07 08 ANNUAL REPORT

HEALTH CARE COMPLAINTS COMMISSION

HEALTH CARE COMPLAINTS COMMISSION

01 About the Commission

Vision

The Health Care Complaints Commission is an independent body that protects the public health and safety by dealing with complaints about health service providers.

Charter and core services

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

- responding to health consumer inquiries
- receiving and assessing complaints about health service providers in NSW
- resolving or assisting in the resolution of complaints
- investigating serious complaints that raise questions of public health and safety
- prosecuting serious complaints about health practitioners.

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

Values

The trust and confidence of the public are essential to the Commission's role. The Commission observes high standards of professionalism and ethical conduct, including:

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

Stakeholders

The Commission works within a complex network of stakeholders, including:

Public and private stakeholders

- health consumers
- the diverse communities of NSW
- members of the Commission's Consumer Consultative Committee
- health service providers
- health professional registration boards and organisations
- the media.

Government stakeholders

- Minister for Health
- Department of Health
- Area Health Services
- Parliament and its Committee on the Commission
- other government agencies.

Contact the Commission

Office address
Level 13
323 Castlereagh Street
Sydney NSW 2000

Business hours
Monday – Friday
9.00am – 5.00pm

Postal address
Locked Mail Bag 18
Strawberry Hills NSW 2012

Document exchange service
DX 11617
Sydney Downtown NSW

Contact details
Telephone: (02) 9219 7444
Freecall: 1800 043 159
Fax: (02) 9281 4585
Telephone typewriter: (02) 9219 7555
Email hccc@hccc.nsw.gov.au
Website www.hccc.nsw.gov.au

02

Table of contents

Disclaimer – Rounding of statistical figures

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

03 Commissioner's foreword and letter of submission

People often tell the Commission that their reason for making a complaint is to find out what happened and to improve things so that what they went through does not happen to anyone else in future.

Due to its size and complexity the health system has difficulty in the systematic and consistent implementation of improvements to the delivery of health services. Service delivery is inherently local and learning from error, where it occurs, often remains at that level. Improvements have traditionally relied on individual practitioners. Peer review processes, have not been transparent, nor are their findings generally amenable for wider dissemination.

Complaints provide an opportunity to examine errors and to try and prevent them happening again. The Commission is working with the Department of Health to monitor the implementation of the recommendations of its investigations and their wider application within the health system. It will continue to work to see if the same process can apply to system changes that come from resolution processes.

To better inform health providers, the Commission has redesigned its classification system for complaints to improve the quality of general information that might be useful to practitioners in helping to prevent complaints. The Commission is also providing information to practitioners on how to deal with complaints when they arise.

Learning from what went wrong requires, firstly, acknowledging the problem – dealing properly with a complaint means being open with the complainant. Traditional peer review processes of errors in health services have not been sufficiently open to complainants. While there is an official policy of 'open disclosure' in the Department of Health, it can be difficult to implement in practice.

The lack of open and honest communication when something goes wrong is an underlying reason for complaints. Some complainants come to the Commission so frustrated by their attempts to deal directly with the health service provider that they also complain of a cover up. Transparency implies accountability, and both are basic ingredients for a better health system. This is an area of continuing and growing interest for the Commission.

Complaints to the Commission often involve tragic situations and significant grief – already difficult emotional situations can then be compounded and aggravated by a lack of openness.

For dealing with these difficult matters, as well as with the continuing pressure of change and improvement to the Commission's processes, I thank the Commission's staff for their work during the year.

Kieran Pehm
Commissioner

The Hon John Della Bosca MLC
Minister for Health
Parliament House
Macquarie Street
SYDNEY NSW 2000

HEALTH CARE COMPLAINTS COMMISSION

Dear Minister

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 2008 for presentation to the Parliament of NSW.

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

Yours faithfully

Kieran Pehm
Commissioner

04 Executive summary

The previous changes to the Commission's procedures have enabled it to manage a higher number of complaints without compromising on quality or timeliness. This was illustrated when during the second half of the 2007-08 year, the Commission dealt with a substantial rise in inquiries and complaints.

Inquiries and complaints

Inquiries to the Commission increased by 11.4% on last year's figure. Written complaints also increased by 14.9%.

A significant part of this increase (8.0%) can be directly attributed to complaints about the deregistered doctor Graeme Reeves, and complaints referred by the Special Commission of Inquiry into Acute Care in Public Hospitals in NSW, led by Mr Peter Garling SC.

Leaving aside these complaints, there was still an increase of 6.9%, which may be the result of a general increase in publicity about health complaints since early 2008, as well as the increased promotional activities of the Commission.

Assessing complaints

Despite the high influx of complaints in the second half of the reporting period, the performance of the Assessments Division remains strong. Assessment staff continue to meet key performance indicators – the average time taken to assess a complaint remained stable at 39 days.

Resolving complaints

As anticipated by the Commission, the proportion of complaints assessed as suitable for resolution options increased to 35.3% as compared to last year's figure of 30.8%.

Investigating complaints

Due to the more rigorous assessment of complaints, fewer, yet more serious complaints were referred for formal investigation. This resulted in an improvement in the quality and timeliness of investigations. The introduction of a new procedures manual in March 2008 has also impacted positively on the quality and speed of investigations.

Prosecuting complaints

The Legal Division finalised 86 matters during 2007-08. Four medical practitioners, 20 nurses and four psychologists were deregistered. The outcomes of other matters included the reprimanding of practitioners or imposing conditions on their practice.

Legislative changes

In May 2008, the NSW Parliament passed the *Medical Practice (Amendment) Act 2008*.

This legislation was prompted by concerns arising from matters involving Ms Suman Sood and Mr Graeme Reeves.

The changes increased the transparency of disciplinary proceedings against medical practitioners before Professional Standards Committees of the Medical Board.

Corporate goals

In 2007-08, the Commission achieved most of its set targets relating to its five corporate goals.

These goals are underpinned by detailed strategies, which are set out in the corporate plan that can be accessed on the Commission's website.

Corporate Goals

Comprehensive and responsive complaint handling

See chapters 8, 12 –14 for details on performance against this goal during 2007-08.

Investigating serious complaints

See chapter 15 for details on performance against this goal during 2007-08.

Prosecuting serious complaints

See chapter 16 for details on performance against this goal during 2007-08.

Being accountable

See chapters 8 and 18 for details on performance against this goal during 2007-08.

Being a continuously improving organisation

See appendices A and B for details on performance against this goal during 2007-08.

04 Executive summary

Inquiries received

Chart 4.1 sets out the number of inquiries received by the Commission during 2007-08 compared to the previous two years. Inquiries increased by 11.4% on the 2006-07 year.

In most cases, the Commission provided information or discussed strategies about how concerns could be pursued directly with the health service provider. In other cases, the Commission referred the caller to a more appropriate body or assisted them to make a complaint to the Commission.

Written complaints

Chart 4.2 sets out the number of written complaints received during 2007-08 compared to previous years. The number of written complaints increased by 14.9% from 2006-07.

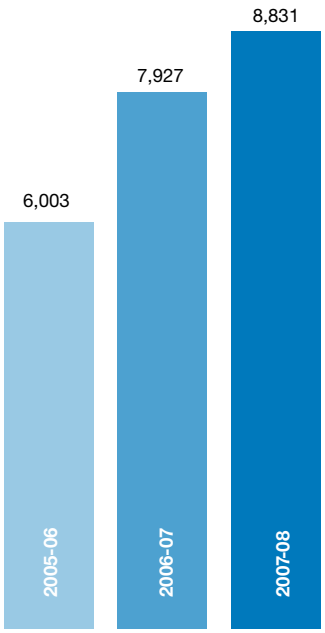
The number of complaints increased substantially in the last quarter of the 2007-08 year due to increased publicity and promotional activities, as well as the Garling Inquiry referring complaints to the Commission.

Complaints finalised

Chart 4.3 sets out the number of complaints finalised over the last three years.

In previous years, the Commission's finalisation of complaints had exceeded those received. However, in 2007-08, the high number of complaints that were received in the last quarter meant less being finalised than were received.

Chart 4.1
Number of inquiries received from 2005-06 to 2007-08



Counted by inquiry

Chart 4.2
Number of complaints received from 2005-06 to 2007-08

Counted by provider identified in complaint

Chart 4.3
Number of complaints finalised from 2005-06 to 2007-08

Counted by provider identified in complaint

Assessments finalised

In 2007-08, the Commission received 3,128 written complaints and assessed 2,889 complaints.

The proportion of complaints discontinued after assessment fell slightly to 34.0%. The proportion of complaints resolved during the assessment process or referred for resolution options – assisted resolution, conciliation and local resolution – increased to 35.3%.

Investigations finalised

During 2007-08, the Commission finalised 338 investigations.

The proportion of investigations finalised with adverse outcomes for health service providers continues to increase, while those terminated with no further action decreases.

Prosecutions finalised

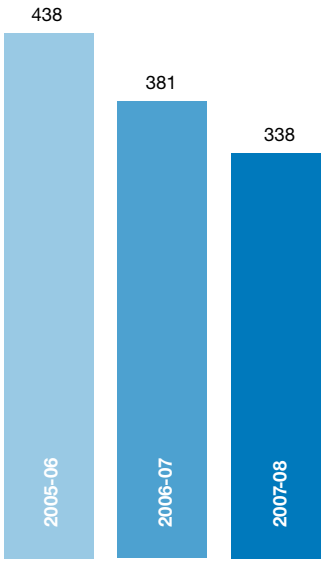
In 2007-08, the Legal Division finalised 79 disciplinary matters (a matter may include multiple complaints against the same practitioner). In a further seven cases, the Director of Proceedings determined not to prosecute.

Four medical practitioners, 20 nurses and four psychologists were deregistered as a result of disciplinary proceedings against them.

Chart 4.4
Number of assessments finalised from 2005-06 to 2007-08

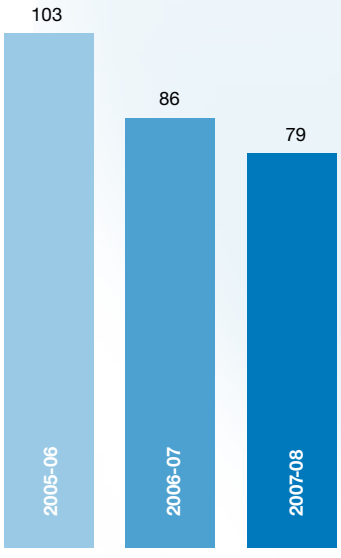
Counted by provider identified in complaint

Chart 4.5
Number of investigations finalised from 2005-06 to 2007-08



Counted by provider identified in complaint

Chart 4.6
Number of disciplinary actions finalised from 2005-06 to 2007-08



Counted by matter

05

The case of Vanessa Anderson

On 6 November 2005, sixteen-year-old Vanessa Anderson was hit in the head by a golf ball, resulting in a depressed fracture of her skull.

Vanessa was taken to Hornsby Hospital, where she had a CT scan. She was then admitted to Royal North Shore Hospital and, in the course of her treatment there, given panadeine forte and endone to relieve her pain.

Sadly, Vanessa died at the hospital on 8 November 2005.

In addition to an investigation by the Commission, Vanessa's death was the subject of a Coronial inquest. The Deputy State Coroner found that Vanessa had died from 'respiratory arrest due to the depressant effect of opiate medication'.

The 'root cause analysis' investigation

As required by legislation and policy, Royal North Shore Hospital conducted a root cause analysis investigation (RCA) into the circumstances leading to Vanessa's death.

The RCA team found the following systemic factors had contributed to Vanessa's death:

- There were no hospital-wide pain management guidelines.
- There were no clear lines of responsibility for treating pain and prescribing analgesia, leading to multiple team involvement in pain management beyond the primary care team.
- The differing levels of knowledge on the part of clinicians from various disciplines about the management of pain may have led to unrealistic expectations regarding pain relief goals for Vanessa.
- The illegibility of a written order for analgesia may have led to an increase in the dosage and frequency of other analgesia being prescribed.

The RCA also identified some other relevant systemic issues:

- the patient admission process
- communication about admission and the escalation of care
- the supervision of junior staff
- poor neurological observations.

As a result of the recommendations from the RCA – as well as those from a quality assurance review and a high level clinical and managerial review – Royal North Shore Hospital subsequently implemented various reforms including:

- guidelines for the management of acute pain in the neurosurgery department, which stipulate that decisions about prescribing analgesia outside the guidelines can only be made by a neurosurgical registrar or consultant

- further education for medical and nursing staff about pain assessment and the prescription of pain-relieving drugs
- guidelines and education for junior medical officers about notifying senior consultants
- a policy for nursing staff about the importance of performing routine observations
- further and continuing education about properly documenting all relevant matters in patient medical records.

The family's concerns

In November 2005, the Anderson family wrote to the Coroner, raising a number of concerns in relation to Vanessa's death.

The family also made a complaint to the Commission in November 2005 about Vanessa's care and treatment at Royal North Shore Hospital, and the limited extent of the information that the hospital had given them about the circumstances leading to Vanessa's death.

The Coronial inquest

As mentioned earlier, the Deputy Coroner Carl Milovanovich conducted an inquest into Vanessa's death.

In delivering his findings at the conclusion of the inquest on 21 January 2008[1], the Deputy Coroner emphasised that:

> … the Coroner's role is to investigate the manner and cause of [Vanessa's] death.
>
> It is not the role of the Coroner, nor does a Coroner have jurisdiction, to embark on some form of wide open-ended inquiry into a specific hospital or the Department of Health.

The Deputy Coroner's formal finding was that Vanessa had died from respiratory arrest due to the depressant effect of opiate medication.

The Deputy Coroner considered that there was no need for him to make formal recommendations in light of:

- the various systemic reforms already implemented by Royal North Shore Hospital
- the recent preparation by the Department of Health of guidelines for clinicians across NSW regarding the administration of analgesia and the use of anti-convulsant therapy in the treatment of closed head injuries.

The Deputy Coroner went on to say:

> Vanessa's case should be used as a precedent to highlight how individual errors of judgment, failure to communicate, failure to record accurately, and poor management of staff resources, cumulatively led to the worst possible outcome for Vanessa and her family.
>
> I have never seen a case such as Vanessa's in which almost every conceivable error or omission [occurred], and those errors continued to build one on top of the other.

Significantly, the Deputy Coroner concluded:

> Systemic problems [in the NSW health system] have existed for a number of years, and regrettably they all surface in the death of Vanessa Anderson.
>
> It may be timely that the Department of Health and/or the responsible Minister consider a full and open inquiry into the delivery of health services in NSW.

The Garling Inquiry

Following the Deputy Coroner's comments, the Minister for Health announced on 29 January 2008 that there would be a Special Commission of Inquiry into the delivery of patient care in the NSW health system, to be conducted by Mr Peter Garling SC. The Minister said that the Garling Inquiry would:

> … look at existing models of care within public hospitals – specifically with regard to the supervision of junior staff, clinical note-taking and record keeping, and communication between professionals – and recommend changes to improve the quality and safety of patient care.

The Garling Inquiry was originally required to make its report by the end of July 2008. However, its term was extended and the Inquiry will publish its final report in November 2008.

The Commission's investigation

As previously noted, the Anderson family made a complaint to the Commission about various aspects of Vanessa's care and treatment at Royal North Shore Hospital, as well as the failure by the hospital to give them adequate information about the events leading to Vanessa's death. They believed that the hospital was involved in a 'cover-up'.

The Commission investigated both of these complaints. It was considered appropriate to await the outcome of the Coronial inquest before finalising the Commission's report in February 2008.

1 Deputy State Coroner Carl Milovanovich, Inquest into the death of Vanessa Ann Anderson (available at http://www.lawlink.nsw.gov.au)

05 The case of Vanessa Anderson

Findings

In relation to the hospital's care and treatment of Vanessa, the Commission found the following deficiencies:

- The CT scan from Hornsby Hospital had been lost in the emergency department, and staff at Royal North Shore Hospital did not know that the scan could be viewed electronically.
- There had been grossly inadequate documentation of medical and nursing information in Vanessa's patient record – particularly in relation to a ward round when a doctor had outlined the plan for Vanessa's treatment.
- The communication between medical staff about Vanessa's management was poor.
- The over-prescription of narcotic analgesia, and the non-administration of anti-convulsant medication.

Recommendations

In light of its findings, the Commission recommended that Royal North Shore Hospital should:

- implement the policy developed by the Department of Health concerning the management of closed head injuries, and educate its staff about the policy
- introduce policies and procedures with respect to lines of responsibility between teams when prescribing medication to manage pain
- develop a brochure for patients and their families on the management of pain in patients with closed head injuries
- educate all medical and nursing staff on communicating with consultants and senior medical officers regarding the admission and management of patients
- educate staff on proper documentation in the patient record
- educate nursing staff on documenting all their observations of patients – including routine observations
- introduce the auditing of medical records
- take steps to eliminate the loss of medical records during the transfer of patients within the hospital
- educate staff about the ability to view radiological data electronically.

The Commission is monitoring the hospital's implementation of these recommendations.

In addition, the Commission wrote to the Royal Australian and New Zealand College of Anaesthetists, the Royal College of Surgeons and the Clinical Excellence Commission, recommending training and education for junior doctors about the need for caution when prescribing analgesic drugs for patients with closed head injuries.

Individual practitioners

The Commission's investigation also covered the conduct of a number of individual practitioners. As a result:

- the Director of Proceedings initiated complaints of unsatisfactory professional conduct against a nurse and two medical practitioners
- one medical practitioner was referred to the Medical Board for counselling.

The investigation into the alleged 'cover-up'

The Commission found that the senior management of Royal North Shore had failed to provide a clear explanation to the Anderson family about what had happened to Vanessa.

The hospital had informed the family that an RCA team would be investigating the circumstances leading to Vanessa's death.

Significantly, legislation that came into effect in August 2005 imposed strict restrictions on the extent to which and to whom the information gathered during the RCA investigation could be disclosed.

In February 2006, the hospital provided the Commission with two documents about the outcome of the RCA investigation – a causation statement setting out the RCA team's findings, and an action plan containing the team's recommendations. The hospital agreed to the Commission forwarding these documents to the Anderson family.

As the Commission observed in its report on the matter:

> This information was framed at a very general level and provided little meaningful information to the Andersons.
> Its limited admissions did nothing to enlighten them as to what had occurred and raised yet further questions for them. The Andersons continued to remain highly concerned about almost every aspect of the care and treatment provided to Vanessa.

The open disclosure policy

In June 2007, the Department of Health introduced a policy of open disclosure for the public health system in NSW[2].

The aim of the policy is to:

> establish a standard approach for communication with patients, families, carers and other stakeholders after incidents involving injury, damage, loss or other harm to patients.

Significantly, the policy defines 'open disclosure' as:

> a frank discussion with a patient and/or their support person(s) about an incident that resulted in unintended harm or injury to the patient while receiving health care

and refers to the need for an apology for the distress felt by the patient and/or their family, and an early explanation of the known facts.

The interaction between open disclosure and the RCA privilege

In its report on the complaint by the Anderson family, the Commission made the following comments on the tension between the Department's policy of open disclosure and the broad privilege for information obtained during an RCA:

> Since the RCA is the principal investigative tool for serious incidents, the privilege for information obtained in an RCA has the effect of compromising the effectiveness of open disclosure.
>
> Failure to resolve the tension between the privilege for information obtained by an RCA and open disclosure is likely to leave patients and bereaved [people] in a state similar to the position of the Anderson family … adding to their grief, distress and suspicion, rather than assisting them to understand what happened and begin to cope with their tragic loss.

The Commission recommended that Royal North Shore Hospital should use the Vanessa Anderson matter as a case study to demonstrate and reinforce the need for open disclosure when meeting with a patient's family following a significant adverse incident.

At a broader level, the Commission recommended that the Department of Health should review the legislation governing the RCA process, to ensure that it is consistent with the aims of the Department's open disclosure policy.

Review of the RCA legislation

The 2005 changes to the *Health Administration Act 1982* which created the privilege for information gathered during an RCA, also stipulated that a review of the relevant legislative provisions should be held after three years.

Against this background, the Department of Health has advised the Commission that it will be releasing a discussion paper about the operation of the RCA provisions following the publication of the Garling Inquiry's final report in November 2008. The discussion paper will provide an opportunity for key stakeholders and the community at large to consider the interaction and tensions between the open disclosure policy and the RCA privilege, and to make submissions on the issues involved.

The Commission's research

The Commission has conducted extensive research during the year into the practical operation of RCA processes and open disclosure. This has included:

- consulting with the Australian Commission on Safety and Quality in Health Care in relation to its ongoing project work on open disclosure
- attending a meeting of stakeholders from all Australian jurisdictions to consider the various legal regimes governing RCA processes
- holding discussions with the various Area Health Services in NSW about how they have engaged in open disclosure and administered RCAs
- participating in a seminar for health service providers and administrators on open disclosure.

It should also be noted in this context that a particular complaint matter considered by the Commission's Director of Proceedings during the year highlighted the Commission's concerns about the interpretation and application of the RCA legislation. The matter raised the question of whether the legislation prevented the use of an RCA report critical of an individual health practitioner in possible disciplinary proceedings against the practitioner.

The Director of Proceedings obtained legal advice on this question from the Office of the Crown Solicitor. Significantly,

2 NSW Department of Health, Open disclosure policy, PD2007_040, June 2007 (available at http://www.health.nsw.gov.au)

05 The case of Vanessa Anderson

the Office of the Crown Solicitor observed that the provisions concerning the RCA privilege are ambiguous, and that their application in particular matters is uncertain. The Office of the Crown Solicitor suggested it may be possible to clarify the scope and application of the RCA privilege by legislative amendment.

The Commission will be using this advice, and the research that it has conducted during the year, to prepare a submission to the Department's discussion paper and its review of the RCA legislation.

Further observations

It is clear that the statutory privilege protecting information and evidence obtained through RCA investigations can have the effect of restricting and compromising open disclosure.

It also appears that health service providers are reluctant to co-operate with investigations such as RCAs unless the evidence that they give is privileged and cannot be used in other legal and disciplinary processes. Furthermore, the conventional approach of legal advisers has been to advise health service providers that they should make no admissions to patients or their families that might incur some form of liability.

These factors inhibit effective open disclosure – compounding the grief of patients and their families, and sometimes leading to complaints of 'cover-up' such as that made by the family of Vanessa Anderson.

The Australian Commission on Safety and Quality in Health Care

In April 2008, the Australian Commission on Safety and Quality in Health Care published a report[3] on its open disclosure project. The report contained an evaluation of how open disclosure processes have been working in different Australian jurisdictions, and set out the challenges to be met in achieving more effective open disclosure by health service providers to patients and their families.

In particular, the evaluation in the report found that:

> Open disclosure is met with approval and relief on the part of health professionals and consumers – staff can now discuss matters that in the past were often seen as too difficult to discuss, and consumers feel pleased for being told what happened.

It was also noted that health professionals and consumers were concerned to integrate open disclosure more firmly in everyday clinical practice.

Significantly, the evaluation also found that that open disclosure currently creates uncertainties about:

- the types of incidents that trigger open disclosure
- the impact of open disclosure on the reputation of health professionals and their organisations
- whether colleagues will support those carrying out open disclosure
- the legal and insurance implications of open disclosure.

In July 2008, the Australian Commission on Quality and Safety in Health Care sought tenders to conduct research into patient experiences of open disclosure including:

- interviewing 100 patients
- filming documentary-quality educational stories from patients
- developing survey instruments to study patient and staff experiences of open disclosure
- developing patient-centred indicators of successful open disclosure.

Over the coming year, the Commission will continue to contribute to the work of the Australian Commission on Quality and Safety in Health Care in this important area of health policy and practice, in addition to working with NSW authorities.

3 Australian Commission on Quality and Safety in Health Care, Evaluation of the pilot of the National Open Disclosure Standard (available at http://www.safetyandquality.org)

06

The case of Graeme Reeves

In February 2008, the media gave considerable publicity to complaints by a large number of women about Mr Graeme Reeves, a deregistered obstetrician and gynaecologist. These former patients of Mr Reeves alleged that he had mistreated them, sexually assaulted them and/or performed unnecessary and mutilating gynaecological surgery. The case of Ms Carolyn Dewaegeneire received particular attention – Ms Dewaegeneire had successfully sued Mr Reeves for 'negligent' gynaecological surgery – but had been unable to recover the substantial damages awarded against him.

The nature and extent of the complaints about Mr Reeves led to:

- The NSW Police Force establishing Strike Force 'Tarella' to investigate the complaints of criminal conduct.
- The Minister for Health announcing that the government would introduce legislation requiring medical practitioners to report gross misconduct by other medical practitioners.
- The Department of Health asking the Hon Ms Deirdre O'Connor to review Mr Reeves' complaints and disciplinary history – to identify areas where the relevant legislation could be improved – as well as the employment of Mr Reeves in the NSW public health system – to identify any gaps in relevant policies.

The resulting changes to legislation and policy are set out in chapter 7 'Legislative changes'.

This chapter explains how the Commission has dealt with, and is dealing with, the complaints about Mr Reeves, the former Dr Reeves. As he has been deregistered, he is referred to as Mr Reeves.

1985 to 1996

Mr Reeves' initial employment in the public health system

In 1985, Mr Reeves was appointed as a visiting medical officer in obstetrics and gynaecology at Hornsby Ku-ring-gai Hospital. He was re-appointed to this position in 1988 and again in 1991.

The Health Care Complaints Commission was established in 1994.

Until the end of 1996, the Commission dealt with 14 complaints about Mr Reeves. Nine of these – all relating to the treatment of obstetric patients – led to the Commission prosecuting a formal complaint of unsatisfactory professional conduct against Mr Reeves before a Professional Standards Committee ('PSC') of the NSW Medical Board.

06 The case of Graeme Reeves

1997 to 2000

Mr Reeves banned from practising obstetrics

In June 1997, the PSC found Mr Reeves guilty of unsatisfactory professional conduct. It ordered that Mr Reeves be reprimanded and required him to stop practising obstetrics. The PSC decided that Mr Reeves could continue to practise gynaecology.

In addition, the PSC found that Mr Reeves suffered from personality problems and depression that affected his capacity to practise medicine and imposed various health related conditions, requiring him to continue with psychiatric treatment.

Significantly, under the legislation at the time, the proceedings before the PSC were not held in public, nor was the PSC decision made publicly available.

In 1997, the Commission received another three complaints about Mr Reeves. The Commission investigated these complaints and obtained expert opinions. In two cases, the experts found no grounds for criticism. In the third, which concerned obstetric care in 1995-96, the expert was mildly to moderately critical of Mr Reeves.

In view of the 1997 PSC order prohibiting Mr Reeves from practising obstetrics, the Commission took no further action in relation to these matters.

In 2000, the Commission received two complaints about Mr Reeves' rudeness and poor communication. Neither of these raised clinical issues, and the Commission referred them to the Medical Board, which was considering Mr Reeves' participation in its performance assessment program.

2001 to 2003

Mr Reeves in private practice

When his appointment with Hornsby Ku-ring-gai Hospital ended in 2001, Mr Reeves worked as a general practitioner in a medical centre.

The Commission received another complaint alleging verbal abuse by Mr Reeves and referred it to the Medical Board.

Mr Reeves' application for employment with the then Southern Area Health Service

In April 2002, Mr Reeves obtained employment with the Southern Area Health Service as an obstetrician and gynaecologist for Pambula and Bega Hospitals.

In applying for this position, Mr Reeves provided a copy of a letter from the Medical Board dated 27 December 2001 that set out the health related conditions then imposed on him. The letter did not mention the PSC order banning Mr Reeves from practising obstetrics.

Mr Reeves told the Area Health Service that the only restrictions on his practice were health-related, and failed to inform it of the PSC order. The Medical Tribunal[1] which later examined Mr Reeves' conduct observed that he:

> was prepared to take whatever steps he deemed expedient to place himself in a position whereby he could resume practice as an obstetrician [including] bare faced lies and calculated omissions.

Similarly, the Garling Inquiry in its report of July 2008[2] regarding the circumstances of Mr Reeves' employment with the Southern Area Health Service found that:

> Dr Reeves' intentional and calculated dishonesty was the main reason he was recruited to a position that he was legally unable to fulfil.

Commissioner Garling recommended that the Director of Public Prosecutions considers whether Mr Reeves should be criminally prosecuted in relation to his conduct in this respect.

The Southern Area Health Service did not contact the Medical Board to check on Mr Reeves' registration status. This failure was the subject of the following comments by Ms O'Connor in her report[3] about the employment of Mr Reeves:

> The information provided by Dr Reeves indicating that he had been the subject of action by the Medical Board, and had conditions imposed on his registration, should have led the Area Health Service to make direct enquiries of the Medical Board.

1 NSW Medical Tribunal 2004, Decision regarding Dr Graeme Reeves (available at http://www.nswmb.org.au)

2 Peter Garling, SC, First Report of the Special Commission of Inquiry: Inquiry into the circumstances of the appointment of Graeme Reeves by the former Southern Area Health Service (available at http://www.lawlink.nsw.gov.au)

3 The Hon Ms Deirdre O'Connor, Report on the employment of Graeme Reeves, May 2008 (available at www.health.nsw.gov.au)

> Further, such enquiries should also have been prompted by the fact that, during referee checks, a clinician raised an issue about Dr Reeves' practice rights in obstetrics.

However, Ms O'Connor also recognised that Mr Reeves had deliberately deceived the Area Health Service about the full extent of the conditions imposed on him.

Commissioner Garling made the following comments on this aspect of the matter:

> I accept the evidence given on behalf of the relevant staff of the Southern Area Health Service that they understood [the Medical Board's] letter to contain the totality of the restrictions on Dr Reeves' entitlement to practise medicine. In my view, that interpretation was reasonable …

Mr Reeves' employment with the Southern Area Health Service

During 2002, Mr Reeves worked at Pambula and Bega hospitals, as well as conducting his own private practice. His work at the hospitals included practising obstetrics on 36 occasions.

The Commission received a complaint in 2002 that Mr Reeves had conducted inappropriate internal and breast examinations of a patient in his private practice. The Commission referred this complaint to the Medical Board, which had advised that it would be reviewing Mr Reeves' practice.

Action by the Medical Board and the Area Health Service

In November 2002, the Medical Board discovered that Mr Reeves had been practising obstetrics, and wrote to him confirming the terms of the PSC order. Mr Reeves responded with a letter that was, in the words of the Medical Tribunal, 'a litany of lies and deceptive statements'. Despite assurances that he would not practise obstetrics again, he continued to do so, in December 2002 and January 2003.

Commissioner Garling found that, after the Area Health Service discovered that Mr Reeves had been banned from practising obstetrics, it failed to take appropriate steps to enforce this ban. However, he also observed:

> Although more robust steps could have been and ought to have been taken … the relevant Area Health Service staff could not have expected the level of defiance that Dr Reeves would show, despite the express directions given to him and his undertakings to stop practising obstetrics.

In February 2003, the Medical Board considered whether it should suspend Mr Reeves. The Board did not suspend him, but did re-impose the condition prohibiting him from practising obstetrics. The Area Health Service then took steps to terminate Mr Reeves' employment.

In 2003, the Commission received a complaint about a death after surgery performed in 1999 at Hornsby Ku-ring-gai Hospital. A registrar, with Mr Reeves as the consultant, performed the surgery. The Commission obtained a report on the matter from the Area Health Service, which was received by a Commission medical officer. The matter was finalised after a meeting between the complainant and a Commission Resolution Officer.

2004 to 2007

The Commission's prosecution before the Medical Tribunal

In early 2004, the Commission initiated a prosecution against Mr Reeves before the Medical Tribunal, alleging that he had engaged in professional misconduct, both in his application for employment with the Southern Area Health Service, and in his practice of obstetrics in breach of the PSC order.

In July 2004, the Tribunal deregistered Mr Reeves for three years, noting that he had:

> persistently demonstrated a lack of integrity of such magnitude that he could not be regarded as possessing the moral and ethical standards required in a medical practitioner. He has shown himself to possess a major defect in his character which is manifest by his dishonest and deceptive conduct and his flouting of his obligations.

In 2004, the Commission received a complaint about gall bladder surgery that Mr Reeves had performed in 2002. The Commission checked whether Mr Reeves had been in breach of the conditions imposed on him in performing this surgery. Since there had been no such breach, and Mr Reeves had already been deregistered, no further action was taken.

06 The case of Graeme Reeves

In April 2007, Ms Dewaegeneire wrote to the Commission about the gynaecological surgery that Mr Reeves had performed on her in 2002. She pointed out that Mr Reeves would be able to apply for re-registration in July 2007, and asked what action the Commission proposed to take. The Commission advised her that the Medical Board defended applications for re-registration, and the Commission had therefore referred her complaint to the Board, so that it could be taken into account if Mr Reeves applied for re-registration.

2008

The Commission's handling of the new complaints

The extensive publicity about Mr Reeves in February 2008 prompted the Commission to issue a media release, encouraging any person with a complaint to contact the Commission.

Over the next four months, the Commission received 97 telephone inquiries and 43 complaints about Mr Reeves. In addition, in July 2008, the Garling Inquiry referred a number of complaints to the Commission – including five complaints not previously received by the Commission. The Commission also reviewed the 24 complaints that it had received about Mr Reeves between 1990 and 2007.

Where appropriate, and with the consent of the complainant, the Commission referred any matters raising issues of possible criminal conduct to Strike Force 'Tarella'.

The Commission is carefully assessing all of the complaints received in 2008, so that these matters can be properly considered by the Medical Tribunal in the event that Mr Reeves applies for re-registration.

The Joint Parliamentary Committee's report

On 26 June 2008, the Joint Parliamentary Committee on the Health Care Complaints Commission published a report[4] about the Commission's handling of the complaints about Mr Reeves.

The Committee found that the time taken by the Commission to investigate and prosecute the early complaints about Mr Reeves was inappropriate, but also noted that systemic failures of this type were endemic at the Commission at that time.

The Committee also acknowledged that the Commission had properly exercised its prosecution role when it argued before the PSC that Mr Reeves should be banned from conducting any obstetric, gynaecological and invasive procedures.

The Committee went on to make made the following comments on the PSC decision:

> … having regard to the Medical Board's own psychiatric evidence about Reeves, the PSC erred in deciding to limit Reeves' ban to the practice of obstetrics ...

However, the Committee also acknowledged that it had the benefit of hindsight, and that it might be

> unreasonable to expect the PSC to have foreseen Reeves' subsequent extraordinary pattern of deceit.

The Committee recognised that the Commission has made considerable improvements to the timeliness of its operations. The Committee also observed that the Commission had undergone 'a process of considerable improvement in the manner in which it exercises its functions', particularly in its engagement with both complainants and health care providers.

The Committee made a number of recommendations, including possible legislative amendments – these are discussed further in chapter 7 'Legislative changes'.

4 Joint Parliamentary Committee on the Health Care Complaints Commission, Report about the Commission's handling of complaints about Dr Graeme Reeves, June 2008 (available at http://www.parliament.nsw.gov.au)

07

Legislative changes

Medical Practice (Amendment) Act 2008

On 4 June 2008, the NSW Parliament passed the *Medical Practice (Amendment) Act*. This legislation made the following important changes:

- expanding the circumstances in which the Medical Board can suspend medical practitioners
- formally requiring the Commission and the health registration authorities (Registration Boards) to consider previous complaints and adverse findings when dealing with a current complaint about a health practitioner
- increasing the transparency of disciplinary proceedings against medical practitioners before Professional Standards Committees of the Medical Board
- introducing mandatory reporting requirements for the medical profession – medical practitioners must report other practitioners whom they believe have engaged in sexual abuse, drug or alcohol abuse, or a gross departure from accepted standards of professional practice or competence.

These changes were prompted by concerns arising from matters involving Ms Suman Sood and Mr Graeme Reeves.

Ms Suman Sood

From 1992, Ms Sood practised in the area of women's health, including the termination of pregnancies. A number of complaints had been made about her, including one in May 2002 that she had improperly procured a miscarriage.

In June 2002, the Medical Board decided to suspend Ms Sood from practice. Ms Sood successfully challenged the suspension in the Supreme Court in July 2002. This raised concerns about whether the Board's powers to suspend practitioners or impose conditions were inappropriately limited.

In July 2004, Ms Sood undertook not to perform terminations of pregnancies in NSW.

Ms Sood had been charged with manslaughter in relation to the death of a baby, as well as with offences relating to the unlawful administration of a drug with intent to procure a miscarriage. In August 2006, a District Court jury found Ms Sood not guilty of manslaughter, but convicted her of the other offences.

In August 2006, just prior to the Commission's prosecution of Ms Sood before the NSW Medical Tribunal, Ms Sood asked that her name be removed from the register of medical practitioners.

07 Legislative changes

In October 2006, the Medical Tribunal found her guilty of professional misconduct, on the basis that she:

- lacked competence
- had failed to keep proper medical records and had created false records
- had been dishonest with her patients, other professionals and the Health Insurance Commission, and had knowingly misled the Medical Board and the District Court
- had shown indifference to orders of the Medical Board.

The Medical Tribunal deregistered Ms Sood for ten years.

Review of the legislation

In August 2006, the then Minister for Health initiated a review of:

- the Medical Board's power to suspend a medical practitioner or impose conditions on their registration, and the avenues of review and appeal against the Board's decisions
- the procedures for dealing with multiple complaints about health practitioners.

