Physiotherapist	Chiropractor	Chinese medicine practitioner	Optometrist	Podiatrist	Occupational therapist	Osteopath	Medical radiation practitioner	Aboriginal/Torres Strait Islander health practitioner	No.	%
Treatment	1,351	424	116	4	38	12	7	3	5	6	-	-	-	-	**1,966**	**38.7%**
Communication/information	695	144	62	38	48	6	4	4	4	4	-	-	2	-	**1,011**	**19.9%**
Professional conduct	313	42	280	62	64	10	7	14	5	3	5	8	3	-	**816**	**16.1%**
Medication	244	7	51	81	1	-	-	1	-	-	-	-	-	-	**385**	**7.6%**
Fees/costs	98	78	2	11	6	2	4	2	6	3	-	-	-	-	**212**	**4.2%**
Reports/certificates	139	2	-	1	28	1	1	-	-	-	1	-	-	-	**173**	**3.4%**
Access	97	18	2	2	9	-	-	-	1	-	-	-	-	-	**129**	**2.5%**
Environment/management of facilities	46	11	14	14	9	1	3	2	-	1	2	-	-	-	**103**	**2.0%**
Consent	70	15	9	1	5	-	-	-	-	-	1	-	-	-	**101**	**2.0%**
Medical records	67	7	13	1	3	2	2	-	-	1	-	-	-	-	**96**	**1.9%**
Grievance processes	21	8	4	-	5	1	-	-	-	-	-	-	-	-	**39**	**0.8%**
Discharge/transfer arrangements	14	1	1	-	-	-	-	-	-	-	-	-	-	-	**16**	**0.3%**
Total	**3,155**	**757**	**554**	**215**	**216**	**35**	**28**	**26**	**21**	**18**	**9**	**8**	**5**	**-**	5,047	**99.4%**
	Previously registered health practitioners															
Professional conduct	8	2	3	6	3	-	-	-	-	-	-	-	-	-	**22**	**0.4%**
Treatment	2	2	-	-	-	-	-	-	-	-	-	-	-	-	**4**	**0.1%**
Communication/information	1	1	-	-	-	-	-	-	-	-	-	-	-	-	**2**	**0.0%**
Fees/costs	-	1	-	-	-	-	-	-	-	-	-	-	-	-	**1**	**0.0%**
Reports/certificates	1	-	-	-	-	-	-	-	-	-	-	-	-	-	**1**	**0.0%**
Total	**12**	**6**	**3**	**6**	**3**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	30	**0.6%**
Grand total	**3,167**	**763**	**557**	**221**	**219**	**35**	**28**	**26**	**21**	**18**	**9**	**8**	**5**	**-**	5,077	100.0%
No. of practitioners with NSW as principal place of practice as at 30.6.2013*	30,333	6,204	94,901	8,460	10,289	7,191	1,564	1,649	1,589	1,001	4,264	515	4,575	21	**172,556**	

Counted by issues raised in complaint
*Data provided by Australian Health Practitioner Registration Agency

Table 16.6 - Complaints received about unregistered and unknown health practitioners by issue category 2012-13

	Unregistered and unknown health practitioner																			
Issue category	Administration/ clerical staff	Alternative health provider	Assistant in nursing	Social worker	Counsellor/therapist	Naturopath	Cosmetic therapist	Dental technician	Massage therapist	Psychotherapist	Residential care worker	Speech pathologist	Ambulance personnel	Hypnotherapist	Optical dispenser	Dietitian/nutritionist	Homeopath	Other/unknown	No.	%
Professional conduct	8	19	18	4	5	3	3	1	6	2	1	1	-	1	-	-	1	7	80	**41.0%**
Communication/information	18	5	3	5	4	3	-	1	-	1	1	-	-	-	1	1	-	4	47	**24.1%**
Treatment	1	5	5	2	4	3	4	5	1	-	1	2	-	-	1	-	-	2	36	**18.5%**
Medication	9	1	1	-	-	3	1	-	-	-	-	-	-	-	-	-	-	-	15	**7.7%**
Consent	-	-	1	3	1	-	-	-	-	-	-	-	-	-	-	-	-	1	6	**3.1%**
Environment/management of facilities	2	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	1	4	**2.1%**
Fees/costs	-	1	-	1	-	1	-	-	-	-	-	-	-	1	-	-	-	-	4	**2.1%**
Grievance processes	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	1	**0.5%**
Medical records	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	1	**0.5%**
Reports/certificates	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	1	**0.5%**
Grand total	**38**	**31**	**28**	**15**	**14**	**14**	**8**	**7**	**7**	**3**	**3**	**3**	**2**	**2**	**2**	**1**	**1**	**16**	**195**	**100.0%**

Counted by issues raised in complaint

Appendices

Table 16.7 - Complaints received about health organisations 2008-09 to 2012-13

	2008-09		2009-10		2010-11		2011-12		**2012-13**	
Health organisation	No.	%	No.	%	No.	%	No.	%	**No.**	**%**
Public hospital	620	48.8%	614	48.5%	763	49.7%	698	45.9%	**763**	**47.5%**
Correction and detention facility	138	10.9%	127	10.0%	136	8.9%	171	11.2%	**187**	**11.6%**
Medical centre	83	6.5%	69	5.5%	69	4.5%	97	6.4%	**99**	**6.2%**
Private hospital	62	4.9%	81	6.4%	71	4.6%	82	5.4%	**81**	**5.0%**
Dental facility	39	3.1%	32	2.5%	55	3.6%	51	3.4%	**62**	**3.9%**
Pharmacy	68	5.4%	53	4.2%	62	4.0%	60	3.9%	**61**	**3.8%**
Community health service	43	3.4%	33	2.6%	47	3.1%	60	3.9%	**53**	**3.3%**
Medical practice	29	2.3%	22	1.7%	29	1.9%	31	2.0%	**53**	**3.3%**
Aged care facility	41	3.2%	39	3.1%	38	2.5%	49	3.2%	**47**	**2.9%**
Radiology facility	12	0.9%	27	2.1%	21	1.4%	28	1.8%	**37**	**2.3%**
Psychiatric hospital/unit	26	2.0%	8	0.6%	17	1.1%	32	2.1%	**32**	**2.0%**
Ambulance service	23	1.8%	30	2.4%	36	2.3%	21	1.4%	**28**	**1.7%**
Pathology centre/lab	10	0.8%	16	1.3%	22	1.4%	17	1.1%	**20**	**1.2%**
Local Health District	37	2.9%	37	2.9%	30	2.0%	23	1.5%	**18**	**1.1%**
Alternative health service	1	0.1%	12	0.9%	22	1.4%	9	0.6%	**15**	**0.9%**
Day procedure centre	5	0.4%	7	0.6%	9	0.6%	6	0.4%	**8**	**0.5%**
Aboriginal health centre	n/a	0.0%	4	0.3%	2	0.1%	9	0.6%	**7**	**0.4%**
Drug and alcohol service	6	0.5%	6	0.5%	10	0.7%	5	0.3%	**6**	**0.4%**
Government department	8	0.6%	5	0.4%	23	1.5%	23	1.5%	**5**	**0.3%**
Multi-purpose service	-	0.0%	3	0.2%	1	0.1%	1	0.1%	**4**	**0.2%**
Chiropractic facility	-	0.0%	1	0.1%	7	0.5%	-	0.0%	**2**	**0.1%**
Rehabilitation facility	2	0.2%	5	0.4%	2	0.1%	2	0.1%	**2**	**0.1%**
Supported accommodation services	2	0.2%	4	0.3%	7	0.5%	3	0.2%	**2**	**0.1%**
Blood bank	-	0.0%	1	0.1%	2	0.1%	1	0.1%	**1**	**0.1%**
Boarding house	-	0.0%	-	0.0%	-	0.0%	-	0.0%	**1**	**0.1%**
Physiotherapy facility	1	0.1%	4	0.3%	5	0.3%	1	0.1%	**1**	**0.1%**
Podiatry practice	-	0.0%	-	0.0%	-	0.0%	3	0.2%	**1**	**0.1%**
Psychology facility	-	0.0%	-	0.0%	2	0.1%	2	0.1%	**1**	**0.1%**
Sexual assault service	-	0.0%	-	0.0%	-	0.0%	-	0.0%	**1**	**0.1%**
Health fund	1	0.1%	7	0.6%	14	0.9%	8	0.5%	**-**	**0.0%**
Nursing agency	-	0.0%	1	0.1%	-	0.0%	2	0.1%	**-**	**0.0%**
Optometrist facility	3	0.2%	4	0.3%	6	0.4%	5	0.3%	**-**	**0.0%**
Other/unknown health organisation	10	0.8%	14	1.1%	26	1.7%	21	1.4%	9	0.6%
Total	**1,270**	**100.0%**	**1,266**	**100.0%**	**1,534**	**100.0%**	**1,521**	**100.0%**	**1,607**	**100.0%**

Counted by provider identified in complaint

Table 16.8 - Complaints received about public hospitals by service area 2008-09 to 2012-13

	2008-09		2009-10		2010-11		2011-12		**2012-13**	
Service area	No.	%	No.	%	No.	%	No.	%	**No.**	**%**
Emergency medicine	158	25.5%	192	31.3%	206	26.9%	174	24.9%	**207**	**27.1%**
Surgery	85	13.7%	102	16.6%	92	12.1%	134	19.2%	**122**	**16.0%**
Mental health	80	12.9%	90	14.7%	84	11.0%	66	9.5%	**111**	**14.5%**
Obstetrics	33	5.3%	53	8.6%	64	8.4%	33	4.7%	**52**	**6.8%**
General medicine	110	17.7%	32	5.2%	87	11.4%	57	8.2%	**49**	**6.4%**
Oncology	5	0.8%	3	0.5%	14	1.8%	11	1.6%	**19**	**2.5%**
Administration	16	2.6%	10	1.6%	16	2.1%	21	3.0%	**17**	**2.2%**
Gynaecology	11	1.8%	2	0.3%	9	1.2%	13	1.9%	**15**	**2.0%**
Paediatric medicine	9	1.5%	9	1.5%	32	4.2%	15	2.1%	**15**	**2.0%**
Neurology	2	0.3%	10	1.6%	8	1.0%	9	1.3%	**14**	**1.8%**
Cardiology	6	1.0%	9	1.5%	17	2.2%	17	2.4%	**13**	**1.7%**
Radiology	4	0.6%	4	0.7%	3	0.4%	7	1.0%	**12**	**1.6%**
Gastroenterology	2	0.3%	1	0.2%	11	1.4%	12	1.7%	**10**	**1.3%**
Midwifery	7	1.1%	4	0.7%	7	0.9%	14	2.0%	**10**	**1.3%**
Palliative care	8	1.3%	9	1.5%	14	1.8%	20	2.9%	**9**	**1.2%**
Respiratory/thoraric medicine	-	0.0%	6	1.0%	7	0.9%	17	2.4%	**9**	**1.2%**
Aged care	6	1.0%	11	1.8%	5	0.7%	9	1.3%	**8**	**1.0%**
Intensive care	16	2.6%	4	0.7%	8	1.0%	4	0.6%	**8**	**1.0%**
Other service area	62	10.0%	63	10.3%	79	10.4%	65	9.3%	**63**	**8.2%**
Total	**620**	**100.0%**	**614**	**100.0%**	**763**	**100.0%**	**698**	**100.0%**	**763**	**100.0%**

Counted by provider identified in complaint

Table 16.9 - Complaints received about public hospitals by Local Health District in 2011-12 to 2012-13

	2011-12		2012-13		2012-13		
Local Heath District	No.	%	No.	%	Number of emergency department attendances	Number of discharges from hospital	Number of outpatient services
Hunter New England	107	15.3%	110	14.4%	386,078	211,998	3,004,518
South Western Sydney	83	11.9%	84	11.0%	237,603	203,175	2,531,624
Western Sydney	58	8.3%	77	10.1%	155,515	160,432	2,349,421
South Eastern Sydney	61	8.7%	64	8.4%	237,838	161,205	3,292,844
Northern Sydney	57	8.2%	55	7.2%	181,640	130,248	1,329,366
Sydney	43	6.2%	48	6.3%	154,150	146,897	2,059,676
Central Coast	33	4.7%	41	5.4%	116,937	78,491	1,063,997
Illawarra Shoalhaven	31	4.4%	41	5.4%	142,105	103,437	1,069,435
Nepean Blue Mountains	44	6.3%	38	5.0%	110,222	73,542	936,105
Western NSW	41	5.9%	38	5.0%	187,125	80,014	1,179,295
Northern NSW	35	5.0%	36	4.7%	182,537	100,003	1,065,065
Mid North Coast	22	3.2%	34	4.5%	112,234	68,418	750,912
Southern NSW	17	2.4%	34	4.5%	108,539	49,798	547,065
Murrumbidgee	31	4.4%	27	3.5%	139,172	69,827	833,946
St Vincent's Health Network	11	1.6%	19	2.5%	44,285	42,067	621,938
Sydney Children's Hospital Network	12	1.7%	11	1.4%	89,482	48,858	1,011,464
Far West	6	0.9%	3	0.4%	n/a	n/a	n/a
Outside of NSW	5	0.7%	3	0.4%	29,467	8,081	138,814
Unknown public hospital	1	0.1%	-	0.0%	n/a	n/a	n/a
Total	**698**	**100.0%**	**763**	**100.0%**	**2,614,929**	**1,736,491**	**23,785,485**

Counted by provider identified in complaint
* Excludes psychiatric hospitals/units

Appendices

Table 16.10 - Issues raised in all complaints received about health organisations by organisation type 2012-13

		Issue category												Total	
	Health organisation type	Treatment	Communication/ information	Medication	Environment/management of facilities	Access	Discharge/transfer arrangements	Fees/costs	Professional conduct	Grievance processes	Medical records	Consent	Reports/certificates	No.	%
Public	Hospital	809	379	80	64	50	84	9	23	43	23	37	7	**1,608**	**52.3%**
	Correction and detention facility	135	38	67	8	30	1	-	-	-	3	2	2	**286**	**9.3%**
	Community health service	40	24	8	1	7	2	-	4	3	3	5	2	**99**	**3.2%**
	Psychiatric hospital/unit	23	11	5	2	2	3	-	4	1	1	6	-	**58**	**1.9%**
	Ambulance service	15	9	-	2	1	2	4	2	2	1	-	-	**38**	**1.2%**
	Local Health District	10	9	2	3	5	-	-	1	2	-	1	-	**33**	**1.1%**
	Dental facility	13	4	-	-	8	-	-	-	-	-	2	-	**27**	**0.9%**
	Aboriginal health centre	5	2	2	1	2	1	-	1	-	-	-	-	**14**	**0.5%**
	Radiology facility	5	2	-	-	-	-	-	-	-	-	1	-	**8**	**0.3%**
	Drug and alcohol service	1	3	2	-	-	-	-	1	-	-	-	-	**7**	**0.2%**
	Government department	-	4	-	2	-	-	-	1	-	-	-	-	**7**	**0.2%**
	Pathology centres/labs	2	1	-	-	-	-	-	-	-	-	-	-	**3**	**0.1%**
	Public medical centre	1	-	-	-	1	-	-	1	-	-	-	-	**3**	**0.1%**
	Multi-purpose service	1	1	-	-	-	-	-	-	-	-	-	-	**2**	**0.1%**
	Supported accommodation services	1	-	1	-	-	-	-	-	-	-	-	-	**2**	**0.1%**
	Blood bank	1	-	-	-	-	-	-	-	-	-	-	-	**1**	**0.0%**
	Public medical practice	-	-	-	-	1	-	-	-	-	-	-	-	**1**	**0.1%**
	Sexual assault service	-	-	-	-	-	-	-	-	-	-	-	1	**1**	**0.0%**
	Other/unknown public health organisation	-	-	-	1	-	-	-	-	-	-	-	-	**1**	**0.0%**
Public health organisation total		**1,062**	**487**	**167**	**84**	**107**	**93**	**13**	**38**	**51**	**31**	**54**	**12**	**2,199**	**71.6%**
Private	Medical centre	42	45	9	13	18	-	18	2	10	15	4	2	**178**	**5.8%**
	Hospital	69	34	9	13	4	8	9	5	5	1	3	-	**160**	**5.2%**
	Aged care facility	38	19	11	7	-	2	1	5	4	1	5	1	**94**	**3.1%**
	Medical practice	24	10	4	4	6	-	9	3	1	28	2	1	**92**	**3.0%**
	Pharmacy	3	18	38	7	2	-	8	10	-	1	-	-	**87**	**2.8%**
	Dental facility	36	17	1	3	-	-	14	5	3	1	1	-	**81**	**2.6%**
	Radiology facility	14	8	-	2	-	-	1	2	3	2	3	13	**48**	**1.6%**
	Pathology centres/labs	9	11	-	3	-	-	5	1	1	-	-	1	**31**	**1.0%**
	Alternative health service	5	6	1	4	-	-	3	6	-	-	-	-	**25**	**0.8%**
	Correction and detention facility	11	3	5	-	3	-	-	1	-	-	-	1	**24**	**0.8%**
	Day procedure centre	8	2	-	-	-	1	-	1	1	-	-	-	**13**	**0.4%**
	Multi-purpose service	3	1	-	-	-	-	-	-	-	-	1	-	**5**	**0.2%**
	Rehabilitation facility	1	1	-	1	-	-	-	-	-	-	1	-	**4**	**0.1%**
	Community health service	-	1	-	-	-	-	-	-	-	1	-	1	**3**	**0.1%**
	Drug and alcohol service	1	1	-	-	-	-	-	-	1	-	-	-	**3**	**0.1%**
	Physiotherapy facility	2	1	-	-	-	-	-	-	-	-	-	-	**3**	**0.1%**
	Podiatry practice	2	-	-	1	-	-	-	-	-	-	-	-	**3**	**0.1%**
	Ambulance service	1	-	-	1	-	-	-	-	-	-	-	-	**2**	**0.1%**
	Boarding house	1	1	-	-	-	-	-	-	-	-	-	-	**2**	**0.1%**
	Chiropractic facility	-	-	-	-	-	-	1	1	-	-	-	-	**2**	**0.1%**
	Supported accommodation services	1	1	-	-	-	-	-	-	-	-	-	-	**2**	**0.1%**
	Psychiatric hospital/unit	-	1	-	-	-	-	-	-	-	-	-	-	**1**	**0.0%**
	Psychology facility	-	-	-	-	-	-	-	-	1	-	-	-	**1**	**0.0%**
	Other/unknown private health organisation	1	3	2	-	-	-	2	2	-	-	-	-	**10**	**0.3%**
Private health organisation total		**272**	**184**	**80**	**59**	**33**	**11**	**71**	**44**	**30**	**50**	**20**	**20**	**874**	**28.4%**
Grand total		**1,334**	**671**	**247**	**143**	**140**	**104**	**84**	**82**	**81**	**81**	**74**	**32**	**3,073**	**100.0%**