The review was conducted by the Hon Ms Deirdre O'Connor, Professor Peter Castaldi and Mr Vern Dalton, who provided their report to the Minister in October 2006[1]. This report made a number of recommendations that were subsequently reflected in the Medical Practice (Amendment) Bill introduced on 7 May 2008. It was at this time that there was considerable publicity about the case of Mr Graeme Reeves.

The Bill included proposed amendments to the following effect:

- the protection of the health and safety of the public would be the paramount consideration when administering the relevant legislation
- a breach of the *Medical Practice Act* by a medical practitioner – even if they had not been prosecuted or convicted – would constitute 'unsatisfactory professional conduct'.

Powers of the Medical Board

The Board could require information and documents from any person, and require medical practitioners to provide details of their employment, appointments and accreditation.

The Board must suspend a medical practitioner or impose conditions if satisfied that this was 'appropriate for the protection of the health or safety of any person or persons' or 'otherwise in the public interest'.

The Board could impose a condition on a medical practitioner's registration requiring them to participate in a performance assessment. However, if the Commission did not agree with the Board's proposal, the Commission would deal with the matter as a complaint about the medical practitioner.

A medical practitioner could have the decision reconsidered by the Board, or could appeal to the Medical Tribunal on a point of law. Only after an appeal to the Medical Tribunal had been decided could they appeal to the Supreme Court.

The Board could take into account other relevant complaints about a medical practitioner when exercising its complaint-related and disciplinary functions.

Powers of the Commission

When assessing a complaint about any health service provider, the Commission must take into account other complaints, as well as previous findings, decisions and reports about an individual practitioner.

The Commission should consider investigating associated complaints at the same time. If this was not possible, the investigation of one complaint could have regard to another relevant complaint.

The Director of Proceedings should consider prosecuting multiple complaints against a practitioner at the same time.

Powers of the Medical Tribunal and Professional Standards Committee

When making findings in disciplinary proceedings, the Medical Tribunal or a Professional Standards Committee could consider the findings of any Tribunal or Professional Standards Committee, and have regard to the total evidence when dealing with multiple complaints about a medical practitioner.

1 The Hon D O'Connor, Prof P Castaldi, and V Dalton, Review of certain provision of the Medical Practices Act 1992 and the Health Care Complaints Act 1993 : Final report and recommendations, 2006.

Mr Graeme Reeves

Mandatory reporting of misconduct by medical practitioners

On 2 March 2008, following the extensive publicity about Mr Graeme Reeves, the then Minister for Health announced that legislation would be introduced requiring medical practitioners to report instances of gross misconduct by other medical practitioners. The Minister said:

> the community wants more assurance that, where a doctor is grossly incompetent or commits serious misconduct, he or she will be reported and face the consequences.

The Minister said that the legislation would target situations where a medical practitioner reasonably believed another medical practitioner had engaged in sexual abuse, drug or alcohol abuse, or conduct that was a gross departure from accepted professional standards.

Further legislative review

In March 2008, the Department of Health also asked Ms O'Connor to review:

- Mr Reeves' complaints and disciplinary history – to identify any areas where the *Medical Practice Act* and *Health Care Complaints Act* could be improved. Ms O'Connor was also asked to identify any other issues in relation to the regulation of medical practitioners that should be reviewed further.
- Mr Reeves' employment in the public health system – to identify whether there had been compliance with the policies of the time, whether there were gaps in those policies, and whether current policies were adequate. Ms O'Connor was also asked to make recommendations for improvements to the legal and policy framework.

The first report

Ms O'Connor reported on the first matter on 28 March 2008[2], and made the following recommendations:

Professional Standards Committees

In addition to having two medical practitioners and a community member, all Medical Professional Standards Committees should be chaired by a legally qualified member.

The proceedings should also be held in public and the decision made public, unless the Professional Standards Committee directs otherwise.

Breaches of orders and conditions

A Medical Tribunal or Professional Standards Committee, when making orders or imposing conditions on a medical practitioner, should be able to specify that a breach of these orders or conditions would automatically result in the immediate suspension and later deregistration of the medical practitioner.

Considering all complaints

When a deregistered medical practitioner applied for re-registration, all complaints about the practitioner must be taken into account, including any complaints received after the practitioner's deregistration.

These three recommendations were implemented through the *Medical Practice Amendment Act* that was passed on 4 June 2008.

Broadening the Commission's powers

Ms O'Connor recommended that the Commission's powers should be expanded in two ways:

- The Commission's current investigative power to require documents and information from complainants and health service providers should be broadened to apply to any person.
- This broad power should also be available to the Commission in the initial assessment of complaints.

The Department of Health has advised that it is considering implementing these recommendations through a Bill that would contain a variety of amendments to the *Health Care Complaints Act*.

Reviewing the Commission's powers

Ms O'Connor also recommended a review of the scope of the Commission's powers:

- whether the Commission should be able to initiate its own complaints

2 The Hon Ms Deirdre O'Connor, Review of Medical Practice Amendment Bill 2008 (available at www.health.nsw.gov.au)

07 Legislative changes

- whether the power to obtain a search warrant should be broadened to seek evidence that would 'assist in the exercise of the Commission's functions'
- whether the Director of Proceedings should be able to provide immunity from prosecution to medical practitioners who assist the Commission in its investigations.

The Department of Health has advised that it is considering these recommendations.

Issues for further consideration

Ms O'Connor identified a number of other issues for further review, including:

- information-sharing among various bodies in the health system about complaints, legal claims and employment issues concerning medical practitioners
- proactive monitoring by the Medical Board of medical practitioners' compliance with any conditions imposed on them
- applications for re-registration by deregistered medical practitioners, and the role of the Commission in this process
- the model of co-regulation of medical practitioners by the Medical Board and the Commission.

The second report

Ms O'Connor reported on the employment of Mr Reeves in the public health system on 2 May 2008[3], and found that the current employment policies had largely addressed any gaps that previously existed.

Ms O'Connor noted that the Department of Health was planning to introduce a 'Service Check Register', which would be available to health services to help them check applicants, employees and contractors as part of the recruitment process or if disciplinary action was being considered. The register would contain information about a health practitioner regarding:

- their suspension from duties
- their dismissal from a public health organisation
- their resignation in the face of serious disciplinary action
- any conditions imposed on their practice following a disciplinary process.

In June 2008, the Joint Parliamentary Committee on the Health Care Complaints Commission endorsed Ms O'Connor's recommendations.

Ms O'Connor also recommended that a policy be introduced that would ensure Professional Standards Committee and Medical Tribunal decisions were distributed within the NSW health system.

Introduction of the Act

The NSW Parliament passed the *Medical Practice (Amendment) Act* on 4 June 2008. The then Minister for Health said that NSW 'now has the strongest legislation in the country to protect patients against misconduct by doctors'.

The amendments concerning the Medical Board's powers of suspension and the consideration of multiple and associated complaints came into effect on 1 August 2008.

The provisions about the mandatory reporting of misconduct by medical practitioners, and the increased transparency of Professional Standards Committees came into effect on 1 October 2008.

The Joint Parliamentary Committee's report

The Joint Parliamentary Committee on the Health Care Complaints Commission published a report in June 2008 about the Commission's handling of the complaints about Mr Reeves[4], and made the following recommendations:

- The *Health Care Complaints Act* should be reviewed to identify and remove any unnecessary complexities.
- As much as possible, the health registration legislation should be amended to provide for consistent complaint-handling procedures in line with those of the Medical Board.

3 The Hon Ms Deirdre O'Connor, Review of the appointment, management and termination of Dr Graeme Reeves as a visiting medical officer in the NSW public health system, 2008 (available at www.health.nsw.gov.au).

4 NSW Joint Parliament Committee on Health Care Complaints Commission, Report on the investigations by the Health Care Complaints Commission into the complaints made against Mr Graeme Reeves, Report no. 3/53, 2008 (available at www.parliament.nsw.gov.au).

Unregistered health practitioners

As discussed in last year's annual report, the *Health Legislation Amendment (Unregistered Health Practitioners) Act 2006* broadened the Commission's powers in relation to unregistered health practitioners – that is:

- health service providers who are not registered with a Registration Board
- practitioners whose registration has been suspended or cancelled, and who seek to practice in an area where they do not need registration
- registered practitioners who provide health services that are unrelated to their registration.

The amendments gave the Commission power to impose a prohibition order and/or to issue a public warning about the practitioner and their services. A prohibition order bans a practitioner from providing health services, or places conditions on their provision of health services, for a specified period or permanently. It is a criminal offence to breach the order.

If the practitioner advertises their services, they must include the terms of the prohibition order in the advertisement. They must also advise patients of the existence of the order before treating them. Any failure to comply with these requirements is a criminal offence.

Before the Commission can make a prohibition order, it must find that the practitioner has:

- breached the code of conduct for unregistered practitioners, or
- been convicted of an offence under Part 2A of the *NSW Public Health Act*, or an offence under the *NSW Fair Trading Act* or the *Commonwealth Trade Practices Act.*

The Commission must also be of the opinion that the practitioner 'poses a substantial risk to the health of members of the public'.

Introduction of the code of conduct

The code of conduct could only come into effect after a process of public consultation. In January 2008, the Department of Health initiated this process, and sought submissions on a draft code by the end of February 2008. Following the consideration of the submissions, the code came into effect on 1 August 2008.

In brief, the code provides that unregistered health practitioners must provide services in a 'safe and ethical' manner – this includes:

- maintaining competence in their field of practice
- not providing health care outside their experience or training
- prescribing treatments that serve the needs of the client
- referring clients to other health service providers where appropriate
- encouraging clients to inform their medical practitioner of any treatment that they have been receiving
- having a sound understanding of adverse interactions between their treatment and any other treatment
- ensuring that first aid and emergency assistance are available.

Unregistered practitioners must also:

- have an adequate clinical basis to diagnose or treat an illness or condition
- not represent that they can cure cancer or other terminal illnesses
- not attempt to discourage patients from seeking or continuing treatment by a registered medical practitioner
- not practise under the influence of alcohol or unlawful drugs, or medication that may impair their ability to practise
- not practise if they suffer from a physical or mental condition that is likely to detrimentally affect their ability or place patients at risk of harm
- not misrepresent their qualifications, training or professional affiliations
- not make any claims about the efficacy of their treatment or services if those claims cannot be substantiated
- not engage in a sexual or other close personal relationship with their patients
- keep appropriate records, comply with privacy laws, and have appropriate insurance.

Unregistered practitioners must display at their premises in an easily visible position both a copy of the code of conduct and information about how a patient may make a complaint to the Commission.

07 Legislative changes

Cosmetic surgery

In April 2008, the then Minister for Health announced that the government would introduce new regulations regarding the advertising of cosmetic surgery, and that she had also asked the Medical Board to develop guidelines for a 'cooling off' period for people under 18 years of age who were seeking cosmetic surgery.

The new regulation

The *Medical Practice Amendment (Advertising) Regulation 2008* came into effect on 1 July 2008, and amended the advertising provisions of the Medical Practice Regulation as follows:

The regulation provides that any advertising of medical services that contains 'before' and 'after' photographs of a person must comply with the following requirements:

- Photographs that purport to be of the same person must in fact be of the same person.
- The person photographed must in fact have received the advertised medical services.
- The medical services must have been performed by the medical practitioner or medical corporation whose services are being advertised.
- Photographs of the same person must be presented in the same or a similar manner, including framing, lighting and make-up.

In addition, any photograph of a person or part of a person that depicts or claims to depict the result of medical services:

- must not be altered or manipulated in a misleading or deceptive manner
- must be accompanied by a prominent statement to the effect that the photograph shows the result of the medical services performed on one person, and there is no guarantee that other persons will experience the same or a similar result.

The new guidelines

The Medical Board published its cosmetic surgery guidelines in July 2008. These guidelines supplement the relevant general standard of good medical practice set out in the Medical Board's code of professional conduct, which says:

> Good clinical care includes an adequate assessment of the patient's condition, based on the history and clinical signs and appropriate examination.

The guidelines stipulate that the assessment of any person seeking cosmetic surgery should include an exploration of why the surgery is requested, including both external reasons – such as a perceived need to please others – and internal reasons – such as strong feelings about appearance. There should also be an exploration of the person's expectations of the surgery.

If there are indications that the person has self-esteem or mental health problems, they should be referred to a psychiatrist or psychologist for review.

Furthermore, at the initial consultation, the practitioner should provide written and easily understood information about:

- what the surgery involves
- the range of possible outcomes
- associated risks
- recovery times
- requirements during the recovery period
- the total cost
- other options for addressing the person's concerns.

For people under 18 years of age, the guidelines provide that, if the surgery has no medical justification, there must be a cooling off period of three months, followed by a further consultation at which the request should be further explored. The young person should also be encouraged to discuss their desire for cosmetic surgery with their general practitioner during the cooling off period.

08

Outreach and quality improvement

Performance 2007-08

Promote complaint resolution services to people across NSW

- **The Resolution Officers of the Commission presented on 60 occasions to community members and health professionals. In addition, senior staff of the Commission gave 21 presentations to health professionals and provided information to professional organisations.**

Report publicly about the work of the Commission

- **During the year, the Commission reviewed and updated its information material and distributed over 47,000 publications to the public. The Commission provided information packages, including brochures and posters, to over 1,200 public and private health facilities in NSW.**
- **The Commission's website was continuously updated throughout the year and there were 41,505 unique visitors to the website and 278,493 hits during 2007-08.**

In addition to its core services, the Commission aims to help health consumers and stakeholders to be aware of reasonably expected standards in health care. It also provides information and advice to help to improve relationships between patients and health service providers.

In March 2008, the Commission created a new position of Communications and Stakeholder Relations Officer, to enhance its outreach into the community and the health professions.

Code of Practice

In line with the NSW State Plan objective of increasing customer satisfaction with government services, the Commission has developed a Code of Practice that sets out what the public and other stakeholders can expect from the Commission. The development of the code included broad consultation with public, health professionals and government stakeholders.

Information material

Information for health consumers and professionals is available through the Commission's website and its publications. All of this information has been reviewed and updated throughout the year.

08 Outreach and quality improvement

Information that can be downloaded from the Commission's website includes:

- Complaint form
- Concerned about your health care?
- Resolve concerns about your health care!
- Assisting you to resolve your complaint
- Conciliating your complaint
- Fees in your health care
- Your health information.

In addition, the Commission has guidelines for health practitioners about how to respond to patient complaints.

The Commission's annual reports and other corporate documents can also be accessed through the website.

Assisting people with special needs

The updated information material is available in 20 community languages on the Commission's website.

The Commission also arranges for telephone, oral and written interpreter services in common community languages. In addition, it encourages staff who are fluent in a language other than English to use their language skills to assist parties to a complaint.

The Commission has a designated indigenous Resolution Officer position based in Dubbo and will be developing outreach to indigenous health service consumers and health workers in the coming year.

People with a hearing disability can contact the Commission using the TTY number (02) 9219 7555.

Outreach to the community

An important forum to assist with the understanding of consumer concerns is the quarterly Consumer Consultative Committee, whose members represent various health care consumer groups in NSW. The Commission has asked members to include information about the Commission's services on their websites and in their newsletters.

To increase awareness of the Commission among health consumers and professionals, the Commission provided information packages, including brochures and posters, to over 1,200 public and private health facilities in NSW on 1 June 2008. This material explains how to raise and resolve concerns about health care provision, and how to access the services of the Commission.

The Commission has also asked all NSW local councils to provide information about the Commission to their local areas.

The Commission's staff regularly present to the community and health service providers about the functions of the Commission, and promote the Commission's services. In 2007-08, Resolution Officers gave 60 presentations.

Outreach to the health professions

During the year, the Commission started an information series to provide feedback to health practitioners about issues raised in complaints to the Commission.

In 2007-08, the Commissioner and other staff gave 21 presentations to health professionals, often as part of continuing education programs, and also wrote a number of articles for publications by various health professional colleges.

In April 2008, the Commission arranged a training evening for its expert reviewers, which focused on changes to the health registration legislation. This session clarified the criteria for, and expectations of, reports provided by experts to assist the Commission's investigations into health service providers.

The Commission also regularly consulted with the various Registration Boards and other health service provider representatives.

In addition, the Commission met with each of the Area Health Services and the Clinical Excellence Commission, to explore the use of complaints for quality improvement in the health system.

The year ahead

To further improve its services and outreach, the Commission has developed and tested client satisfaction surveys. Both complainants and health service providers are asked for their feedback when a complaint has been finalised. The survey results will be published in the next annual report.

The Commission has also started to collect demographic data from complainants, to enable it to better accommodate the needs of the diverse communities of NSW.

In addition, the Commission is planning to participate in joint outreach activities with other agencies.

09

Trends in complaints

The Commission analyses the issues raised by complaints, to identify matters and trends that it can feed back to health service providers to improve their services.

In 2007-08, the Commission received 3,128 complaints, raising 4,409 issues. (A single complaint may raise multiple issues – for example, poor communication, inadequate diagnosis, incorrect treatment, and over-medication.)

The Commission distinguishes between complaints about individual health practitioners and those about health organisations. For example:

- A person complains that their condition was incorrectly diagnosed – the relevant provider is the practitioner who made the diagnosis.
- A person complains that their X-Ray films have been lost – the relevant provider is the health organisation.

Some complaints raise issues about both individual practitioners and health organisations.

Complaint numbers in perspective

The analysis of complaints can be a useful tool to inform both health service providers and the public about areas where there may be room for improvement. However, it is important to recognise that the health system is complex and diverse, and the Commission is not the only body dealing with complaints about health service providers in NSW. Accordingly, the nature and extent of the complaints received by the Commission can only be a partial indicator of the overall standard of health care delivery.

In this context, the following matters should be noted:

There were 185,109 health practitioners registered in NSW in 2007-08. The Commission received only 1,698 complaints about registered practitioners during that period. Similarly, there were 2,417,818 attendances to public hospital emergency departments in 2007-08, but only 180 complaints to the Commission about public hospital emergency services, care and treatment.

The Commission received a total of 3,128 complaints about public and private health service providers in 2007-08. In comparison, during the calendar year 2007, there were 16,133 complaints received directly by public health service providers and Area Health Services and a total of 111,625 clinical incidents were notified[1].

The Department of Health conducted a statewide survey on patient satisfaction and received over 70,000 responses. This survey found that, overall, 88.1% of patients were satisfied with the care they had received in the NSW public health system.

1 Clinical Excellence Commission, Incident Management in the NSW Public Health System, reports January to June 2007 and July to December 2007 (available at http://www.cec.health.nsw.gov.au)

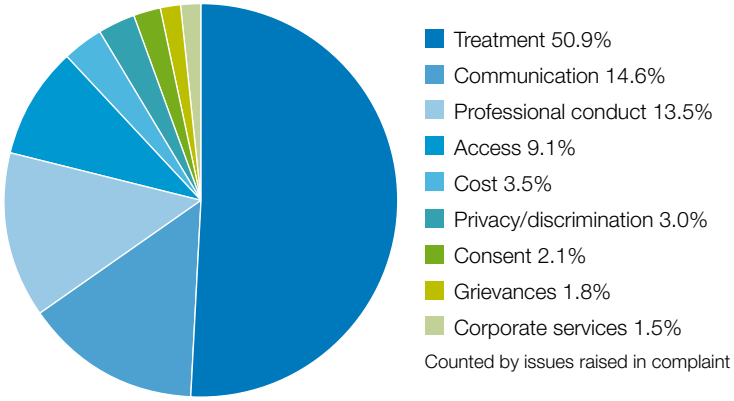
09 Trends in complaints

Issues raised in complaints to the Commission

The Commission classifies the issues raised in complaints using the following categories:

- access – complaints about delays in admission or treatment, or refusal to admit or to provide treatment
- communication – issues such as attitude and the provision of incorrect or inadequate information
- consent – either no consent was given for the treatment, or there was insufficient consent
- corporate services – matters such as poor hygiene
- cost – including complaints about billing practices
- grievances – including complaints about a failure to respond to the patient's concerns
- privacy/discrimination – including the inappropriate disclosure of patient information
- professional conduct – complaints about competence, or about assault, sexual misconduct, or fraud
- treatment – including complaints about inadequate treatment, medication and/or diagnosis.

Chart 9.1 Issues raised in all complaints received 2007-08

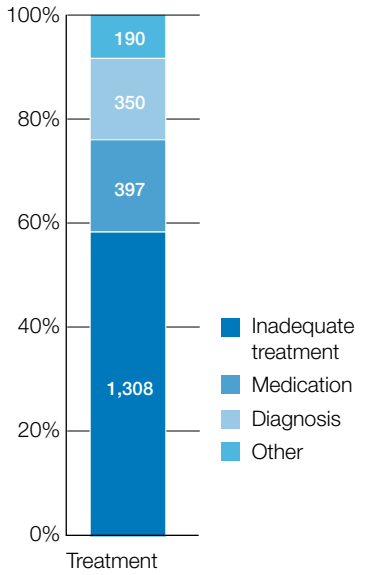


Counted by issues raised in complaint

In 2007-08, the Commission reviewed the way in which it categorises the issues raised in complaints, to allow a more detailed and in-depth analysis of complaints received. As a result, the Commission – together with its Australian and New Zealand counterparts – has developed a system that will permit the comparison of complaints data across jurisdictions. The Commission implemented its revised issues categorisation system on 1 July 2008, and most of the Commission's counterparts in other jurisdictions have agreed to implement the new system in the coming year.

Chart 9.1 shows the breakdown of issues in all complaints received by the Commission in 2007-08.

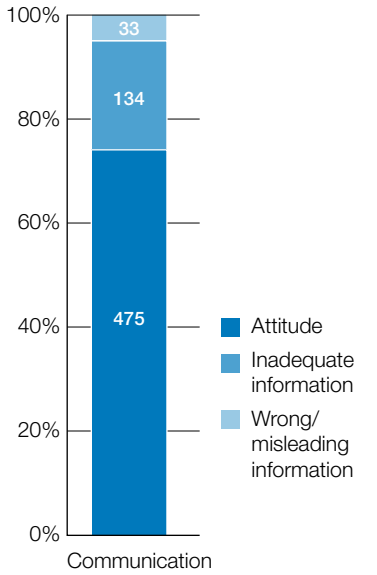
Chart 9.2
Proportion of issues in the category treatment 2007-08



Counted by issues raised in complaint

About half of the complaints to the Commission (50.9%) related to treatment – a drop of 4.7% from last year. Of the 2,245 issues about treatment, the majority concerned inadequate treatment (1,308), followed by medication (397) and diagnosis (350).

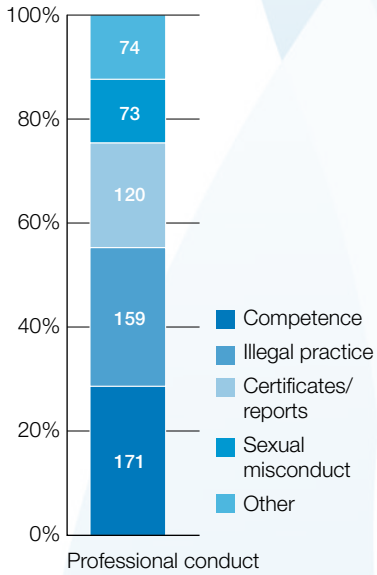
Chart 9.3
Proportion of issues in the category communication 2007-08



Counted by issues raised in complaint

The proportion of complaints about communication increased by 3.4% from last year, and were the second most common type of issue dealt with by the Commission (14.6%). There were 475 complaints about attitude, 134 about the provision of inadequate information, and 33 about the provision of wrong or misleading information.

Chart 9.4
Proportion of issues in the category professional conduct 2007-08



Counted by issues raised in complaint

Complaints about professional conduct issues (13.5%) fell by 4.6% from last year. This included 171 complaints about competence, 159 about illegal practices, 120 about incorrect certificates or records, and 73 alleging sexual misconduct.

Access issues rose by 2.7% from last year, to 9.1%.

09 Trends in complaints

Trends in complaints about health practitioners

The Commission received 1,771 complaints about individual health practitioners.

Chart 9.5 shows the three health professions most commonly complained about – medical practitioners, nurses and dentists. Complaints about practitioners in these professions accounted for 87.3% of all complaints about practitioners in 2007-08.

Most complaints were about medical practitioners – in 2007-08, the Commission received 1,145 complaints about medical practitioners. However, given that there are 30,036 medical practitioners registered in NSW, that number of complaints is relatively small.

There were 224 complaints about nurses and midwives. Again, this figure should be considered in the context that there are 119,200 nurses and midwives in NSW.

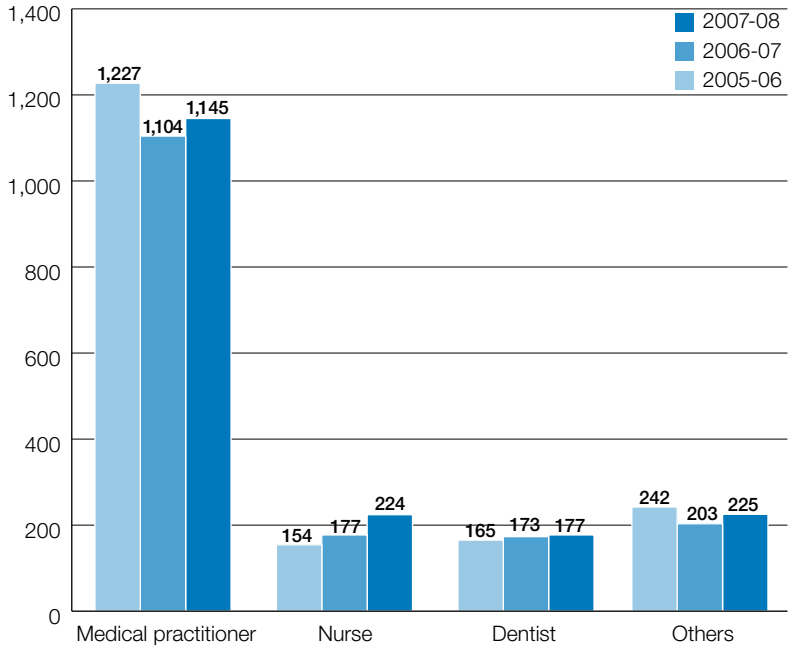
There were also 177 complaints about dentists – there are 5,119 dentists registered in NSW.

A detailed breakdown of the number of complaints received about other health professions can be found in Table 18.12 in the appendices of this report.

Issues raised about health practitioners

Chart 9.6 sets out the types of issues raised in the complaints about medical practitioners, nurses and dentists.

Chart 9.5 Complaints received about health practitioners 2005-06 to 2007-08



Counted by provider identified in complaint

The proportion of complaints about treatment was above the average of all practitioners for dentists and below the average for nurses. This may be explained by the different nature of the provider-patient interaction in the respective professions.

Communication issues were more commonly raised in complaints about medical practitioners (17.0%) than in those about nurses (10.6%) or dentists (9.2%).

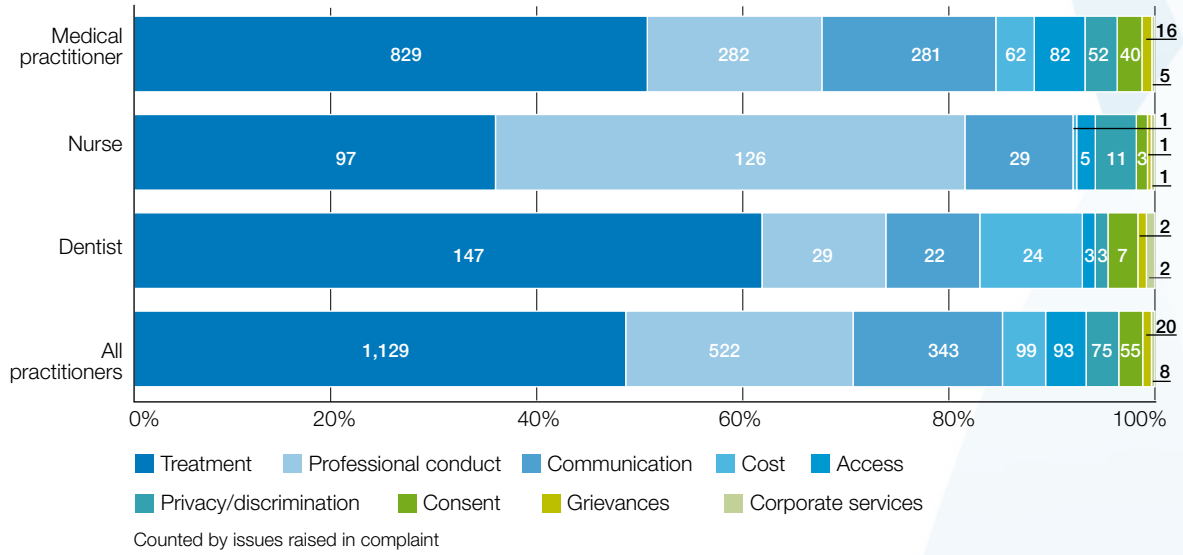
The proportion of complaints about professional conduct was much greater in complaints received about nurses (46.0%) than in those about medical practitioners (17.1%) or dentists (12.1%).

Trends in complaints about health organisations

The Commission has analysed complaints about different types of health organisation over three years. As shown in Chart 9.7, most complaints received about health organisations concern public hospitals. This reflects both the large number of patients dealt with by public hospitals, and the more complex range of health services – associated with higher risks – that public hospitals provide.

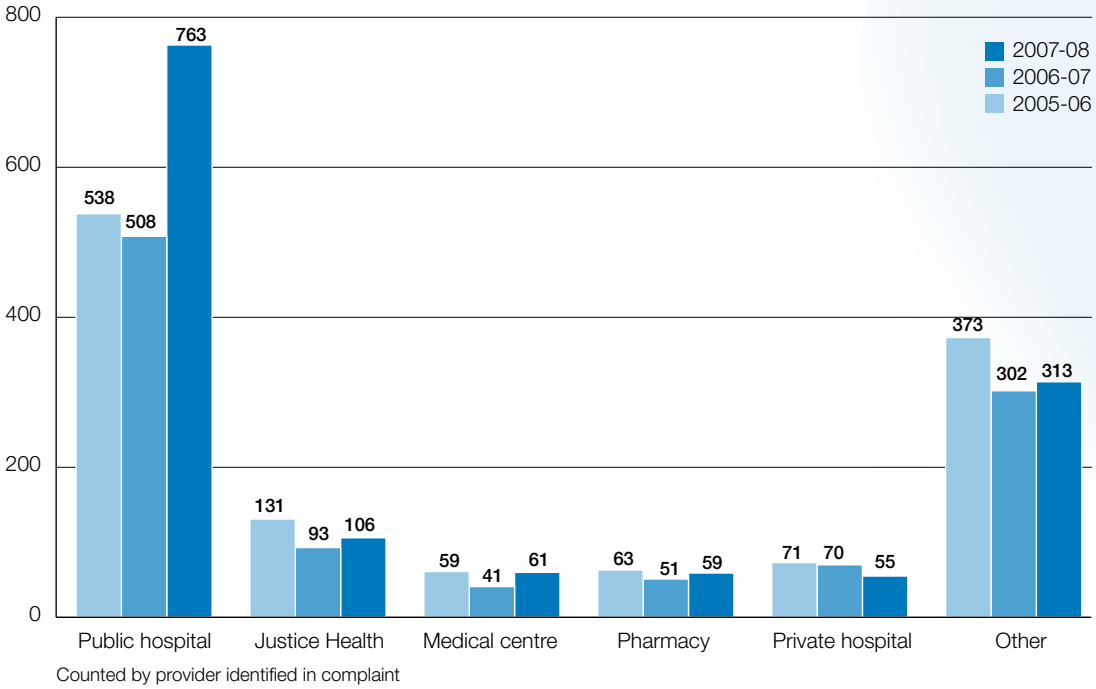
The increase in complaints about public hospitals in 2007-08 is mainly attributable to the Garling Inquiry's referral of 174 complaints about public hospitals to the Commission.

Chart 9.6 Issues raised in complaints received about medical practitioners, nurses and dentists 2007-08



Counted by issues raised in complaint

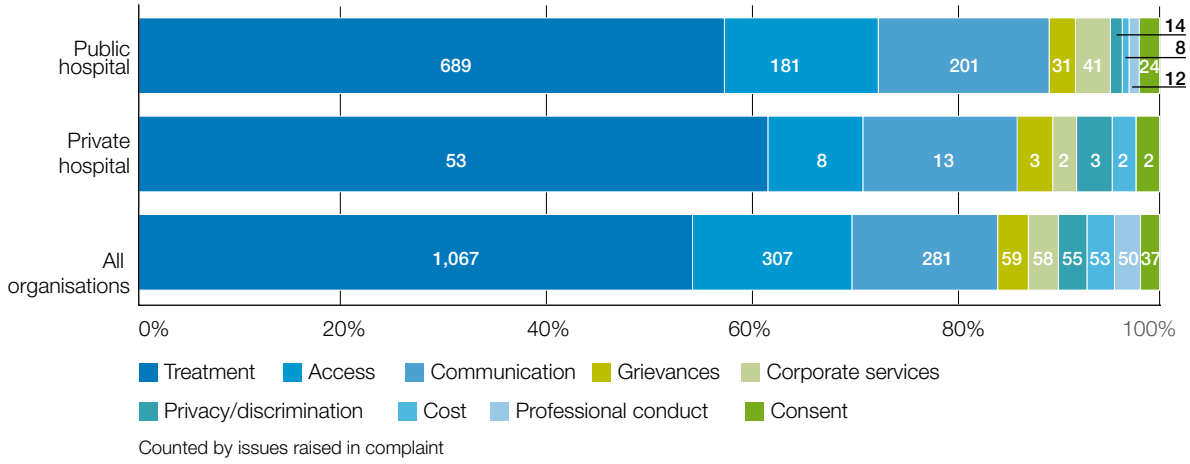
Chart 9.7 Complaints received about health organisations 2005-06 to 2007-08



Counted by provider identified in complaint

09 Trends in complaints

Chart 9.8 Issued raised in complaints received about public and private hospitals 2007-08



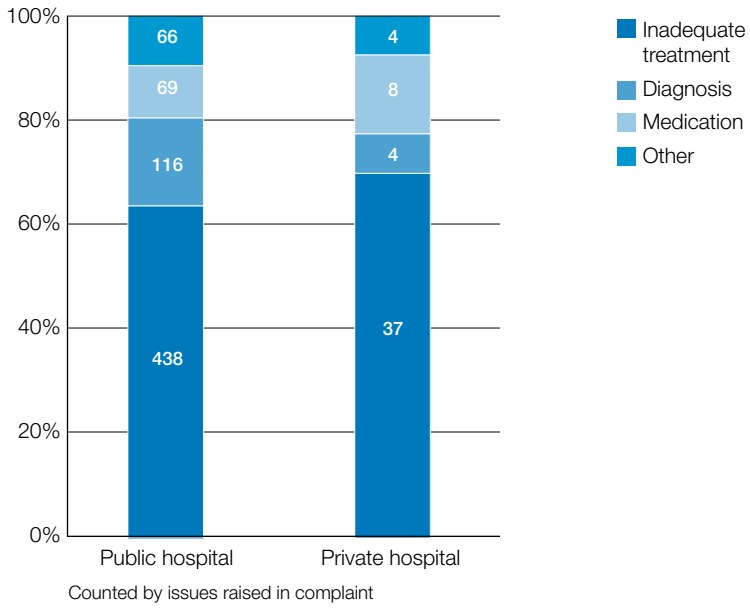
Issues raised in complaints about hospitals

Chart 9.8 illustrates the nature of the issues raised in complaints about public and private hospitals.

Complaints about treatment are the majority of complaints about both public (57.4%) and private (61.6%) hospitals. The proportion of access issues is higher in complaints about public hospitals compared to private hospitals.

Chart 9.9 shows the top three issues in the 'treatment' category for public hospitals as compared to private hospitals. Inadequate treatment was the most common issue – there were 438 complaints about this issue for public hospitals, and 37 for private hospitals.

Chart 9.9 The most common treatment issues raised in complaints received about hospitals 2007-08

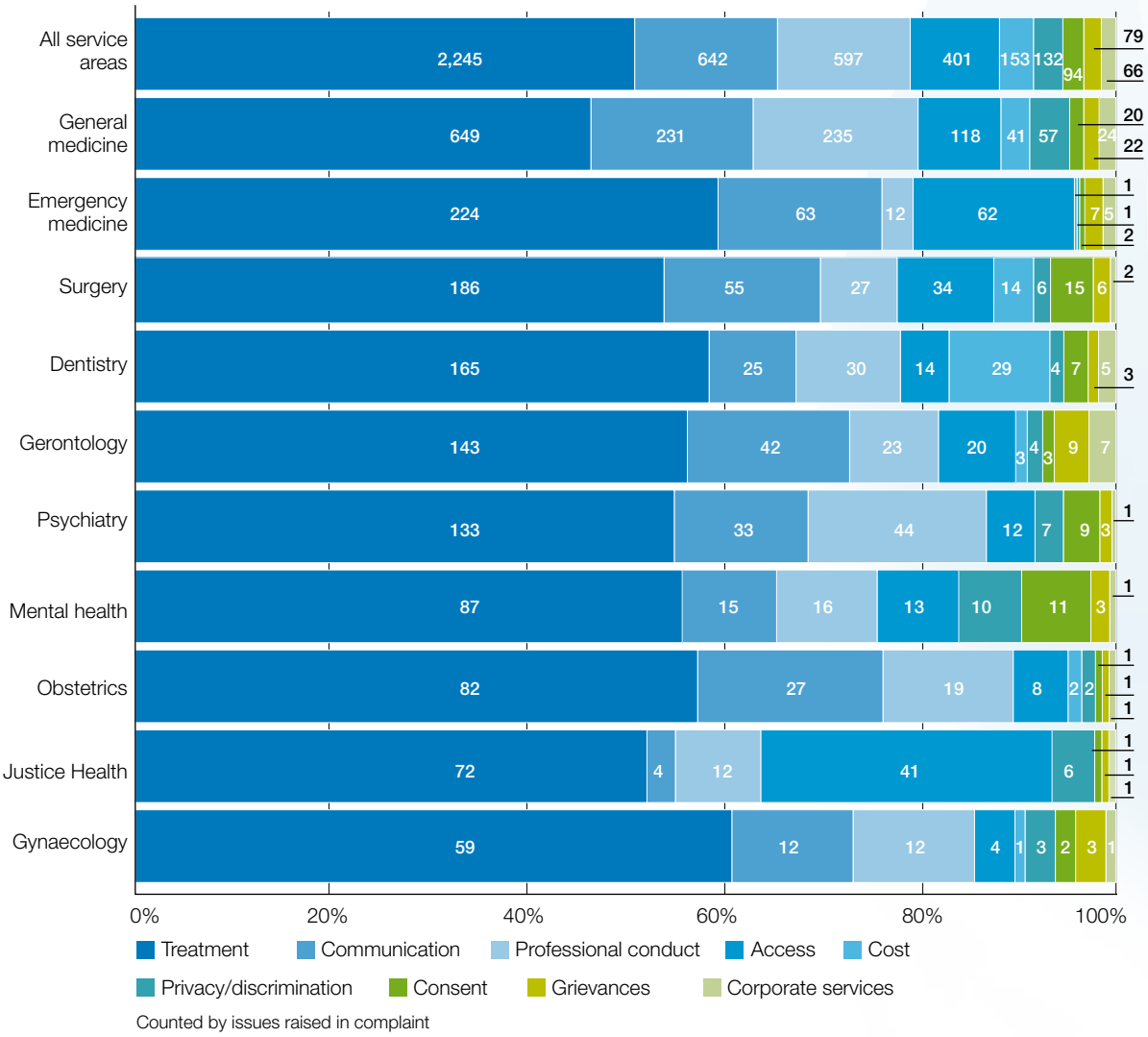


Issues raised in complaints by service area

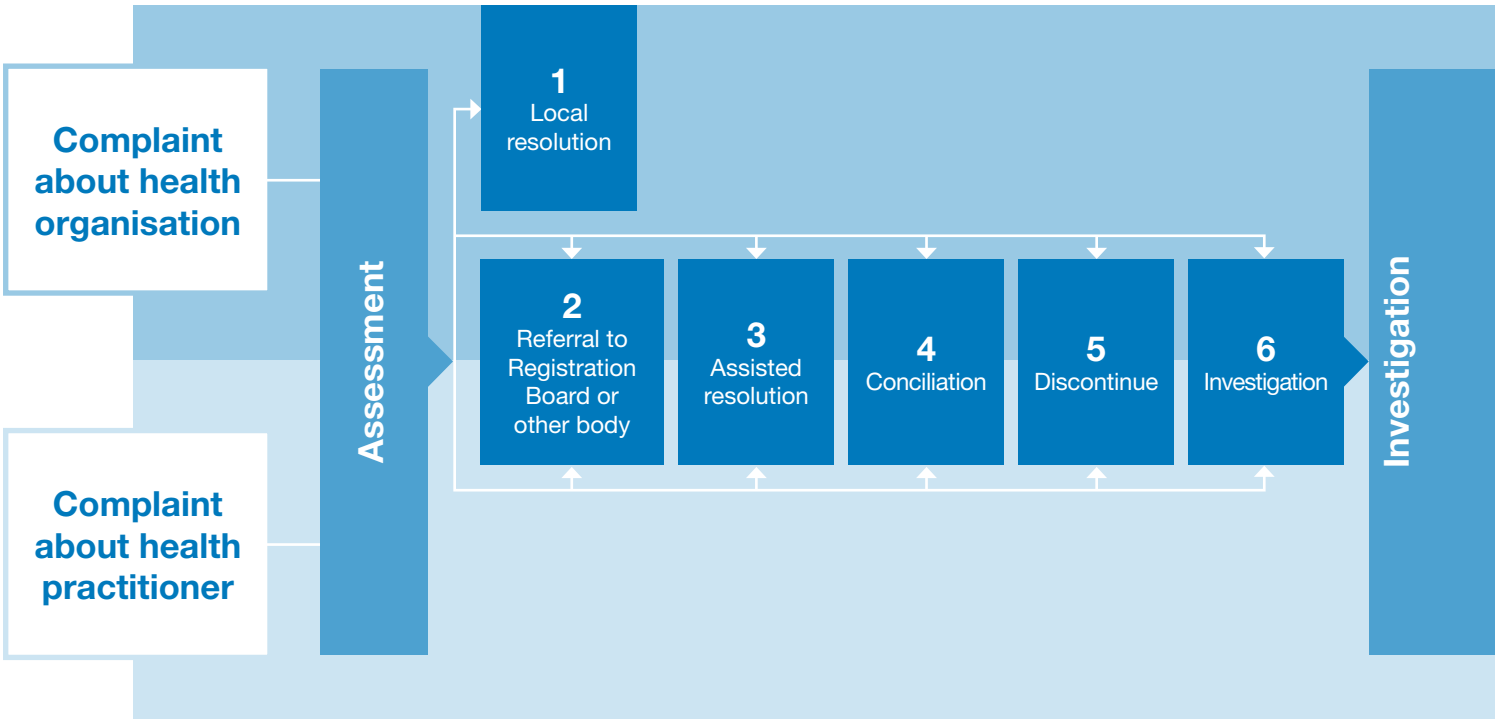
Chart 9.10 summarises the issues raised in complaints about the ten most common service areas.

Treatment issues are more common for emergency medicine and gynaecology than for other health service areas. A common issue for prisoners remains access to health services. Access is also a significant issue in emergency medicine.

Chart 9.10 Issues raised in complaints received by service area 2007-08



10 The complaints process



When the Commission assesses a complaint, it will contact the complainant to clarify the issues; notify the provider and seek their response to the complaint. The Commission may also obtain health records to assist in the assessment of clinical issues; and seek advice from internal nursing and medical advisers.

The Commission assesses all relevant information, including any expert advice. If the complaint concerns an individual practitioner, the Commission also consults with the relevant Registration Board.

The possible outcomes of assessment are:

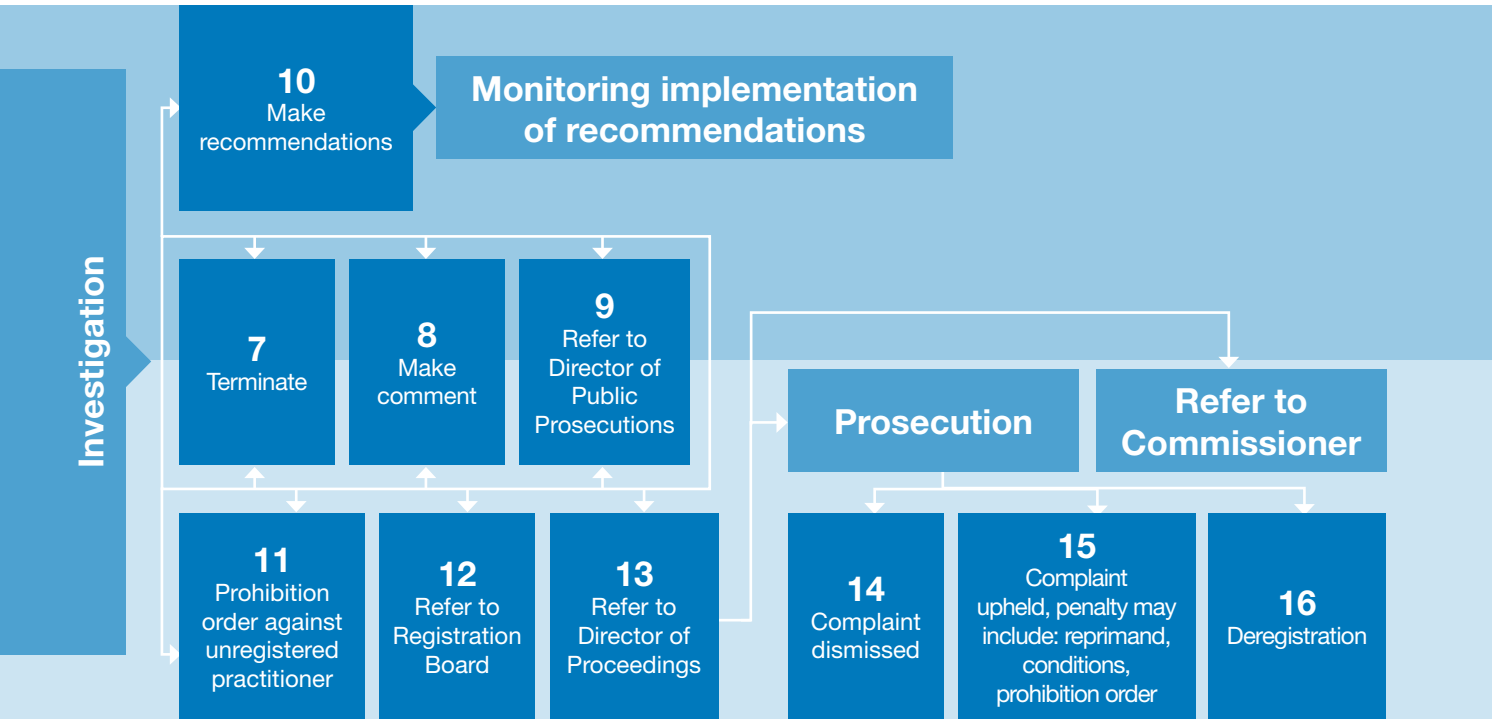
1. The Commission can refer a complaint about a public health organisation back to the health organisation to **resolve locally** with the complainant, if the health organisation has agreed to the referral.
2. In some cases, it is appropriate to **refer** a complaint about an organisation **to another body** to be dealt with by them. This can include referral to the Director-General of the Department of Health if there has been a breach of an Act such as the *Poisons and Therapeutic Goods Act*. Some complaints about individual practitioners are **referred to the relevant Registration Board** to consider taking appropriate action such as counselling, or impairment or performance assessment for medical practitioners and nurses.
3. Often a complaint can be **resolved** with the assistance of a Resolution Officer. Participation in assisted resolution is voluntary.
4. Some complaints are suitable for **conciliation** and are referred to the Health Conciliation Registry. The Registry maintains a panel of independent expert conciliators who facilitate a meeting of the parties to the complaint and guide them in finding a resolution. Conciliation is a voluntary and confidential process.
5. The Commission can **discontinue** dealing with a complaint for many reasons, including the age of the matter complained of, or that it might be better dealt with by some alternative means.
6. The Commission refers complaints about individual practitioners for formal **investigation** where, if substantiated, the complaint would provide grounds for disciplinary action, or involves gross negligence on the part of a practitioner. Complaints about health organisations are investigated where they raise a significant issue of public health or safety, or significant questions about the appropriate care or treatment of an individual.

The purpose of an investigation is to obtain information so that the Commission can determine the most appropriate action (if any) to take. The focus of investigations is on the protection of public health and safety.

At the end of an investigation the Commission may:

7. **Terminate** the complaint (that is, take no further action). This occurs in cases where the investigation found no evidence of inappropriate conduct, care or treatment.
8. Make **comments**. Comments are made to a health practitioner where poor care or treatment was provided, but there is insufficient evidence to justify referral to the Director of Proceedings. Comments to a health organisation acknowledge that the organisation has taken steps to try to prevent poor health service delivery from happening again, therefore the Commission does not need to make formal recommendations.

The Commission receives and deals with complaints about individual health practitioners, such as doctors, optometrists and acupuncturists, and health organisations, such as hospitals. Complaints about health practitioners who are registered under a health registration Act can be received either by the Commission or by the registration authority such as the NSW Medical Board and other Registration Boards.



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

10 Make **recommendations** to a health organisation. Recommendations are made where an investigation discloses poor health service delivery and identifies systemic improvements that should be made. The Commission also provides its report to the Director-General of the Department of Health. The Commission follows up the implementation of recommendations concerning public organisations with the Department and directly with private health organisations. If the Commission is not satisfied that sufficient steps for implementation have been taken within a reasonable time, it may, after consultation with the Director-General, make a report to the Minister. If the Commission is not satisfied with the Minister's response, it may make a special report to Parliament.

11 Issue a **prohibition order or public warning against an unregistered health practitioner**. The prohibition order can take the form of either a blanket or limited order. The unregistered practitioner must advise potential patients of the provisions of the prohibition order before treating them. A breach of the order is a criminal offence.

12 **Refer** the complaint **to the appropriate Registration Board** to take action under the relevant health registration Act. In some cases, the Registration Board may have the power to refer the practitioner for performance or impairment assessment or may decide to counsel the practitioner about their conduct.

13 Refer the complaint to the **Director of Proceedings** who determines whether a complaint should be prosecuted before a disciplinary body. In making her determination, the Director of Proceedings considers the protection of the health and safety of the public; the seriousness of the alleged conduct; the subject of the complaint; the likelihood of proving the alleged conduct; and any submissions made by the health practitioner. Generally, complaints about unsatisfactory professional conduct are prosecuted before a Professional Standards Committee, while proceedings regarding complaints about professional misconduct are prosecuted before a Tribunal, which has the power to suspend or deregister a practitioner. If the Director of Proceedings determines that a matter does not meet the threshold for prosecution, it is referred back to the Commissioner to consider other appropriate action.

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

15 Where the disciplinary body finds the complaint proven, it can **reprimand, fine and/or impose conditions** on the practitioner. The Tribunal or Professional Standards Committee may also issue a **prohibition order against registered practitioner**, which restricts the practitioner from practising in a particular area. For example, a psychiatrist who is deregistered can be prohibited from working as a psychologist.

16 Only a Tribunal has the power to **deregister** a practitioner.

11

Inquiry Service

The Commission's Inquiry Service handles inquiries from people who are concerned about the quality of the health care provided to them or to a family member or friend. Inquiries are usually made by telephone or email, sometimes people visit the Commission's offices.

People making inquiries can be upset or angry, and may be unsure about whether or how to pursue their concerns. Sometimes they need to have, or wish to maintain, an ongoing relationship with their health service provider(s).

Therefore it is vital that Inquiry Service staff are able to respond effectively and with a suitable degree of empathy to those seeking the Commission's help. For this reason, the Commission's Resolution Officers, who are experienced in the assisted resolution of complaints, are also responsible for handling telephone inquiries.

The officers of the Inquiry Service:

- answer questions about the role and jurisdiction of the Commission, and explain how the Commission deals with complaints
- where appropriate, suggest that the caller try to resolve their concerns directly with the health service provider, and provide practical advice on how to do so
- provide information on how to make a written complaint to the Commission and, for this purpose, send out a complaint form
- assist the person to put their complaint in writing
- where urgent action is required, set out the person's concerns as a formal complaint
- refer people to other agencies and organisations that can better address their concerns.

Performance of the Inquiry Service

In 2007-08, the Inquiry Service dealt with 8,831 inquiries – an 11.4% increase on the 7,927 inquiries handled in 2006-07.

There was a notable rise in the number of calls to the Commission during the second six months of the 2007-08 reporting period. The Commission attributes this to the publicity during that time surrounding the quality of health care. In particular, the media attention regarding the complaints about Mr Graeme Reeves, and concerns voiced at the hearings of the Garling Inquiry about the adequacy of NSW hospital services.

The Commission's promotion and education activities also appear to have been successful in raising public awareness of the Commission as an avenue for pursuing complaints about health service providers.

Inquiry outcomes

Chart 11.1 shows how the Inquiry Service dealt with inquiries to the Commission during 2007-08.

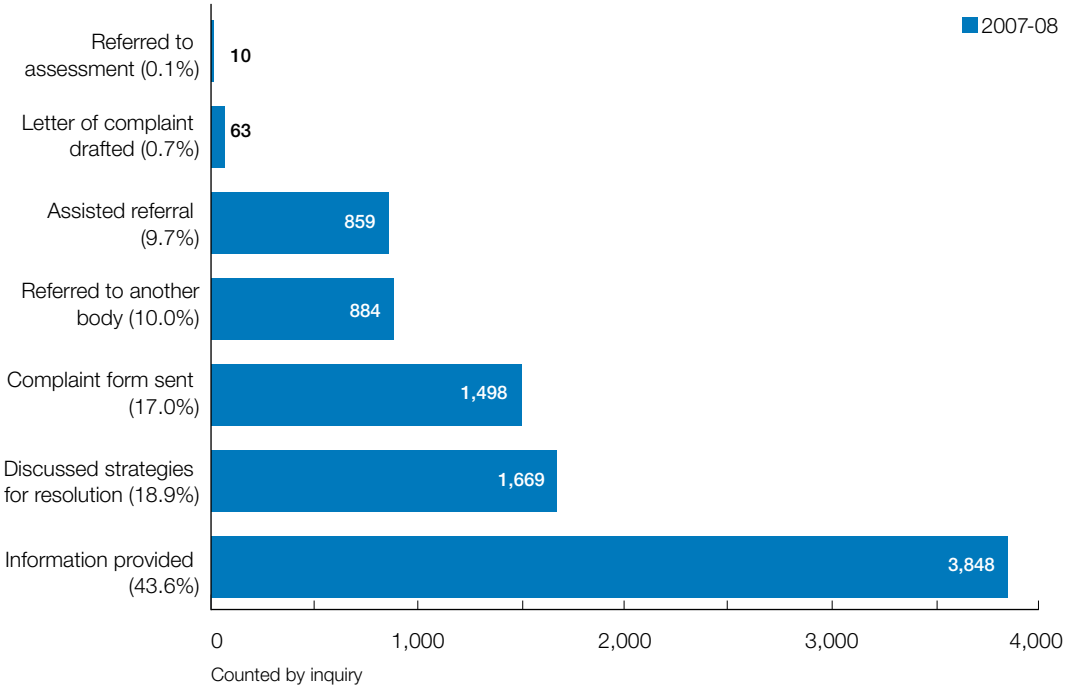
For 43.6% of inquiries, the Inquiry Service provided relevant information.

Significantly, for 18.9% of calls, the Commission officer discussed strategies that could be pursued to try to resolve the concerns in question directly with the health service provider. This sort of constructive and empowering advice – particularly where it leads to a resolution of the caller's concerns – serves to reduce the number of formal written complaints made to the Commission.

10.0% of callers were referred to another body. A further 9.7% of inquiries were dealt with through 'assisted referral' – the Commission officer contacted another agency that was better suited to deal with the caller's concerns, and then provided the caller with details of the agency's contact person.

For 17.0% of calls, the Inquiry Service sent a complaint form and provided information about how to make a complaint. In a small number of cases, the Commission officer assisted the caller to draft a complaint, or prepared a written complaint for urgent assessment.

Chart 11.1 Inquire Service outcomes 2007-08



11 Inquiry Service

Case study 1

A correctional centre inmate telephoned the Inquiry Service to say that he had become increasingly unwell over the last two weeks and had great difficulty breathing. The Inquiry Officer could hear the inmate was having trouble breathing while talking on the phone.

The inmate said that he had asked to see a doctor, and also understood that a nurse had marked his request as urgent – however, the doctor had run out of time and had been unable to see him.

The Inquiry Officer raised the inmate's concerns with Justice Health.

Later that day, the inmate called back to thank the Inquiry Officer for their prompt assistance. Arrangements had been made for the inmate to see the doctor – who had diagnosed pneumonia – and he was now receiving treatment.

Case study 2

A woman called the Inquiry Service to complain that a plastic surgeon had mistakenly removed the wrong lesion from her mother's nose, and to ask what action she could take to pursue her concerns about the situation.

The Inquiry Officer discussed a number of approaches, including arranging a face-to-face meeting with the doctor, and provided advice on how the woman could prepare for such a meeting.

The woman called back later to say that she and her mother had recently met with the doctor. He had acknowledged that he had mistakenly removed the wrong lesion, and apologised for his mistake. He also agreed to pay for further surgery to remove the cancerous lesion as soon as possible.

The woman was very pleased with this outcome, and expressed her appreciation for the advice that the Inquiry Officer had given her.

Case study 3

A woman called to complain about the length of her wait for hip replacement surgery. She also complained that her General Practitioner had refused to contact the hospital to organise this surgery. The woman, who lived alone, said that her condition was deteriorating and the pain was getting worse – she could no longer walk or leave the house without assistance.

The Inquiry Officer explained that the Commission could not force the hospital or surgeon to put her higher on the list for hip replacement surgery.

The woman said that she still wished to make a complaint, but had difficulty in writing as a result of problems with her arm. The Inquiry Officer drafted a letter of complaint, based on the information that the woman had provided.

The Commission subsequently assessed the complaint as suitable for referral to the Resolution Service.

With the assistance of a Resolution Officer, the complaint was resolved when the hospital transferred the woman case to another surgeon who was able to perform the surgery at an earlier date.

12

Assessing complaints

Performance 2007-08

Efficient and timely processing and assessment of complaints and review processes

- **88.2% of complaints received were assessed within the statutory timeframe of 60 days. The average time it took to assess complaints was 39 days.**
- **The Commission finalised 2,889 assessments and received 230 requests for a review of the assessment decision in the same period, which represents 8.0%, a fall from 10.5% in the previous year.**
- **The Commission reached its target of 7.0% with 7.1% of complaints being resolved during assessment.**
- **Criteria to identify complaints that are suitable for referral to the Health Conciliation Registry have been developed and implemented and have also been included in the procedures manuals.**
- **A number of new Casemate process reports covering assessments and reviews of assessment decisions are now in place to improve performance and trend analysis.**

Written complaints are referred to the Director of the Assessment and Resolution Division and the Assessments Manager for consideration. These senior officers identify the main issues raised in the complaint and determine the action that should be taken in order to conduct a proper assessment of the matter. Assessment plans – that is, directions as to the action to be taken – are included on the complaint files allocated to individual Assessment Officers.

The assessment process

Generally speaking, the assessment process involves the Commission's Assessment Officers:

- contacting the complainant, and clarifying the precise issues of the complaint that they wish to pursue
- notifying the health service provider(s) of the complaint, and requesting a written response
- requesting relevant medical records
- where clinical issues are involved, seeking advice on the care and treatment in question from the Commission's internal medical and nurse advisers (in some cases, these advisers will in turn seek further specialist advice)

12 Assessing complaints

- advising the complainant of any resolution options offered by the health service provider – in some cases, this leads to a resolution of the complaint
- preparing an assessment brief which summarises the issues and evidence, and recommends whether and what further action should be taken.

The assessment brief

A panel that includes the Commissioner and the Director of Assessment and Resolutions and/or the Assessment Manager considers the assessment brief. For matters where conciliation has been recommended, the Registrar of the Health Conciliation Registry is also involved in the discussion.

The panel decides how the complaint should be handled, with the options being:

- no further action
- referral for assisted resolution or conciliation by the Commission
- referral for local resolution by a public health organisation
- referral to a Registration Board or some other body for action
- full formal investigation.

Where the complaint is about an individual registered practitioner, the Commission must also consult with the relevant Registration Board about the action considered appropriate. Where the Commission and Registration Board differ, the more serious option must be pursued (for example, if either the Commission or the Board considers that the complaint should be investigated, rather than being referred to the Board for further action, then the matter will be referred for investigation.)

Assessment Officers call the complainant to advise them of the assessment decision, and prepare correspondence advising the complainant and health service provider(s) of the reasons for that decision.

Complaints received

In 2007-08, the Commission received 3,128 complaints about health practitioners and health organisations – a substantial increase of 14.9% on the 2,722 complaints received in 2006-07.

One reason for the increased number of complaints was the establishment of the Garling Inquiry in January 2008. Commissioner Garling conducted a program of public hearings throughout NSW between March and May 2008, at which many members of the public gave evidence. This evidence often included complaints by patients or their families about the quality of care and treatment at public hospitals.

The Garling Inquiry's terms of reference required it to refer any complaints that it received to the Health Care Complaints Commission. Since March 2008, the Garling Inquiry has referred 174 complaints to the Commission.

Another reason for the increase in complaints was the media coverage in February 2008 regarding complaints about Mr Graeme Reeves by many of his former patients. The Commission released a media statement the same month inviting these patients to make written complaints about Mr Reeves to the Commission. By the end of June 2008, the Commission had received 43 complaints about Mr Reeves.

The publicity surrounding both the Garling Inquiry and the case of Mr Reeves may well have heightened the general consciousness of members of the public about issues relating to the quality of health care – and, in turn, their readiness to complain to the Commission and health professional Registration Boards about inadequacies in the provision of that care.

The Commission also began to more actively promote to the community its role in dealing with complaints about health service providers. This may also have been a factor for the rise in complaints made to the Commission during 2007-08.

Performance of the Assessment Branch

During 2007-08, the Commission finalised the assessment of 2,889 complaints. The outcomes were as follows:

- 206 (7.1%) were resolved during the assessment process
- 982 (34.0%) were discontinued – that is, the Commission decided that no further action needed to be taken
- 574 (19.9%) were referred to the Resolution Service for assisted resolution (for the outcome of complaints referred to the Resolution Service, see chapter 13 'Resolving complaints')
- 198 (6.9%) were referred to the Health Conciliation Registry for conciliation (for the outcome of complaints referred to conciliation, see chapter 14 'Conciliating complaints')

- 41 (1.4%) were referred for local resolution because the public health organisation agreed to try to resolve the matter directly with the complainant
- 572 (19.8%) were referred to a Registration Board for action in relation to individual health practitioners
- 56 (1.9%) were referred to another body for action
- 260 (9.0%) were referred to the Investigations Division for full formal investigation (for the outcome of complaints referred to investigation, see chapter 15 'Investigating complaints').

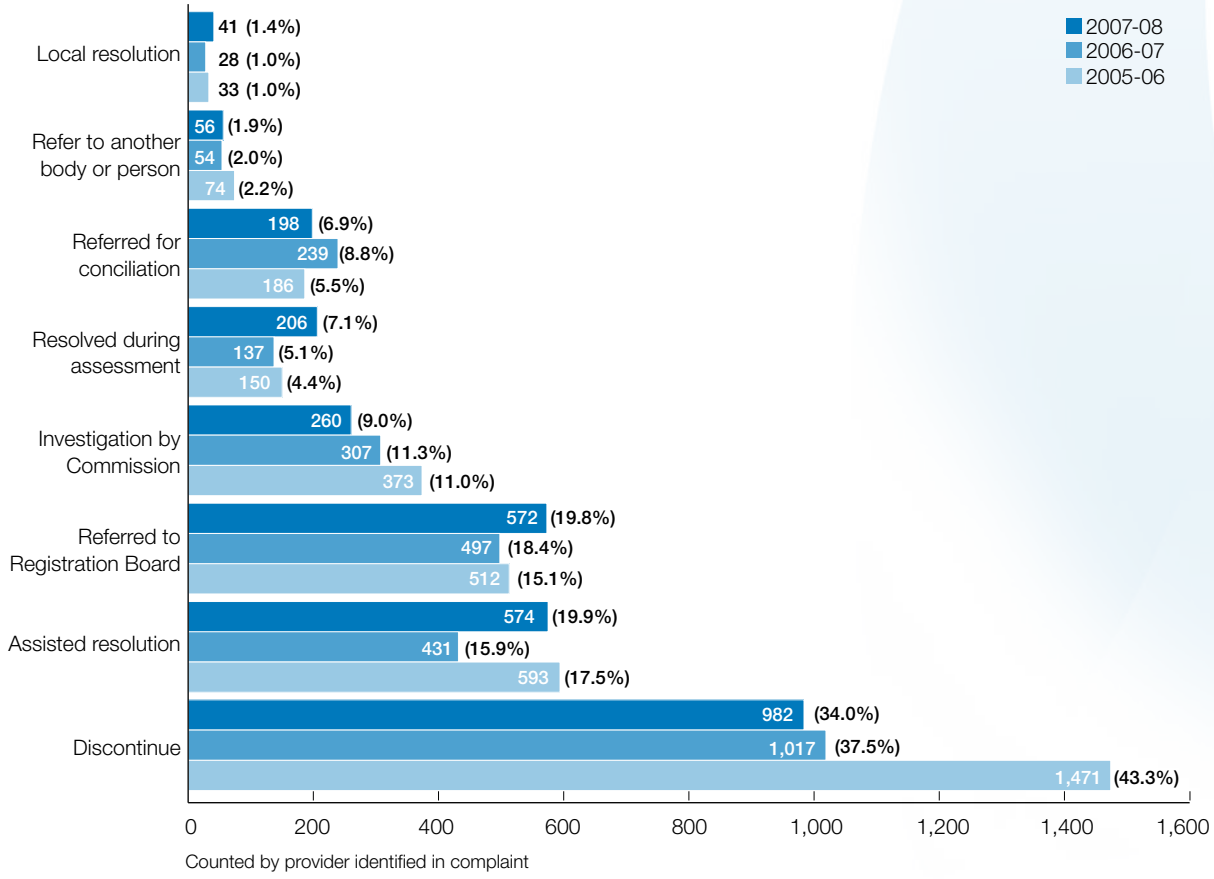
The number of complaints resolved during the assessment process rose from 137 in 2006-07 to 206 in 2007-08 – representing a corresponding increase from 5.1% to 7.1% in the proportion of matters resolved by Assessment Officers.

In addition, the Commission assessed 813 matters (28.1%) as being suitable for one of the resolution options. This is a substantial increase on the 698 complaints dealt with in this way in 2006-07.

Chart 12.2 on the next page details the types of issues that were raised in all complaints assessed by the Commission in 2007-08, and the outcomes of assessment. Key outcomes were:

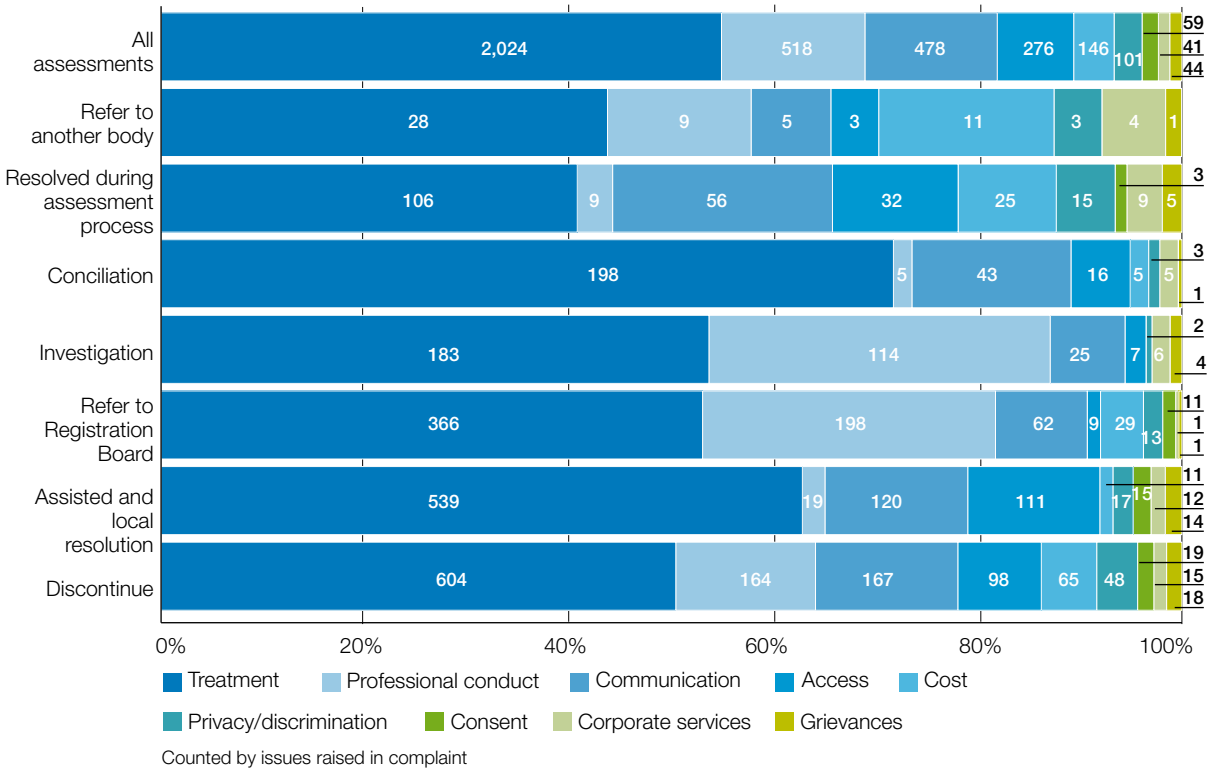
- complaints about treatment were less likely to be discontinued
- complaints that raised issues of access, grievances, consent and communication are more suitable for assisted and local resolution than to refer to a Registration Board
- treatment issues are more often referred for conciliation than any other outcome
- complaints that raise professional conduct issues of the health service provider are more likely referred to investigation.

Chart 12.1 Outcome of assessment of complaints 2005-06 to 2007-08



12 Assessing complaints

Chart 12.2 Issues raised in all complaints assessed 2007-08



Counted by issues raised in complaint

Timeliness of assessment decisions

The *Health Care Complaints Act* imposes two timeframes on the Commission in relation to the assessment of complaints:

- The assessment should be finalised within 60 days.
- The parties to a complaint should be advised of the assessment decision within 14 days of the decision.

In 2007-08, 88.2% of assessment decisions were made within 60 days – with an average turnaround time of 39 days. Furthermore, 91.1% of assessment decision letters were prepared and sent within 14 days of the decision.

Reviews of assessment decisions

If a complainant is dissatisfied with the Commission's assessment decision, they can seek a review of the decision (except where the Commission has decided that the complaint warrants investigation).

In 2007-08, the Commission received 230 requests for review of its assessment decision. This means that reviews were sought for 8.0% of all assessment decisions. This figure has fallen from 10.5% in the previous year, and may indicate that more complainants are satisfied with the explanations provided for the Commission's decisions.

During the year, the Commission finalised 242 reviews. In 216 (89.3%) of these matters, the original decision was confirmed. In the remaining 26 matters (10.7%), the Commission changed the original assessment decision, with the vast majority of matters being referred for assisted resolution or conciliation.

Staff development

During 2007-08, Assessment Officers undertook training to enhance the skills that they need to deal with the assessment process.

Complainants are often angry or distressed about their treatment by health service providers and/or the adverse or unexpected outcomes of treatment. Families or friends who

believe that the death of a loved one has been the result of unsatisfactory health care will be grieving. In these circumstances, it is vital that Assessment Officers have the appropriate skills to communicate with complainants effectively.

In addition, some health practitioners will be surprised, disappointed or affronted that a complaint has been made about their treatment of a patient. This means that they may be unnecessarily defensive and not open to suggesting ways to resolve the complaint. Again, Assessment Officers must have the necessary skills to discuss the matter constructively.

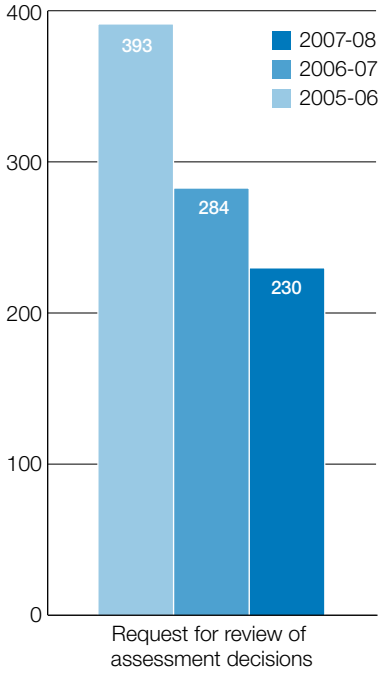
For these reasons, Assessment Officers have participated in dispute resolution and negotiation training, to enhance the quality of their communication with both complainants and health care providers.

In addition, they have undertaken courses in plain English to ensure that all correspondence to complainants and health care providers explaining the reasons for the Commission's decisions is clear and expressed with an appropriate degree of empathy. This is particularly important where the Commission has decided to discontinue dealing with the complaint.