Counted by issues raised in complaint

Table 16.11 - Issues raised in all complaints received by service area 2012-13

	Issue category												Total	
Service area	Treatment	Communication/ information	Professional conduct	Medication	Fees/costs	Access	Environment/management of facilities	Reports/certificates	Consent	Medical records	Grievance processes	Discharge/transfer arrangements	No.	%
General medicine	788	435	276	242	46	123	58	44	26	80	20	16	**2,154**	**25.8%**
Dentistry	500	169	52	7	97	31	14	2	23	8	13	2	**918**	**11.0%**
Surgery	423	183	37	28	32	22	26	10	28	11	16	10	**826**	**9.9%**
Mental health	227	114	87	66	2	12	12	14	36	16	5	16	**607**	**7.3%**
Emergency medicine	320	118	27	17	4	24	9	-	6	6	16	38	**585**	**7.0%**
Pharmacy/pharmacology	7	68	81	132	20	5	22	1	1	2	-	-	**339**	**4.1%**
Aged care	101	65	62	39	1	2	14	3	2	4	7	3	**303**	**3.6%**
Obstetrics	130	58	9	2	3	3	1	3	3	3	4	4	**223**	**2.7%**
Psychology	31	39	59	1	6	7	9	25	4	2	4	-	**187**	**2.2%**
Medico-legal	40	57	7	-	2	2	6	52	3	-	-	-	**169**	**2.0%**
Psychiatry	48	32	21	19	1	6	1	17	6	6	1	1	**159**	**1.9%**
Gynaecology	66	24	7	1	5	2	-	-	4	1	2	2	**114**	**1.4%**
Paediatric medicine	56	28	5	5	3	-	3	2	5	-	2	2	**111**	**1.3%**
Oncology	60	23	4	6	-	-	3	-	-	1	2	3	**102**	**1.2%**
Drug and alcohol	18	9	36	19	-	3	3	-	2	1	2	1	**94**	**1.1%**
Administration	2	23	11	-	13	5	18	1	-	12	5	-	**90**	**1.1%**
Radiology	28	18	6	-	3	1	2	19	4	2	4	-	**87**	**1.0%**
Gastroenterology	34	25	6	4	4	5	1	-	2	-	-	1	**82**	**1.0%**
Ophthalmology	44	17	6	-	4	2	-	-	1	4	1	-	**79**	**0.9%**
Dermatology	44	15	-	1	5	-	1	1	2	-	1	-	**70**	**0.8%**
Cardiology	32	11	5	4	1	-	3	1	1	1	3	7	**69**	**0.8%**
Midwifery	28	17	13	1	-	1	-	1	-	4	-	2	**67**	**0.8%**
Neurology	36	17	-	4	-	-	1	3	1	3	2	-	**67**	**0.8%**
Cosmetic services	31	8	12	3	5	1	3	-	1	1	1	-	**66**	**0.8%**
Anaesthesia	22	6	11	1	6	-	1	-	5	-	1	2	**55**	**0.7%**
Alternative health	5	11	25	3	3	-	3	-	-	2	-	-	**52**	**0.6%**
Pathology	19	16	5	1	3	-	5	1	1	-	1	-	**52**	**0.6%**
Palliative care	13	12	1	10	-	1	1	-	-	-	1	1	**40**	**0.5%**
Physiotherapy	14	7	13	-	2	-	1	-	-	2	1	-	**40**	**0.5%**
Ambulance service	14	10	2	-	4	1	3	-	-	1	2	2	**39**	**0.5%**
Rehabilitation medicine	13	8	3	3	1	1	3	-	2	-	-	2	**36**	**0.4%**
Chiropractice	7	4	11	-	5	-	2	-	-	2	-	-	**31**	**0.4%**
Respiratory/thoraric medicine	15	6	2	1	1	-	-	1	-	1	1	2	**30**	**0.4%**
Counselling	7	9	9	-	-	-	-	1	2	1	-	-	**29**	**0.3%**
Optometry	11	6	4	-	5	3	-	-	-	-	-	-	**29**	**0.3%**
Immunology	9	7	4	4	1	1	-	2	-	-	-	-	**28**	**0.3%**
Non-health related	-	4	17	-	-	-	7	-	-	-	-	-	**28**	**0.3%**
Geriatrics/gerontology	7	8	1	6	-	1	1	-	-	-	-	2	**26**	**0.3%**
Radiography	11	6	4	-	1	-	1	-	1	-	-	-	**24**	**0.3%**
Podiatry	8	4	3	-	3	-	2	-	-	1	-	-	**21**	**0.3%**
Intensive care	7	5	4	1	-	-	2	-	1	-	-	-	**20**	**0.2%**
Acupuncture	4	3	9	-	1	-	-	-	-	-	-	-	**17**	**0.2%**

Table continued on next page

Table 16.11 - Issues raised in all complaints received by service area 2012-13 (continued)

Service area	Issue category: Treatment	Communication/ information	Professional conduct	Medication	Fees/costs	Access	Environment/management of facilities	Reports/certificates	Consent	Medical records	Grievance processes	Discharge/transfer arrangements	Total: No.	Total: %
Haematology	9	3	1	1	-	-	-	-	-	-	1	1	**16**	**0.2%**
Renal medicine	8	4	-	-	-	-	1	-	2	-	-	-	**15**	**0.2%**
Reproductive medicine	6	2	-	2	3	-	-	-	-	-	-	-	**13**	**0.2%**
Pain management	5	1	1	3	1	1	-	-	-	-	-	-	**12**	**0.1%**
Massage therapy	1	1	7	-	1	-	1	-	-	-	-	-	**11**	**0.1%**
Traditional Chinese medicine	-	1	6	1	1	-	-	-	-	-	-	-	**9**	**0.1%**
Endocrinology	3	1	-	1	-	1	-	-	2	-	-	-	**8**	**0.1%**
Occupational health	-	1	3	-	-	-	2	1	1	-	-	-	**8**	**0.1%**
Rheumatology	5	-	-	-	1	1	-	-	1	-	-	-	**8**	**0.1%**
Health education/information	-	3	2	1	-	-	1	-	-	-	-	-	**7**	**0.1%**
Developmental disability	2	1	1	2	-	-	-	-	-	-	-	-	**6**	**0.1%**
Nephrology	1	2	-	-	-	1	-	-	1	-	-	-	**5**	**0.1%**
Osteopathy	1	-	2	-	-	-	-	-	1	-	1	-	**5**	**0.1%**
Sleep medicine	4	-	1	-	-	-	-	-	-	-	-	-	**5**	**0.1%**
Infectious diseases	4	-	-	-	-	-	-	-	-	-	-	-	**4**	**0.0%**
Natural therapy	1	1	1	1	-	-	-	-	-	-	-	-	**4**	**0.0%**
Occupational therapy	-	-	3	-	-	-	1	-	-	-	-	-	**4**	**0.0%**
Psychotherapy	-	1	2	-	-	-	-	-	-	-	1	-	**4**	**0.0%**
Sexual assault service	1	1	-	-	-	-	-	2	-	-	-	-	**4**	**0.0%**
Early childhood	2	-	-	1	-	-	-	-	-	-	-	-	**3**	**0.0%**
Nutrition and dietetics	-	1	-	-	-	-	2	-	-	-	-	-	**3**	**0.0%**
Prosthetics and orthotics	2	1	-	-	-	-	-	-	-	-	-	-	**3**	**0.0%**
Speech therapy	2	-	1	-	-	-	-	-	-	-	-	-	**3**	**0.0%**
Family planning	1	-	1	-	-	-	-	-	-	-	-	-	**2**	**0.0%**
Hypnotherapy	-	-	1	-	1	-	-	-	-	-	-	-	**2**	**0.0%**
Autopsy	1	-	-	-	-	-	-	-	-	-	-	-	**1**	**0.0%**
Aviation medicine	1	-	-	-	-	-	-	-	-	-	-	-	**1**	**0.0%**
Forensic pathology	-	-	1	-	-	-	-	-	-	-	-	-	**1**	**0.0%**
Other/unknown service area	-	1	9	3	-	-	-	-	-	-	-	-	**13**	**0.2%**
Total	**3,340**	**1,731**	**1,000**	**647**	**301**	**269**	**250**	**207**	**181**	**178**	**121**	**120**	**8,345**	**100.0%**

Counted by issues raised in complaint

Table 16.12 - Source of complaints 2008-09 to 2012-13

	2008-09		2009-10		2010-11		2011-12		**2012-13 ***	
Source	No.	%	No.	%	No.	%	No.	%	**No.**	**%**
Consumer	1,224	44.5%	1,479	48.8%	1,863	52.7%	1,999	56.2%	**2,403**	**63.4%**
Family or friend	554	20.1%	560	18.5%	722	20.4%	737	20.7%	**800**	**21.1%**
Health professional	24	0.9%	35	1.2%	74	2.1%	55	1.5%	**194**	**5.1%**
Department of Health (State and Commonwealth)	30	1.1%	25	0.8%	25	0.7%	20	0.6%	**135**	**3.6%**
Professional council	809	29.4%	841	27.7%	711	20.1%	646	18.2%	**112**	**3.0%**
Government department	25	0.9%	30	1.0%	43	1.2%	23	0.6%	**49**	**1.3%**
Legal representative	18	0.7%	20	0.7%	30	0.8%	16	0.5%	**27**	**0.7%**
Consumer organisation	11	0.4%	-	0.0%	8	0.2%	21	0.6%	**18**	**0.5%**
Court	8	0.3%	3	0.1%	5	0.1%	8	0.2%	**12**	**0.3%**
Parliament/Minister	27	1.0%	33	1.1%	19	0.5%	14	0.4%	**6**	**0.2%**
Professional association	-	0.0%	-	0.0%	4	0.1%	-	0.0%	**6**	**0.2%**
College	-	0.0%	-	0.0%	10	0.3%	2	0.1%	**4**	**0.1%**
Other source	22	0.8%	5	0.2%	21	0.6%	14	0.4%	**22**	**0.6%**
Total	**2,752**	**100.0%**	**3,031**	**100.0%**	**3,535**	**100.0%**	**3,555**	**100.0%**	**3,788**	**100.0%**

Counted by complainant

* The Commission reviewed its categorisation of case sources in 2012-13 which resulted in data for the 2012-13 year not being directly comparable with prior years.

Table 16.13 - Outcome of assessment of complaints 2008-09 to 2012-13

	2008-09		2009-10		2010-11		2011-12		**2012-13**	
Assessment decision	No.	%	No.	%	No.	%	No.	%	**No.**	**%**
Discontinued	1,291	38.5%	1,447	41.2%	1,978	48.6%	2,017	49.2%	**2,148**	**47.3%**
Referred to professional council	755	22.5%	806	22.9%	790	19.4%	753	18.4%	**887**	**19.5%**
Referred to the Commission's Resolution Service*	728	21.7%	735	20.9%	686	16.8%	615	15.0%	**714**	**15.7%**
Referred for local resolution	56	1.7%	41	1.2%	206	5.1%	239	5.8%	**252**	**5.5%**
Resolved during assessment	188	5.6%	206	5.9%	166	4.1%	180	4.4%	**240**	**5.3%**
Investigation by Commission	270	8.1%	223	6.3%	184	4.5%	194	4.7%	**209**	**4.6%**
Referred to another body or person	61	1.8%	54	1.5%	63	1.5%	105	2.6%	**94**	**2.1%**
Total	**3,349**	**100.0%**	**3,512**	**100.0%**	**4,073**	**100.0%**	**4,103**	**100.0%**	**4,544**	**100.0%**

Counted by provider identified in complaint

* Prior to July 2010, the two resolution options of assisted resolution and conciliation were reported separately. Due to the restructure of the Resolution Section, complaints are now referred to the Resolution Service and a decision is made as part of the resolution process whether assisted resolution or conciliation is the more appropriate form of trying to resolve the complaint.

Table 16.14 - Outcome of assessment of complaints by issues identified in complaint 2012-13

		Outcome							Total	
Issue category	Issue name	Discontinued	Referred to the Commission's Resolution Service	Referred to professional council	Resolved during assessment	Local resolution	Investigation by Commission	Referred to another body	No.	%
Treatment	Inadequate treatment	821	512	294	89	84	43	17	**1,860**	**22.3%**
	Diagnosis	188	101	63	12	6	8	-	**378**	**4.5%**
	Unexpected treatment outcome/complications	106	88	38	8	1	5	-	**246**	**2.9%**
	Delay in treatment	71	54	16	10	36	-	-	**187**	**2.2%**
	Inadequate care	77	69	14	8	13	3	-	**184**	**2.2%**
	Inadequate/inappropriate consultation	97	10	35	11	-	5	-	**158**	**1.9%**
	Inadequate prosthetic equipment	47	13	11	8	1	-	1	**81**	**1.0%**
	Rough and painful treatment	39	10	16	-	2	1	1	**69**	**0.8%**
	No/inappropriate referral	33	4	6	3	3	3	1	**53**	**0.6%**
	Wrong/inappropriate treatment	24	7	11	-	2	2	-	**46**	**0.6%**
	Infection control	15	12	4	3	1	-	1	**36**	**0.4%**
	Coordination of treatment/results follow-up	10	5	7	3	3	4	-	**32**	**0.4%**
	Excessive treatment	13	2	4	1	1	1	1	**23**	**0.3%**
	Withdrawal of treatment	8	-	-	-	2	-	-	**10**	**0.1%**
	Experimental treatment	2	-	1	-	-	-	-	**3**	**0.0%**
	Attendance	1	-	-	-	-	-	-	**1**	**0.0%**
Treatment total		**1,552**	**887**	**520**	**156**	**155**	**75**	**22**	3,367	**40.4%**
Communication/ information	Attitude/manner	614	153	118	86	56	9	9	**1,045**	**12.5%**
	Incorrect/misleading information provided	220	53	49	23	12	2	-	**359**	**4.3%**
	Inadequate information provided	141	115	35	14	10	5	-	**320**	**3.8%**
	Special needs not accommodated	10	3	-	2	6	1	-	**22**	**0.3%**
Communication/information total		**985**	**324**	**202**	**125**	**84**	**17**	**9**	1,746	**20.9%**
Professional conduct	Impairment	16	-	119	-	-	25	2	**162**	**1.9%**
	Competence	38	3	80	1	-	16	5	**143**	**1.7%**
	Illegal practice	52	-	47	3	1	21	10	**134**	**1.6%**
	Breach of guideline/law	28	-	53	1	-	10	15	**107**	**1.3%**
	Sexual misconduct	23	2	15	-	1	36	1	**78**	**0.9%**
	Inappropriate disclosure of information	44	2	17	4	5	-	-	**72**	**0.9%**
	Boundary violation	17	-	28	1	-	23	-	**69**	**0.8%**
	Misrepresentation of qualifications	15	1	10	3	-	5	26	**60**	**0.7%**
	Assault	33	5	10	2	-	8	-	**58**	**0.7%**
	Breach of condition	9	-	9	1	-	15	-	**34**	**0.4%**
	Financial fraud	9	-	7	3	-	4	3	**26**	**0.3%**
	Discriminatory conduct	13	-	6	-	2	-	-	**21**	**0.3%**
	Annual declaration not lodged/incomplete/wrong or misleading	1	-	-	-	-	2	1	**4**	**0.0%**
Professional conduct total		**298**	**13**	**401**	**19**	**9**	**165**	**63**	968	**11.6%**
Medication	Prescribing medication	159	47	62	11	34	36	12	**361**	**4.3%**
	Dispensing medication	42	5	80	11	9	5	3	**155**	**1.9%**
	Administering medication	52	29	34	6	15	4	3	**143**	**1.7%**
	Supply/security/storage of medication	8	2	7	1	-	-	1	**19**	**0.2%**
Medication total		**261**	**83**	**183**	**29**	**58**	**45**	**19**	678	**8.1%**

Table continued on next page

Table 16.14 - Outcome of assessment of complaints by issues identified in complaint 2012-13 (continued)

		Outcome							Total	
Issue category	Issue name	Discontinued	Referred to the Commission's Resolution Service	Referred to professional council	Resolved during assessment	Local resolution	Investigation by Commission	Referred to another body	No.	%
Fees/costs	Billing practices	174	12	34	32	4	-	6	**262**	**3.1%**
	Cost of treatment	20	-	3	5	1	-	-	**29**	**0.3%**
	Financial consent	9	-	2	-	1	-	-	**12**	**0.1%**
Fees/costs total		**203**	**12**	**39**	**37**	**6**	**-**	**6**	**303**	**3.6%**
Access	Refusal to admit or treat	125	20	15	10	13	-	-	**183**	**2.2%**
	Waiting lists	13	9	1	5	15	-	-	**43**	**0.5%**
	Service availability	14	5	-	2	9	-	-	**30**	**0.4%**
	Access to facility	1	-	-	-	2	-	-	**3**	**0.0%**
	Access to subsidies	1	-	-	1	-	-	-	**2**	**0.0%**
	Remoteness of service	-	1	-	-	-	-	-	**1**	**0.0%**
Access total		**154**	**35**	**16**	**18**	**39**	**-**	**-**	**262**	**3.1%**
Environment/ management of facilities	Administrative processes	81	10	23	12	19	4	8	**157**	**1.9%**
	Cleanliness/hygiene of facility	19	4	12	4	5	1	1	**46**	**0.6%**
	Physical environment of facility	6	7	2	2	7	-	1	**25**	**0.3%**
	Staffing and rostering	4	-	-	-	2	-	2	**8**	**0.1%**
	Statutory obligations/accreditation standards not met	4	-	3	-	-	-	-	**7**	**0.1%**
Environment/management of facilities total		**114**	**21**	**40**	**18**	**33**	**5**	**12**	**243**	**2.9%**
Reports/certificates	Accuracy of report/certificate	116	9	23	3	1	-	-	**152**	**1.8%**
	Refusal to provide report/certificate	17	2	1	1	-	-	-	**21**	**0.3%**
	Timeliness of report/certificate	8	1	1	1	1	-	-	**12**	**0.1%**
	Report written with inadequate or no consultation	5	-	6	-	-	-	-	**11**	**0.1%**
	Cost of report/certificate	-	-	1	-	-	-	-	**1**	**0.0%**
Reports/certificates total		**146**	**12**	**32**	**5**	**2**	**-**	**-**	**197**	**2.4%**
Medical records	Access to/transfer of records	52	4	5	19	3	-	2	**85**	**1.0%**
	Record keeping	29	7	29	2	4	9	1	**81**	**1.0%**
	Records management	10	-	3	1	-	-	-	**14**	**0.2%**
Medical records total		**91**	**11**	**37**	**22**	**7**	**9**	**3**	**180**	**2.2%**
Consent	Consent not obtained or inadequate	76	24	17	4	4	13	-	**138**	**1.7%**
	Involuntary admission or treatment	17	2	-	1	4	-	-	**24**	**0.3%**
	Uninformed consent	3	3	1	-	-	-	-	**7**	**0.1%**
Consent Total		**96**	**29**	**18**	**5**	**8**	**13**	**-**	**169**	**2.0%**
Grievance processes	Inadequate/no response to complaint	56	33	6	13	4	1	-	**113**	**1.4%**
	Information about complaints procedures not provided	2	-	-	-	-	-	-	**2**	**0.0%**
	Reprisal/retaliation as result of complaint lodged	1	-	1	-	-	-	-	**2**	**0.0%**
Grievance processes total		**59**	**33**	**7**	**13**	**4**	**1**	**-**	**117**	**1.4%**
Discharge/transfer arrangements	Inadequate discharge	26	54	4	7	7	1	-	**99**	**1.2%**
	Delay	3	6	-	-	-	-	-	**9**	**0.1%**
	Mode of transport	-	2	-	-	3	-	-	**5**	**0.1%**
Discharge/transfer arrangements total		**29**	**62**	**4**	**7**	**10**	**1**	**-**	**113**	**1.4%**
Grand total		**3,988**	**1,522**	**1,499**	**454**	**415**	**331**	**134**	**8,343**	**100.0%**