The year ahead

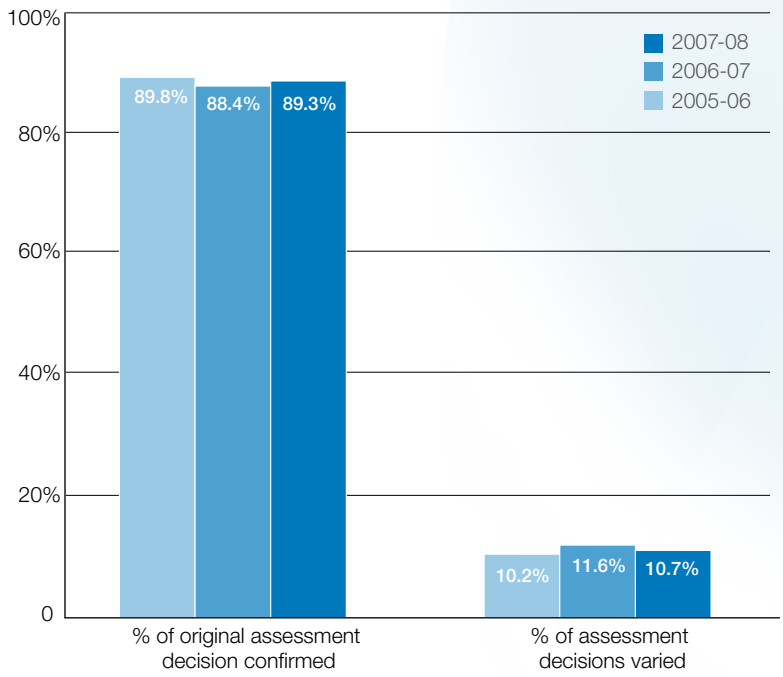
The Commission plans to involve Assessment Officers in additional training in the coming year, to further assist them in meeting the challenges of dealing effectively with complainants and health service providers.

Chart 12.3
Request for review of assessment decision 2005-06 to 2007-08



Counted by provider identified in complaint

Chart 12.4
Outcome of reviews of assessment decision 2005-06 to 2007-08



Counted by provider identified in complaint

13

Resolving complaints

Performance 2007-08

Promote the use of health complaint resolutions to people of NSW

- **During the year, 60.1% of complaints finalised by the Resolution Service were fully or partially resolved.**
- **89.8% of complaints resolutions were finalised within six months compared to 88.7% in the previous year.**
- **The Commission has changed its customer satisfaction surveys during the year to allow for comparison of the results across different activities.**
- **The specification for a new resolution process in the case management system – Casemate – was developed. It is anticipated that the new process will be implemented by the end of October 2008.**

Promote complaint resolution services to people across NSW

- **30.5% (179 out of 586) of complaints that were finalised by the Resolution Service were resolved by regional Resolution Officers.**

The Resolution Service deals with complaints that have been assessed as suitable for assisted resolution.

There are six Resolution Officers located within the Sydney metropolitan area, with a further three based in Newcastle, Dubbo and Lismore to accommodate the needs of regional complainants and health service providers. These officers work with both the complainant and provider to try to resolve the concerns raised.

The assisted resolution process

A Resolution Officer contacts the parties to see if they wish to participate in an assisted resolution. It is emphasised that the officer will have an independent and impartial role in the process, and will not be an advocate for either side.

Participation by the parties is voluntary – if one or both of the parties decline to participate, the Resolution Officer must close their file on the matter.

If the parties agree to participate, the Resolution Officer works with them to generate ideas on how the complaint might be resolved.

Strategies vary depending on the nature of the complaint, the outcome that the complainant is seeking, and the level at which the parties wish to engage. When the strategies have become clear, the Resolution Officer develops a resolution management plan tailored to the individual case. Appropriate timeframes are set and approved by the manager of the Resolution Service.

If the parties are willing to discuss the matter face-to-face, the Resolution Officer organises a meeting. An agenda is developed, and the Resolution Officer assists the participants in their preparation for the meeting. This is designed to ensure that the parties listen to each other and communicate effectively.

If the parties do not wish to meet, the Resolution Officer can act as a 'go-between' for the parties. They may obtain responses to the complainant's concerns from the health service provider, and discuss the response with the complainant.

The results that can be achieved include:

- an explanation of why the incident or treatment outcome occurred
- an acknowledgement that a mistake was made
- an apology
- an offer of further treatment
- improved communication between the patient and the health service provider(s)
- a review of current practice
- an agreement about action to be taken, so that the same thing will not happen again.

The Resolution Officer can follow up any agreement reached between the parties.

Performance of the Resolution Service

During 2007-08, the Commission assessed 574 (19.9%) complaints as suitable for assisted resolution, compared to 431 (15.9%) in 2006-07.

The Resolution Service finalised 586 assisted resolution processes this year – an increase from the 476 finalised during the previous year.

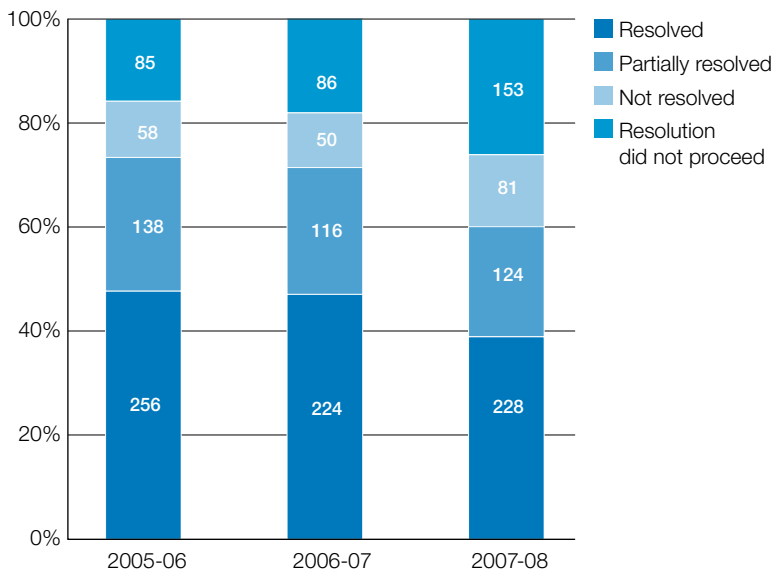
The complaints dealt with by the Resolution Service largely concerned access to treatment, the quality of treatment, and communication issues – these accounted for 91.8% of the complaints finalised by the Resolution Service in 2007-08.

Outcomes

In 153 (26.1%) of the matters referred to the Resolution Service, the resolution process did not proceed. In most of these cases the complainant and/or the health service provider advised the Resolution Officer that they were unwilling to participate in a resolution process. (Some complainants sought a review of the Commission's initial assessment decision – for the outcome of reviews, see chapter 12 'Assessing complaints' under the heading 'Reviewing assessment decisions').

In some cases, the complainant informed the Resolution Officer that they would not proceed because they wished to pursue their complaint through other means. This included seeking legal advice or approaching other bodies such as the Privacy Commission and the Anti-Discrimination Board.

Chart 13.1 Resolution Service outcomes 2005-06 to 2007-08



Counted by provider identified in complaint

13 Resolving complaints

In the 433 matters where the assisted resolution process did proceed, 52.7% of complaints (228) were fully resolved and 28.6% (124) partly resolved.

For 81 complaints (18.7%), the attempt to resolve the complaint was unsuccessful, the reasons included:

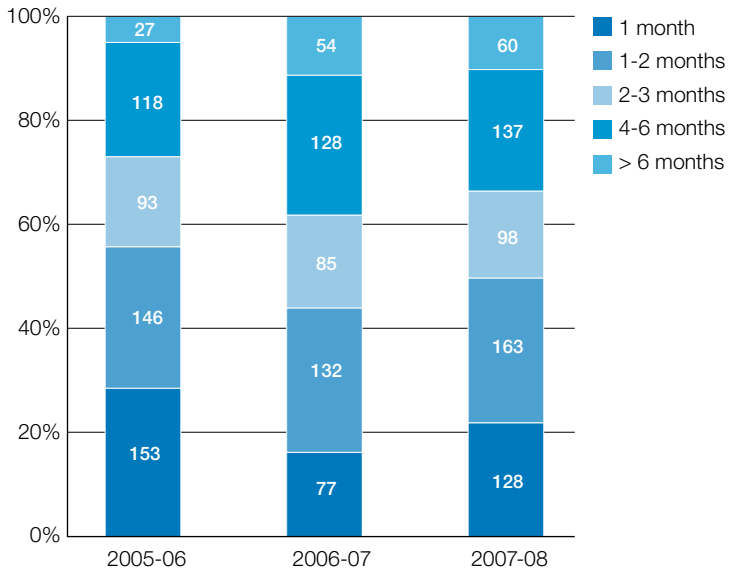
- the expectations of the complainant could not be met
- there was disagreement on what actually happened in relation to crucial issues
- the resolution options suggested were not acceptable to the complainant or the health service provider
- the grief of the complainant over the death of their relative made it difficult for them to accept the explanation offered by the health service provider.

In a small number of cases, the Resolution Officer was unable to maintain contact with one of the parties.

The resolution rates for the three most common types of issues dealt with by assisted resolution is very high.

The highest resolution rate was for complaints about access (84.7%). Resolution Officers can often help complainants to understand the criteria, priorities and timelines involved in accessing medical treatment and other health services.

Chart 13.2 Average time taken to finalise complaints referred to the Resolution Service 2005-06 to 2007-08



Counted by provider identified in complaint

The second highest resolution rate was for complaints about communication (83.8%). The understanding and perceptions of complainants about their discussions with health service providers can often be clarified by a neutral party, such as a Resolution Officer.

Complaints about poor medical treatment and/or clinical outcomes saw a lower rate of resolution (80.7%). Although the health service provider may provide an explanation, the complainant can continue to suffer from a poor treatment outcome that cannot be remedied.

Timeliness

Resolution Officers offer a prompt service, but often have to progress at a pace that is comfortable for the complainant, especially where they are grieving over the death of a loved one. Matters demanding an immediate response are usually dealt with quickly; however, obtaining a written response from the health service provider can sometimes slow the process.

In 2007-08, 89.8% of the matters referred for assisted resolution were finalised within six months – with 49.7% being finalised within two months, and a further 27.3% within four months.

Results of the Resolution Service satisfaction survey

The Resolution Service has for some time sought feedback through a satisfaction survey sent to complainants and health service providers with whom there has been significant contact during the resolution process. Surveys are posted with a reply-paid envelope.

From 1 July 2007 to the end of April 2008, the Commission continued to send out surveys, with 209 being sent to complainants and 165 to health service providers. The complainant response rate was 42.1%, and the provider response rate 50.3%.

Key results included:

- 75.4% thought that the officer understood their concerns
- 67.8% found the officer helpful in generating resolution options
- 68.4% believed that the involvement of the officer was helpful in resolving the matter
- 76.0% thought that the officer had been fair.

Following the recommendation of an internal audit, the Commission developed an improved survey procedure that was implemented on a trial basis from 1 May 2008. Since 1 July 2008, the Commission has continued to send out the new survey forms with closure letters.

The aim is to develop a comprehensive profile of the views of complainants and health service providers on the adequacy of the services provided by the Resolution Service.

In a survey received regarding a complaint resolved through the assisted resolution process, the complainant was highly complimentary of the service provided by the Commission's Resolution Officer. The complainant said that he was 'very impressed' with this 'professional, courteous, knowledgeable' officer who had kept him fully informed throughout the process, and went on to say that he was 'thankful that there is an impartial agency that one can access to have a health care complaint resolved'.

Case study 1 – complaint about a mental heath service

A woman complained that a mental health service had not provided adequate care to her mother who suffered from schizophrenia.

The woman's particular concern was that the mental health service had initially visited her mother every day, but had later reduced this to a visit every third day. The woman said this situation had resulted in her mother not taking her medication, and the need for her mother to be admitted to hospital.

The Commission referred the complaint to its Resolution Service to try to resolve the woman's concerns.

The Resolution Officer discussed the matter with both the daughter and the mental health service. It appeared that there had been a lack of follow-up by the service with the mother, and also a failure by the service to communicate with the family – there had been no communication between the mental health team and the daughter prior to the involvement of the Resolution Officer.

The mother had been admitted to hospital to stabilise her medication. This provided an opportunity to improve the communication between the mental health service and the daughter, both at the hospital and in the community. A meeting was arranged to discuss the mother's current treatment and a future treatment plan.

Following the meeting, the daughter was satisfied that suitable lines of communication had been established, and that ongoing medical treatment would be more appropriate to her mother's needs.

13 Resolving complaints

Case study 2 – complaint about the treatment of a burns victim

A man complained to the Commission that his teenage daughter had received inadequate care in hospital when she was admitted for the treatment of severe burns.

The man said that his daughter had waited several hours to be transferred to a ward and that, during this time, a nurse did not attend to the care of his daughter's injuries, ignored his daughter's requests for further pain relief, and was rude.

The daughter had been transferred to an antenatal ward. The father complained that the ward was poorly equipped and that the staff there lacked expertise in the management of burns. Although the daughter was eventually transferred to a specialist burns unit in another hospital, the hospital staff were confused about the need for his daughter's transfer and the transfer arrangements.

The Commission sought a response to the complaint from the hospital.

The hospital's investigation found that, while the clinical care provided by the hospital met the guidelines for dealing with burns injuries, there were deficiencies in aspects of the daughter's accommodation and in staff communication. The hospital wrote a letter of apology to the man and his family, advising that it had reviewed its procedures and made appropriate changes to improve its standard of care.

The matter was referred to the Resolution Service.

The Resolution Officer contacted the complainant, who requested more details of the changes to the hospital's procedures on the basis that he had made his complaint in order to help prevent similar incidents in the future.

The Resolution Officer negotiated with the hospital to write to the complainant again.

The hospital's further letter set out in detail the nature of the improvements that had been implemented by the hospital as a result of the man's complaint:

- The relevant procedures had been reviewed.
- A nurse had been the subject of performance management.
- Certain staff attended educational sessions with the aim of improving the level of service that they provided to patients suffering burn injuries.
- The burn dressings protocol was to be attached to the medical records of burns patients when they changed wards.
- Staff had been directed to consider the special needs of burns patients and, if a suitable bed was not available, they were to expedite the patient's transfer to a specialist unit as a matter of priority.

The man was satisfied with the hospital's apology and with its detailed explanation of the systemic changes that it had implemented in response to the concerns that he had raised in his complaint.

14

Conciliating complaints

Performance 2007-08

Promote use of health complaint resolutions to people of NSW

- **198 complaints (6.9% of all complaints assessed) were referred for conciliation. This is a slight fall from the previous year where 239 complaints (8.8%) were referred.**
- **The Health Conciliation Registry finalised 207 complaints.**
- **In 106 matters, the parties agreed to participate in conciliation. Of these, 80 (75.5%) resulted in a resolution of the complaint.**
- **66.2% of conciliations were completed within six months.**
- **A conciliation procedures manual was prepared and finalised as planned in December 2007.**

Promote complaint resolution services to people across NSW

- **There were 90 formal conciliation meetings, including 30 in regional areas.**

One of the techniques that the Commission uses to try to resolve complaints is conciliation.

Conciliation is a voluntary process. The Commission will not refer a complaint for conciliation if the complainant has clearly indicated that they do not wish to meet with the health service provider, or if the Commission does not see conciliation as an appropriate way of resolving their complaint. The health service provider must also consent to participate in conciliation.

Conciliation is confidential. This means that anything said and any document prepared for the purpose of the conciliation cannot be used elsewhere, except with the consent of the parties. The confidentiality of the process is designed to encourage the parties to speak openly to each other.

Matters referred for conciliation

The types of complaints that are suitable for conciliation generally fall within the following categories:

- there has been a breakdown in communication between the parties

14 Conciliating complaints

- the complainant was given insufficient information or an inadequate explanation about why there was a poor outcome or an adverse event
- the complainant may also be seeking a refund and/or compensation.

The Health Conciliation Registry

The Commission's Health Conciliation Registry, which is staffed by the Registrar and another Commission officer, is responsible for facilitating conciliations. The Registry uses a panel of experienced conciliators appointed by the Minister for Health.

Preparatory steps

As a first step, the Registry obtains the consent of both parties to participate in conciliation.

If a party is uncomfortable about attending a meeting with the other party, the Registry tries to find another way to facilitate a resolution of the complainant's concerns – usually by acting as a 'go between' in negotiations between the parties.

Where the parties do agree to meet, the Registry helps them to prepare for the meeting. Discussions with the complainant cover the key issues that they want addressed, as well as the type of outcome that they are seeking.

The Registry provides a list of the complainant's issues and an agenda for the meeting to the health service provider(s) and the conciliator in advance of the meeting.

Claims for compensation

The confidentiality of the evidence provided and documents prepared for conciliation means that there is scope to resolve a claim by the complainant for compensation.

The Registry provides details of the claim to the health service provider and asks them to forward these details to the provider's insurer. Whether the claim can be resolved usually depends on the amount being sought and the evidence provided in support of the claim, and on the readiness of the insurer to assess the claim informally. In cases where the insurer is prepared to deal with a claim directly and without the need for involvement by the Health Conciliation Registry, the complainant will often withdraw from the conciliation process.

Conciliation meetings

A conciliation meeting involves an independent conciliator assisting the complainant and the health service provider to try to reach an agreement that resolves the complainant's concerns.

The meeting is held at a place convenient to both parties – at the Registry's Sydney office, somewhere else in the metropolitan area, or at a regional location.

The meeting usually begins with the health service provider offering an apology or expressing regret for the complainant's distress. This generally sets a constructive tone for further discussions.

If there has been a misunderstanding, the health service provider can acknowledge the need to improve communication with the patient and/or the family.

Where the provider acknowledges that a mistake occurred, they can provide information about the remedial steps they have taken to address the situation – for example, in the case of a hospital, the counselling and training of staff, and the monitoring of staff performance. If there was a systemic failure, a reassurance can be made that there have been changes to policies or procedures, with a view to ensuring that a similar incident will not occur again.

Performance of the Health Conciliation Registry

In 2007-08, the Commission referred 198 complaints to the Health Conciliation Registry for conciliation. Complaints about communication and treatment accounted for 87.3% of the matters referred for conciliation.

The Registry finalised 207 matters in 2007-08.

Complaints where conciliation did not proceed

In 101 complaints (48.8%), the conciliation process did not proceed.

Of these, there were 60 where the complainant did not consent, and a further 18 where they withdrew their consent. Most of the complainants who withdrew did so because their compensation claim was being dealt with directly by the health provider's insurer, and they therefore saw no need for a conciliation meeting with the provider.

In 13 complaints where consent was declined, the Registry referred these matters to the Commission's Resolution Service to address the issues.

In a further 15 complaints, the health service provider did not consent to conciliation and withdrew their consent in seven complaints.

In addition, there was one complaint where the conciliation process did not need to proceed because the complaint had been resolved before contact by the Registry with the parties.

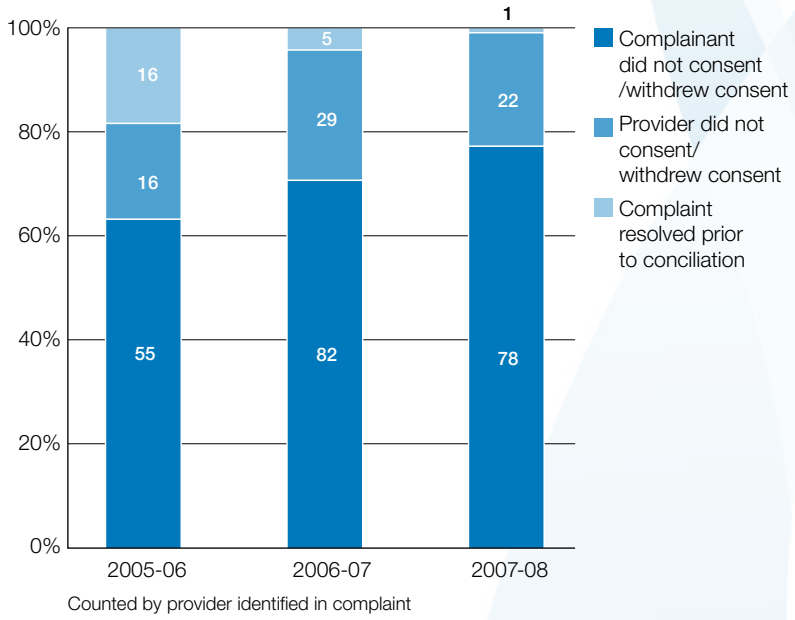
Conciliation outcomes

Of the 106 complaints where the parties did consent to conciliation, 80 (75.5%) resulted in a resolution of the complaint:

- For 63 complaints, an agreement was reached at the conciliation meeting.
- For In 17 complaints, the Registry helped the parties to resolve the complaint without a conciliation meeting.

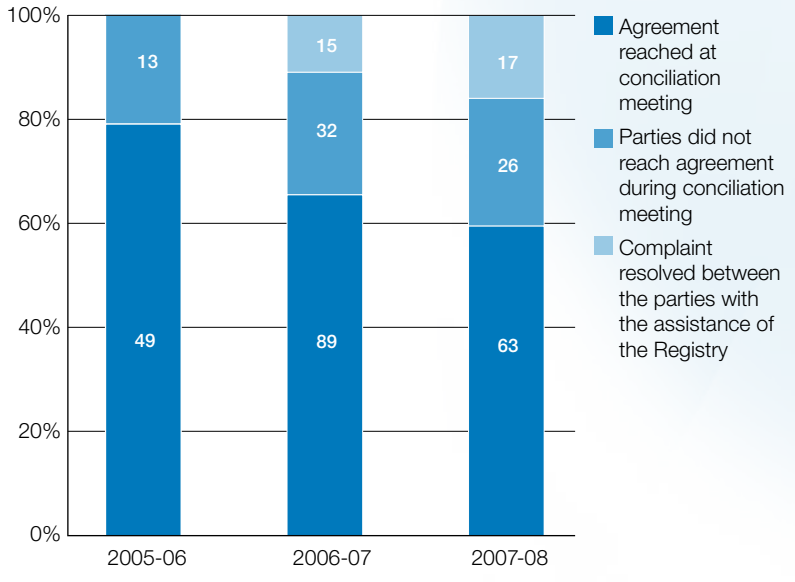
There were 26 complaints where the parties could not reach an agreement to resolve the complainant's concerns at the conciliation meeting. However, in 10 of these complaints, the conciliation meeting nevertheless helped to clarify the complainant's concerns.

Chart 14.1 Reasons for conciliation not proceeding 2005-06 to 2007-08



Counted by provider identified in complaint

Chart 14.2 Outcome of conciliation processes that did proceed 2005-06 to 2007-08



Counted by provider identified in complaint

14 Conciliating complaints

The two most common issues dealt with through the conciliation process are treatment and communication.

For complaints about treatment, the confidentiality of the conciliation process gives the parties an opportunity to frankly discuss the circumstances that led to the adverse outcome. Complaints about poor communication can often be resolved with the assistance of a neutral conciliator.

Timeliness

In 2007-08, the Registry finalised:

- 38.2% of complaints within three months
- another 28.0% within six months
- a further 21.8% within twelve months.

Measures to increase the rate of consent

For the last two years, the Health Conciliation Registry has been focusing on increasing the rate of participation in conciliation.

If a party indicates that they are not prepared to consent, the Registry contacts them to explore the reasons for this and to discuss the matter further. In some cases, the Registry has been able to offer a conciliation process that is better tailored to the circumstances of the matter. The parties are also advised that they can bring a support person to conciliation meetings.

Feedback on conciliations

Following a conciliation meeting, the participants – including any support persons – are asked to provide feedback about both the meeting and the Registry's involvement in the matter. This feedback has been used by the Registry to review and improve its services.

The following are some examples of positive complainant feedback:

> I felt very comfortable during the whole process … the conciliator was genuinely trying to understand the whole situation … he was very professional and understanding in dealing with everyone concerned.
>
> This has provided me with an opportunity to find out answers to questions regarding my husband's death. The hospital's representative took on board my concerns.
>
> I was impressed by the openness of the hospital representatives, by their willingness to accept some responsibility and their enthusiasm to get the problems fixed.

There has also been positive feedback from health service providers:

> Excellent facilitator – very worthwhile experience – very positive outcomes. The conciliator was professional, gracious and well skilled in assisting in achieving the outcomes.

15

Investigating complaints

Performance 2007-08

Ensure a best practice approach for the conduct of all investigations

- Since 2004-05, the average time taken to complete an investigation has fallen by almost 300 days.
- Over 50% of investigations into health practitioners were referred to the Director of Proceedings to consider disciplinary proceedings.
- Investigations complied with statutory requirements.
- A new procedures manual was developed and implemented in March 2008, setting timeframes for investigative tasks. In the last quarter of the year, 92.2% of investigations were finalised within 12 months (target 80%).
- Eighty percent of investigations staff completed an investigative skills training course that had been developed during the year (target 80%).
- During the year, the Commission referred 129 investigations to the Director of Proceedings to consider prosecution. In the same period, the Director of Proceedings returned seven complaints to investigation staff to obtain further information, which equals 5.4% (target <15%).
- All specifications for the enhancement of the investigation processes in Casemate were finalised and a preliminary version prepared. It is anticipated that the changes will be implemented by October 2008 (target March 2008).

Improve health care systems through recommendations arising from investigations

- The majority of recommendations made to health organisations since 2005-06 have been implemented.
- Guidelines for making recommendations are being developed (target December 2007) and will be implemented along with Casemate enhancements for the recording and analysis of recommendations in 2008-09.

15 Investigating complaints

Complaints referred for investigation are handled by the Investigations Division, which is led by the Director of Investigations, and consists of three teams of investigators, each headed by a manager.

The Division has a broad skills base, with staff coming from clinical, legal and policing backgrounds.

The investigation process

In conducting its investigations, the Division obtains statements from complainants and any other relevant witnesses, and can exercise its compulsive powers to require complainants and health service providers to provide statements or information and records. Expert advice on the quality of clinical care is obtained from the Commission's panel of experts.

In addition to using these investigative methods, the Commission can:

- access telephone call records
- obtain professional assistance to download text messages and analyse information from computers
- employ forensic experts to analyse handwritten documents.

It is anticipated that the Commission will increasingly use such techniques to gather information needed for the effective investigation of complaints.

Investigation reports

At the end of an investigation, a report is prepared and provided to the complainant and the health service provider(s) involved. This report summarises the issues, details the evidence gathered, and sets out the Commission's findings. The report is not provided where the complaint is referred to the Director of Proceedings to consider prosecution.

Outcomes for health practitioners

Investigation outcomes for individual practitioners may include:

- The complaint is not substantiated – no further action is taken.
- Evidence that there was poor conduct or treatment falling short of 'unsatisfactory professional conduct' – as defined by the legislation – appropriate comments may be made to the practitioner or the matter referred to the relevant Registration Board.
- Sufficient evidence of 'unsatisfactory professional conduct' by a registered practitioner – the matter is referred to the Director of Proceedings to determine whether to initiate disciplinary proceedings. (The definition of 'unsatisfactory professional conduct' is discussed in more detail in chapter 16 'Prosecuting complaints'.)
- Evidence of possible criminal conduct – the matter is referred to the Director of Public Prosecutions to consider possible criminal charge(s).

Recommendations and comments to health organisations

If the investigation finds that a health organisation has provided inadequate care, the Commission makes comments and/or recommendations:

- Comments are made when the organisation has already changed its practices to address systemic issues.
- Recommendations are made where the systemic issues have not been addressed adequately or at all, and are designed to initiate long-term improvements.

The Investigations Division is responsible for monitoring the implementation of the Commission's recommendations. Where these concern public health organisations, there is close consultation with the Department of Health and the Area Health Services.

For example, recommendations from four Commission investigations of inadequate prenatal and postnatal care contributed to a Department of Health state-wide review of relevant policies and the release of a new information bulletin on foetal welfare, obstetric emergency and neonatal resuscitation training.

Performance of the Investigations Division

The Investigations Division finalised 338 investigations in 2007-08. There were 254 investigations into health practitioners – mostly medical practitioners and nurses – and 84 into health organisations – mostly public hospitals.

Investigations finalised into practitioners

As shown in Chart 15.1, as a result of the more thorough assessment process, there has been a substantial fall in investigations terminated because the complaint was not substantiated. At the same time, more than half of the complaints investigated were referred to the Director of Proceedings to consider whether to initiate disciplinary proceedings.

Compared to previous years, there were fewer cases where the Commission made comments to a practitioner or referred them to the relevant Registration Board.

Chart 15.2 on the next page shows the investigations outcome for investigation into treatment and professional conduct by health practitioners. These issues accounted for 92.2% of all issues raised in such investigations finalised in 2007-08.

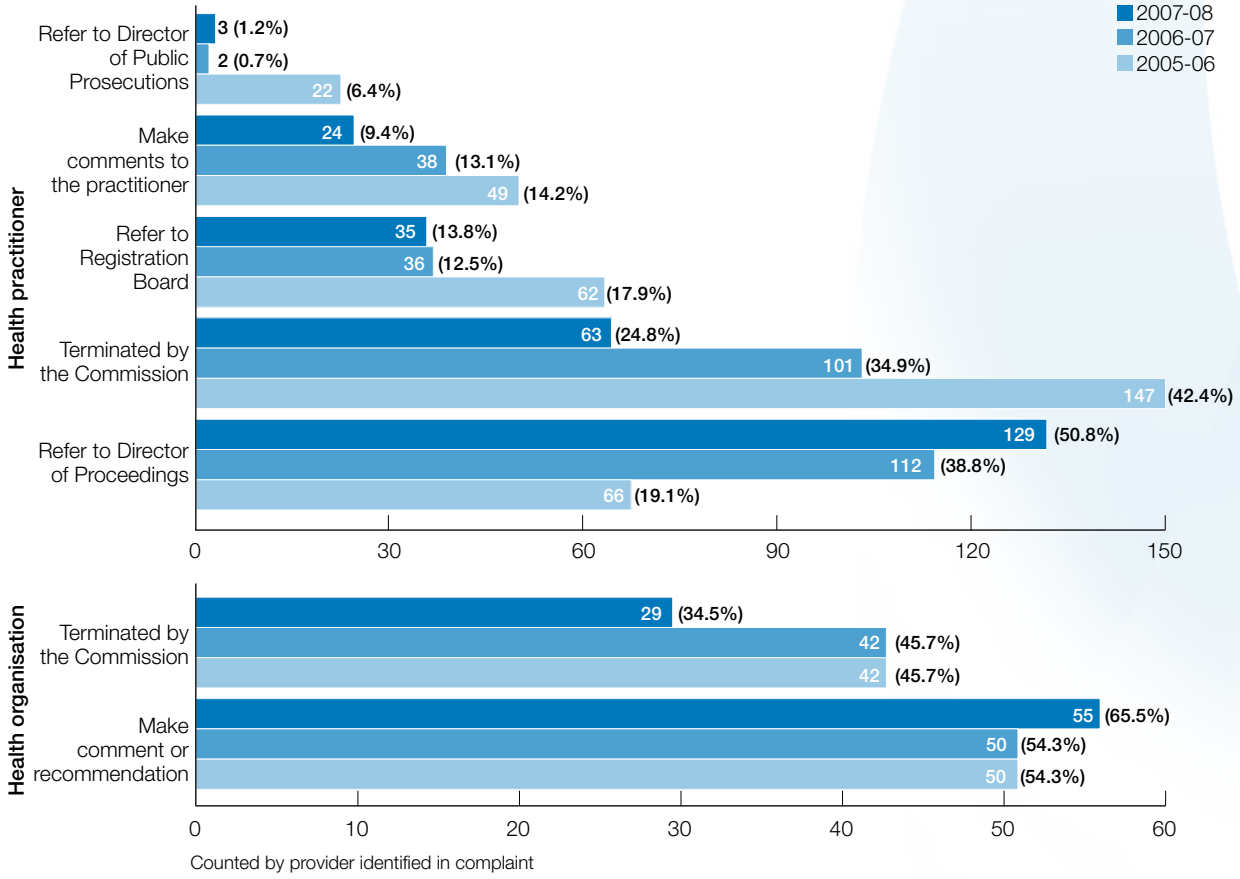
Over 70% of complaints about professional conduct issues were referred to the Director of Proceedings. This includes complaints about the competence of a practitioner, or allegations of illegal practices or sexual misconduct.

Investigations finalised into organisations

There was a 10.0% increase in cases where the Commission made comments or recommendations to a health organisation, as shown in Chart 15.1.

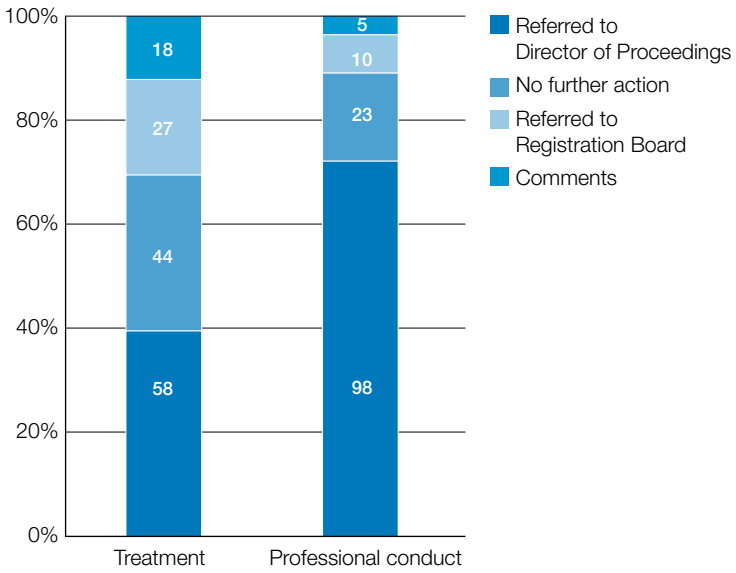
Most recommendations were made in response to findings of poor treatment. This category accounted for 84.1% of all issues in investigations against health organisations that were finalised during 2007-08.

Chart 15.1 Outcome of investigations into health practitioners and health organisations 2005-06 to 2007-08



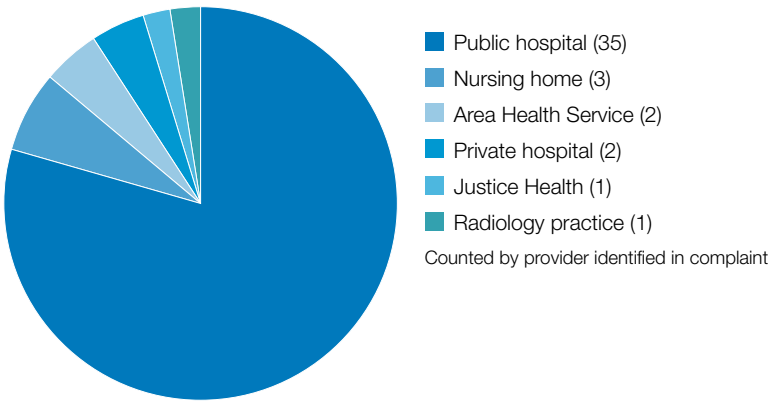
15 Investigating complaints

Chart 15.2 Outcome of treatment and professional conduct issues raised in investigations against health practitioners 2007-08



Counted by provider identified in complaint

Chart 15.3 Types of facilities where recommendations were made to 2007-08



Counted by provider identified in complaint

Most recommendations were directed to public hospitals, as shown in Chart 15.3.

Implementation of recommendations

The Commission concentrates on making practical recommendations.

Since 2005-06, the Commission has made a total of 233 recommendations to health organisations as a result of 103 investigations. This includes the 96 recommendations that resulted from 44 investigations finalised by the Commission in 2007-08.

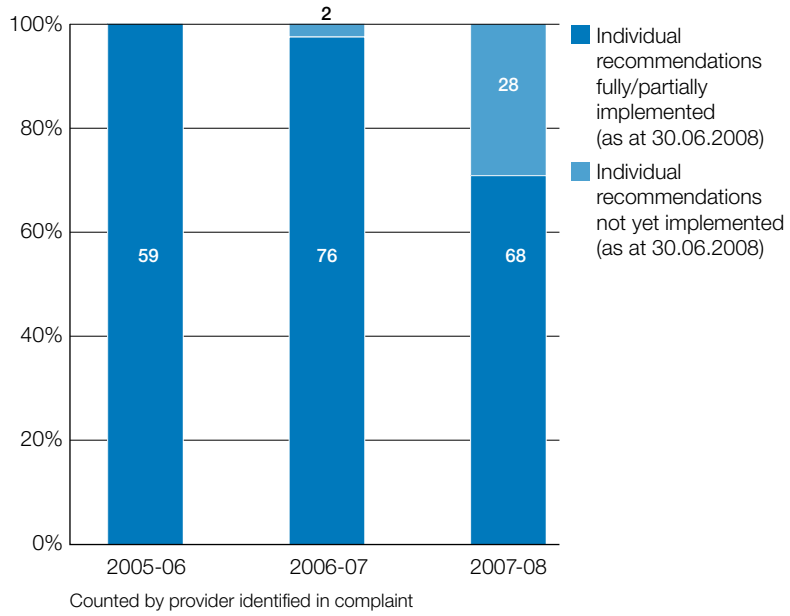
Chart 15.4 shows that nearly all of the recommendations made in 2005-06 and 2006-07 have been implemented, and 70.8% of the recommendations made in 2007-08 have also been implemented.

Timeliness

Since 2004-05, the average time taken to complete an investigation has dropped from 595 days to 309 days. In 2007-08, 68.3% of investigations were finalised within 12 months, and a further 26.6% within 18 months.