Counted by issues raised in complaint

Table 16.15 - Outcome of assessment of complaints by service area 2012-13

	Outcome							Total	
Service area	Discontinued	Referred to professional council	Referred to Commission's Resolution Service	Local resolution	Resolved during assessment	Investigation by Commission	Referred to another body	No.	%
General medicine	626	222	98	95	53	67	17	**1,178**	**25.9%**
Dentistry	269	138	43	9	48	23	13	**543**	**11.9%**
Surgery	160	47	140	18	14	13	-	**392**	**8.6%**
Mental health	184	44	64	42	9	17	2	**362**	**8.0%**
Emergency medicine	82	22	98	33	24	6	-	**265**	**5.8%**
Pharmacy/pharmacology	84	117	4	2	12	12	10	**241**	**5.3%**
Aged care	71	53	29	-	2	10	14	**179**	**3.9%**
Psychology	53	56	1	-	-	5	3	**118**	**2.6%**
Obstetrics	29	16	31	5	8	4	1	**94**	**2.1%**
Medico-legal	75	11	-	-	1	1	1	**89**	**2.0%**
Psychiatry	45	10	8	1	1	4	-	**69**	**1.5%**
Drug and alcohol	26	18	4	4	2	6	2	**62**	**1.4%**
Radiology	28	5	13	3	7	1	2	**59**	**1.3%**
Administration	32	3	3	6	9	-	5	**58**	**1.3%**
Gynaecology	23	3	23	1	2	-	-	**52**	**1.1%**
Oncology	11	9	24	3	3	-	1	**51**	**1.1%**
Paediatric medicine	28	6	11	3	-	1	-	**49**	**1.1%**
Midwifery	6	13	15	-	4	4	-	**42**	**0.9%**
Gastroenterology	20	4	8	1	4	1	-	**38**	**0.8%**
Ophthalmology	18	3	6	2	1	1	2	**33**	**0.7%**
Anaesthesia	14	8	6	-	2	1	-	**31**	**0.7%**
Neurology	15	4	9	1	2	-	-	**31**	**0.7%**
Alternative health	22	2	-	-	-	2	4	**30**	**0.7%**
Non-health related	15	5	-	2	1	6	1	**30**	**0.7%**
Ambulance service	12	-	5	7	5	-	-	**29**	**0.6%**
Pathology	18	2	3	-	4	2	-	**29**	**0.6%**
Cardiology	11	4	7	-	4	1	-	**27**	**0.6%**
Cosmetic services	17	3	1	-	2	1	1	**25**	**0.6%**
Palliative care	3	4	15	1	1	-	1	**25**	**0.6%**
Dermatology	15	2	4	2	1	-	-	**24**	**0.5%**
Physiotherapy	11	6	-	-	-	1	4	**22**	**0.5%**
Chiropractice	8	6	-	-	-	2	3	**19**	**0.4%**
Optometry	11	6	-	1	-	-	-	**18**	**0.4%**
Rehabilitation medicine	7	1	7	-	1	-	1	**17**	**0.4%**
Respiratory/thoraric medicine	7	1	5	2	1	-	-	**16**	**0.4%**
Counselling	12	1	-	-	-	1	-	**14**	**0.3%**
Podiatry	5	6	-	-	1	-	1	**13**	**0.3%**
Radiography	5	2	2	-	3	-	-	**12**	**0.3%**

Table continued on next page

Table 16.15 - Outcome of assessment of complaints by service area 2012-13 (continued)

	Outcome							Total	
Service area	Discontinued	Referred to professional council	Referred to Commission's Resolution Service	Local resolution	Resolved during assessment	Investigation by Commission	Referred to another body	No.	%
Immunology	5	4	2	-	-	-	-	**11**	**0.2%**
Intensive care	1	1	6	1	-	2	-	**11**	**0.2%**
Acupuncture	5	3	-	-	-	-	1	**9**	**0.2%**
Geriatrics/gerontology	2	2	4	-	-	-	1	**9**	**0.2%**
Massage therapy	2	-	-	-	3	3	-	**8**	**0.2%**
Pain management	3	1	2	2	-	-	-	**8**	**0.2%**
Haematology	1	1	4	-	-	1	-	**7**	**0.2%**
Prosthetics and orthotics	4	-	2	1	-	-	-	**7**	**0.2%**
Health education/information	3	1	-	-	-	2	-	**6**	**0.1%**
Reproductive medicine	6	-	-	-	-	-	-	**6**	**0.1%**
Endocrinology	4	-	-	-	1	-	-	**5**	**0.1%**
Occupational health	4	1	-	-	-	-	-	**5**	**0.1%**
Renal medicine	2	-	1	1	1	-	-	**5**	**0.1%**
Rheumatology	5	-	-	-	-	-	-	**5**	**0.1%**
Traditional Chinese medicine	2	1	-	-	-	1	-	**4**	**0.1%**
Developmental disability	2	-	-	1	-	-	-	**3**	**0.1%**
Hypnotherapy	2	-	-	-	1	-	-	**3**	**0.1%**
Nutrition and dietetics	-	-	-	2	1	-	-	**3**	**0.1%**
Osteopathy	1	1	-	-	-	1	-	**3**	**0.1%**
Sexual assault service	2	1	-	-	-	-	-	**3**	**0.1%**
Sleep medicine	3	-	-	-	-	-	-	**3**	**0.1%**
Infectious diseases	-	-	2	-	-	-	-	**2**	**0.0%**
Occupational therapy	-	1	-	-	-	-	1	**2**	**0.0%**
Speech therapy	2	-	-	-	-	-	-	**2**	**0.0%**
Autopsy	-	-	1	-	-	-	-	**1**	**0.0%**
Aviation medicine	-	-	1	-	-	-	-	**1**	**0.0%**
Early childhood	1	-	-	-	-	-	-	**1**	**0.0%**
Family planning	-	1	-	-	-	-	-	**1**	**0.0%**
Forensic pathology	1	-	-	-	-	-	-	**1**	**0.0%**
Natural therapy	1	-	-	-	-	-	-	**1**	**0.0%**
Nephrology	1	-	-	-	-	-	-	**1**	**0.0%**
Personal care	-	-	1	-	-	-	-	**1**	**0.0%**
Psychotherapy	-	-	-	-	-	1	-	**1**	**0.0%**
Other/unknown service area	5	5	1	-	1	5	2	**19**	**0.4%**
Total	**2,148**	**887**	**714**	**252**	**240**	**209**	**94**	**4,544**	**100.0%**

Counted by provider identified in complaint

Appendices

Table 16.16 - Outcome of assessment of complaints by type of health service provider 2012-13

	Outcome							Total	
Health service provider type	Discontinued	Referred to professional council	Referred to the Commission's Resolution Service	Referred for local resolution	Resolved during assessment	Investigation by Commission	Referred to another body	No.	%
Medical practitioner	919	328	170	-	73	94	24	1,608	35.4%
Dental practitioner	237	138	36	-	37	16	10	474	10.4%
Nurse/midwife	124	207	8	-	2	45	6	392	8.6%
Pharmacist	45	80	2	-	4	12	9	152	3.3%
Psychologist	59	66	1	-	-	5	4	135	3.0%
Administration/clerical staff	24	-	-	-	-	-	1	25	0.6%
Physiotherapist	10	6	-	-	1	1	2	20	0.4%
Assistant in nursing	11	-	-	-	-	8	-	19	0.4%
Chiropractor	8	6	-	-	-	2	-	16	0.4%
Alternative health provider	12	-	-	-	-	-	3	15	0.3%
Optometrist	8	6	-	-	-	-	-	14	0.3%
Chinese medicine practitioner	6	4	-	-	-	2	1	13	0.3%
Podiatrist	4	6	-	-	1	-	1	12	0.3%
Social worker	9	-	-	-	-	-	-	9	0.2%
Counsellor/therapist	7	-	-	-	-	-	-	7	0.2%
Medical radiation practitioner	3	1	1	-	-	-	1	6	0.1%
Massage therapist	1	-	-	-	1	3	-	5	0.1%
Naturopath	4	-	-	-	-	1	-	5	0.1%
Occupational therapist	2	2	-	-	-	-	1	5	0.1%
Residential care worker	3	-	-	-	-	1	-	4	0.1%
Osteopath	-	-	-	-	-	2	1	3	0.1%
Hypnotherapist	2	-	-	-	-	-	-	2	0.0%
Psychotherapist	-	-	-	-	-	2	-	2	0.0%
Speech pathologist	2	-	-	-	-	-	-	2	0.0%
Ambulance personnel	1	-	-	-	-	-	-	1	0.0%
Cosmetic therapist	1	-	-	-	-	-	-	1	0.0%
Dietitian/nutritionist	-	-	-	-	1	-	-	1	0.0%
Homeopath	1	-	-	-	-	-	-	1	0.0%
Optical dispenser	1	-	-	-	-	-	-	1	0.0%
Other/unknown health practitioner	8	-	-	-	-	-	3	11	0.2%
Total health practitioner	**1,512**	**850**	**218**	**-**	**120**	**194**	**67**	**2,961**	**65.2%**

Table continued on next page

Table 16.16 - Outcome of assessment of complaints by type of health service provider 2012-13 (continued)

	Outcome							Total	
Health service provider type	Discontinued	Referred to professional council	Referred to the Commission's Resolution Service	Referred for local resolution	Resolved during assessment	Investigation by Commission	Referred to another body	No.	%
Public hospital	206	-	356	112	53	4	1	732	16.1%
Correction and detention facility	53	-	22	109	3	-	-	187	4.1%
Medical centre	78	1	8	-	8	-	2	97	2.1%
Private hospital	36	-	35	-	10	1	2	84	1.8%
Pharmacy	25	36	2	-	8	-	1	72	1.6%
Dental facility	37	-	5	6	9	3	3	63	1.4%
Community health service	30	-	16	6	4	-	-	56	1.2%
Medical practice	48	-	-	-	2	-	-	50	1.1%
Aged care facility	15	-	12	-	1	5	14	47	1.0%
Radiology facility	21	-	12	-	7	-	-	40	0.9%
Ambulance service	11	-	7	7	5	-	-	30	0.7%
Psychiatric hospital/unit	12	-	7	8	-	-	-	27	0.6%
Pathology centres/labs	13	-	2	-	3	-	-	18	0.4%
Local Health District	8	-	2	3	1	-	-	14	0.3%
Alternative health centre	4	-	-	-	3	-	2	9	0.2%
Aboriginal health centre	5	-	3	-	-	-	-	8	0.2%
Drug and alcohol service	7	-	-	-	1	-	-	8	0.2%
Alternative health practice	3	-	1	-	1	-	1	6	0.1%
Day procedure centre	4	-	2	-	-	-	-	6	0.1%
Multi-purpose service	3	-	2	-	-	-	-	5	0.1%
Government department	4	-	1	-	-	-	-	5	0.1%
Psychology facility	2	-	-	-	-	-	-	2	0.0%
Rehabilitation facility	1	-	-	-	1	-	-	2	0.0%
Blood bank	-	-	1	-	-	-	-	1	0.0%
Boarding house	1	-	-	-	-	-	-	1	0.0%
Chiropractic facility	-	-	-	-	-	-	1	1	0.0%
Physiotherapy facility	1	-	-	-	-	-	-	1	0.0%
Podiatry practice	1	-	-	-	-	-	-	1	0.0%
Sexual assault service	1	-	-	-	-	-	-	1	0.0%
Supported accommodation services (not aged care)	1	-	-	-	-	-	-	1	0.0%
Other/unknown health organisation	5	-	-	1	-	2	-	8	0.2%
Total health organisation	**636**	**37**	**496**	**252**	**120**	**15**	**27**	**1,583**	**34.8%**
Grand total	**2,148**	**887**	**714**	**252**	**240**	**209**	**94**	**4,544**	**100.0%**