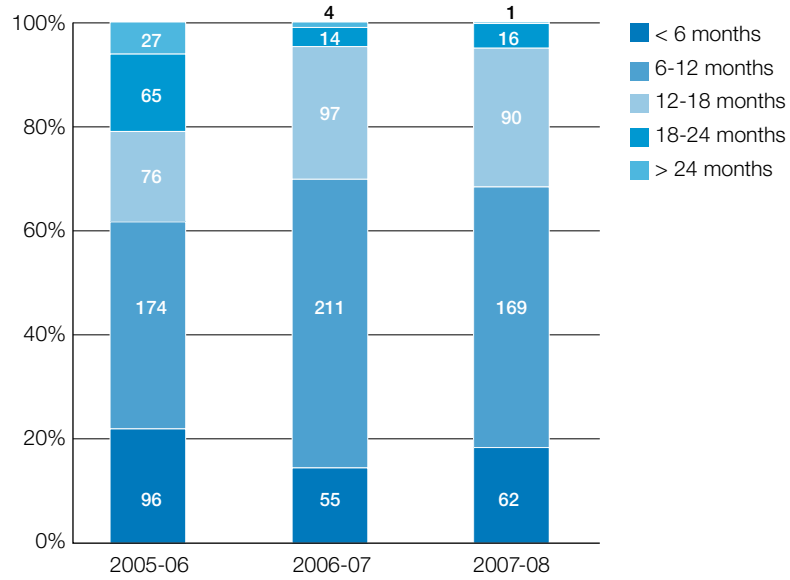
During the reporting year, the Commission modified its case management system to allow an investigation to be 'paused'. This occurs in circumstances where a Coronial inquiry or a criminal investigation or trial is relevant to the complaint, and the evidence should be taken into account in the Commission's investigation.

Chart 15.4 Implementation rate for recommendations made 2005-06 to 2007-08



Counted by provider identified in complaint

Chart 15.5 Time taken to complete investigations 2005-06 to 2007-08



Counted by provider identified in complaint

When 'pauses' are taken into account, the average time taken to complete an investigation in 2007-08 was 299 days. On the same basis, 72.8% of investigations were finalised within 12 months, and a further 24.0% within 18 months.

In March 2008, a new procedures manual was issued. This contributed to an improvement in timeliness with 92.2% of the investigations finalised during the period April – June 2008 being completed in less than 12 months.

Requests for review

A complainant can request a review of the outcome of the Commission's investigation into a health practitioner.

In 2007-08, the Commission received and finalised 15 requests for review of an investigation outcome. None of these reviews resulted in a decision by the Commissioner to re-open the investigation.

15 Investigating complaints

Procedures manual

A new investigations procedures manual was developed to provide direction and time frames for:

- receiving and allocating investigations
- preparing investigation plans
- identifying 'fast-track' actions to streamline investigations
- monitoring the progress of investigations
- finalising investigations.

Professional development

During 2007-08, an investigators' training course tailored to the needs of the Commission was developed. Topics included:

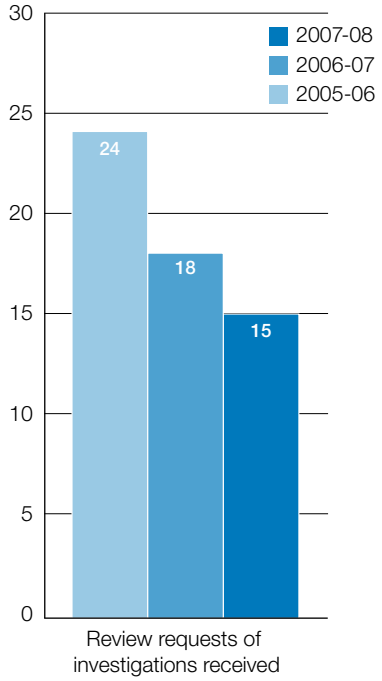
- gathering and managing evidence
- producing formal records of interview
- validating data and conducting data analysis
- conducting searches and seizing evidence
- preparing investigation reports
- preparing briefs of evidence.

Most of the investigative staff have completed the training, and all participants were awarded a Certificate IV in Government Investigations.

In addition, the investigation managers are currently working on the following projects:

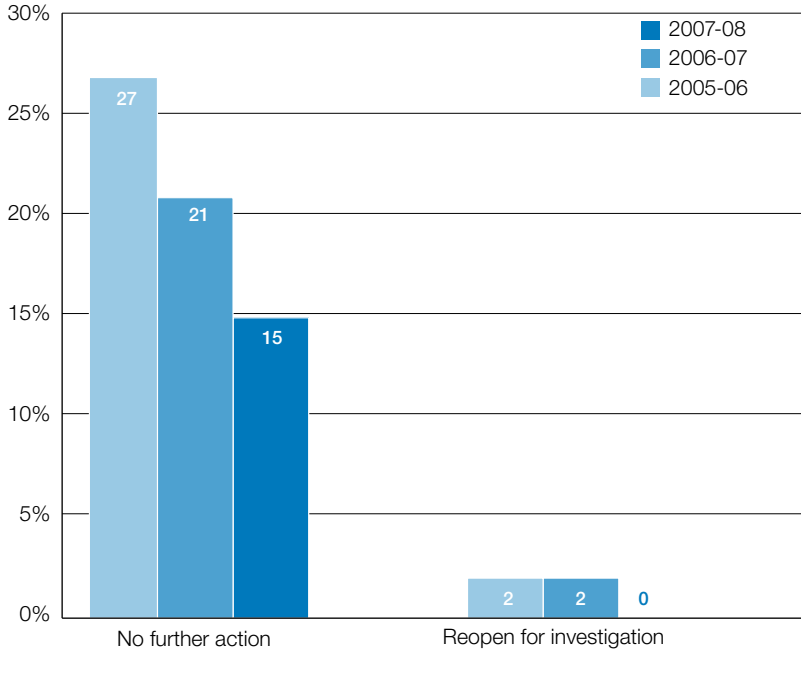
- developing a memorandum of understanding between the Commission and the Coroner's office
- developing agreements with the other Divisions of the Commission in relation to the hand-over of files, and other areas of co-operation
- enhancing the recording of the Commission's recommendations, to permit more ready access to previous recommendations and ensure consistency in the development of future recommendations.

Chart 15.6
Requests for review of investigation decision 2005-06 to 2007-08



Counted by provider identified in complaint

Chart 15.7
Outcome of reviews of investigation decision 2005-06 to 2007-08



Counted by provider identified in complaint

Case study – complaint about the death of a patient with epilepsy

The Commission investigated a complaint about the care and treatment of a woman at a large metropolitan hospital.

The woman had a history of unusual epileptic seizures. She was admitted to the hospital to supervise her withdrawal from medication and to monitor her, to better understand and manage her seizures.

On the third night, the woman went to sleep at about 2.00am. Her sister was in the hospital room that night.

When hospital staff went to wake the woman at 6.00am, they discovered that she had died.

The hospital reviewed the video used to monitor the woman. The video showed that the woman had rolled over in her sleep. At this time, the monitoring equipment had recorded a faster than normal heart rate. There were no obvious signs of a seizure that could be observed from the tape, nor had the woman's sister noticed any seizure. The woman's heart rate had then slowed and stopped.

The Coroner found that the woman had suffered a sudden unexplained death in epilepsy ('SUDEP').

The Commission investigated a complaint by the woman's family about the hospital.

The Commission found that SUDEP may account for between 8% and 17% of deaths in people with epilepsy. The risk factors include non-compliance with medication and poorly controlled seizures.

The hospital acknowledged that these risk factors for SUDEP had not been discussed with the woman before her admission.

The Commission made recommendations to the hospital, which were adopted as follows:

- SUDEP as a risk factor is now discussed with all patients and their families prior to admissions for monitoring seizures.
- The hospital gives a brochure on SUDEP written by the Epilepsy Foundation of Victoria to all patients admitted for monitoring.
- Continuous pulse monitoring has been introduced, with alarms activated by reduced heart rate audible throughout the hospital unit.
- Further training has been provided to the nursing staff.

16

Prosecuting complaints

Performance 2007-08

Independent and timely determination to prosecute

- In 2007-08, 129 investigations against an individual registered health practitioner (50.8% of all investigations into health practitioners) were referred to the Director of Proceedings to determine whether to prosecute or not.
- 76.0% of the matters were considered by the Director of Proceedings within three months of being referred (target 80.0%).

Professional and competent prosecutions of serious complaints in the public interest

- 89.0% of legal advices were provided within 21 days or within an agreed timeframe (target 80.0%).
- The planned review and update of the prosecutions manual will be undertaken during 2008-09. Preparatory steps were completed during this year.
- Casemate system upgrade was completed in December 2007 as planned.
- Since December 2007, the information on compliance with Court/Tribunal deadlines can be captured by Casemate. The compliance rate will be reported in 2008-09 (target 80.0%).
- A report will also be available in 2008-09 in relation to the percentage of bill of costs prepared or sent to cost consultants for assessment within 45 days.
- The recovery of legal costs was reported quarterly to the Executive.

Where the Commission's investigation of a registered health practitioner has found evidence of unsatisfactory professional conduct, the matter is referred to the Commission's Director of Proceedings. The Director determines whether disciplinary proceedings should be initiated against the practitioner. In performing this function, the Director of Proceedings is not subject to the direction of the Commissioner.

When determining whether to initiate disciplinary proceedings, the Director of Proceedings must take into account:

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

If the Director of Proceedings decides that disciplinary proceedings should not be initiated, the matter can be referred to the Commissioner to decide whether, and what other action, should be taken. Options for further action include referral to the relevant Registration Board for counselling.

Where the Director of Proceedings does decide to initiate disciplinary proceedings, a formal complaint against the practitioner is lodged with either a Professional Standards Committee of the relevant health registration authority or with the relevant Tribunal. The disciplinary body's role is to decide whether the practitioner has been guilty of unsatisfactory professional conduct.

(Where the conduct warrants suspension or deregistration, it is termed 'professional misconduct'.)

Disciplinary action includes reprimanding the practitioner and/or imposing conditions on their practice.

Only Tribunals have the power to suspend or deregister a practitioner.

The meaning of 'unsatisfactory professional conduct'

In 2005, the definition of 'unsatisfactory professional conduct' for a number health practitioners including medical practitioners was amended to mean:

> conduct that demonstrates that the knowledge, skill or judgment possessed or care exercised by the practitioner in their practice is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.

Until recently, there had been no decisions by Courts, Tribunals or Professional Standards Committees clearly explaining how the crucial words 'significantly below the standard' should be interpreted.

In September 2007, the Medical Tribunal found that, as a general principle, the word 'significant' in this context means 'not trivial, of importance, or substantial'.

The Tribunal also said that the reference in the legislation to the standards of knowledge, skill, judgment and care expected of a practitioner 'of an equivalent level of training or experience' had introduced:

> the concept of differing levels of experience and skill requiring different standards, so that [a] registrar would not be held accountable for failing to be as skilled as the most eminent specialist.

The Tribunal's decision has assisted the Director of Proceedings in determining whether the evidence in particular matters warrants prosecution of the practitioner.

The decision has also been used by the Commission in investigating complaints about the care and treatment provided by registered health practitioners. The Commission must necessarily rely on the opinion of expert practitioners when determining whether the quality of the care and treatment in question fell 'significantly below' the expected standards. The Medical Tribunal's decision has meant that the Commission has been able to give clearer guidance to its panel of experts in seeking opinions on the adequacy or otherwise of the clinical care and treatment provided by registered health practitioners.

Performance of the Legal Division

In 2007-08, 129 complaints were referred to the Director of Proceedings. This can be compared to the 112 complaints referred in 2006-07. (It should be noted that multiple complaints about a practitioner may be bundled into a single legal matter.)

Prosecution outcomes

In 2007-08, the Legal Division finalised 86 matters.

In seven cases, the Director of Proceedings decided not to prosecute the matter, with five of these cases being referred to the Commissioner to consider other possible action.

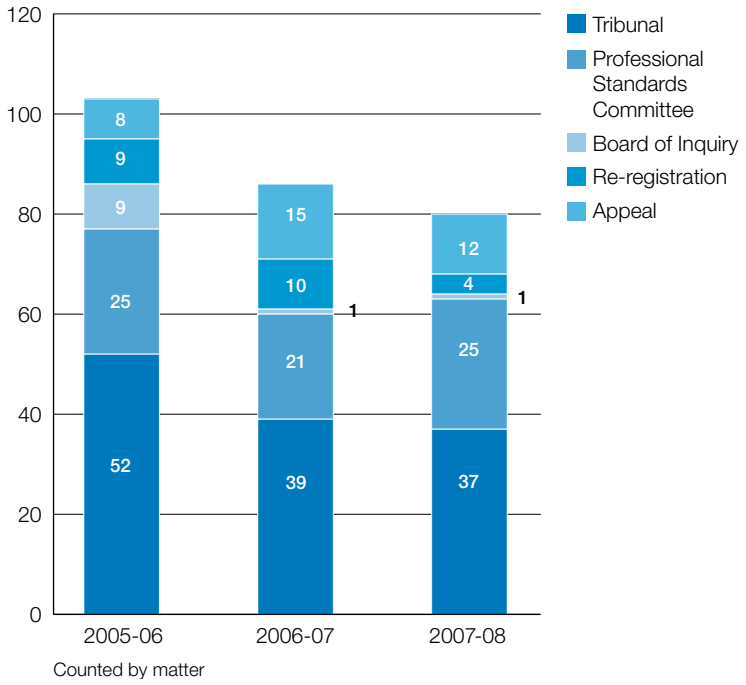
16 Prosecuting complaints

As shown in Chart 16.1, the remaining 79 matters included:

- 63 disciplinary proceedings
- four review and re-registration applications
- 12 appeals and other applications.

The outcomes of these various proceedings are set out in Table 16.1.

Chart 16.1 Legal matters finalised 2005-06 to 2007-08



Casemate improvements

As foreshadowed in last year's annual report, an upgrade of the Casemate system for the Legal Division was finalised in December 2007. This upgrade introduced processes that more accurately reflect the work of the Division. 'Activity planners' assist staff to comply with timetables and directions by disciplinary bodies. Activities can be viewed at both a case and divisional level to assist with workflow and planning.

Officers can also directly record on the system the Commission's costs in relation to any proceedings – including the time spent by solicitors and support staff in preparing and conducting prosecutions. This replaces the old system where bills of costs were prepared after the event. It is expected that the new Casemate function will vastly reduce the time involved in producing a bill of costs, and also ensure that all costs incurred are included in the bill.

In addition, new Casemate processes have been introduced to capture the extent and timeliness of:

- responding to subpoenas issued in civil or criminal proceedings
- dealing with Freedom of Information applications
- appearing in proceedings in which the Commission is involved, such as proceedings before the Administrative Decisions Tribunal
- providing legal advice to the Commissioner and to the other Divisions of the Commission.

The year ahead

The two senior Legal Officers have started working on projects that will enhance the effectiveness and timeliness of the Commission's operations:

- a review and centralisation of Legal Division precedents
- the introduction of an agreement between the Investigations and Legal Divisions that will formalise timeframes for the movement of files between the Divisions, and introduce protocols for the opening and closing of Casemate processes.

It is expected that both projects will be completed by the end of December 2008.

In addition, there will be a comprehensive review and update of the Legal Division's procedures manual in 2008-09.

Table 16.1 Outcome of legal matters finalised 2007-08

Profession Standards Committee (PSC)		
Medical Professional Standards Committee	caution	1
	caution and conditions	2
	conditions	1
	not proved and dismissed	3
	reprimand	1
	reprimand and conditions	8
Nurses and Midwives Professional Standards Committee	caution and conditions	1
	not proved and dismissed	2
	reprimand	2
	reprimand and conditions	2
	terminated and referred to Tribunal*	2
Psychologists Board of Inquiry**	reprimand and conditions	1
	Total	26
Tribunal		
Medical Tribunal	deregistered	4
	fine and conditions	1
	reprimand and conditions	1
Nurses and Midwives Tribunal	caution and conditions	1
	conditions	4
	deregistered	20
	not proved and dismissed	1
Physiotherapists Tribunal	reprimand and suspended	1
Psychologists Tribunal	deregistered	4
	Total	37
Appeal		
Court of Appeal	Appeal by respondent – withdrawn	2
	Appeal by Commission – dismissed	2
	Appeal by respondent – dismissed	1
Supreme Court	Appeal by respondent – dismissed	1
	Appeal by Commission withdrawn	1
Medical Tribunal	Appeal by Commission – upheld	1
	Appeal by respondent – upheld	1
District Court	Appeal by Commission – dismissed	1
Federal Magistrates Court	Application by respondent – dismissed	1
Administrative Decisions Tribunal	Application by respondent – dismissed	1
	Total	12
Re-registration		
Nurses and Midwives Tribunal	Application dismissed	1
	Application allowed with conditions	1
	Application withdrawn prior to hearing	2
	Total	4
Determination not to prosecute		
	Determined not to prosecute	7
	Total	7
Grand total		86

* Matters referred to the Tribunal will proceed separately. The outcome of these matters is reported separately.

** The Psychologists Board does formally established a Board of Inquiry instead of a Professional Standards Committee.

16 Prosecuting complaints

Case study – prosecution of a psychologist for professional misconduct

Mr Jacobus Biersteker was registered as both a psychologist and nurse, and offered counselling services in a community in regional NSW. As a registered psychologist, he was bound by the relevant code of conduct and, as a member of the Australian Psychological Society, subject to that organisation's code of ethics.

In 2001, Mr Biersteker started treating a woman for depression. The woman had been referred to Mr Biersteker by her husband, who also referred his son to Mr Biersteker for counselling.

After the woman had been receiving counselling from Mr Biersteker for some time, the woman's husband suggested that she should see a female psychologist instead. This suggestion was opposed by Mr Biersteker, who continued to treat the woman.

Some time later, the woman's husband discovered letters and poems to his wife from Mr Biersteker. When the husband confronted his wife about this, she admitted to having a sexual relationship with Mr Biersteker that had started during a counselling session in 2001. The husband's discovery of the relationship between his wife and Mr Biersteker led to the termination of the counselling.

The husband was concerned about another woman whom he had referred to Mr Biersteker, and made a complaint about Mr Biersteker's conduct to the Commission.

The Commission's investigation of the complaint led to the Director of Proceedings initiating disciplinary proceedings against Mr Biersteker before the Psychologists Tribunal. The Director's formal complaint alleged that Mr Biersteker had been guilty of professional misconduct and sought an order for his deregistration as a psychologist.

In April 2007, the Tribunal found the complaint proved and decided to deregister Mr Biersteker as a psychologist for two years.

The Commission also sought a prohibition order that would prevent Mr Biersteker from providing any mental health services or practising as a mental health nurse during the time that he was deregistered as a psychologist.

The Tribunal decided to make such an order on the basis that Mr Biersteker posed 'a substantial risk to the health of members of the public'. Mr Biersteker was also required to disclose the Tribunal's prohibition order to any potential patient or employer.

17

Finance

Over the past five years, total expenses have increased from $10.4 million to $10.8 million. During the five year period additional funding had been provided to the Commission in 2003-04 and 2004-05 to reform the Commission's operations and clear the backlog of investigation cases and finalise the investigation of complaints against the Macarthur Area Health Service.

Table 17.1 Comparison of finances 2003-04 to 2007-08

Actual	2003-04 $000	2004-05 $000	2005-06 $000	2006-07 $000	2007-08 $000
Total expenses	10,416	11,080	10,306	10,436	10,798
Total retained revenue	865	373	323	750	590
Gain/(loss) on sale of non-current assets	–	–	(24)	(1)	–
Net cost of services	9,551	10,707	10,007	9,687	10,209

A budget for the reporting period is given in the following audited financial statements. The Commission ends the year in a strong financial position. No significant issues were raised by the Auditor General regarding the Commission's finances. No after-balance-date events occurred which will have a significant effect in the succeeding year on the Commission's operations or clients.

The outline budget below includes a 2.5% projected increase in employee related expenses in line with the NSW Government's Wages Policy. The NSW Government funded a 2.5% increase in employee salaries.

17 Finance

HEALTH CARE COMPLAINTS COMMISSION

Table 17.2 Outline budget for 2008-09 financial year

Operating Statement	2008-09 $000
Expenses	
Operating Expenses	
Employee related	7,517
Other operating expenses	3,118
Depreciation and amortisation	293
Total expenses	10,948
Less	
Retained revenue	
Sales of goods and services	44
Investment income	80
Other revenue	290
Total retained revenue	414
Net cost of services	10,534

Account Payment Performance

The processing of accounts for payment and the recording of the Commission financial data is incorporated into the Sun finance system which is maintained by the Independent Commission Against Corruption as part of the Commission's new shared corporate service arrangement. Previous to December 2007, the Commission's processing of accounts was administered by the Department of Art Sport and Recreation as part of shared corporate services arrangement in place between the two agencies.

The payment performance analysis is as follows:

Table 17.3 Aged analysis at end of each quarter 2007-08

Quarter	Current (i.e. within due date $	Less than 30 days overdue $	Between 30 and 60 days overdue $	Between 60 and 90 days overdue $	More than 90 days overdue $
September	973,974	203,715	19,897	1,216	2,311
December	808,766	102,162	9,157	9,063	1,584
March	980,975	83,821	87,882	16,679	7,373
June	1,735,028	127,103	28,395	9,462	4,373

Table 17.4 Accounts paid on time within each quarter

Quarter	Total accounts paid on time			Total amount paid $
	Target %	Actual %	$	
September	85	90%	973,974	1,088,690
December	85	85%	808,766	952,962
March	85	85%	980,975	1,164,395
June	85	91%	1,735,028	1,909,560

The format is in accordance with the requirements of Treasury Circular TC 01/12. No interest was paid on overdue amounts.

HEALTH CARE COMPLAINTS COMMISSION

GPO BOX 12
Sydney NSW 2001

INDEPENDENT AUDITOR'S REPORT

HEALTH CARE COMPLAINTS COMMISSION and CONTROLLED ENTITY

To Members of the New South Wales Parliament

I have audited the accompanying financial report of the Health Care Complaints Commission (the Commission), which comprises the balance sheets as at 30 June 2008, the operating statements, statements of recognised income and expense, cash flow statements and a summary of compliance with financial directives for the year then ended, a summary of significant accounting policies and other explanatory notes for both the Commission, and the Commission and controlled entity (the consolidated entity).The consolidated entity comprises the Commission and the entity it controlled at the year's end or from time to time during the financial year.

Auditor's Opinion

In my opinion, the financial report:

- presents fairly, in all material respects, the financial position of the Commission and the consolidated entity as at 30 June 2008, and of their financial performance and their cash flows for the year then ended in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations)
- is in accordance with section 41B of the *Public Finance and Audit Act 1983* (the PF&A Act) and the Public Finance and Audit Regulation 2005.

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

The Commissioner's Responsibility for the Financial Report

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

Auditor's Responsibility

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

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

HEALTH CARE COMPLAINTS COMMISSION

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

My opinion does *not* provide assurance:

- about the future viability of the Commission or consolidated entity,
- that they have carried out their activities effectively, efficiently and economically,
- about the effectiveness of their internal controls, or
- on the assumptions used in formulating the budget figures disclosed in the financial report.

Independence

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

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

Peter Barnes
Director, Financial Audit Services

20 October 2008
SYDNEY

HEALTH CARE COMPLAINTS COMMISSION

FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2008

Statement by Commissioner

Pursuant to Section 41C(1B) of the *Public Finance and Audit Act 1983* , I state that:

a. the accompanying financial statements in respect of the year ended 30 June 2008 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 2005, and the Financial Reporting Directions published in the Financial Reporting Code for Budget Dependent General Government Sector Agencies or issued by the Treasurer under section 9(2) of the Act;

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

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

Kieran Pehm
Commissioner

17 October 2008

17 Finance

HEALTH CARE COMPLAINTS COMMISSION

Start of Audited Financial Statements

Operating Statement for the Year Ended 30 June 2008

	Notes	Parent			Consolidated		
		Actual 2008 $'000	Budget 2008 $'000	Actual 2007 $'000	Actual 2008 $'000	Budget 2008 $'000	Actual 2007 $'000
Expenses excluding losses							
Operating Expenses							
Employee Related	2(a)	–	–	–	7,359	7,330	6,968
Personnel Services	2(a)	7,359	7,330	6,968	–	–	–
Other Operating Expenses	2(b)	3,234	2,969	3,162	3,234	2,969	3,162
Depreciation and Amortisation	2(c)	205	320	306	205	320	306
Total Expenses Excluding Losses		**10,798**	**10,619**	**10,436**	**10,798**	**10,619**	**10,436**
Revenue							
Sale of Goods and Services	3(a)	1	2	–	1	2	–
Investment Revenue	3(b)	129	75	113	129	75	113
Other Revenue	3(c)	460	186	637	460	186	637
Total Revenue		**590**	**263**	**750**	**590**	**263**	**750**
Gain/(Loss) on Disposal	4	**–**	**–**	**(1)**	**–**	**–**	**(1)**
Net Cost of Services		**10,209**	**10,356**	**9,687**	**10,209**	**10,356**	**9,687**
Government Contributions							
Recurrent Appropriations	5	9,494	9,594	9,285	9,494	9,594	9,285
Capital Appropriation	5	–	–	12	–	–	12
Acceptance by the Crown Entity of employee benefits and other liabilities	6	472	325	268	472	325	268
Total Government Contributions		**9,966**	**9,919**	**9,565**	**9,966**	**9,919**	**9,565**
Surplus/(Deficit) for the Year	15	**(243)**	**(437)**	**(122)**	**(243)**	**(437)**	**(122)**

The accompanying notes form part of these financial statements.

Statement of Recognised Income and Expense for the Year Ended 30 June 2008

	Notes	Parent			Consolidated		
		Actual 2008 $'000	Budget 2008 $'000	Actual 2007 $'000	Actual 2008 $'000	Budget 2008 $'000	Actual 2007 $'000
Total Income and Expense Recognised Directly in Equity		**–**	**–**	-	**–**	**–**	**–**
Surplus/(Deficit) for the Year	15	(243)	(437)	(122)	(243)	(437)	(122)
Total Income and Expense Recognised for the Year		**(243)**	**(437)**	**(122)**	**(243)**	**(437)**	**(122)**
Effect of Changes in Accounting Policies and Correction of Errors		–	–	–	–	–	–

The accompanying notes form part of these financial statements.

HEALTH CARE COMPLAINTS COMMISSION

Balance Sheet as at 30 June 2008

	Notes	Parent			Consolidated		
		Actual 2008 $'000	Budget 2008 $'000	Actual 2007 $'000	Actual 2008 $'000	Budget 2008 $'000	Actual 2007 $'000
Assets							
Current Assets							
Cash and Cash Equivalents	8	2,138	2,107	2,125	2,138	2,107	2,125
Receivables	9	311	324	295	311	324	295
Other	10	10	78	78	10	78	78
Total Current Assets		**2,459**	**2,509**	**2,498**	**2,459**	**2,509**	**2,498**
Non-Current Assets							
Plant and Equipment	11	535	392	584	535	392	584
Intangible Assets	12	331	196	324	331	196	324
Total Non-Current Assets		**866**	**588**	**908**	**866**	**588**	**908**
Total Assets		**3,325**	**3,097**	**3,406**	**3,325**	**3,097**	**3,406**
Liabilities							
Current Liabilities							
Payables	13	576	441	418	576	441	418
Provisions	14	705	808	703	705	808	703
Total Current Liabilities		**1,281**	**1,249**	**1,121**	**1,281**	**1,249**	**1,121**
Non-Current Liabilities							
Provisions	14	6	4	4	6	4	4
Total Non-Current Liabilities		**6**	**4**	**4**	**6**	**4**	**4**
Total Liabilities		**1,287**	**1,253**	**1,125**	**1,287**	**1,253**	**1,125**
Net Assets		**2,038**	**1,844**	**2,281**	**2,038**	**1,844**	**2,281**
Equity							
Accumulated Funds	15	2,038	1,844	2,281	2,038	1,844	2,281
Total Equity		**2,038**	**1,844**	**2,281**	**2,038**	**1,844**	**2,281**

The accompanying notes form part of these financial statements.

HEALTH CARE COMPLAINTS COMMISSION

Cash Flow Statement for the Year Ended 30 June 2008

	Notes	Parent			Consolidated		
		Actual 2008 $'000	Budget 2008 $'000	Actual 2007 $'000	Actual 2008 $'000	Budget 2008 $'000	Actual 2007 $'000
Cash Flows from Operating Activities							
Payments							
Employee Related		–	–	–	(6,931)	(6,865)	(6,726)
Personnel Services		(6,931)	(6,865)	(6,726)	–	–	–
Fees – barristers/reviews		(710)	(752)	(727)	(710)	(752)	(727)
Fees – shared corporate services		(677)	(605)	(558)	(677)	(605)	(558)
Fees – rental charges		(771)	(750)	(748)	(771)	(750)	(748)
Other		(859)	(1,192)	(1,174)	(859)	(1,192)	(1,174)
Total Payments		(9,947)	(10,164)	(9,933)	(9,947)	(10,164)	(9,933)
Receipts							
Sale of Goods and Services		–	2	156	–	2	156
Interest Received		119	75	92	119	75	92
Legal cost recoveries		416	384	482	416	384	482
Other		92	91	153	92	91	153
Total Receipts		627	552	883	627	552	883
Cash Flows from Government							
Recurrent Appropriation	5	9,494	9,594	9,285	9,494	9,594	9,285
Capital Appropriation	5	–	–	12	–	–	12
Cash Reimbursements from Crown Entity		–	–	–	–	–	–
Net Cash Flows from Government		9,494	9,594	9,297	9,494	9,594	9,297
Net Cash from Operating Activities		174	(18)	247	174	(18)	247
Cash Flows from Investing Activities							
Proceeds from Sale of Plant and Equipment		–	–	–	–	–	–
Purchase of Plant and Equipment		(161)	–	(166)	(161)	–	(166)
Net Cash Flows from Investing Activities		(161)	–	(166)	(161)	–	(166)
Net Increase/(Decrease) in Cash and Cash Equivalent		13	(18)	81	13	(18)	81
Opening Cash and Cash Equivalents		2,125	1,909	2,044	2,125	1,909	2,044
Closing Cash and Cash Equivalents	8	2,138	1,891	2,125	2,138	1,891	2,125

The accompanying notes form part of these financial statements.

HEALTH CARE COMPLAINTS COMMISSION

Summary of Compliance with Financial Directives for the Year Ended 30 June 2008

	2008				2007			
	Recurrent Appropriation	Expenditure/ Net Claim on Consolidated Fund	Capital Appropriation	Expenditure/ Net Claim on Consolidated Fund	Recurrent Appropriation	Expenditure/ Net Claim on Consolidated Fund	Capital Appropriation	Expenditure/ Net Claim on Consolidated Fund
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Original Budget Appropriation/ Expenditure								
Appropriation Act	9,594	9,494	–	–	9,384	9,285	12	12
Additional Appropriations								
S21A PF&AA – special appropriation								
S24 PF&AA – transfer of functions between departments								
S26 PF&AA – Commonwealth specific purpose payments								
	9,594	9,494	–	–	9,384	9,285	12	12
Other Appropriations/ Expenditure								
Treasurer's Advance								
Under expenditure on protected items	(100)							
Section 22 – expenditure for certain works and services								
Transfers from another agency (Section 32 of the *Appropriation Act*)								
Enforced savings – reduction due to abolishment of ORC								
	(100)	–	–	–	–	–	–	–
Total Appropriations								
Expenditure/Net Claim on Consolidated Fund (includes transfer payments)	9,494	9,494	–	–	9,384	9,285	12	12
Amount drawn down against Appropriation		9,494		–		9,285		12
Liability to Consolidated Fund*		–		–		–		–

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

The 'Liability to Consolidated Fund' represents the difference between the 'Amount drawn down against Appropriation' and the 'Total Expenditure/Net Claim on Consolidated Fund.'

The accompanying notes form part of these statements

17 Finance

HEALTH CARE COMPLAINTS COMMISSION

Notes to and Forming Part of the Financial Statements for the Year Ended 30 June 2008

1. Summary of Significant Accounting Policies

(a) Reporting Entity

The Health Care Complaints Commission, 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 report for the economic entity consisting of the controlling and controlled entities, all inter – entity transactions and balances have been eliminated.

The Health Care Complaints Commission (HCCC) is a NSW Government Agency, responsible for protecting the public from substandard 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 HCCC was established as a body corporate under Section 75 of the *Health Care Complaints Act, 1993* and is a separate reporting entity under Schedule 2 of the *Public Finance and Audit Act 1983*, outside the control of the NSW Department of Health.

The reporting entity is consolidated as part of NSW Total State Sector Accounts.

This consolidated financial report for the year ended 30 June 2008 has been authorised for issue by the Commissioner on 17 October 2008.

(b) Basis of Preparation

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

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

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

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

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

(c) Statement of Compliance

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

(d) Income Recognition

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

(i) Parliamentary Appropriation and Contributions

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

(ii) Rendering of Services

Revenue is recognised when the service is provided.

(iii) Investment Revenue

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

(iv) Legal Cost Recoveries

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

(e) Employee Benefits and Other Provisions

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

Liabilities for salaries and wages (including non-monetary benefits), annual leave paid and sick leave that falls due wholly within 12 months of the reporting date and 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.

(ii) 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 the employee benefits and other liabilities'.

Notes to and Forming Part of the Financial Statements for the Year Ended 30 June 2008

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 07/04) to employees with five or more years of service using current rates of pay. These factors were determined based on an actuarial review to approximate present value.

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

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

(f) Insurance

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

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

Revenues, expenses and assets are recognised net of the amount of GST, except where:

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

(h) 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.

(i) Capitalisation Thresholds

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.

(j) Revaluation of Plant and Equipment

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

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

Fair value of property, plant and equipment is determined based on the best available market evidence, including current market selling prices for the same or similar assets. Where there is no 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.

(k) Impairment of Plant and Equipment

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

(l) Depreciation of 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. All material separately identifiable components of assets are depreciated over their shorter useful lives.

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

Asset category	Depreciation life in years
Computer Hardware	5
Plant and Equipment	10
Leasehold Improvements	5

(m) Maintenance

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

(n) Leased Assets

Operating lease payments are charged to the Operating Statement in the periods in which they are incurred.

HEALTH CARE COMPLAINTS COMMISSION

Notes to and Forming Part of the Financial Statements for the Year Ended 30 June 2008

(o) Intangible Assets

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

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

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

Intangible assets are subsequently measured at fair value only if there is an active market. As there is no active market for the HCCC's intangible assets, the assets are carried at cost less any accumulated amortisation.

The HCCC's intangible assets, computer software are amortised using the straight line method over a period of five years.

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

(p) Loans and Receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. These financial assets are recognised initially at fair value, usually based on the transaction cost or face value. Subsequent measurement is at amortised cost using the effective interest method, less an allowance for any impairment of receivables. Any changes are accounted for in the Operating Statement 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.

(q) 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 operating statement.

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

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

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

- where substantially all the risks and rewards have been transferred;

or

- where the Commission has not transferred substantially all the risks and rewards or transferred control, the asset is recognised to the extent of the Commission's continuing involvement in the asset.

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

A financial liability is derecognised when the obligation specified in the contract is discharged or cancelled or expires.

(s) 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.

(t) Financial Guarantees

A financial guarantee contract is a contract that requires the issuer to make specified payments to reimburse the holder for a loss it incurs because a specified debtor fails to make payment when due in accordance with the original or modified terms of a debt instrument.

Financial guarantee contracts are recognised as a liability at the time the guarantee is issued and initially measured at fair value, where material. After initial recognition, the liability is measured at the higher of the amount determined in accordance with AASB 137 Provisions, Contingent Liabilities and Contingent Assets and the amount initially recognised for financial guarantee contracts at 30 June 2008 and at 30 June 2007.

(u) Budgeted Amounts

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

The budgeted amounts in the Operating Statement and the Cash Flow Statement are generally based on the amounts disclosed in the NSW Budget Papers (as adjusted above). However, in the Balance Sheet the amounts vary from the Budget Papers, as the opening balances of the budgeted amounts are based on carried forward actual amounts i.e. per the audited financial report (rather than carried forward estimates).

Notes to and Forming Part of the Financial Statements for the Year Ended 30 June 2008

(v) 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.

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

The following new Accounting Standards/Interpretations have not been applied and are not yet effective (NSW TC 08/04). However, the HCCC is not able to reliably measure the impact of the initial application of these standards on its financial results.

- AASB 101 (Sept 2007) and AASB 2007-8 regarding presentation of financial statements;
- AASB 1004 (Dec 2007) regarding contributions;
- AASB 1049 (Oct 2007) regarding the whole of government and general government sector financial reporting;
- AASB 1050 (Dec 2007) regarding administered items;
- AASB 1052 (Dec 2007) regarding disaggregated disclosures;
- AASB 2007-9 regarding amendments arising from the review of AASs 27, 29 and 31;
- Interpretation 4 (Feb 2007) regarding determining whether an arrangement contains a lease;
- Interpretation 1038 (Dec 2007) regarding contributions by owners.