Counted by provider identified in complaint

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Table 16.17 - Time taken to assess complaints 2008-09 to 2012-13

	2008-09	2009-10	2010-11	2011-12	**2012-13**
Percentage of complaints assessed within 60 days	88.9%	82.3%	84.6%	88.1%	**94.5%**
Average days to assess complaints	42	46	43	43	**40**

Counted by provider identified in complaint

Table 16.18 - Requests for review of assessment decision 2008-09 to 2012-13

	2008-09	2009-10	2010-11	2011-12	**2012-13**
Requests for review of assessment decision	281	278	305	292	**389**
Percentage of all assessments finalised	8.4%	7.9%	7.5%	7.1%	**8.6%**

Counted by provider identified in complaint

Table 16.19 - Outcome of reviews of assessment decision 2008-09 to 2012-13

	2008-09		2009-10		2010-11		2011-12		**2012-13**	
Review result	No.	%	No.	%	No.	%	No.	%	**No.**	**%**
Original assessment decision confirmed	261	96.0%	252	94.4%	281	93.7%	267	88.7%	**344**	**93.2%**
Assessment decision varied	11	4.0%	15	5.6%	19	6.3%	34	11.3%	**25**	**6.8%**
Total	**272**	**100.0%**	**267**	**100.0%**	**300**	**100.0%**	**301**	**100.0%**	**369**	**100.0%**

Counted by provider identified in complaint

Table 16.20 - Outcome of assisted resolutions 2008-09 to 2012-13

			2008-09		2009-10		2010-11		2011-12		**2012-13**	
Outcome			No.	%	No.	%	No.	%	No.	%	**No.**	**%**
Resolution did proceed	Resolved	Resolved	244	39.4%	216	39.1%	262	40.4%	239	36.6%	**283**	**44.5%**
		Partially resolved	167	26.9%	119	21.5%	143	22.0%	152	23.3%	**123**	**19.3%**
	Not resolved	Not resolved	103	16.6%	99	17.9%	88	13.6%	54	8.3%	**59**	**9.3%**
Resolution did proceed total			**514**	**82.9%**	**434**	**78.5%**	**493**	**76.0%**	**445**	**68.1%**	**465**	**73.1%**
Resolution did not proceed total			**106**	**17.1%**	**119**	**21.5%**	**156**	**24.0%**	**208**	**31.9%**	**171**	**26.9%**
Grand total			**620**	**100.0%**	**553**	**100.0%**	**649**	**100.0%**	**653**	**100.0%**	**636**	**100.0%**

Counted by provider identified in complaint

Table 16.21 - Outcome of conciliations 2008-09 to 2012-13

			2008-09		2009-10		2010-11		2011-12		2012-13	
Outcome		Reason	No.	%	No.	%	No.	%	No.	%	**No.**	**%**
Conciliation process did proceed	Resolved	Agreement reached at conciliation meeting	43	18.9%	26	18.2%	21	47.7%	18	81.8%	**14**	**77.8%**
		Complaint resolved with the assistance of the Registry	15	6.6%	6	4.2%	1	2.3%	-	0.0%	**-**	**0.0%**
	Not resolved	Consent withdrawn	34	14.9%	20	14.0%	4	9.1%	2	9.1%	**4**	**22.2%**
		The conciliation was helpful in clarifying concerns	27	11.8%	8	5.6%	10	22.7%	-	0.0%	**-**	**0.0%**
		Parties did not reach agreement during conciliation meeting	10	4.4%	6	4.2%	-	0.0%	2	9.1%	**-**	**0.0%**
Total conciliation process did proceed			**129**	**56.6%**	**66**	**46.2%**	**36**	**81.8%**	**22**	**100.0%**	**18**	**100.0%**
Conciliation process did not proceed total			**99**	**43.4%**	**77**	**53.8%**	**8**	**18.2%**	**-**	**0.0%**	**-**	**0.0%**
Grand total			**228**	**100.0%**	**143**	**100.0%**	**44**	**100.0%**	**22**	**100.0%**	**18**	**100.0%**

Counted by provider identified in complaint

Table 16.22 - Time taken to complete resolution processes 2008-09 to 2012-13

	2008-09		2009-10		2010-11		2011-12		2012-13	
Time taken to complete	No.	%	No.	%	No.	%	No.	%	**No.**	**%**
0-1 month	176	20.8%	145	20.8%	143	20.6%	143	21.2%	**116**	**17.7%**
1- 2 months	230	27.1%	168	24.1%	149	21.5%	123	18.2%	**133**	**20.3%**
2- 3 months	129	15.2%	118	17.0%	103	14.9%	122	18.1%	**96**	**14.7%**
3- 4 months	90	10.6%	85	12.2%	66	9.5%	83	12.3%	**77**	**11.8%**
4- 5 months	48	5.7%	48	6.9%	59	8.5%	52	7.7%	**62**	**9.5%**
5- 6 months	53	6.3%	45	6.5%	41	5.9%	50	7.4%	**48**	**7.3%**
6- 7 months	31	3.7%	32	4.6%	32	4.6%	28	4.1%	**34**	**5.2%**
7- 8 months	17	2.0%	14	2.0%	36	5.2%	21	3.1%	**25**	**3.8%**
8- 9 months	14	1.7%	9	1.3%	19	2.7%	21	3.1%	**18**	**2.8%**
9-10 months	15	1.8%	13	1.9%	9	1.3%	7	1.0%	**12**	**1.8%**
10-11 months	4	0.5%	3	0.4%	6	0.9%	11	1.6%	**10**	**1.5%**
11-12 months	12	1.4%	3	0.4%	7	1.0%	4	0.6%	**6**	**0.9%**
>12 months	29	3.4%	12	1.7%	23	3.3%	10	1.5%	**17**	**2.6%**
Total	**848**	**100.0%**	**696**	**100.0%**	**693**	**100.0%**	**675**	**100.0%**	**654**	**100.0%**

Counted by provider identified in complaint

Table 16.23 - Outcome of investigations 2008-09 to 2012-13

		2008-09		2009-10		2010-11		2011-12		2012-13	
Investigation outcome		No.	%	No.	%	No.	%	No.	%	No.	%
Health practitioner	Referred to Director of Proceedings	100	50.0%	141	59.5%	109	60.9%	131	62.1%	85	46.7%
	Referred to professional council	36	18.0%	44	18.6%	37	20.7%	36	17.1%	45	24.7%
	No further action	45	22.5%	32	13.5%	21	11.7%	30	14.2%	27	14.8%
	Referred to professional council under s20A	-	0.0%	-	0.0%	-	0.0%	5	2.4%	14	7.7%
	Public statement/prohibition order	2	1.0%	4	1.7%	6	3.4%	7	3.3%	8	4.4%
	Comments to the practitioner	16	8.0%	14	5.9%	6	3.4%	2	0.9%	3	1.6%
	Referred to Director of Public Prosecutions	1	0.5%	2	0.8%	-	0.0%	-	0.0%	-	0.0%
Health practitioner total		**200**	**100.0%**	**237**	**100.0%**	**179**	**100.0%**	**211**	**100.0%**	182	100.0%
Health organisation	Comments or recommendations	39	63.9%	33	94.3%	22	91.7%	9	81.8%	16	84.2%
	No further action	22	36.1%	2	5.7%	2	8.3%	2	18.2%	3	15.8%
Health organisation total		**61**	**100.0%**	**35**	**100.0%**	**24**	**100.0%**	**11**	**100.0%**	19	100.0%
Grand total		**261**	**100.0%**	**272**	**100.0%**	**203**	**100.0%**	**222**	**100.0%**	201	100.0%

Counted by provider identified in complaint

Table 16.24 - Investigations into health organisations and health practitioners finalised 2008-09 to 2012-13