HEALTH CARE COMPLAINTS COMMISSION

Notes to and Forming Part of the Financial Statements for the Year Ended 30 June 2008

2. Expenses excluding losses

	Parent		Consolidated	
	2008 $'000	2007 $'000	2008 $'000	2007 $'000
(a) Employee related expenses				
Salaries and Wages (including recreation leave)	–	–	6,196	5,974
Superannuation – Defined Benefits Plans	–	–	178	137
Superannuation – Defined Contributions Plans	–	–	324	344
Workers' Compensation Insurance	–	–	37	47
Long Service Leave	–	–	274	123
Payroll Tax and Fringe Benefits Tax	–	–	350	343
Personnel services	7,359	6,968	–	–
	7,359	6,968	7,359	6,968
(b) Other operating expenses				
Auditors Remuneration – Audit or Review of Financial Reports	11	13	11	13
Bad and Doubtful Debts	35	22	35	22
Consultancy	173	163	173	163
Equipment and plant	34	50	34	50
Equipment Leasing	6	47	6	47
Fees for Services Rendered	643	619	643	619
Legal fees and adverse costs	653	782	653	782
Fees – legal witness	45	46	45	46
Maintenance	4	34	4	34
Fees – translators	48	18	48	18
Transcript fees	52	41	52	41
Fees – peer review reports	156	164	156	164
Training	90	85	90	85
Printing	49	13	49	13
Rental Expenses relating to Operating Leases	848	790	848	790
Stores	187	88	187	88
Telephone, postal and internet	129	137	129	137
Travelling	65	50	65	50
Other	6	–	6	–
	3,234	3,162	3,234	3,162
(c) Depreciation and amortisation expense				
Plant and Equipment – Depreciation	89	204	89	204
Intangible Assets – Amortisation	116	102	116	102
	205	306	205	306

Notes to and Forming Part of the Financial Statements for the Year Ended 30 June 2008

3. Revenue

	Parent		Consolidated	
	2008 $'000	2007 $'000	2008 $'000	2007 $'000
(a) Sale of Goods and Services	1	–	1	–
	1	–	1	–
(b) Investment revenue				
Interest	129	113	129	113
	129	113	129	113
(c) Other revenue				
Legal cost recoveries	417	482	417	482
Other	43	155	43	155
	460	637	460	637

4. Gain/(Loss) on Disposal

Gain/(loss) on disposal of plant and equipment				
Proceeds from sale	–	–	–	–
Written down value of assets disposed	–	(1)	–	(1)
Net gain/(loss) on disposal of plant and equipment	–	(1)	–	(1)

5. Appropriations

Recurrent Appropriations				
Total recurrent drawdown from NSW Treasury (per Summary of Compliance)	9,494	9,285	9,494	9,285
	9,494	9,285	9,494	9,285
Capital Appropriations				
Total capital drawdowns from NSW Treasury (per Summary of Compliance)	–	12	–	12
	–	12	–	12

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

Payroll tax on superannuation	16	8	16	8
Superannuation	178	137	178	137
Long Service Leave	278	123	278	123
	472	268	472	268

HEALTH CARE COMPLAINTS COMMISSION

Notes to and Forming Part of the Financial Statements for the Year Ended 30 June 2008

7. Program Information

Program 40.1.1 – Health Care Complaints

Program Objective(s):

To investigate, monitor, review and resolve complaints about health care services in New South Wales. To work with stakeholders to improve the safety and quality of health care services and to ensure that professional standards are met by health care providers.

8. Current Assets – Cash and Cash Equivalents

	Parent		Consolidated	
	2008 $'000	2007 $'000	2008 $'000	2007 $'000
Cash at bank and on hand	2,138	2,125	2,138	2,125
	2,138	2,125	2,138	2,125
For the purpose of the Cash Flow Statement, cash and cash equivalents includes cash on hand and cash at bank. Cash and cash equivalent assets recognised in the Balance Sheet are reconciled at the end of the financial year to the Cash Flow statement as follows:				
Cash and Cash Equivalents (per Balance Sheet)	2,138	2,125	2,138	2,125
Closing Cash and Cash Equivalents (Per Cash Flow Statement)	**2,138**	**2,125**	**2,138**	**2,125**

9. Current Assets – Receivables

Other revenue	433	382	433	382
Less Allowance for impairment	(122)	(87)	(122)	(87)
	311	295	311	295

10. Current Assets – Other

	10	78	10	78
	10	78	10	78

Notes to and Forming Part of the Financial Statements for the Year Ended 30 June 2008

11. Non-current Assets – Plant and Equipment

	Parent	Consolidated
	Plant and Equipment $'000	Plant and Equipment $'000
At 1 July 2007		
Gross Carrying Amount	1,255	1,255
Accumulated Depreciation	(641)	(641)
Net carrying amount at fair value	584	584
At 30 June 2008		
Gross Carrying Amount	1,265	1,265
Accumulated Depreciation	(730)	(730)
Net carrying amount at fair value	535	535
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:		
Year ended 30 June 2008		
Net carrying amount at start of year	584	584
Additions	40	40
Disposals	–	–
Depreciation Expense	(89)	(89)
Net carrying amount at end of year – at fair value	535	535
At 1 July 2006		
Gross Carrying Amount	1,077	1,077
Accumulated Depreciation	(437)	(437)
Net carrying amount at fair value	640	640
At 30 June 2007		
Gross Carrying Amount	1,225	1,225
Accumulated Depreciation	(641)	(641)
Net carrying amount at fair value	584	584
Reconciliation		
A reconciliation of the carrying amount of plant and equipment at the beginning and end of the previous reporting period is set out below:		
Year ended 30 June 2007		
Net carrying amount at start of year	640	640
Additions	148	148
Disposals	–	–
Depreciation Expense	(204)	(204)
Net carrying amount at end of year – at fair value	584	584

HEALTH CARE COMPLAINTS COMMISSION

Notes to and Forming Part of the Financial Statements for the Year Ended 30 June 2008

12. Intangible Assets

	Parent	Consolidated
	Plant and Equipment $'000	Plant and Equipment $'000
At 1 July 2007		
Gross Carrying Amount	525	525
Accumulated amortisation and impairment	(201)	(201)
Net carrying amount at fair value	324	324
At 30 June 2008		
Gross Carrying Amount	647	647
Accumulated amortisation and impairment	(316)	(316)
Net carrying amount at fair value	331	331
Reconciliation		
Year ended 30 June 2008		
Net carrying amount at start of year	324	324
Additions (acquired separately)	122	122
Disposals	–	–
Amortisation (recognised in 'depreciation and amortisation')	(116)	(116)
Net carrying amount at end of year – at fair value	331	331
At 1 July 2006		
Gross Carrying Amount	508	508
Accumulated amortisation and impairment	(99)	(99)
Net carrying amount at fair value	409	409
At 30 June 2007		
Gross Carrying Amount	525	525
Accumulated amortisation and impairment	(201)	(201)
Net carrying amount at fair value	324	324
Reconciliation		
Year ended 30 June 2007		
Net carrying amount at start of year	409	409
Additions (acquired separately)	18	18
Disposals	(1)	(1)
Amortisation (recognised in 'depreciation and amortisation')	(102)	(102)
Net carrying amount at end of year – at fair value	324	324

Notes to and Forming Part of the Financial Statements for the Year Ended 30 June 2008

13. Current Liabilities – Payables

	Parent		Consolidated	
	2008 $'000	2007 $'000	2008 $'000	2007 $'000
Accrued salaries, wages and on costs	–	–	58	48
Payable for personnel services	58	48	–	–
Creditors	–	108	–	108
Other	518	263	518	263
	576	419	576	419

14. Current/Non Current Liabilities – Provisions

Employee benefit and related on-costs				
Recreation leave	–	–	595	620
Payroll tax on long service leave	–	–	70	56
Long service leave on-costs	–	–	46	32
Provision for personnel services	711	708	–	–
Total	**711**	**708**	**711**	**708**
Aggregate employee benefits and related on costs				
Provisions – Current	–	–	–	–
Provisions – Non-current	–	–	–	–
Provision for personnel services – current	705	703	705	703
Provision for personnel services – Non-current	6	4	6	4
Accrued salaries, wages and on-costs (Note 12)	–	–	–	–
Payable for personnel services	58	48	58	48
	769	**755**	**769**	**755**

15. 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 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 HCCC, to set risk limits and controls and to monitor risks. Compliance with policies is reviewed by the HCCC's internal auditors (Deloitte, Touche and Tohmatsu) and the Audit Committee on a continuous basis.

HEALTH CARE COMPLAINTS COMMISSION

Notes to and Forming Part of the Financial Statements for the Year Ended 30 June 2008

15. Financial Instruments (continued)

(a) Financial instrument categories

Financial Assets:	Note	Category	Carrying Amount 2008 $'000	Carrying Amount 2007 $'000
Class				
Cash and cash equivalents	8	N/A	2,138	2,125
Receivables[1]	9	Loans and receivables	321	373
Financial Liabilities:	**Note**	**Category**	**Carrying Amount 2008 $'000**	**Carrying Amount 2007 $'000**
Class:				
Payables[2]	12	Financial liabilities measured at amortised cost	576	419

Notes

[1] Excludes statutory receivables and prepayment (not within scope of AASB 7)

[2] Excludes 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 5.84%. The average rate for the year ended 2006-07 was 5.14%.

Receivables – debtors

All debtors are recognised as amounts receivable at balance date. Collectibility of 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 debtors.

The HCCC is not materially exposed to concentrations of credit risk to a single debtor or to a group of debtors. Based on past experience, debtors that are not past due (2008:$165; 2007:$nil) and not less than 12 months past due (2008:$nil; 2007:$nil) are not considered impaired and together these represent 1% of the total debtors.

Debtors which are currently past due (2008:$217,335; 2007:$265,958) represent 99% of the total debtors. These debtors comprise debts arising from tribunal ordered costs against medical practioners. All of the debts reported in the financial statements are being settled by agreed regular instalments and are not considered to be impaired.

Notes to and Forming Part of the Financial Statements for the Year Ended 30 June 2008

15. Financial Instruments (continued)

(b) Credit risk (continued)

	Total	Past due but not impaired	Considered impaired
2008			
< 3 months overdue	–	–	
3 months – 6 months overdue	–	–	
> 6 months overdue	217	217	
2007			
< 3 months overdue	–	–	
3 months – 6 months overdue	–	–	
> 6 months overdue	266	266	

The ageing analysis excludes statutory receivables, as these are not within the scope of AASB 7.

(c) Liquidity risk

Liquidity risk is the risk that the 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 or breaches 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 Treasurer's Direction 219.01. If trade terms are not specified, payment is made no later than the end of the month following the month in which an invoice or a statement is received. Treasurer's Direction 219.01 allows the Minister to award interest for late payment.

(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.

16. Changes in Equity

Accumulated Funds				
Balance at the beginning of the financial year	2,281	2,403	2,281	2,403
Surplus/(deficit) for the year from ordinary activities	(243)	(122)	(243)	(122)
Balance at the end of the financial year	**2,038**	**2,281**	**2,038**	**2,281**

HEALTH CARE COMPLAINTS COMMISSION

Notes to and Forming Part of the Financial Statements for the Year Ended 30 June 2008

17. Commitments for Expenditure

	Parent		Consolidated	
	2008 $'000	2007 $'000	2008 $'000	2007 $'000
(a) Other Expenditure Commitments				
Aggregate other expenditure for the acquisition of stationery contracted for at balance date and not provided for:				
Not later than one year	–	–	–	–
Other	–	–	–	–
Total (including GST)	–	–	–	–
(b) Operating Lease Commitments				
Future non-cancellable operating lease rentals not provided for and payable:				
Not later than one year	902	924	902	924
Later than one year not later than 5 years	1,626	2,852	1,626	2,852
Later than five years	–	–	–	–
Total (including GST)	2,528	3,776	2,528	3,776

Total Commitments above included input tax creditors of $229,000 (2006-07 $343,000) that are expected to be recovered from the Australian Taxation Office.

18. Contingent Assets

These 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 negligent.

The amounts are subject to negotiation and determination and total $902,457 (2006-07 $900,000).

19. Contingent Liabilities

Adverse costs awarded against the HCCC, across a range of cases, and estimated to be nil at 30 June 2007 (2006-07 $Nil).

Notes to and Forming Part of the Financial Statements for the Year Ended 30 June 2008

20. Budget Review

Net Cost of Services

There was a variance of $147,000 between budgeted and actual net cost of services. This variance can be attributed to higher than anticipated legal counsel expenses nad unanticipated TRIM software upgrades.

Assets and liabilities

Current assets were $50,000 under budget as the result of legal counsel expenses mentioned above.

Non current assets were $228,000 higher than budgeted due to unanticipated TRIM software upgrades.

Liabilities were higher than budgeted by $34,000 due to increase in current liabilities (expenditure accruals) as at year end for rent and insurance.

Cash Flows

The Commission's revenue increased by $75,000 compared to budget due to the higher than anticipated legal cost recoveries during the reporting year.

Recurrent appropriation was lower than budgeted by $100,000 due to less than anticipated adverse costs (protected item) requirements.

21. Reconciliation of Net Cash Flows from Activities to Net Cost of Services

	Parent		Consolidated	
	2008 $'000	2007 $'000	2008 $'000	2007 $'000
Net cash used on operating activities	174	247	174	247
Depreciation	(205)	(306)	(205)	(306)
Increase/(decrease) in provisions	4	(73)	4	(73)
Acceptance by the Crown Entity of employee benefits and other liabilities	(472)	(268)	(472)	(268)
Cash flows from Government/Appropriations	(9,494)	(9,297)	(9,494)	(9,297)
Increase/(decrease) in receivables and other	(58)	223	(58)	223
Increase in creditors	(158)	(212)	(158)	(212)
Net loss on sale of plant and equipment	–	(1)	–	(1)
Net Cost of Services	(10,209)	(9,687)	(10,209)	(9,687)

22. After Balance Date Events

No after balance date events have occurred.

End of Audited Financial Report

17 Finance

OFFICE OF THE HEALTH CARE COMPLAINTS COMMISSION

GPO BOX 12
Sydney NSW 2001

INDEPENDENT AUDITOR'S REPORT

OFFICE OF THE HEALTH CARE COMPLAINTS COMMISSION

To Members of the New South Wales Parliament

I have audited the accompanying financial report of the Office of the Health Care Complaints Commission (the Office), which comprises the balance sheet as at 30 June 2008, the operating statement, statement of recognised income and expense and cash flow statement and a summary of compliance with financial directives for the year then ended, a summary of significant accounting policies and other explanatory notes.

Auditor's Opinion

In my opinion, the financial report:

- presents fairly, in all material respects, the financial position of the Office as at 30 June 2008, and its financial performance and cash flows for the year then ended in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations)
- is in accordance with section 41B of the *Public Finance and Audit Act 1983* (the PF&A Act) and the Public Finance and Audit Regulation 2005.

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

The Commissioner's Responsibility for the Financial Report

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

Auditor's Responsibility

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

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

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

My opinion does *not* provide assurance:

- about the future viability of the Office,
- that it has carried out its activities effectively, efficiently and economically, or
- about the effectiveness of its internal controls.

Independence

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

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

Peter Barnes
Director, Financial Audit Services

20 October 2008
SYDNEY

17 Finance

OFFICE OF THE HEALTH CARE COMPLAINTS COMMISSION

OFFICE OF THE HEALTH CARE COMPLAINTS COMMISSION

FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2008

Statement by Commissioner

Pursuant to Section 41C(1B) of the *Public Finance and Audit Act 1983*, I state that:

a. the accompanying financial statements in respect of the year ended 30 June 2008 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 2005, and the Financial Reporting Directions published in the Financial Reporting Code for Budget Dependent General Government Sector Agencies or issued by the Treasurer under section 9(2) of the Act;

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

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

Kieran Pehm
Commissioner

17 October 2008

OFFICE OF THE HEALTH CARE COMPLAINTS COMMISSION

Start of Audited Financial Statements

Operating Statement for the Year Ended 30 June 2008

	Note	Actual 2008 $'000	Actual 2007 $'000
Expenses excluding losses			
Operating Expenses			
Employee Related	2	7,359	6,968
Total Expenses Excluding Losses		7,359	6,968
Revenue			
Personnel Services	3	7,359	6,968
Total Revenue		7,359	6,968
Surplus/(Deficit) for the Year		–	–

The accompanying notes form part of these financial statements.

Statement of Recognised Income and Expense for the year ended 30 June 2008

	Note	Actual 2008 $'000	Actual 2007 $'000
Total Income and Expense Recognised Directly in Equity		–	–
Surplus/(Deficit) for the Year		–	–
Total Income and Expense Recognised for the Year		–	–
Effect of Changes in Accounting Policies and Correction of Errors		–	–

The accompanying notes form part of these financial statements.

17 Finance

OFFICE OF THE HEALTH CARE COMPLAINTS COMMISSION

Balance Sheet as at 30 June 2008

	Note	Actual 2008 $'000	Actual 2007 $'000
Assets			
Current Assets			
Receivables	4	763	751
Total Current Assets		**763**	**751**
Non-Current Assets			
Receivables	4	6	4
Total Non-Current Assets		6	4
Total Assets		**769**	**755**
Liabilities			
Current Liabilities			
Payables	5	58	48
Provisions	6	705	703
Total Current Liabilities		**763**	**751**
Non-Current Liabilities			
Provisions	6	6	4
Total Non-Current Liabilities		**6**	**4**
Total Liabilities		769	755
Net Assets		–	–
Accumulated Funds		–	–
Total Equity		**–**	**–**

The accompanying notes form part of these financial statements.

OFFICE OF THE HEALTH CARE COMPLAINTS COMMISSION

Cash Flow Statement for the Year Ended 30 June 2008

	Note	Actual 2008 $'000	Actual 2007 $'000
Cash Flows from Operating Activities			
Payments			
Employee Related		–	–
Other		–	–
Total Payments		–	–
Receipts			
Sale of Goods and Services		–	–
Interest Received		–	–
Other		–	–
Total Receipts		–	–
Cash Flows from Government			
Recurrent Appropriation		–	–
Capital Appropriation		-	–
Cash Reimbursements from Crown Entity		–	–
Net Cash Flows from Government		–	–
Net Cash from Operating Activities		–	–
Cash Flows from Investing Activities			
Purchase of Plant and Equipment			–
Net Cash Flows from Investing Activities		–	–
Net Increase in Cash and Cash Equivalents		–	–
Opening Cash and Cash Equivalents		–	–
Closing Cash and Cash Equivalents		–	–

The accompanying notes form part of these financial statements.

17 Finance

OFFICE OF THE HEALTH CARE COMPLAINTS COMMISSION

Summary of Compliance with Financial Directives for the Year Ended 30 June 2008

	2008				2007			
	Recurrent Appropriation	Expenditure/ Net Claim on Consolidated Fund	Capital Appropriation	Expenditure/ Net Claim on Consolidated Fund	Recurrent Appropriation	Expenditure/ Net Claim on Consolidated Fund	Capital Appropriation	Expenditure/ Net Claim on Consolidated Fund
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Original Budget Appropriation/ Expenditure								
Appropriation Act								
Additional Appropriations								
S21A PF&AA – special appropriation								
S24 PF&AA – transfer of functions between departments								
S26 PF&AA – Commonwealth specific purpose payments								
	–	–	–	–	–	–	–	–
Other Appropriations/ Expenditure								
Treasurer's Advance								
Under expenditure on protected items								
Section 22 – expenditure for certain works and services								
Transfers from another agency (Section 32 of the *Appropriation Act*)								
Enforced savings – reduction due to abolishment of ORC								
	–	–	–	–	–	–	–	–
Total Appropriations								
Expenditure/Net Claim on Consolidated Fund (includes transfer payments)	–	–	–	–	–	–	–	–
Amount drawn down against Appropriation		–		–		–		–
Liability to Consolidated Fund*		–		–		–		–

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

The 'Liability to Consolidated Fund' represents the difference between the 'Amount drawn down against Appropriation' and the 'Total Expenditure/Net Claim on Consolidated Fund.'

The accompanying notes form part of these statements

Notes to and Forming Part of the Financial Statements for the Year Ended 30 June 2008

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 NSW Total State Sector Accounts.

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

(b) Basis of Preparation

The OHCCC's financial statements are a general purpose financial report which has been prepared in accordance with:

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

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

The financial statements are prepared in accordance with the historical cost convention. All amounts are rounded to the nearest one thousand dollars and are expressed in Australian currency.

(c) Statement of Compliance

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

(d) Income Recognition

Income is measured at the fair value of the consideration or contributions, received or receivable. Revenue from the rendering of personnel services is recognised when the service is provided and only to the extent that the associated recoverable expenses are recognised.

(e) Employee Benefits and Other Provisions

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

Liabilities for salaries and wages (including non-monetary benefits), annual leave paid and sick leave that falls due wholly within 12 months of the reporting date and 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.

(ii) 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 the 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 07/04) to employees with five or more years of service using current rates of pay.

These factors were determined based on an actuarial review to approximate present value.

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

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

(f) Insurance

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

(g) Loans and Receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. These financial assets are recognised initially at fair value, usually based on the transaction cost or face value. Subsequent measurement is at amortised cost using the effective interest method, less an allowance for any impairment of receivables. Any changes are accounted for in the Operating Statement 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.

OFFICE OF THE HEALTH CARE COMPLAINTS COMMISSION

Notes to and Forming Part of the Financial Statements for the Year Ended 30 June 2008

(h) 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 started interest rate are measured at he original invoice amount where the effect of discounting is immaterial.

(i) 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.

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

The following new Accounting Standards/Interpretations have not been applied and are not yet effective (NSW TC 08/04). However, the HCCC is not able to reliably measure the impact of the initial application of these standards on its financial results.

- AASB 101 (Sept 2007) and AASB 2007-8 regarding presentation of financial statements;
- AASB 1004 (Dec 2007) regarding contributions;
- AASB 1049 (Oct 2007) regarding the whole of government and general government sector financial reporting;
- AASB 1050 (Dec 2007) regarding administered items;
- AASB 1052 (Dec 2007) regarding disaggregated disclosures;
- AASB 2007-9 regarding amendments arising from the review of AASs 27, 29 and 31;
- Interpretation 4 (Feb 2007) regarding determining whether an arrangement contains a lease;
- Interpretation 1038 (Dec 2007) regarding contributions by owners.

2. Expenses excluding losses

	2008 $'000	2007 $'000
Employee related expenses		
Salaries and Wages (including recreation leave)	6,196	5,974
Superannuation – Defined Benefits Plans	178	137
Superannuation – Defined Contributions Plans	324	344
Workers' compensation Insurance	37	47
Long Service Leave	274	123
Payroll tax and Fringe Benefits Tax	350	343
	7,359	6,968

3. Revenue

Rendering of personnel services	7,359	6,968
	7,359	6,968

4. Current/Non-current Assets – Receivables

Personnel Services – Current	763	751
Personnel Services – Non-Current	6	4
	769	755

5. Current Liabilities – Payables

Accrued salaries, wages and on costs	58	48
	58	48

Notes to and Forming Part of the Financial Statements for the Year Ended 30 June 2008

6. Current/Non Current Liabilities – Provisions

	2008 $'000	2007 $'000
Employee benefit and related on-costs		
Recreation leave	595	620
Payroll tax on long service leave	70	56
Long service leave on-costs	46	32
Total	711	708
Aggregate employee benefits and related on costs		
Provisions – Current	705	703
Provisions – Non Current	6	4
Accrued salaries, wages and on costs	58	48
	769	755

7. Contingent Liabilities and Contingent Assets

There are no contingent liabilities or contingent assets at 30 June 2008 (2007 – $Nil).

8. Financial Instruments

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

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

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

Compliance with policies is reviewed by the OHCCC's internal auditors (Deloitte, Touche and Tohmatsu) and the Audit Committee on a continuous basis.

(a) Financial instrument categories

Financial Assets:	Note	Category	Carrying Amount 2008 $'000	Carrying Amount 2007 $'000
Class				
Receivables[1]	9	Receivables	769	755
Financial Liabilities:	**Note**	**Category**	**Carrying Amount 2008 $'000**	**Carrying Amount 2007 $'000**
Class:				
Payables[2]	12	Financial liabilities measured at amortised cost	58	48

Notes

[1] Excludes statutory receivables and prepayment (not within scope of AASB 7)

[2] Excludes unearned revenue (not within scope of AASB 7)

OFFICE OF THE HEALTH CARE COMPLAINTS COMMISSION

Notes to and Forming Part of the Financial Statements for the Year Ended 30 June 2008

8. Financial Instruments (continued)

(b) Credit risk

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

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

Receivables – debtors

All receivables are for personnel services receivable and are recognised as amounts receivable at balance date. Review of the collectibility of debtors is not required as the only debtor is the HCCC.

The OHCCC is not materially exposed to concentrations of credit risk to a single debtor or to a group of debtors. Based on past experience, debtors that are not past due (2008:$755,000; 2007:$769,000) and not less than 12 months past due (2008:$nil; 2007:$nil) are not considered impaired and together these represent 1% of the total debtors.

	Total	Past due but not impaired	Considered impaired
2008			
< 3 months overdue	–	–	
3 months – 6 months overdue	–	–	
> 6 months overdue	217	217	
2007			
< 3 months overdue	–	–	
3 months – 6 months overdue	–	–	
> 6 months overdue	266	266	

The ageing analysis excludes statutory receivables, as these are not within the scope of AASB 7.

(c) Liquidity risk

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

During the current and prior years, there were no defaults or breaches on any loans payable. No assets have been pledged as collateral. The OHCCC's exposure to liquidity risk is deemed insignificant based on prior periods' data and other current assessment of risk.

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

(d) Market risk

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

9. After Balance Date Events

No after balance date events have occurred.

End of Audited Financial Report

18

Appendices

Performance in 2007-08

Provide timely, accurate and relevant reporting to the Minister and the Joint Parliamentary Committee

- **The Commission provided quarterly performance reports to the Minister for Health and the Joint Parliamentary Committee and has not received any adverse responses during 2007-08.**
- **The Joint Parliamentary Committee concluded in its review on the Commission's previous annual report:**

  > ... in 2006-07 the Commission has undergone a process of considerable improvement in the manner in which it exercises its functions under the Act, and particularly how it engages with both health care complainants and others involved in the provision of health care in NSW. The Committee ... does acknowledge the efforts of the Commission to address operational areas which the Committee has previously noted as deficient.
  >
  > The Committee considers that in 2006-07 the Commission has genuinely picked up pace in the important areas of internal operations and its external 'outreach' to raise public awareness of its services, and the Committee looks forward to working with the Commission to ensure that the pace and progress of positive change is maintained.

- **The Commission responded to 89 ministerial requests for information in an average of 7.7 days during 2007-08 (target 14 days). This compares to 48 responses provided in an average time of 16.7 days in the previous year.**

Report publicly about the work of the Commission

- **The Annual Report 2006-07 was delivered without delay to the Minister for Health and the Treasurer on 30 October 2008. The report was tabled in Parliament on 29 November 2008.**
- **A clean audit certificate for annual financial statements was received on 19 October 2007.**

18 Appendices

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

- More than 94% of staff were rated competent.
- Learning and development plans were implemented and individual staff members undertook on average three days of training during 2007-08.
- The Commission's three year OHS and Risk Management Plan 2006-2009 performance measures have been actioned according to timeframes and a review on compliance of the plan's actions was undertaken as part of the recent OHS and risk management audit that was conducted by Deloitte Touche Tohmatsu.
- The current EEO management plan 2007-08 was developed and endorsed in September 2007 and the previous year's plan was reported to the Department of Premier and Cabinet in October 2007. The actions of the current plan have been undertaken according to the Plan's timeframes.
- The EAPS Forward Plan 2007-08 was developed and endorsed in September 2007 and the EAPS self assessment for 2006-07 was completed and forwarded to the NSW Community Relations Commission in September 2007. The majority of EAPS actions identified in the plan have been completed according to timeframes with some to be rolled over into the new plan.
- The Disability Action Plan 2006-09 also continues to be actioned according to timeframes. The Commission does not have a separate Aboriginal Affairs Plan, instead strategies have been identified in the EEO Management Plan.
- Commission was accredited to ISO27001:2005 International Standards for Information Security in January 2008.
- Casemate enhancement projects were completed during the year and included:
  - extending the system's use to the Legal Division
  - integration with TRIM document management system
  - redesigning review of decision (section 28) and revised assessment (section 20A) processes
  - implementing client satisfaction survey functionality
  - enhancing the security of the Internet-based remote access facility
  - enhancing management reporting
  - document scanning using the new Helpdesk system accessible via the Intranet.
- TRIM Electronic Document and Records Management System (EDRMS) was successfully rolled out on 13 May 2008.
- All key corporate documents are available to staff on the Commission's intranet site.
- The Commission had monthly staff meeting during the year to inform staff about important changes and information that impact on their work. Results of the quarterly performance report were also presented at these meetings.

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

- All meetings conducted according to meeting schedules – for example, Executive Management Group second weekly; ICT Steering Committee meeting held every four months; Audit Committee held as scheduled; OHS meeting held quarterly.
- Strategic Plan, Corporate Plan and Divisional Business plans were developed and implemented. Results are reported on quarterly.
- Monthly staff establishment and financial reports were generated and distributed on a monthly basis and discussed at the Executive Meetings.
- Performance agreements were in place for all staff with twice-yearly reviews occurring.

Appendix A – Access to services

Complaints about the Commission

Requests for review

If a complainant is not satisfied with the Commission's assessment of their complaint, or the outcome of an investigation into a health practitioner, they are entitled to seek a review of the matter by the Commission.

The number of requests for review in 2007-08 – together with the outcomes of these review requests – appear in chapter 12 'Assessing complaints' and chapter 15 'Investigating complaints'.

Complaints about conduct

During the year, the Commission received a complaint about the conduct of one of its inquiry officers, alleging that the officer had made 'rude and inconsiderate' remarks to the complainants during a telephone call. Following enquiries, the Commission advised the complainants that, while there were differing versions of the conversation, the officer acknowledged that she had not been as sensitive to the complainants' grief and distress as she should have been. The Commission apologised for this, and advised that the officer had received guidance in relation to the matter from her supervisor.

The Commission also received ongoing complaints about the conduct of the Commission from a medical practitioner.

Complaints to the Minister and the Joint Parliamentary Committee

Some complainants and health service providers complain to the Minister for Health about the Commission's decisions and/or operations. While the Commission is accountable to the Minister, the *Health Care Complaints Act* specifically provides that the Commission is not subject to the direction of the Minister in relation to the exercise of its complaint-handling functions. Accordingly, the Minister will explain to the complainant that the Commission is an independent agency, and that the legislation precludes the Minister from intervening in the Commission's handling of the particular complaint.

Similarly, complaints are sometimes made to the Joint Parliamentary Committee on the Health Care Complaints Commission. While the Committee has the responsibility of monitoring the Commission's operations, the legislation also provides that the Committee is not entitled to reconsider the Commission's handling of particular complaints.

Complaints to the Ombudsman and ICAC

Both complainants and health service providers who are the subject of a complaint are entitled to complain to the Ombudsman and/or the Independent Commission Against Corruption.

The Commission is aware of three complaints about the Commission that were made to the Ombudsman in 2007-08.

One complaint was made by the medical practitioner mentioned above. Following preliminary enquiries, the Ombudsman found that the Commission had dealt with a particular complaint matter appropriately.

The second complaint was about the Commission's handling of a particular complaint file. Following preliminary enquiries, the Ombudsman found that the Commission had acted reasonably in relation to the matter.

The third complaint was about the Commission's handling of a Freedom of Information application. The Ombudsman advised the complainant that the Commission had correctly informed her that the Commission was exempt from the operation of the *Freedom of Information Act* in relation to her application.

Complaints alleging discrimination

During the year, the Commission was notified by the Anti-Discrimination Board of two separate complaints made to the Board alleging discrimination by the Commission both instigated by the same medical practitioner referred to above. The Commission provided detailed responses to both complaints, denying any discrimination against the complainants. The Board subsequently decided that both complaints were lacking in substance. The complainants then sought leave to pursue proceedings against the Commission before the Administrative Decisions Tribunal. The Tribunal dismissed one of these applications in June 2008, while the other application has been listed for hearing in late 2008.

The Commission was also notified by the Human Rights and Equal Opportunities Commission (HREOC) of another complaint of discrimination. The Commission provided HREOC with its response to this complaint and denied any discrimination. In July 2008, HREOC decided that the complaint was 'lacking in substance'.

Complaints alleging breach of privacy

The Commission received three complaints during 2007-08 that alleged a breach of privacy by the Commission – one was from a complainant to the Commission, and the other two by health practitioners. Following internal review, the Commission found that there had been no breach of privacy in any of these matters.

Compliments

Finally, it should be noted that the Commission maintains a file recording compliments made by complainants, health service providers and other individuals and agencies in relation to their dealings with the staff of the Commission. The Commission ensures that such compliments are passed on to the officers concerned.

Freedom of Information

The *Freedom of Information Act 1989* provides that the Commission is exempt from the operation of the Act in relation to the Commission's complaint handling, investigative, complaints resolution and reporting functions, by reason of the combined operation of section 9 and Schedule 2 of the Act.

A – new FOI applications

In 2007-08, the Commission received nine Freedom of Information applications, all of which were made by individuals (as compared to three applications in 2006-07, all of which were also made by individuals).

18 Appendices

B – discontinued applications

In 2007-08 – as in the previous year – no applications were discontinued.

C – completed applications

D – applications granted or otherwise available in full

E – applications granted or otherwise available in part

F – applications refused

G – exemptdocuments

All nine applications received in 2007-08 were dealt with on the basis that the applicant was seeking access to documents in relation to which the Commission was exempt from the operation of the *Freedom of Information Act*.

H – Ministerial certificates

No Ministerial certificates were issued in 2007-08 or the previous reporting period.

I – formal consultations

There were no applications that required consultation in 2007-08 or the previous reporting period.

J – amendment of personal records

K – notation of personal records

There were no requests for the amendment of personal records in 2007-08 or the previous reporting period.

L – fees and costs

M – fee discounts

N – fee refunds

In 2007-08, there was no fee provided for three applications, and a fee provided for six applications, all of which were refunded. In the previous reporting period, a fee was provided for one of the three applications.

O – days taken to complete request

P – processing times (hours)

Not applicable – the Commission was exempt from the operation of the *Freedom of Information Act* in relation all applications received in 2007-08 and the previous reporting period.

Q – number of reviews

R – results of internal reviews

There were no requests for internal review in 2007-08 or the previous reporting period.

Privacy management plan

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

In 2007-08, the Commission initiated a project to review its privacy management plan. It is expected that this project will be completed by the end of 2008, and that a revised privacy management plan will be finalised and implemented at that time.

Details of the Commission's handling of complaints about alleged breaches of privacy during 2007-08 can be found in under the heading 'Complaints alleging breach of privacy'.

Appendix B – Organisation and management

Corporate structure

As shown in the organisation chart, the Health Care Complaints Commission currently has three operational Divisions, a small Corporate Services Unit and an Executive Unit. The Commissioner, Mr Kieran Pehm was appointed to the position on 29 June 2005, by the Governor of New South Wales for a five-year term.

The Commission's services are complemented by the Office of the Health Care Complaints Commission (OHCCC), which provides personnel services to the Health Care Complaints Commission. The OHCCC is a division of the Government Service that was established under the *Public Sector Employment and Management Act 2002*. This report includes separate financial statements for both entities in chapter 17.

Senior Executive Service

In the 2007-08 reporting period the Commission had a total of four SES positions. The positions and their incumbents are:

- Commissioner, SES Level 6 – Kieran Pehm, Bachelor of Arts (BA) and Bachelor of Law (LLB), Master of Law (LLM)
- Director of Proceedings, SES Level 2 – Karen Mobbs, Bachelor of Arts (BA) and Bachelor of Law (LLB), FMRC Legal
- Director of Investigations, SES Level 2 – Bret Coman, Bachelor of Policing (Investigations), Master of Public Policy and Administration
- Director of Assessments and Resolutions, SES Level 1 – Ian Thurgood, Certificate in Orthopaedic Nursing, Certificate of General Nursing, Accredited Mediator

Performance of the Commissioner

The Commission is required under annual reporting legislation to report on the performance and salary of any Senior Executive Service (SES) officer at level 5 or above. Mr Kieran Pehm, the Commissioner throughout 2007-08, was the only senior officer in this SES reporting category. The position of Commissioner of the Health Care Complaints Commission is renumerated at SES Level 6 and Mr Pehm's current package is $253,501.

The Commissioner is responsible to the Minister for Health for the overall management, performance and the achievement of the Health Care Complaints Commission's legislative requirements. The Minister of Health advised that Mr Pehm's performance during 2007-08 was competent and effective.

With respect to normal operations, the vast majority of performance indicators have been met or partially met.

An increased proportion of complaints are being assessed for resolution options and investigations are reserved for the most serious matters.

The overall governance of the Commission continues to improve with a regular program of internal audit informing procedural change. The Commission introduced a full electronic records management system during the year.

The Commissioner responded well to unusual challenges during the year including informing the review that arose as a result of the public concern about the former doctor Graeme Reeves.