		2008-09		2009-10		2010-11		2011-12		2012-13	
	Health practitioner	No.	%	No.	%	No.	%	No.	%	No.	%
Health practitioners	Medical practitioner	112	42.9%	149	54.8%	98	48.3%	124	55.9%	**91**	**45.3%**
	Nurse/midwife	69	26.4%	53	19.5%	37	18.2%	47	21.2%	**31**	**15.4%**
	Dental practitioner	1	0.4%	5	1.8%	5	2.5%	6	2.7%	**21**	**10.4%**
	Pharmacist	-	0.0%	12	4.4%	5	2.5%	9	4.1%	**8**	**4.0%**
	Assistant in nursing	-	0.0%	-	0.0%	2	1.0%	3	1.4%	**6**	**3.0%**
	Osteopath	1	0.4%	-	0.0%	-	0.0%	1	0.5%	**5**	**2.5%**
	Chiropractor	1	0.4%	6	2.2%	7	3.4%	3	1.4%	**4**	**2.0%**
	Massage therapist	1	0.4%	1	0.4%	2	1.0%	1	0.5%	**4**	**2.0%**
	Podiatrist	2	0.8%	-	0.0%	2	1.0%	1	0.5%	**3**	**1.5%**
	Psychologist	6	2.3%	3	1.1%	7	3.4%	5	2.3%	**3**	**1.5%**
	Alternative health provider	1	0.4%	1	0.4%	3	1.5%	2	0.9%	**2**	**1.0%**
	Residential care worker	-	0.0%	-	0.0%	1	0.5%	1	0.5%	**2**	**1.0%**
	Chinese medicine practitioner	-	0.0%	1	0.4%	-	0.0%	1	0.5%	**1**	**0.5%**
	Dental technician	-	0.0%	-	0.0%	1	0.5%	1	0.5%	**1**	**0.5%**
	Acupuncturist	-	0.0%	-	0.0%	1	0.5%	-	0.0%	**-**	**0.0%**
	Administration/clerical staff	-	0.0%	1	0.4%	2	1.0%	3	1.4%	**-**	**0.0%**
	Homeopath	1	0.4%	-	0.0%	-	0.0%	-	0.0%	**-**	**0.0%**
	Hypnotherapist	-	0.0%	-	0.0%	-	0.0%	1	0.5%	**-**	**0.0%**
	Medical radiation practitioner	2	0.8%	-	0.0%	-	0.0%	-	0.0%	**-**	**0.0%**
	Natural therapist	-	0.0%	1	0.4%	-	0.0%	-	0.0%	**-**	**0.0%**
	Naturopath	-	0.0%	-	0.0%	1	0.5%	2	0.9%	**-**	**0.0%**
	Optometrist	1	0.4%	-	0.0%	1	0.5%	-	0.0%	**-**	**0.0%**
	Physiotherapist	1	0.4%	3	1.1%	3	1.5%	-	0.0%	**-**	**0.0%**
	Psychotherapist	1	0.4%	1	0.4%	1	0.5%	-	0.0%	**-**	**0.0%**
Health practitioner total		**200**	**76.6%**	**237**	**87.1%**	**179**	**88.2%**	**211**	**95.0%**	**182**	**90.5%**
Health organisations	Public hospital	46	23.0%	30	12.7%	20	11.2%	8	3.6%	**11**	**5.5%**
	Dental facility	1	0.5%	-	0.0%	-	0.0%	-	0.0%	**4**	**2.0%**
	Drug and alcohol service	1	0.5%	-	0.0%	1	0.6%	-	0.0%	**2**	**1.0%**
	Private hospital	4	2.0%	2	0.8%	-	0.0%	1	0.5%	**2**	**1.0%**
	Aged care facility	2	1.0%	1	0.4%	-	0.0%	-	0.0%	**-**	**0.0%**
	Local Health District	3	1.5%	2	0.8%	-	0.0%	-	0.0%	**-**	**0.0%**
	College/association	-	0.0%	-	0.0%	2	1.1%	-	0.0%	**-**	**0.0%**
	Medical centre	1	0.5%	-	0.0%	-	0.0%	-	0.0%	**-**	**0.0%**
	Medical practice	-	0.0%	-	0.0%	1	0.6%	-	0.0%	**-**	**0.0%**
	Pathology centre/lab	2	1.0%	-	0.0%	-	0.0%	-	0.0%	**-**	**0.0%**
	Radiology practice	1	0.5%	-	0.0%	-	0.0%	-	0.0%	**-**	**0.0%**
	Other health organisation	-	0.0%	-	0.0%	-	0.0%	2	0.9%	**-**	**0.0%**
Health organisation total		**61**	**23.4%**	**35**	**12.9%**	**24**	**11.8%**	**11**	**5.0%**	**19**	**9.5%**
Grand total		**261**	**100.0%**	**272**	**100.0%**	**203**	**100.0%**	**222**	**100.0%**	**201**	**100.0%**

Counted by provider identified in complaint

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Table 16.25 - Investigations finalised by issue category 2008-09 to 2012-13

	2008-09		2009-10		2010-11		2011-12		2012-13	
	No.	%	No.	%	No.	%	No.	%	**No.**	**%**
Professional conduct	145	37.6%	163	33.1%	158	43.3%	208	56.8%	**138**	**39.3%**
Treatment	170	44.0%	196	39.8%	131	35.9%	106	29.0%	**136**	**38.7%**
Medication	27	7.0%	53	10.8%	32	8.8%	26	7.1%	**24**	**6.8%**
Consent	3	0.8%	7	1.4%	3	0.8%	1	0.3%	**19**	**5.4%**
Communication/information	16	4.1%	39	7.9%	15	4.1%	7	1.9%	**13**	**3.7%**
Medical records	6	1.6%	13	2.6%	10	2.7%	5	1.4%	**10**	**2.8%**
Environment/management of facilities	7	1.8%	5	1.0%	5	1.4%	3	0.8%	**5**	**1.4%**
Discharge/transfer arrangements	4	1.0%	11	2.2%	4	1.1%	4	1.1%	**2**	**0.6%**
Grievance processes	7	1.8%	3	0.6%	-	0.0%	-	0.0%	**2**	**0.6%**
Access	1	0.3%	-	0.0%	-	0.0%	1	0.3%	**1**	**0.3%**
Fees/costs	-	0.0%	2	0.4%	4	1.1%	4	1.1%	**1**	**0.3%**
Reports/certificates	-	0.0%	1	0.2%	3	0.8%	1	0.3%	**-**	**0.0%**
Total	**386**	**100.0%**	**493**	**100.0%**	**365**	**100.0%**	**366**	**100.0%**	**351**	**100.0%**

Counted by issues raised in complaint

Table 16.26 - Outcome of investigations finalised by profession and organisation type 2012-13

	Health practitioner														Total	
Outcome	Medical practitioner	Nurse/midwife	Dental practitioner	Pharmacist	Assistant in nursing	Osteopath	Chiropractor	Massage therapist	Podiatrist	Psychologist	Alternative health practitioner	Residential care worker	Chinese medicine practitioner	Dental technician	**No.**	**%**
Referred to Director of Proceedings	46	16	7	3	-	5	2	-	3	3	-	-	-	-	**85**	**46.7%**
Referred to professional council	26	6	11	2	-	-	-	-	-	-	-	-	-	-	**45**	**24.7%**
No further action	12	4	3	-	1	-	2	2	-	-	-	1	1	1	**27**	**14.8%**
Referred to professional council under s20A	6	5	-	3	-	-	-	-	-	-	-	-	-	-	**14**	**7.7%**
Prohibition order/public statement	-	-	-	-	3	-	-	2	-	-	2	1	-	-	**8**	**4.4%**
Comments	1	-	-	-	2	-	-	-	-	-	-	-	-	-	**3**	**1.6%**
Total	**91**	**31**	**21**	**8**	**6**	**5**	**4**	**4**	**3**	**3**	**2**	**2**	**1**	**1**	**182**	**100.0%**

	Health organisation					
	Public hospital	Dental facility	Drug and alcohol service	Private hospital	**No.**	**%**
Recommendations	8	2	-	-	**10**	**52.6%**
Comments	3	-	2	1	**6**	**31.6%**
No further action	-	2	-	1	**3**	**15.8%**
Total	**11**	**4**	**2**	**2**	**19**	**100.0%**

Counted by provider identified in complaint

Table 16.27 - Request for review of investigation decision 2008-09 to 2012-13

	2008-09	2009-10	2010-11	2011-12	**2012-13**
Request for review of investigation decision	4	2	3	4	**5**
Percentage of all investigations finalised	1.5%	0.7%	1.5%	1.8%	**2.5%**

Counted by provider identified in complaint

Table 16.28 - Outcome of reviews of investigation decision 2008-09 to 2012-13

	2008-09		2009-10		2010-11		2011-12		**2012-13**	
Outcome	No.	%	No.	%	No.	%	No.	%	**No.**	**%**
Original investigation decision confirmed	5	83.3%	2	100.0%	3	75.0%	2	66.7%	**6**	**100.0%**
Re-opened for investigation	1	16.7%	-	0.0%	1	25.0%	1	33.3%	**-**	**0.0%**
Total	**6**	**100.0%**	**2**	**100.0%**	**4**	**100.0%**	**3**	**100.0%**	**6**	**100.0%**

Counted by provider identified in complaint

Table 16.29 - Time taken to complete investigations* 2008-09 to 2012-13

	2008-09		2009-10		2010-11		2011-12		**2012-13**	
Time taken	No.	%	No.	%	No.	%	No.	%	**No.**	**%**
0- 1 months	3	1.1%	1	0.4%	-	0.0%	2	0.9%	**2**	**1.0%**
1- 2 months	5	1.9%	1	0.4%	3	1.5%	6	2.7%	**11**	**5.5%**
2- 3 months	10	3.8%	4	1.5%	7	3.4%	20	9.0%	**8**	**4.0%**
3- 4 months	22	8.4%	18	6.6%	6	3.0%	22	9.9%	**10**	**5.0%**
4- 5 months	13	5.0%	26	9.6%	6	3.0%	17	7.7%	**19**	**9.5%**
5- 6 months	26	10.0%	20	7.4%	23	11.3%	23	10.4%	**13**	**6.5%**
6- 7 months	24	9.2%	30	11.0%	24	11.8%	19	8.6%	**16**	**8.0%**
7- 8 months	27	10.3%	28	10.3%	24	11.8%	32	14.4%	**24**	**11.9%**
8- 9 months	28	10.7%	27	9.9%	20	9.9%	22	9.9%	**21**	**10.4%**
9-10 months	17	6.5%	34	12.5%	30	14.8%	11	5.0%	**22**	**10.9%**
10-11 months	27	10.3%	19	7.0%	19	9.4%	12	5.4%	**19**	**9.5%**
11-12 months	25	9.6%	23	8.5%	21	10.3%	16	7.2%	**15**	**7.5%**
12-18 months	30	11.5%	36	13.2%	16	7.9%	19	8.6%	**14**	**7.0%**
18-24 months	4	1.5%	4	1.5%	4	2.0%	1	0.5%	**7**	**3.5%**
24-30 months	-	0.0%	1	0.4%	-	0.0%	-	0.0%	**-**	**0.0%**
Total	**261**	**100.0%**	**272**	**100.0%**	**203**	**100.0%**	**222**	**100.0%**	**201**	**100.0%**
Average days	**250**		**263**		**260**		**222**		**244**	

Counted by provider identified in complaint
* Excludes time when investigation was paused