Commission staff

The Commission employed a total of 85 staff at the end of 2007-08. The Commission's staff mix was comprised of 61 permanent staff, 20 staff employed on a temporary basis and four staff employed in SES contract positions. The majority of the Commission employees (84.7%) including the SES staff are full time and 15.3% of staff are employed on a part time work arrangement.

The Commission had four staff seconded into its operational divisions from other public sector agencies: one staff member was seconded from South Eastern Sydney and Illawarra Area Heath Service, one member of staff from the Office of Director of Public Prosecutions, one member of staff from WorkCover and another from the Ombudsman's Office.

Staff attrition in 2007-08

During the year, eight permanent staff resigned. Five temporary staff completed their contracts. A further six officers were seconded or transferred to another agency and for another three officers their secondment at the Commission ended.

Table 18.2 below sets out the average full time equivalent staffing levels for the last three years and provides a more accurate indication of staff trends. The Commission's average number of full time equivalent employees (FTE) during 2007-08 was 76.4, a decrease of 0.2 FTE from the previous year.

Table 18.2
Average full time equivalent staffing 2004-05 to 2007-08

2004-05	2005-06	2006-07	2007-08
90	74.9	76.6	76.4

Table 18.1 Senior Executive Service

	2006-07	2007-08
Number of female executive officers	one	one
Number of executive positions at each level	Level 6 – one	Level 6 – one
	Level 2 – two	Level 2 – two
	Level 1 – one	Level 1 – one

18 Appendices

Chart 18.1 Organisational chart

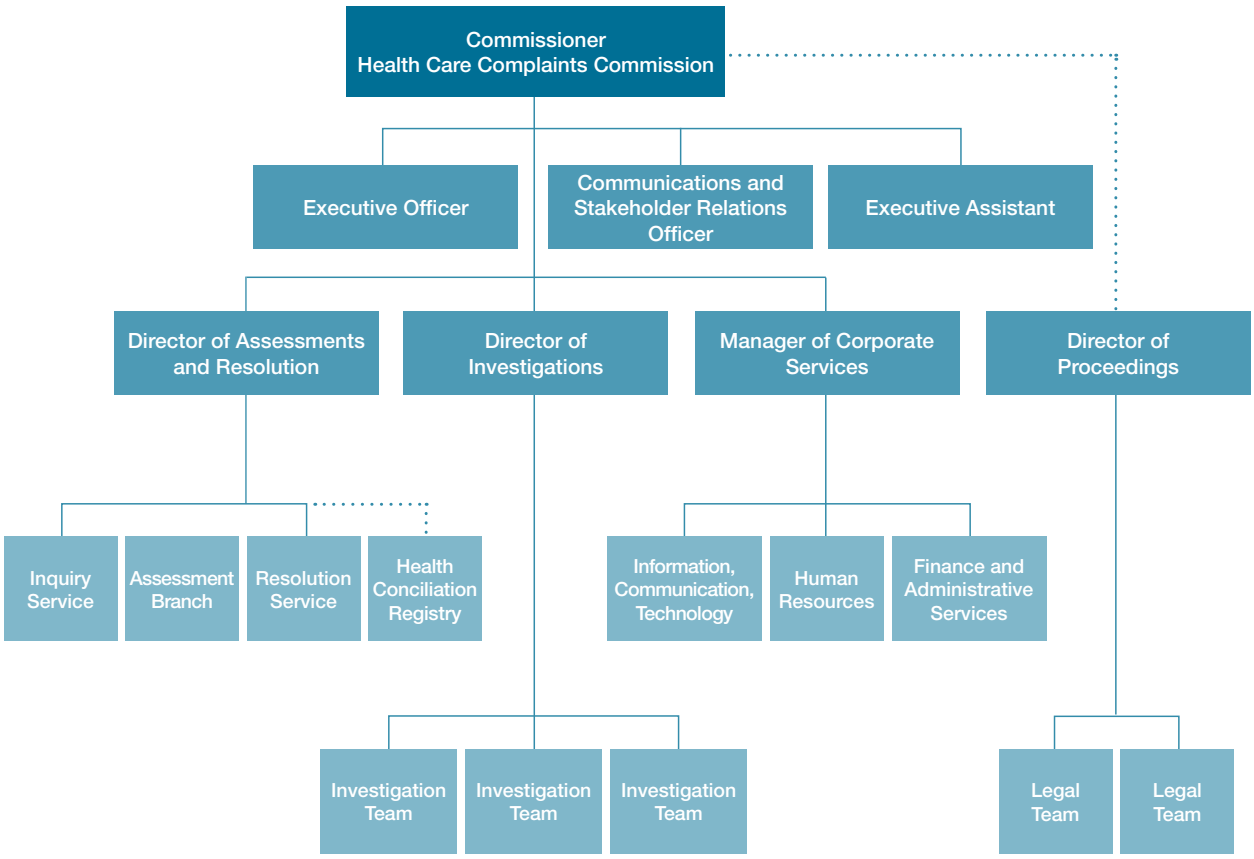


Table 18.3 Staff numbers by employment category 2004-05 to 2007-08

Employment basis	2004-05	2005-06	2006-07	2007-08
Permanent full-time	57	57	68	55
Permanent part-time	6	4	2	6
Temporary full-time	9	11	6	13
Temporary part-time	5	3	1	7
Contract – SES	4	4	4	4
Contract – non SES	–	–	–	–
Training positions	–	–	–	–
Retained staff	–	–	–	–
Casual	–	–	–	–
Total	**81**	**79**	**81**	**85**
Subtotals				
Permanent	63	61	70	61
Temporary	14	14	7	20
Contract	4	4	4	4
Full-time	70	72	78	72
Part-time	11	7	3	13

Climate survey

The Commission engaged Corporate Focus to conduct a staff climate survey during the reporting period. The primary purpose of the survey was to ensure that issues important to employees were identified and responded to effectively (within practicable boundaries).

The survey was sent to approximately 82 employees and responses were received from 77.0% of staff.

Overall, the survey findings revealed that staff are generally satisfied with their current work environment at the Commission and in particular value the work life balance the Commission offers with flexible work arrangements.

The survey also revealed that the overall culture of the Commission was fairly balanced, that is, neither constructive nor constraining. One of the key themes was that employees felt they were doing something useful by working at the Commission.

The year ahead

A survey findings workshop will be held with the staff survey reference group to present back on the key findings. The aim of the workshop is to formulate a range of suggestions for action by the Commission.

Conditions of employment and movement in salaries and allowances

Commission staff, including members of the Senior Executive Service, are officers appointed under the *Public Sector Employment and Management Act 2002*.

Commission staff who were employed under the Crown Employees (Public Sector - Salaries 2007) Award received a 4% increase to salaries and related allowances with effect from the beginning of the first full pay period on or after 1 July 2007. This salary increase flowed on to the majority of Commission staff.

The Commission continues to employ on a temporary contractual basis, a small number of medical advisers who are employed under the Crown Employees (Health Care Complaints Commission, Medical Advisers) Award 2007. Within the terms of this Award, these temporary Medical Advisers received a 4% salary adjustment with effect from 1 October 2007, in line with salary increases which had been granted in the Crown Employees (Medical Specialist, Various Agencies) Award.

The Commissioner and the divisional Directors are members of the Senior Executive Service (SES). The Statutory and Other Offices Remuneration Tribunal (SOORT) determined a performance based increase of 2.5% for the Commission's SES officers, effective 1 October 2007.

Conditions of employment are principally set by the *Public Sector Employment and Management Act 2002* and for the majority of staff, the Crown Employees (Public Service Conditions of Employment) Reviewed Award 2006. Employees' conditions and entitlements are managed in accordance with the guidelines set by the NSW Department of Premier and Cabinet's personnel handbook, the Commission's internal policies and workplace agreement.

Industrial relations

During 2007-08, the Commission, its officers, and the Public Service Association of NSW (PSA) have maintained a strong commitment to joint consultation through the convening of bimonthly Workplace Consultative Committee meetings.

The Commission has a Workplace Agreement that provides details relating to flexible working hours and work practices, dispute settlement procedures and consultation. The Workplace Consultative Committee is currently reviewing the Commission's Workplace Agreement. It is anticipated that a new Agreement will be finalised later in 2008.

There were no industrial disputes involving the Commission during the reporting period.

Equal employment opportunity (EEO) and diversity program

The Commission's EEO Management Plan, Disability Action Plan and Ethnic Affairs Priority Statement provides the foundation for meeting the NSW Government's benchmarks that represent employment indicators of people from identified EEO groups. A number of key strategies have been developed within these plans to facilitate the process. The percentage figures Tables 18.4 and 18.5 reflect the Commission's achievements in meeting the NSW Government benchmarks and the accompanying distribution index.

Tables 18.6 and 18.7 illustrate the percentage and trends of Commission staff in relation to the various EEO employment groups against the established NSW Government benchmarks.

Please note that staff recorded with a disability and staff with a disability requiring work place adjustments increased significantly for 2007-08 due to staff EEO details being recorded on the new payroll system as part of provision of shared corporate services by the Independent Commission Against Corruption.

Workplace Consultative Committee

The Commission's Workplace Consultative Committee meets bi-monthly and provides a forum for the Public Service Association of NSW (PSA) and staff to raise issues relating to conditions of employment and any proposals to change operational procedures or improve the health, safety and/or training requirements.

The Committee includes representatives of the Executive, PSA and Commission staff.

18 Appendices

Table 18.4 Trends in the representation of EEO groups 2005 to 2008

	% of total staff				
	Benchmark or target %	2005	2006	2007	2008
Women	50	70	73	70	72
Aboriginal people and Torres Strait Islanders	2	1.3	0	1.3	1.2
People whose first language was not English	20	15	16	19	16
People with a disability	12	8	6	9	18
People with a disability who require a work-related adjustment	7	not recorded	not recorded	not recorded	8.2%

Table 18.5 Trends in the distribution of EEO groups 2005 to 2008

EEO group	Distribution index				
	Benchmark or target	2005	2006	2007	2008
Women	100	99	93	91	90
Aboriginal people and Torres Strait Islanders	100	Not calculated as EEO group numbers are less than 20			
People whose first language was not English	100				
People with a disability	100				
People with a disability requiring work-related adjustment	100				

Notes:
1. Staff numbers are as at 30 June.
2. Excludes casual staff

Tables 18.6 and 18.7 show the gender and EEO target groups of staff by salary level and employment basis, that is, permanent, temporary, full-time or part-time.

Table 18.6 Staff numbers by EEO group and salary levels in 2007-08

Level	Total Staff	Respondents	Men	Women	Aboriginal people and Torres Strait Islanders	People from racial, ethnic, ethno-religious minority groups	People whose language first spoken as a child was not English	People with a disability	People with a disability requiring work-related adjustment
< $35,266	–	–	–	–	–	–	–	–	–
$35,266 - $46,319	1	1	1	–	–	–	–	1	1
$46,320 - $51,783	10	10	1	9	–	7	4	2	1
$51,320 - $65,526	14	14	3	11	–	1	2	1	–
$65,527 - $84,737	34	34	7	27	1	6	4	6	4
$84,738 - $105,923	18	18	8	10	–	3	2	3	1
> $105,923 (non SES)	4	4	1	3	–	1	1	2	–
> $105,923 (SES)	4	4	3	1	–	–	1	–	–
Total	85	85	24	61	1	18	14	15	7

Table 18.7 Staff numbers by EEO group and basis of employment 2007-08

Employment Basis	Total Staff	Respondents	Men	Women	Aboriginal people and Torres Strait Islanders	People from racial, ethnic, ethno-religious minority groups	People whose language first spoken as a child was not English	People with a disability	People with a disability requiring work-related adjustment
Permanent full-time	55	55	18	37	1	12	7	12	7
Permanent part-time	6	6	–	6	–	1	–	–	–
Temporary full-time	13	13	1	12	–	3	4	1	–
Temporary part-time	7	7	2	5	–	2	2	2	–
Contract – SES	4	4	3	1	–	–	1	–	–
Contract – non SES	–	–	–	–	–	–	–	–	–
Training positions	–	–	–	–	–	–	–	–	–
Retained staff	–	–	–	–	–	–	–	–	–
Casual	–	–	–	–	–	–	–	–	–
Total	**85**	**85**	**24**	**61**	**1**	**18**	**14**	**15**	**7**
Subtotals									
Permanent	61	61	18	43	1	13	7	12	7
Temporary	20	20	3	17	–	5	6	3	–
Contract	4	4	3	1	–	–	1	–	–
Full-time	68	68	19	49	1	15	11	13	7
Part-time	13	13	2	11	–	3	2	2	–

Personnel policies and practices

Commission staff's conditions of employment are governed by the Crown Employees (Public Service Conditions of Employment) Reviewed Award 2006, and are supported by guidelines set out in the Department of Premier and Cabinet's personnel handbook and memorandums and circulars. The Commission also has a number of policies and procedures in place to assist staff to understand and administer their conditions of employment as well as equal employment opportunity, occupational health, safety and security issues and operational requirements.

During the reporting period the following new policies and procedures were developed and a number of existing policies were updated to incorporate changes made to the legislation and industrial instruments underpinning the policies:

- Use of Car Park Policy
- Telephone Policy
- Administration and Services Manual
- Sick Leave Policy
- Workplace Injury Management and Workers Compensation Policy and Procedures.

A review of the Commission's Occupational Health and Safety Policy and its Recruitment and Selection Policy also occurred during the reporting period as well as a review of the Commissions Workplace Agreement.

Staff education and development

The Commission is committed to providing staff with the opportunity to participate in a range of learning and development activities and programs. These activities include attending forums, seminars, conferences, performing higher duties and undertaking external and internal training courses.

The Commission also encourages staff to undertake further study to enhance their skills and provides assistance in the form of study and examination leave. During 2007-08, 11 staff members applied for and were granted study leave to undertake tertiary studies.

During 2007-08 staff from across the Commission attended training and education activities in the core learning and development streams as identified in Table 18.8.

A total of 1628.35 hours were spent by Commission staff in attendance at the training activities, which is an average of three days of training per full time equivalent staff member for the reporting period.

During 2007-08 a management development program was designed for the Commission's 12 senior managers in order to provide them with an overall understanding of managing within the public sector environment as well as to provide skills and knowledge in working with staff and leading teams. Part of the program includes undertaking the

18 Appendices

Department of Premier and Cabinet's Public Sector Management Program's unit on 'Managing Down – Operational Management in the Public Sector'. This subject forms part of the Public Sector Management course, which is a course that provides a beneficial pathway to a Graduate Certificate qualification for public sector employees. An important aspect of the course is work based projects.

A training needs analysis was also undertaken by the 12 managers to assist in developing a schedule of other training activities specifically designed to assist them in performing their management roles and enhancing their leadership skills.

During 2008, the Commission converted to an Electronic Records Management System (TRIM) and rolled out employee self service (ESS) for use by all staff employed at the Commission. The implementation of both systems involved attendance by staff at in-house training sessions. Staff will continue to receive ongoing training in TRIM until the full implementation of the system is completed at the end of 2008.

Also during 2007-08, the Commission:

- developed training competencies for all of its operational positions
- developed and implemented an on-line corporate induction program
- developed and implemented an on-line OHS training module.

The year ahead

As a result of upgrading the Commission's computer equipment and windows software in 2008-09 to MS Office 2007, the Commission will be concentrating on providing staff with training in the suite of MS Office 2007 courses.

The schedule of training for senior managers resulting from the training needs analysis will be finalised and implemented.

Performance management

The performance management system was implemented across the Commission during 2006-07 and staff prepared a new agreement and Learning and Development Plan for the performance period 2007-08.

The performance agreements link divisional business plan objectives to the responsibilities and performance targets of individual staff member. As a result, staff are accountable for delivering results of corporate objectives and goals.

More than 94% of staff performance reviews were rated fully competent or better.

The performance agreement also includes a Learning and Development Plan. The plan addresses training and personal development needs that complement the competency of individual staff to assist them performing in their positions.

Access and equity

In September 2007 the Commission developed a new, 12-month Equal Employment Opportunity (EEO) Management Plan (2007-08) to provide a comprehensive framework to support its commitment to achieving Part 9A of the *Anti-Discrimination Act* and the three key outcomes of:

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

Through its EEO management plan, the Commission has developed strategies to assist it meeting these key outcomes as well as to achieve the NSW Government targets for the representation of EEO groups within its workforce. The Commission was commended by the Director of Equal Opportunity in Public Employment for its achievements in:

- increasing the representation of women from 67% to 73% since 2003
- increasing the representation of people whose first language was not English, over the same period.

Grievance support contact officers

The Commission has two grievance support officers and ensures that these officers receive appropriate training to fulfil their role.

Table 18.8 Training activities 2007-08

Core learning and development stream	Number of participants						
	No. of hours	Assessments	Investigations	Legal	Corporate Services	Executive	Total
Information technology	520	64	43	29	25	9	170
Organisational development	179	8	6	4	5	3	26
Risk management	22	6	1	1	3	–	11
Project management	24	1	–	–	–	–	1
Technical skills	659.4	14	13	10	–	4	41
Leadership and management	224	7	4	3	4	0	18
Total	1628.4	100	67	47	37	16	267

Flexible work arrangements

The Commission has policies and procedures to promote flexible work practices to allow balancing work and family responsibilities.

EEO and diversity related training

EEO and diversity training is considered a mandatory requirement for all new employees to the Commission. The aim of the training is to enable staff to understand the Commission's policies and expectations in relation to EEO and anti-discrimination, bullying and harassment prevention and the Commission's Code of Conduct. During October 2007, 12 staff who had recently joined the Commission attended a training session in Discrimination, Harassment and Bullying Prevention.

Employee assistance program

The Commission renegotiated a further one-year agreement with an external agency, International Psychological Services Pty Ltd, to provide professional and confidential counselling services for staff and their families.

No employee of the Commission sought assistance during the reporting period.

Accommodating the requirements of staff with (temporary or permanent) disabilities

The Commission employs an accredited rehabilitation provider to ergonomically assess and make recommendations for specific equipment and workstation adjustments to assist staff with disabilities.

The year ahead

Projects for 2008-09 will include the development of a three year EEO management plan 2008-11 and training of staff in the Commission's new Code of Conduct and Code of Practice.

NSW Government Action Plan for Women

The NSW Government Action Plan for Women is a whole-of-government approach to improving the economic and social participation of women in NSW. The Commission supports the plan by having policies and practices in place that provide a flexible, equitable and safe environment to encourage a high representation of women within its workplace.

Of the Commission's staff, 72% are women. Eighty-five percent of female staff earn in excess of $51,784 per year and 23% earn in excess of $84,738 per annum.

The Commission also provides learning and development opportunities specifically for female employees. During 2007-08, four female employees attended the UNIFEM breakfast seminar organised as part of international women's day and three female employees attended the Australian Women and Leadership Conference.

The Commission also fully supported its female staff members undertaking tertiary study by granting nine female employees study leave during the reporting period.

Aboriginal affairs – two ways together results

The Commissioner is responsible for delivering Aboriginal affairs results as part of its overall performance. The Commission has a Corporate Plan and a Results and Services Plan in place that addresses its key areas relating to service planning and delivery, staffing requirements, risk and development. Due to its size, it does not have a separate service plan that solely addresses Aboriginal participation in decision making and the other identified key areas.

In early 2007, the Commission established and filled an identified Aboriginal and Torres Strait Islander (ATSI) complaints Resolution Officer's position.

The joint curriculum venture with Charles Sturt University for Aboriginal health care workers was to be established during 2007-08. The concept was for the Resolution Service in Western NSW to target tertiary students studying in health related fields. Information sessions about the Commission and principles of good complaint management being were to be offered to students at Charles Sturt University campuses at Orange and Bathurst. The Dubbo campus offers one of the few training courses for Aboriginal health workers in the state and had expressed an interest in working with the Commission in educating their students. Unfortunately, due to nil enrolments in the subject during the reporting period, it was not possible to progress the initiative. Contact is being maintained with the University to proceed this initiative once enrolments have been received.

The year ahead

The Commission will explore new methods to deliver services to Indigenous people.

Disability Action Plan

The Commission developed a three year Disability Action Plan in 2006 in line with the NSW Government's Disability Policy Framework and section 9 of the NSW *Disability Services Act 1993*.

The plan is part of the commitment to provide an accessible workplace and services to people including staff with disabilities and, where possible, to eliminate discriminatory practices.

The following was accomplished during 2007-08:

- a section on disability and equitable access was included in the new corporate on-line induction program
- a quote was obtained covering the redesign of the reception area.

During 2007-08, building management of the Commission premises:

- upgraded the signage in the main foyer area
- erected additional directional signage to enhance orientation
- erected a railing along the building's frontage to restrict pedestrian access over the step area
- Commission directory entry to a new font and typeset
- conducted CSIRO slip tests on the public access ground floor areas, which re-assured that the floor is compliant.

Other key strategies identified in the Disability Action Plan included:

- undertaking workplace and other reasonable adjustments to support staff with disabilities to continue their work in the Commission

- engaging an external provider to prepare and co-ordinate return-to-work plans for staff with temporary disabilities and/or work related injuries
- purchasing ergonomic equipment recommended by an external adviser to assist staff in workplace adjustment.

For the second year, the Commission also supported the Department of Ageing, Disability and Home Care 2008 'Don't Dis My Ability' campaign to celebrate the international day of people with a disability by providing a sponsorship of $5,500.

The year ahead

The access audit items that were identified as a lower level of priority will be examined and appropriate action taken during the next reporting period.

A new three year Disability Action Plan incorporating the new guidelines set by the NSW Government will be developed and implemented.

Ethnic Affairs Priority Statement

The Commission recognises its legislative obligations and upholds principles of multiculturalism. It is committed to the ongoing support of these principles to both staff and clients who are from culturally and linguistically diverse (CALD) backgrounds.

During the reporting period, the Commission developed a new one-year Ethnic Affairs Priorities Statement (EAPS) and Management Plan in accordance with the NSW Government's principles of multiculturalism, as defined in the *Community Relations Commission and Principles of Multiculturalism Act*. The Commission as a key agency for EAPS reporting also completed its self assessment report against the EAPS Standards Framework for the period 2006-07.

During the year, the Commission improved service delivery to people from culturally and linguistically diverse backgrounds by:

- translating the Commission's publications, accessible on the website, into the ten most common community languages
- translating information on how to access the Commission's services into 20 languages
- including information on how to get assistance in other languages onto the Commission's letterhead
- displaying signs in 20 languages in the Reception area of the Commission to assist people from non-English speaking backgrounds
- redesigning the Commission's bi-lingual skills directory to enhance accessibility and usage.
- Inviting staff who speak a language other than English to be placed on the directory to assist Commission staff in dealing with CALD clients in a situation that required unplanned interpretation of information
- promoting the community language allowance scheme (CLAS) to staff – one staff member is sponsored to undertake the CLAS examinations facilitated by the Community Relations Commission in August 2008
- providing an external telephone interpreter service
- engaging accredited interpreters when required for assisting in the conduct of Commission business
- developing a manual and Information Kit on the use of interpreters for staff to ensure that they are aware of services which are available to assist them when dealing with members of diverse communities
- advising staff on the religious holidays on the Commission Intranet.

The year ahead

The Commission's complaint form is currently being translated into 20 community languages and will be accessible on the website in October 2008.

A three year EAPS management plan will be developed and implemented.

Occupational health and safety

Providing a safe and secure working environment to staff and clients is a major objective of the Commission. The Commission has an Occupational Health, Safety and Risk Management Plan to assist it in achieving this objective. The Plan incorporates the five performance targets of the NSW Government's Working Together: Public Sector OHS and Injury Management Strategy 2005-2008.

OHS and Risk Management Plan strategies achieved during 2007-08 included:

- conducting the Occupational Health and Safety Audit by Deloitte as required by the Commission's Working Together Strategy
- having an ongoing strategy/program in place to systematically review all staff workstations with an ergonomic assessment – during 2007-08, an accredited occupational therapist conducted assessments for fourteen staff
- having a policy to conduct an ergonomic assessment of an employee's workstation within three days of the employee starting with the Commission – six individual workplace assessments were undertaken by an accredited rehabilitation provider in response to notification of potentially work related incidents
- continuing to ensure the staff safety by training staff in emergency fire evacuation exercises and first aid
- training First Aid Officers and Fire Wardens
- training the Commission's OHS Committee in safety audits and conducting quarterly workplace

Table 18.9 Occupational health and safety incidents, injuries and claims 2007-08

	2006-07	2007-08
Number of new claims	5	2
Number of Workers Compensation claims accepted	4	2
Fall, trip, slip outside workplace	1	5
Work practice / set up related	10	2
Total injuries	11	7

inspections to identify and assess potential and/or actual hazards associated with the workplace

- introducing an OHS online awareness training module for staff joining the Commission
- reimbursing officers who choose to have an influenza vaccination for the cost of receiving the vaccination.
- establishing an OHS information site on the Commission's Intranet.

OHS Committee

The OHS Committee comprises staff members representing various work groups of the Commission, including the Executive. The Committee meets quarterly to review OHS policies and practices, and facilitate the resolution of safety issues and assist in mitigating reported hazards.

Code of Conduct

The Commission, in consultation with its staff, developed a new Code of Conduct during the reporting period. The new Code was endorsed by the Commissioner in June 2008 and is accessible on the Commission's Intranet.

One of the major changes from the previous Code of Conduct was the inclusion of the Commission's core values and services as well as more detailed information on conflicts of interest.

Consultants

During the reporting period there were 320 engagements of medical practitioners to provide clinical advice on health care complaints at a total cost of $129,849.

Records Management

During the year, the Commission progressed work scheduled in the Records Management Program 2006-08 in accordance with obligations under S.12 (2) of the *State Records Act 1998*.

The main activities concentrated on the EDRMS Project (Electronic Documents and Record Management System) using both internal and contract services to configure and implement TRIM Context 6.2, which was purchased late in the previous year.

A significant success for the project included the integration of TRIM with the Commission's case management system Casemate. This enables all case related documents to be created and captured into TRIM via processes actioned in Casemate and correspondingly linked back to and searched via Casemate.

The TRIM/Casemate solution was rolled out to all Commission users on 14 May 2008.

Work continuing into the next year includes:

- updating the Functional Retention and Disposal Authority for Commission functional records with approval by the State Records Authority of NSW
- appraisal, sentencing and retention/disposal activities for the Commissions closed and archived files
- increasing the use of TRIM functionality, new technology and digital records, for example, scanning to minimise paper records.

Ongoing training in good record keeping practices and change management programs will be provided to all staff to maximise the benefits of the new records system and the management of electronic records.

Energy Management

The Commission continues its commitment to the NSW Government Energy Management Policy in support of the National Greenhouse Strategy.

The Commission's premises at Central Square has a four star accredited Australian Building Greenhouse rating from the Department of Energy, Utilities and Sustainability.

The Greenpower component of electricity power purchased by the Commission increased from 6% to 25% in 2007-08.

Information and Communications Technology

The Information and Communications Technology Strategic Plan 2005-08 aligns the Commission's information and communications technology requirements with its overall strategic direction.

The major information and communications technology initiatives for the year included:

Enhancement of Casemate

Enhancements to the Commission's complaint handling and case management system Casemate during 2007-08 included:

- extending the system's use to the Legal Division and re-engineering legal processes in accordance with business requirements
- integrating with TRIM document management system for document creation and search from Casemate
- redesigning the review of decision (section 28) and revised assessment (section 20A) process
- implementing client satisfaction survey functionality.

As part of continuous improvement, further enhancements to Casemate in the next financial year will include:

- implementation of the new investigation processes
- redesigning the resolution processes
- developing the Internet website including online complaints lodgement
- implementing a new complaint issues list to adapt national standards.

Document scanning

The first stage of document scanning was implemented in 2006-07. The Assessments Division scans and links documents to Casemate to allow easy and quick access to these.

With the implementation of TRIM Electronic Document and Records Management System at the end of 2007-08, stage 2 of the document scanning project will be undertaken in early 2008-09 and involves the scanning and linking documents to TRIM for all incoming mail, facsimiles, and other documents.

18 Appendices

Accreditation to ISO27001 Standards for Information Security

The Commission achieved accreditation to ISO27001 Standards for Information Security. As required under the standards, an Information Security Management Systems (ISMS) was developed and implemented. A number of policies and procedures including a Business Continuity Plan (BCP) and a Disaster Recover Plan (DRP) were also developed and implemented. Ongoing compliance with the standards is ensured through monthly internal audits and six monthly external audits.

Electronic service delivery

The Commission has been continuously enhancing the look, feel and navigation of both the Internet and the Intranet websites. Contents on both websites are regularly reviewed and updated to provide the most current information.

AURION HR/Payroll employee self service (ESS) was made available to all Commission staff in January 2008 as part of the shared corporate service arrangement for payroll services provided by the Independent Commission Against Corruption.

The implementation of the new Helpdesk system has allowed staff to more efficiently lodge and monitor helpdesk requests via the Intranet. The system has been enhanced to provide management reporting as required.

Casemate reports have been made available on the Intranet to provide easier, more secure and flexible access.

The Commission has also enhanced the security of its Internet-based remote access facility by implementing a secure token authentication system and implementing additional firewalls. Staff can access the Commission's systems and network using wired or unwired (mobile) Internet from any external location.

Risk Management and Insurance Activities

Reviewing key business risks ensures the Commission effectively manages the risks associated with its operational and administrative activities and makes best use of opportunities. An annual business risk assessment is undertaken as part of the Commission's corporate planning process and identifies the key risk areas of the Commission. Strategies and treatments for these risks are included in divisional business plans.

The Commission has developed business continuity plans for its operational areas and Information and Communication Technology functions and a Crisis Management Plan that coordinates the Commission's response to a major disruption and the required recovery action. A review of business continuity planning by the Commission's internal auditors was conducted towards the end of 2007-08.

Fraud and corruption prevention strategy and guidelines for staff were prepared at the end of June 2008 for implementation in early 2008-09.

The NSW Treasury Managed Fund (TMF) provides insurance cover for worker's compensation, motor vehicles, public liability, property and miscellaneous items. Worker's compensation insurance is provided by Allianz Australia Insurance Ltd with GIO General Ltd providing insurance cover for the remaining categories.

The Commission's claims management for fund year 2007-08 is reflected in the deposit premiums for 2008-09. The Commission achieved reductions in premiums for workers compensation ($2,450), public liability ($360), motor vehicle ($180) and property insurance ($2,850). Motor vehicle insurance, which increased by $720, is in line with the increase in the number of Commission motor vehicles.

Audit Committee and Internal Audit

The audit committee oversees business risks and governance issues including:

- financial reporting practices
- management and internal controls
- internal audit.

Internal audits and assessments help to maximise the Commission's effectiveness and efficiency in specific activities and processes. The Commission has appointed independent auditors to do internal audits and assessments on an ongoing basis.

A number of audit projects completed during 2007-08 focussed on the effectiveness and efficiency of the following Commission processes:

Recovery of legal costs

Recommendations included implementing measures to monitor and track the timeliness of recovery action. This would include modifications to Casemate recording and reporting capabilities and the development of documentation such as templates to improve accuracy and timeliness. Also recommended was the development of a procedure in the Sun financial system to recognise debts when legal costs are settled.

Logical Information Technology access controls in Casemate

Recommendations included improving the process of currency of administrator access rights. It was also suggested to implement associated security policies and to notify staff of changes to Information Technology policies.

Business Continuity Management

Recommendations included to improve the planning documents and provide greater staff awareness of the processes involved in managing and responding to a major disruption.

Occupational Health and Safety assessment

Recommendations included improving the processes for ensuring contractor compliance with OHS legislation as well as the Commission's management of contractors. This includes developing a standard Safe Work Method Statement (SWMS) template and a standard agreement on OHS as part of building and maintenance contracts. In addition, it was suggested to develop a document control procedure as part of the Commission's records management practices.