Appendices

Table 16.30 - Legal matters finalised 2008-09 to 2012-13

		2008-09		2009-10		2010-11		2011-12		**2012-13**	
		No.	%	No.	%	No.	%	No.	%	**No.**	**%**
Tribunal	Proved	38	44.7%	46	47.4%	50	46.7%	39	41.5%	**53**	**60.2%**
	Not proved	-	0.0%	7	7.2%	7	6.5%	1	1.1%	**-**	**0.0%**
	Withdrawn	-	0.0%	-	0.0%	-	0.0%	4	4.3%	**2**	**2.3%**
	Total	**38**	**44.7%**	**53**	**54.6%**	**57**	**53.3%**	**44**	**46.8%**	**55**	**62.5%**
Professional Standards Committee	Proved	27	31.8%	21	21.6%	21	19.6%	25	26.6%	**13**	**14.8%**
	Not proved	1	1.2%	9	9.3%	6	5.6%	3	3.2%	**3**	**3.4%**
	Withdrawn	-	0.0%	-	0.0%	-	0.0%	-	0.0%	**2**	**2.3%**
	Terminated and referred to Tribunal	-	0.0%	-	0.0%	-	0.0%	2	2.1%	**-**	**0.0%**
	Total	**28**	**32.9%**	**30**	**30.9%**	**27**	**25.2%**	**30**	**31.9%**	**18**	**20.5%**
Appeal		13	15.3%	10	10.3%	14	13.1%	13	13.8%	**10**	**11.4%**
Re-registration		6	7.1%	4	4.1%	9	8.4%	7	7.4%	**5**	**5.7%**
Grand total		**85**	**100.0%**	**97**	**100.0%**	**107**	**100.0%**	**94**	**100.0%**	**88**	**100.0%**

Counted by matter

Table 16.31 - Open complaints as at 30 June

	2009		2010		2011		2012		**2013**	
Open process	No.	%	No.	%	No.	%	No.	%	**No.**	**%**
Assessment	597	49.5%	566	46.3%	611	48.5%	609	49.5%	**667**	**51.4%**
Legal processes	200	16.6%	233	19.1%	227	18.0%	257	20.9%	**160**	**12.3%**
Resolution process	109	9.0%	169	13.8%	202	16.0%	172	14.0%	**250**	**19.3%**
Investigation	227	18.8%	184	15.0%	170	13.5%	148	12.0%	**161**	**12.4%**
Review of assessment	25	2.1%	35	2.9%	36	2.9%	25	2.0%	**37**	**2.9%**
Brief preparation	4	0.3%	5	0.4%	11	0.9%	14	1.1%	**17**	**1.3%**
Conciliation	42	3.5%	30	2.5%	4	0.3%	4	0.3%	**5**	**0.4%**
Review of investigation	1	0.1%	1	0.1%	-	0.0%	1	0.1%	**-**	**0.0%**
Total	**1,205**	**100.0%**	**1,223**	**100.0%**	**1,261**	**100.0%**	**1,230**	**100.0%**	**1,297**	**100.0%**

Counted by provider identified in complaint

APPENDIX B

Summary of results in relation to key performance indicators

Number	Description	Target	Result 2012-13	Status
GOAL 1.	**COMPREHENSIVE AND RESPONSIVE COMPLAINT HANDLING**			
1.1.1.1	Percentage of complaints assessed within 60 days	100%	94.5%	NOT-MET
1.1.1.2	Percentage of complaints not assessed within 60 days where an extension was approved	100%	99.2%	NOT-MET
1.1.1.3	Request for reviews of assessment decision as a percentage of assessments finalised	<= 10%	8.6%	MET
1.1.1.4	Percentage of reviews completed within six weeks	>= 90%	83.5%	NOT-MET
1.1.1.5	Percentage of 'Reason for decision letters' completed within 14 days	100%	99.4%	NOT-MET
1.1.2.1	Percentage of 7-day file audits rated satisfactory	>= 90%	96.4%	MET
1.1.2.2	Percentage of 21-day audits completed on-time	>= 90%	98.3%	MET
1.1.2.3	Percentage of 21-day file audits rated satisfactory	>= 90%	99.0%	MET
1.1.3.1	Percentage of matters consented for resolution that have a resolution plan submitted within 28 days of the parties being advised that the complaint has been referred for resolution	>= 90%	90.3%	MET
1.1.3.2	Percentage of resolutions/conciliations completed within 4 months	>= 70%	64.5%	NOT-MET
1.1.3.3	Percentage of matters that proceeded to resolution/conciliation that were resolved or partially resolved	>=80%	87.0%	MET
1.1.3.4	Percentage of complaint resolution/conciliation clients satisfied with service	>= 80%	86.1%	MET
GOAL 2.	**INVESTIGATE SERIOUS COMPLAINTS**			
2.1.1.1	Percentage of investigations finalised within twelve months	>= 90%	89.6%	NOT-MET
2.1.1.2	Percentage of investigations with investigation plans in place within 14 days	100%	100.0%	MET
2.1.2.1	Percentage of file reviews completed on time	>= 80%	92.5%	MET
2.1.2.3	Percentage of investigations with a request for review	<= 5%	2.5%	MET
2.1.3.1	Percentage of investigations that the Director of Proceedings did not refer back for further information	>= 90%	90.6%	MET
2.1.3.2	Briefs of Evidence to Legal Division that were sent within 28 days of the investigation being closed	>= 80%	72.9%	NOT-MET
2.2.1.1	Percentage of recommendations made during the previous reporting year that are implemented during period	>= 90%	100.0%	MET
GOAL 3.	**PROSECUTE SERIOUS COMPLAINTS**			
3.1.1.1	Percentage of complaints considered by Director of Proceedings within three months of referral	>= 80%	86.0%	MET
3.1.1.2	Percentage of matters referred for prosecution within 30 days of consultation with the relevant professional council	>= 80%	62.7%	NOT-MET
3.2.1.1	Success rate of disciplinary matters heard and finalised before Tribunal and Professional Standards Committees	>= 90%	95.7%	MET
3.2.3.1	Percentage of compliance with timeframes imposed by Professional Standards Committees, Tribunals and Courts	>= 80%	86.2%	MET
3.2.4.1	Percentage of bill of costs prepared or sent to cost consultants for assessment within 120 days	>= 75%	74.6%	NOT-MET
3.2.4.2	Quarterly reporting on recovery of legal costs to Executive	100%	100.0%	MET

Table continued on next page

APPENDIX B

Summary of results in relation to key performance indicators (continued)

Number	Description	Target	Result 2012-13	Status
GOAL 4.	**ACCOUNTABILITY**			
4.1.1.1	Reports provided to the Minister and Joint Parliamentary Committee on the Commission on a quarterly basis	100%	100.0%	MET
4.1.2.1	Responses to Ministerials submitted within 14 days	>= 90%	96.1%	MET
4.1.2.2	Responses and submissions to Joint Parliamentary Committee on the Commission within requested timeframes	100%	100.0%	MET
4.2.1.1	Annual Report prepared and provided to Minister and Treasurer by required due date	100%	100.0%	MET
4.2.1.2	Clean audit certificate for prior annual financial statements achieved for annual financial statements	100%	100.0%	MET
4.2.1.3	Percentage of compliance with Treasury annual report checklist	100%	100.0%	MET
4.3.1.1	Number of publications distributed	20,000	5,485	NOT-MET
4.3.1.2	Number of website visitors	>= 100,000	184,045	MET
4.3.1.3	Number of website hits	>= 4,000,000	6,808,569	MET
4.3.1.4.	Number of presentations	>= 60	59	NOT-MET
4.3.1.5	Number of media releases about publicly available decisions compliant with Commission's obligations.	100%	100.0%	MET
GOAL 5.	**OUR ORGANISATION**			
5.1.1.1	Average number of training/ staff development engagements per FTE	>=2	3.8	MET
5.1.2.1	Development and reporting of WHS, EEO, Multicultural Plan, and Disability Action Plans comply with relevant agency timeframes	100%	100.0%	MET
5.1.3.1	Monthly general staff briefings on events, outcomes, activities, changes, significant organisational changes	100%	100.0%	MET
5.1.3.2	Percentage of key corporate documents distributed to all staff and/or included on the intranet	100%	100.0%	MET
5.2.1.1	Regular meetings held to monitor performance	100%	100.0%	MET
5.2.2.1	Compliance with information security standard ISO 27001 – 2005	100%	100.0%	MET
5.2.3.1	Complete planning processes for corporate and divisional levels according to the Commission's Corporate Governance Framework Document	100%	100.0%	MET
5.2.4.1	Monthly financial management and staffing reports showing performance against budget.	100%	100.0%	MET
5.2.4.2	Quarterly reports to executive on complaint-handling performance against key performance indicators	100%	100.0%	MET
5.2.5.1	Percentage of performance agreements developed and reviewed for staff	100%	100.0%	MET
5.2.5.2	Percentage of staff rated competent or better at performance review	>= 90%	97.4%	MET

APPENDIX C

List of expert advisors

The Commission would like to thank its expert advisers listed below who assist the Commission in its investigation of serious complaints about health service providers. The Commissson would also like to thank those experts who provided telephone advice throughout the year that helped clarifying clinical issues during the assessment of the complaint.

Dr Richard Abbott
Dr Ion Alexander
Dr Roger Allan
Dr Bruce Allen
Dr Stephen Allnutt
Mr Mark Apolinario
Ms Deborah Armitage
Dr Mark Arnold
Mr John Baker
Dr Michael Baldwin
Dr Gary Banks
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Dr Harry Champion
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Ms Janine Learmont
Dr Vinoo Lele
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Dr Peter Liu
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Mr Lawrence Whitman
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Prof. Chris Zaslawski
Mr Shijing Zhang

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Any report made to the Minister under section 44 (2)	There was no report made to the Minister under section 44(2)	
Any notification and request made to the Director-General under section 60.	There were no notifications or requests made under section 60.	
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HEALTH CARE COMPLAINTS COMMISSION ANNUAL REPORT 2012-13

Production costs	$10,000
Availability of Annual Report	Electronic copies of this report are available on the Commission's website www.hccc.nsw.gov.au

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