Appendix C – Complaints statistics

Table 18.10 Summary of complaints received by issue category 2005-06 to 2007-08

Issue category	2005-06		2006-07		2007-08	
	No.	%	No.	%	No.	%
Treatment	1,924	56.7%	1,813	55.7%	2,245	50.9%
Communication	265	7.8%	366	11.2%	642	14.6%
Professional conduct	595	17.5%	590	18.1%	597	13.5%
Access	224	6.6%	210	6.4%	401	9.1%
Cost	178	5.3%	106	3.3%	153	3.5%
Privacy/discrimination	115	3.4%	68	2.1%	132	3.0%
Consent	56	1.7%	52	1.6%	94	2.1%
Grievances	11	0.3%	17	0.5%	79	1.8%
Corporate services	24	0.7%	36	1.1%	66	1.5%
Total	3,392	100.0%	3,258	100.0%	4,409	100.0%

Counted by issues raised in complaint

Table 18.11 Breakdown of category of complaints received 2007-08

Issue category	Issue name	Total	%
Treatment	Inadequate treatment	1,308	29.7%
	Medication	397	9.0%
	Diagnosis	350	7.9%
	Coordination of treatment	41	0.9%
	Rough/painful treatment	40	0.9%
	Infection control	38	0.9%
	Wrong/inappropriate treatment	34	0.8%
	Negligent treatment	31	0.7%
	Withdrawal/denial of treatment	6	0.1%
Treatment total		2,245	50.9%
Communication	Attitude	475	10.8%
	Inadequate information	134	3.0%
	Wrong/misleading information	33	0.7%
Communication total		642	14.6%
Professional conduct	Competence	171	3.9%
	Illegal practices	159	3.6%
	Certificates/reports	120	2.7%
	Sexual misconduct	73	1.7%
	Impairment	22	0.5%
	Accuracy/inadequacy of records	18	0.4%
	Assault	17	0.4%
	Financial fraud	11	0.2%
	Breach of conditions	6	0.1%
Professional conduct total		597	13.5%

table continued on next page

Table 18.11 Breakdown of category of complaints received 2007-08 (continued)

Issue category	Issue name	Total	%
Access	Delay in admission or treatment	151	3.4%
	Service availability	71	1.6%
	Refusal to admit or treat	71	1.6%
	Discharge or transfer arrangements	62	1.4%
	Waiting lists	15	0.3%
	Referral	14	0.3%
	Attendance	9	0.2%
	Transport	8	0.2%
Access total		401	9.1%
Cost	Billing practices	124	2.8%
	Information on costs	19	0.4%
	Overcharging	7	0.2%
	Public/private election	1	0.0%
	Government subsidies	1	0.0%
	Private health insurance	1	0.0%
Cost total		153	3.5%
Privacy/discrimination	Privacy/confidentiality	68	1.5%
	Access to records	41	0.9%
	Inconsiderate service	13	0.3%
	Discrimination	10	0.2%
Privacy/discrimination total		132	3.0%
Consent	Consent not informed/failure to warn	32	0.7%
	Consent not obtained	30	0.7%
	Involuntary admission	13	0.3%
	Consent invalid	12	0.3%
	Failure to consult consumer	7	0.2%
Consent total		94	2.1%
Grievances	Inadequate/no response to complaint	71	1.6%
	Reprisal/retaliation	8	0.2%
Grievances total		79	1.8%
Corporate services	Hotel services	23	0.5%
	Hygiene/environmental standards	22	0.5%
	Administrative services	21	0.5%
Corporate services total		66	1.5%
Grand total		4,409	100.0%

Counted by issues raised in complaint

Table 18.12 Complaints received about registered and unregistered health care practitioners 2005-06 to 2007-08

	2005-06		2006-07		2007-08	
Health practitioner	**No.**	**%**	**No.**	**%**	**No.**	**%**
Registered health practitioner						
Medical practitioner	1,227	68.6%	1,104	66.6%	1,145	64.7%
Nurse	154	8.6%	177	10.7%	224	12.6%
Dentist	165	9.2%	173	10.4%	177	10.0%
Psychologist	70	3.9%	81	4.9%	77	4.3%
Dental technician and prosthetist	24	1.3%	8	0.5%	21	1.2%
Chiropractor	17	1.0%	18	1.1%	15	0.8%
Physiotherapist	19	1.1%	15	0.9%	15	0.8%
Pharmacist	17	1.0%	21	1.3%	9	0.5%
Podiatrist	10	0.6%	13	0.8%	8	0.5%
Optometrist	6	0.3%	10	0.6%	5	0.3%
Osteopath	1	0.0%	4	0.2%	2	0.1%
Optometrical dispenser	–	0.0%	1	0.0%	–	0.0%
Total registered health practitioner	1,710	95.6%	1,625	98.0%	1,698	95.9%
Unregistered health practitioner						
Previously registered health practitioner	1	0.1%	3	0.2%	44	2.5%
Alternative health provider	17	0.9%	5	0.3%	10	0.6%
Psychotherapist	2	0.1%	1	0.1%	3	0.2%
Radiographer	–	0.0%	1	0.1%	3	0.2%
Acupuncturist	1	0.1%	–	0.0%	2	0.1%
Naturopath	2	0.1%	1	0.1%	2	0.1%
Residential care worker	–	0.0%	–	0.0%	2	0.1%
Counsellor/therapist	7	0.4%	2	0.1%	1	0.1%
Dietitian/nutritionist	–	0.0%	1	0.1%	1	0.1%
Health education officer	–	0.0%	–	0.0%	1	0.1%
Home/respite care worker	–	0.0%	–	0.0%	1	0.1%
Other	30	1.7%	7	0.4%	1	0.1%
Social worker	1	0.1%	–	0.0%	1	0.1%
Welfare officer	–	0.0%	–	0.0%	1	0.1%
Administration/clerical staff	2	0.1%	2	0.1%	–	0.0%
Ambulance personnel	–	0.0%	2	0.1%	–	0.0%
Assistant in nursing	2	0.1%	2	0.1%	–	0.0%
Natural therapist	4	0.2%	2	0.1%	–	0.0%
Occupational therapist	1	0.1%	1	0.1%	–	0.0%
Traditional Chinese medicine practitioner	8	0.4%	2	0.1%	–	0.0%
Total unregistered health practitioner	78	4.4%	32	2.0%	73	4.1%
Grand total	1,788	100.0%	1,657	100.0%	1,771	100.0%

Counted by provider identified in complaint

18 Appendices

Table 18.13 Complaints received about registered health practitioners by issue category 2007-08

Issue Category	Medical practitioner	Nurse	Dentist	Psychologist	Dental technician and prosthetist	Chiropractor	Physiotherapist	Podiatrist	Pharmacist	Optometrist	Osteopath	Total	%
Treatment	829	97	147	15	18	7	2	3	7	4	–	1,129	48.2%
Professional conduct	282	126	29	50	2	9	10	6	2	3	3	522	22.3%
Communication	281	29	22	4	1	1	3	–	1	1	–	343	14.6%
Cost	62	1	24	6	3	1	1	1	–	–	–	99	4.2%
Access	82	5	3	2	–	–	–	1	–	–	–	93	4.0%
Privacy/ discrimination	52	11	3	6	–	–	3	–	–	–	–	75	3.2%
Consent	40	3	7	4	–	1	–	–	–	–	–	55	2.3%
Grievances	16	1	2	–	1	–	–	–	–	–	–	20	0.9%
Corporate services	5	1	2	–	–	–	–	–	–	–	–	8	0.3%
Total	1,649	274	239	87	25	19	19	11	10	8	3	2,344	100.0%
No. of practitioners registered in NSW as at 30.6.2008	30,036	119,200	5,119	9,963	1,269	1,414	6,799	926	8,106	1,715	562	185,109	

Counted by issues raised in complaint

Table 18.14 Complaints received about unregistered health practitioners by issue category 2007-08

Issue Category	Previously registered health practitioner	Alternative health provider	Psychotherapist	Home/respite care worker	Radiography	Acupuncturist	Naturopath	Other	Residential care worker	Counsellor/therapist	Dietitian/nutritionist	Health education officer	Social worker	Welfare officer	Total	%
Treatment	36	6	1	1	–	–	–	2	2	–	1	–	–	–	49	50.0%
Professional conduct	12	5	1	–	2	2	2	–	–	–	–	–	–	1	25	25.5%
Communication	12	1	1	1	1	–	–	–	–	–	–	1	1	–	18	18.4%
Consent	2	–	–	–	–	–	–	–	–	–	–	–	–	–	2	2.0%
Privacy/ discrimination	1	–	1	–	–	–	–	–	–	–	–	–	–	–	2	2.0%
Access	–	–	–	1	–	–	–	–	–	–	–	–	–	–	1	1.0%
Cost	–	–	–		–	–	–	–	–	1	–	–	–	–	1	1.0%
Total	63	12	4	3	3	2	2	2	2	1	1	1	1	1	98	100.0%

Counted by issues raised in complaint

Table 18.15 Complaints received about health organisations 2005-06 to 2007-08

Organisation	2005-06		2006-07		2007-08	
	No.	%	No.	%	No.	%
Public hospital	538	43.6%	508	47.7%	763	56.2%
Justice Health	131	10.6%	93	8.7%	106	7.8%
Medical centre	59	4.8%	41	3.8%	61	14.5%
Pharmacy	63	5.1%	51	4.8%	59	4.3%
Private hospital	71	5.7%	70	6.6%	55	4.1%
Community health service	40	3.2%	49	4.6%	43	3.2%
Nursing home	67	5.4%	48	4.5%	40	2.9%
Area Health Service	61	4.9%	29	2.7%	27	2.0%
Psychiatric hospital	8	0.6%	5	0.4%	26	1.9%
Ambulance service	22	1.8%	21	2.0%	24	1.8%
Medical practice	19	1.5%	20	1.9%	24	1.8%
Pathology centre/lab	18	1.5%	12	1.1%	17	1.3%
Dental unit – public	30	2.4%	15	1.4%	14	1.0%
Radiology practice	24	1.9%	18	1.7%	10	0.7%
Rehabilitation management	n/a		n/a		10	0.7%
Hostel – aged	3	0.2%	5	0.4%	8	0.6%
Dental surgery – private	12	1.0%	13	1.2%	7	0.5%
Optometrist practice	8	0.6%	4	0.4%	7	0.5%
Alternative health service	1	0.1%	8	0.8%	5	0.4%
Health fund	1	0.1%	4	0.4%	5	0.4%
Women's health centre	2	0.2%	3	0.3%	5	0.4%
Day procedure centre	2	0.2%	5	0.4%	4	0.3%
Government department	–	0.0%	–	0.0%	4	0.3%
Group home – mental health	4	0.3%	1	0.1%	4	0.3%
Men's health clinic	–	0.0%	1	0.1%	4	0.3%
Multi purpose service	–	0.0%	–	0.0%	4	0.3%
Nursing agency	–	0.0%	1	0.1%	4	0.3%
Chiropractic practice	1	0.1%	2	0.2%	2	0.1%
Domestic residence	–	0.0%	–	0.0%	2	0.1%
Drug and alcohol service	1	0.1%	4	0.4%	2	0.1%
Hostel – other	–	0.0%	–	0.0%	2	0.1%
Methadone clinic	2	0.2%	2	0.2%	2	0.1%
Physiotherapy clinic	5	0.4%	3	0.3%	2	0.1%
Blood bank	–	0.0%	1	0.1%	1	0.1%
College/Association	3	0.2%	4	0.4%	1	0.1%
Dental laboratory	–	0.0%	2	0.2%	1	0.1%
Group home – development disability	1	0.1%	3	0.3%	1	0.1%
Optical laboratory	–	0.0%	–	0.0%	1	0.1%
Disciplinary body	–	0.0%	2	0.2%	–	0.0%
Family planning clinic	–	0.0%	2	0.2%	–	0.0%
Other	34	2.8%	11	1.0%	–	0.0%
Public development disability hospital	2	0.2%	4	0.4%	–	0.0%
Tribunal	2	0.2%	–	0.0%	–	0.0%
Total	1,235	100.0%	1,065	100.0%	1,357	100.0%

Counted by provider identified in complaint

18 Appendices

Table 18.16 Complaints received about public and private hospitals by most common service areas 2007-08

Service area	Public		Private		Total	
	No.	%	No.	%	No.	%
General medicine	196	25.7%	13	23.6%	209	25.6%
Emergency medicine	180	23.6%	4	7.3%	184	22.5%
Surgery	69	9.0%	15	27.3%	84	10.3%
Gerontology	68	8.9%	2	3.6%	70	8.6%
Psychiatry	50	6.6%	4	7.3%	54	6.6%
Obstetrics	28	3.7%	5	9.1%	33	4.0%
Mental health	24	3.1%	1	1.8%	25	3.1%
Cardiology	18	2.4%	1	1.8%	19	2.3%
Paediatric medicine	16	2.1%	–	0.0%	16	2.0%
Gynaecology	14	1.8%	–	0.0%	14	1.7%
Other service areas	100	13.1%	10	18.2%	110	13.4%
Total	763	100.0%	55	100.0%	818	100.0%

Counted by provider identified in complaint

Table 18.17 Complaints received about public hospitals by Area Health Service 2005-06 to 2007-08

Area Health Service	2005-06		2006-07		2007-08		2007-08		
	No.	%	No.	%	No.	%	Separations	Non-admitted patient services	Emergency department attendances
South Eastern Sydney/Illawarra	98	18.2%	106	20.9%	137	18.0%	287,672	5,151,581	378,450
Northern Sydney/ Central Coast	72	13.4%	73	14.4%	121	15.9%	177,611	2,858,729	243,315
Sydney South West	104	19.4%	92	18.1%	106	13.9%	297,202	3,931,366	342,787
Sydney West	96	17.8%	90	17.7%	104	13.6%	226,749	4,323,500	293,311
Hunter/New England	60	11.2%	59	11.6%	102	13.4%	186,611	2,635,932	361,718
North Coast	49	9.1%	36	7.1%	81	10.6%	151,348	2,044,246	308,960
Greater Western	37	6.9%	24	4.7%	63	8.3%	88,071	1,436,297	230,710
Greater Southern	21	3.9%	28	5.5%	47	6.2%	109,033	1,428,520	258,567
Interstate/Unknown	1	0.2%	–	–	2	0.3%	–	–	–
Total	538	100.0%	508	100.0%	763	100.0%	1,524,297	23,810,171	2,417,818

Excludes public developmental disability hospitals and psychiatric hospitals
Sydney West includes Westmead Children's Hospital
Counted by provider identified in complaint

Table 18.18 Issues raised in all complaints received by service area 2007-08

Service area	Treatment	Communication	Professional conduct	Access	Cost	Privacy/ discrimination	Consent	Grievances	Corporate services	Total	%
General medicine	649	231	235	118	41	57	20	22	24	1,397	31.7%
Emergency medicine	224	63	12	62	1	1	2	7	5	377	8.6%
Surgery	186	55	27	34	14	6	15	6	2	345	7.8%
Dentistry	165	25	30	14	29	4	7	3	5	282	6.4%
Gerontology	143	42	23	20	3	4	3	9	7	254	5.8%
Psychiatry	133	33	44	12	–	7	9	3	1	242	5.5%
Mental health	87	15	16	13	–	10	11	3	1	156	3.5%
Obstetrics	82	27	19	8	2	2	1	1	1	143	3.2%
Justice Health	72	4	12	41	–	6	1	1	1	138	3.1%
Gynaecology	59	12	12	4	1	3	2	3	1	97	2.2%
Pharmacy	69	8	6	2	3	3	–	–	–	91	2.1%
Psychology	16	5	48	2	7	7	5	–	–	90	2.0%
Cardiology	32	11	6	8	7	3	1	1	3	72	1.6%
Paediatric medicine	37	7	3	5	–	–	–	1	2	55	1.2%
Midwifery	27	6	9	3	–	–	3	2	–	50	1.1%
Dermatology	16	9	2	3	2	2	3	–	–	37	0.8%
Neurology	17	6	4	2	1	–	1	1	1	33	0.7%
Ambulance service	9	1	1	13	5	–	–	3	–	32	0.7%
Gastroenterology	16	2	2	6	3	–	–	–	2	31	0.7%
Ophthalmology	13	9	3	1	2	1	2	–	–	31	0.7%
Oncology	18	6	3	2	–	–	1	–	–	30	0.7%
Radiology	16	6	2	–	2	–	1	2	1	30	0.7%
Anaesthesia	9	3	4	1	6	–	1	–	–	24	0.5%
Physiotherapy	3	3	12	1	1	3	1	–	–	24	0.5%
Chiropractic	8	2	9	–	1	–	1	–	–	21	0.5%
Alternative health	7	1	10	1	–	1	–	–	–	20	0.5%
Optometry	10	2	4	–	2	–	–	1	–	19	0.4%
Pathology	9	2	–	–	3	3	–	2	–	19	0.4%
Rehabilitation medicine	9	6	–	2	–	–	–	1	1	19	0.4%
Community health	10	3	–	1	–	3	–	–	–	17	0.4%
Intensive care	12	2	1	2	–	–	–	–	–	17	0.4%
Palliative care	4	10	–	1	–	–	–	2	–	17	0.4%
Prosthetics and orthotics	11	1	1	1	2	–	–	1	–	17	0.4%
Renal medicine	7	4	–	4	–	–	1	–	–	16	0.4%
Administration	–	1	2	3	2	4	–	–	3	15	0.3%
Reproductive medicine	6	2	–	1	5	–	1	–	–	15	0.3%
Urology	8	1	1	–	2	–	–	2	1	15	0.3%

table continued on next page

18 Appendices

Table 18.18 Issues raised in all complaints received by service area 2007-08 (continued)

Service area	Treatment	Communication	Professional conduct	Access	Cost	Privacy/ discrimination	Consent	Grievances	Corporate services	Total	%
Drug and alcohol services	5	–	3	2	1	–	–	–	1	12	0.3%
Non health related	2	3	4	2	–	–	–	1	–	12	0.3%
Podiatry	3	–	7	1	1	–	–	–	–	12	0.3%
Radiography	3	–	4	–	1	1	–	–	–	9	0.2%
Counselling	–	1	5	–	1	–	–	–	–	7	0.2%
Haematology (clinical)	5	–	–	1	–	–	–	–	1	7	0.2%
Immunology	5	1	1	–	–	–	–	–	–	7	0.2%
Infectious diseases	4	1	1	–	–	–	–	–	–	6	0.1%
Neonatology	4	–	1	–	–	–	–	–	1	6	0.1%
Endocrinology	3	2	–	–	–	–	–	–	–	5	0.1%
Other	–	–	1	2	1	–	–	–	–	4	0.1%
Personal care	2	–	1	1	–	–	–	–	–	4	0.1%
Psychotherapy	1	1	1	–	–	1	–	–	–	4	0.1%
Respiratory medicine	1	2	–	1	–	–	–	–	–	4	0.1%
Rheumatology	–	2	1	–	1	–	–	–	–	4	0.1%
Social and welfare work	–	3	1	–	–	–	–	–	–	4	0.1%
Osteopathy	–	–	3	–	–	–	–	–	–	3	0.1%
Developmental disability	2	–	–	–	–	–	–	–	–	2	0.0%
Family planning	1	–	–	–	–	–	–	1	–	2	0.0%
Nuclear medicine	1	–	–	–	–	–	1	–	–	2	0.0%
Home births	1	–	–	–	–	–	–	–	–	1	0.0%
Nutrition and dietetics	1	–	–	–	–	–	–	–	–	1	0.0%
Public health	–	–	–	–	–	–	–	–	1	1	0.0%
Speech therapy	1	–	–	–	–	–	–	–	–	1	0.0%
Therapy	1	–	–	–	–	–	–	–	–	1	0.0%
Total	2,245	642	597	401	153	132	94	79	66	4,409	100.0%

Counted by issues raised in complaint

Table 18.19 Source of complaints 2005-06 to 2007-08

Source	2005-06		2006-07		2007-08	
	No.	%	No.	%	No.	%
Consumer	1,256	48.8%	901	39.1%	1,073	39.3%
Registration Board	486	18.9%	697	30.3%	666	24.4%
Family or friend	563	21.9%	491	21.3%	627	23.0%
Government department	25	1.0%	19	0.9%	198	7.3%
Parliament/Minister	39	1.5%	42	1.8%	40	1.5%
Legal representative	30	1.2%	37	1.6%	29	1.1%
Consumer organisation	19	0.7%	54	2.4%	28	1.0%
Health professional	66	2.5%	18	0.8%	25	0.9%
Department of Health (State and Commonwealth)	42	1.6%	22	1.0%	18	0.7%
Other	23	0.9%	9	0.4%	13	0.5%
Courts	15	0.6%	8	0.3%	11	0.4%
Non-government organisation	2	0.1%	3	0.1%	1	0.0%
Professional association	7	0.3%	1	0.0%	1	0.0%
Total	2,573	100.0%	2,302	100.0%	2,730	100.0%

Counted by complainant

Table 18.20 Outcome of assessment of complaints 2005-06 to 2007-08

Assessment decision	2005-06		2006-07		2007-08	
	No.	%	No.	%	No.	%
Discontinue	1,471	43.3%	1,017	37.5%	982	34.0%
Assisted resolution	593	17.5%	431	15.9%	574	19.9%
Referred to Registration Board	512	15.1%	497	18.4%	572	19.8%
Investigation by Commission	373	11.0%	307	11.3%	260	9.0%
Resolved during assessment	150	4.4%	137	5.1%	206	7.1%
Referred for conciliation	186	5.5%	239	8.8%	198	6.9%
Refer to another body or person	74	2.2%	54	2.0%	56	1.9%
Local resolution	33	1.0%	28	1.0%	41	1.4%
Total	3,392	100.0%	2,710	100.0%	2,889	100.0%

Counted by provider identified in complaint

18 Appendices

Table 18.21 Outcome of complaints assessed by issues identified in complaint 2007-08

Issue category	Issue name	Discontinue	Assisted and local resolution	Refer to Registration Board	Investigation	Conciliation	Resolved during assessment process	Refer to another body	Total	%
Treatment	Inadequate treatment	356	322	222	125	136	68	9	1,238	33.6%
	Medication	112	90	85	22	14	25	18	366	9.9%
	Diagnosis	96	100	36	24	40	9	–	305	8.3%
	Infection control	14	5	12	1	–	3	1	36	1.0%
	Rough/painful treatment	9	5	5	4	1	–	–	24	0.7%
	Coordination of treatment	5	9	1	1	5	–	–	21	0.6%
	Wrong/inappropriate treatment	9	3	4	3	–	–	–	19	0.5%
	Negligent treatment	2	4	1	3	2	1	–	13	0.4%
	Withdrawal/denial of treatment	1	1	–	–	–	–	–	2	0.1%
	Treatment total	**604**	**539**	**366**	**183**	**198**	**106**	**28**	**2,024**	**54.9%**
Professional conduct	Illegal practices	49	2	69	27	1	–	3	151	4.1%
	Competence	12	7	56	37	3	2	2	119	3.2%
	Certificates/reports	73	6	29	–	–	7	1	116	3.1%
	Sexual misconduct	10	–	13	39	–	–	–	62	1.7%
	Impairment	1	–	16	3	1	–	1	22	0.6%
	Assault	5	2	9	2	–	–	–	18	0.5%
	Accuracy/inadequacy of records	9	2	1	1	–	–	–	13	0.4%
	Financial fraud	5	–	1	4	–	–	2	12	0.3%
	Breach of conditions	–	–	4	1	–	–	–	5	0.1%
	Professional conduct total	**164**	**19**	**198**	**114**	**5**	**9**	**9**	**518**	**14.0%**
Communication	Attitude	140	97	49	15	26	40	5	372	10.1%
	Inadequate information	21	21	10	10	15	15	–	92	2.5%
	Wrong/misleading information	6	2	3	–	2	1	–	14	0.4%
	Communication total	**167**	**120**	**62**	**25**	**43**	**56**	**5**	**478**	**13.0%**
Access	Delay in admission or treatment	34	40	3	5	9	12	–	103	2.8%
	Refusal to admit or treat	33	17	2	–	1	5	–	58	1.6%
	Service availability	14	21	–	1	1	3	3	43	1.2%
	Discharge or transfer arrangements	10	15	3	1	4	7	–	40	1.1%
	Waiting lists	4	5	–	–	–	1	–	10	0.3%
	Referral	3	5	1	–	–	1	–	10	0.3%
	Attendance	–	3	–	–	1	2	–	6	0.2%
	Transport	–	5	–	–	–	1	–	6	0.2%
	Access total	**98**	**111**	**9**	**7**	**16**	**32**	**3**	**276**	**7.5%**

table continued on next page

Table 18.21 Outcome of complaints assessed by issues identified in complaint 2007-08 (continued)

Issue category	Issue name	Discontinue	Assisted and local resolution	Refer to Registration Board	Investigation	Conciliation	Resolved during assessment process	Refer to another body	Total	%
Cost	Billing practices	44	10	23	–	5	22	10	114	3.1%
	Information on costs	17	–	2	–	–	2	–	21	0.6%
	Overcharging	4	1	3	–	–	1	–	9	0.2%
	Private health insurance	–	–	–	–	–	–	1	1	0.0%
	Government subsidies	–	–	1	–	–	–	–	1	0.0%
	Cost total	**65**	**11**	**29**	**–**	**5**	**25**	**11**	**146**	**4.0%**
Privacy/discrimination	Privacy/confidentiality	33	5	8	1	1	3	3	54	1.5%
	Access to records	13	8	1	1	–	12	–	35	0.9%
	Inconsiderate service	–	2	4	–	1	–	–	7	0.2%
	Discrimination	2	2	–	–	1	–	–	5	0.1%
	Privacy/discrimination total	**48**	**17**	**13**	**2**	**3**	**15**	**3**	**101**	**2.7%**
Consent	Consent not obtained	5	8	4	4	2	3	–	26	0.7%
	Consent not informed/failure to warn	5	3	5	1	1	–	–	15	0.4%
	Involuntary admission	5	3	–	–	–	–	–	8	0.2%
	Consent invalid	1	1	2	1	2	–	–	7	0.2%
	Failure to consult consumer	3	–	–	–	–	–	–	3	0.1%
	Consent total	**19**	**15**	**11**	**6**	**5**	**3**	**–**	**59**	**1.6%**
Grievances	Inadequate/no response to complaint	15	13	–	4	1	5	–	38	1.0%
	Reprisal/retaliation	3	1	1	–	–	–	1	6	0.2%
	Grievances total	**18**	**14**	**1**	**4**	**1**	**5**	**1**	**44**	**1.2%**
Corporate services	Hygiene/environmental standards	6	5	1	–	–	3	2	17	0.5%
	Administrative services	6	4	–	–	–	1	1	12	0.3%
	Hotel services	3	3	–	–	–	5	1	12	0.3%
	Corporate services total	**15**	**12**	**1**	**–**	**–**	**9**	**4**	**41**	**1.1%**
Grand total		**1,198**	**858**	**690**	**341**	**276**	**260**	**64**	**3,687**	**100.0%**

Counted by issues raised in complaint

18 Appendices

Table 18.22 Outcome of complaints assessed by service area 2007-08

Service area	Discontinue	Assisted and local resolution	Refer to Registration Board	Investigation	Resolved during assessment process	Conciliation	Refer to another body	Total	%
General medicine	371	147	158	83	71	54	23	907	31.4%
Dentistry	24	13	159	–	9	1	–	206	7.1%
Emergency medicine	40	83	14	24	21	23	–	205	7.1%
Surgery	76	55	19	17	11	26	–	204	7.1%
Psychiatry	102	50	12	4	9	5	1	183	6.3%
Gerontology	36	52	16	17	7	16	15	159	5.5%
Mental health	43	35	5	14	5	3	1	106	3.7%
Justice Health	51	35	3	3	10	–	–	102	3.5%
Pharmacy	12	3	57	1	1	3	6	83	2.9%
Psychology	19	1	55	1	2	–	–	78	2.7%
Obstetrics	10	16	4	21	3	6	–	60	2.1%
Cardiology	13	15	2	5	2	5	1	43	1.5%
Gynaecology	7	11	7	4	4	5	–	38	1.3%
Paediatric medicine	6	11	–	3	1	9	1	31	1.1%
Midwifery	2	7	2	15	–	2	–	28	1.0%
Ambulance service	11	6	–	1	7	2	–	27	0.9%
Dermatology	13	2	3	4	2	1	1	26	0.9%
Ophthalmology	10	3	2	1	4	3	–	23	0.8%
Radiology	10	4	2	3	3	1	–	23	0.8%
Gastroenterology	8	6	4	–	1	2	–	21	0.7%
Oncology	2	3	–	4	2	8	1	20	0.7%
Anaesthesia	10	–	1	3	3	2	–	19	0.7%
Neurology	6	6	3	2	–	2	–	19	0.7%
Chiropractic	5	1	9	2	–	–	–	17	0.6%
Community health	8	6	–	–	3	–	–	17	0.6%
Physiotherapy	7	3	7	–	–	–	–	17	0.6%
Alternative health	7	–	–	8	–	–	1	16	0.6%
Pathology	8	3	1	1	3	–	–	16	0.6%
Prosthetics and orthotics	4	3	8	–	1	–	–	16	0.6%
Palliative care	1	4	–	–	–	8	1	14	0.5%
Reproductive medicine	2	3	1	–	5	2	1	14	0.5%
Administration	5	2	–	–	3	–	–	10	0.3%
Drug and alcohol services	7	1	1	–	–	1	–	10	0.3%
Podiatry	4	1	5	–	–	–	–	10	0.3%
Non health related	8	1	–	–	–	–	–	9	0.3%
Intensive care	1	1	1	1	2	2	–	8	0.3%

table continued on next page

Table 18.22 Outcome of complaints assessed by service area 2007-08 (continued)

Service area	Discontinue	Assisted and local resolution	Refer to Registration Board	Investigation	Resolved during assessment process	Conciliation	Refer to another body	Total	%
Optometry	3	–	2	1	2	–	–	8	0.3%
Radiography	2	2	–	2	1	1	–	8	0.3%
Renal medicine	–	4	–	2	–	2	–	8	0.3%
Neonatology	1	1	–	3	1	1	–	7	0.2%
Rehabilitation medicine	5	1	–	–	1	–	–	7	0.2%
Urology	1	4	–	2	–	–	–	7	0.2%
Counselling	2	–	3	1	–	–	–	6	0.2%
Haematology (clinical)	–	3	2	1	–	–	–	6	0.2%
Infectious diseases	2	1	–	–	2	–	–	5	0.2%
Immunology	1	–	1	2	–	–	–	4	0.1%
Other	3	–	–	–	–	–	1	4	0.1%
Rheumatology	1	1	1	–	1	–	–	4	0.1%
Nuclear medicine	1	1	–	–	–	1	–	3	0.1%
Osteopathy	–	–	2	1	–	–	–	3	0.1%
Personal care	1	2	–		–	–	–	3	0.1%
Psychotherapy	2	–	–	1	–	–	–	3	0.1%
Social and welfare work	2	–	–	–	–	1	–	3	0.1%
Developmental disability	–	–	–	–	–	–	2	2	0.1%
Endocrinology	2	–	–	–	–	–	–	2	0.1%
Family planning	1	–	–	–	1	–	–	2	0.1%
Respiratory medicine	–	1	–	1	–	–	–	2	0.1%
Therapy	2	–	–	–	–	–	–	2	0.1%
Home births	–	–	–	1	–	–	–	1	0.0%
Nutrition and dietetics	1	–	–	–	–	–	–	1	0.0%
Psychogeriatrics	–	–	–	–	1	–	–	1	0.0%
Public health	–	–	–	–	1	–	–	1	0.0%
Speech therapy	–	1	–	–	–	–	–	1	0.0%
Total	982	615	572	260	206	198	56	2,889	100.0%

Counted by provider identified in complaint

18 Appendices

Table 18.23 Time taken to assess complaints 2005-06 to 2007-08

	2005-06	2006-07	2007-08
Percentage of complaints assessed within 60 days	55.6%	83.7%	88.2%
Average days to assess complaints	61	39	39

Counted by provider identified in complaint

Table 18.24 Resolution Service outcomes 2005-06 to 2007-08

		2005-06		2006-07		2007-08	
Outcome		No.	%	No.	%	No.	%
Resolution did proceed							
Resolved	Resolved	256	47.7%	224	47.0%	228	38.9%
	Partially resolved	138	25.7%	116	24.4%	124	21.2%
Not resolved	Not resolved	58	10.8%	50	10.5%	81	13.8%
Resolution did proceed total		452	84.2%	390	81.9%	433	73.9%
Resolution did not proceed							
	Referred for other process	27	5.0%	35	7.4%	50	8.5%
	Process did not proceed	58	10.8%	51	10.7%	103	17.6%
Resolution did not proceed total		85	15.8%	86	18.1%	153	26.1%
Grand total		537	100.0%	476	100.0%	586	100.0%

Counted by provider identified in complaint

Table 18.25 Time taken to complete resolution process 2005-06 to 2007-08

	2005-06		2006-07		2007-08	
Time taken to complete	No.	%	No.	%	No.	%
1-30 days	153	28.5%	77	16.1%	128	21.8%
1-2 months	146	27.2%	132	27.7%	163	27.8%
2-3 months	93	17.3%	85	17.8%	98	16.7%
3-4 months	62	11.5%	59	12.4%	62	10.6%
4-5 months	34	6.3%	40	8.4%	53	9.0%
5-6 months	22	4.1%	29	6.1%	22	3.8%
6-7 months	9	1.7%	16	3.4%	16	2.7%
7-9 months	10	1.9%	15	3.2%	24	4.1%
9-12 months	8	1.5%	17	3.6%	18	3.1%
>12 months	0	0.0%	6	1.3%	2	0.3%
Total	537	100.0%	476	100.0%	586	100.0%

Counted by provider identified in complaint

Table 18.26 Outcome of conciliations 2005-06 to 2007-08

Outcome and reason	2005-06		2006-07		2007-08	
	No.	%	No.	%	No.	%
Conciliation process did proceed						
Resolved						
Agreement reached at conciliation meeting	49	32.9%	89	35.3%	63	30.4%
Complaint resolved between the parties with the assistance of the Registry	–	0.0%	15	6.0%	17	8.2%
Not resolved						
The conciliation was helpful in clarifying my concerns	–	0.0%	–	0.0%	10	4.8%
Parties did not reach agreement during conciliation meeting	13	8.7%	32	12.7%	16	7.7%
Total conciliation process did proceed	62	41.6%	136	54.0%	106	51.2%
Conciliation process did not proceed						
Conciliation did not proceed	71	47.7%	111	44.0%	100	48.3%
Complaint resolved prior to conciliation	16	10.7%	5	2.0%	1	0.5%
Total conciliation process did not proceed	87	58.4%	116	46.0%	101	48.8%
Grand total	149	100.0%	252	100.0%	207	100.0%

Counted by provider identified in complaint

Table 18.27 Outcome of investigations 2005-06 to 2007-08

Investigation result	2005-06		2006-07		2007-08	
	No.	%	No.	%	No.	%
Health organisation						
Make comment or recommendation	50	54.3%	50	54.3%	55	65.5%
Terminated by the Commission	42	45.7%	42	45.7%	29	34.5%
Health organisation total	92	100.0%	92	100.0%	84	100.0%
Health practitioner						
Refer to Director of Proceedings	66	19.1%	112	38.8%	129	50.8%
Terminated by the Commission	147	42.4%	101	34.9%	63	24.8%
Refer to Registration Board	62	17.9%	36	12.5%	35	13.8%
Make comments to the practitioner	49	14.2%	38	13.1%	24	9.4%
Refer to Director of Public Prosecutions	22	6.4%	2	0.7%	3	1.2%
Health practitioner total	346	100.0%	289	100.0%	254	100.0%
Grand total	438	100.0%	381	100.0%	338	100.0%

Counted by provider identified in complaint

18 Appendices

Table 18.28 Investigations into health organisations and health practitioners finalised 2005-06 to 2007-08

	2005-06		2006-07		2007-08	
Description	**No.**	**%**	**No.**	**%**	**No.**	**%**
Health organisation						
Public hospital	65	70.6%	62	67.3%	63	75.0%
Private hospital	10	10.9%	7	7.6%	6	7.1%
Nursing home	5	5.4%	8	8.7%	4	4.8%
Area Health Service	1	1.1%	–	0.0%	3	3.6%
College/association	–	0.0%	–	0.0%	2	2.4%
Justice Health	2	2.2%	–	0.0%	2	2.4%
Community health service	1	1.1%	2	2.2%	1	1.2%
Medical centre – private	4	4.3%	1	1.1%	1	1.2%
Pathology centre/lab	–	0.0%	–	0.0%	1	1.2%
Radiology practice	1	1.1%	1	1.1%	1	1.2%
Ambulance service	1	1.1%	2	2.2%	–	0.0%
Drug and alcohol service	2	2.2%	–	0.0%	–	0.0%
Hostel	–	0.0%	1	1.1%	–	0.0%
Methadone clinic	–	0.0%	2	2.2%	–	0.0%
Private medical practice	–	0.0%	5	5.4%	–	0.0%
Public development disability hospital	–	0.0%	1	1.1%	–	0.0%
Health organisation total	92	100.0%	92	100.0%	84	100.0%
Health practitioner						
Medical practitioner	191	55.2%	175	60.6%	150	59.1%
Nurse	113	32.6%	68	23.6%	75	29.5%
Psychologist	9	2.6%	17	5.9%	9	3.5%
Alternative health provider	17	4.9%	–	0.0%	6	2.4%
Chiropractor	3	0.8%	3	1.0%	3	1.2%
Ambulance personnel	–	0.0%	–	0.0%	2	0.8%
Dentist	2	0.6%	11	3.8%	2	0.8%
Naturopath	–	0.0%	–	0.0%	2	0.8%
Pharmacist	2	0.6%	2	0.7%	2	0.8%
Physiotherapist	2	0.6%	2	0.7%	2	0.8%
Podiatrist	2	0.6%	–	0.0%	1	0.4%
Acupuncturist	1	0.3%	–	0.0%	–	0.0%
Assistant in nursing	1	0.3%	–	0.0%	–	0.0%
Dental technician and prosthetist	1	0.3%	–	0.0%	–	0.0%
Natural therapist	–	0.0%	2	0.7%	–	0.0%
Optometrist	1	0.3%	–	0.0%	–	0.0%
Psychotherapist	–	0.0%	1	0.3%	–	0.0%
Social worker	1	0.3%	1	0.3%	–	0.0%
Traditional Chinese medicine practitioner	–	0.0%	7	2.4%	–	0.0%
Health practitioner total	346	100.0%	289	100.0%	254	100.0%
Grand total	438	100.0%	381	100.0%	338	100.0%

Counted by provider identified in complaint

Table 18.29 Issues raised in investigations finalised 2005-06 to 2007-08

Category	2005-06		2006-07		2007-08	
	No.	%	No.	%	No.	%
Treatment	297	52.4%	271	60.8%	237	57.2%
Professional conduct	203	35.9%	129	28.9%	141	34.1%
Communication	15	2.6%	23	5.2%	19	4.6%
Access	22	3.9%	5	1.1%	10	2.4%
Consent	4	0.7%	4	0.9%	6	1.4%
Privacy/discrimination	4	0.7%	4	0.9%	1	0.2%
Corporate services	8	1.4%	4	0.9%	–	0.0%
Cost	6	1.1%	5	1.1%	–	0.0%
Grievances	2	0.4%	1	0.2%	–	0.0%
Miscellaneous	5	0.9%	–	0.0%	–	0.0%
Total	566	100.0%	446	100.0%	414	100.0%

Counted by issues raised in complaint

Table 18.30 Outcome of investigations finalised by profession and organisation type 2007-08

Health practitioner	Medical practitioner	Nurse	Psychologist	Alternative health provider	Chiropractor	Ambulance personnel	Dentist	Naturopath	Pharmacist	Physiotherapist	Podiatrist	Total	%
Referred to Director of Proceedings	67	48	9	–	2	–	–	–	2	1	–	129	50.8%
Terminated by Commission	43	12	–	3	1	–	–	2		1	1	63	24.8%
Referred to Board for further action	21	12	–	–	–	–	2	–	–	–	–	35	13.8%
Make comments to practitioner	17	3	–	3	–	1	–	–	–	–	–	24	9.4%
Referred to Director of Public Prosecutions	2	–	–	–	–	1	–	–	–	–	–	3	1.2%
Health practitioner total	150	75	9	6	3	2	2	2	2	2	1	254	100.0%

Health organisation	Public hospital	Private hospital	Nursing home	Area health service	College/association	Justice Health	Community health service	Medical centre	Pathology centre/lab	Radiology practice		Total	%
Recommendations	35	2	3	2	–	1	–	–	–	1		44	52.4%
Terminated by Commission	23	–	1	1	2	–	1	1	–	–		29	34.5%
Comments	5	4	–	–	–	1	–	–	1	–		11	13.1%
Health organisation total	63	6	4	3	2	2	1	1	1	1		84	100.0%
Grand total	213	81	13	9	5	4	3	3	3	3	1	338	100.0%

Counted by provider identified in complaint

18 Appendices

Table 18.31 Time taken to complete investigations 2005-06 to 2007-08

Time taken to complete	2005-06		2006-07		2007-08	
	No.	%	No.	%	No.	%
< 6 months	96	21.9%	55	14.4%	62	18.3%
6-12 months	174	39.7%	211	55.4%	169	50.0%
12-18 months	76	17.4%	97	25.4%	90	26.6%
18-24 months	65	14.8%	14	3.7%	16	4.7%
24-30 months	18	4.1%	3	0.8%	1	0.3%
30-36 months	7	1.6%	–	0.0%	–	0.0%
> 36 months	2	0.5%	1	0.3%	–	0.0%
Total	438	100.0%	381	100.0%	338	100.0%
Average days taken to complete investigations	352		318		309	

Counted by provider identified in complaint

Table 18.32 Open complaints as at 30 June of 2006 to 2008

Category	2005-06		2006-07		2007-08	
	No.	%	No.	%	No.	%
Open assessments	334	28.5%	342	33.2%	583	45.7%
Open investigations	322	27.5%	286	27.8%	215	16.9%
Open complaints in legal	171	14.6%	129	12.5%	209	16.4%
Open resolutions	155	13.3%	137	13.3%	152	11.9%
Open conciliations	98	8.4%	105	10.2%	95	7.5%
Open assessment reviews	82	7.0%	28	2.7%	18	1.4%
Open investigation reviews	8	0.7%	3	0.3%	3	0.2%
Total	1,170	100.0%	1,030	100.0%	1,275	100.0%

Counted by provider identified in complaint

Appendix D – List of expert advisers

The Commission would like to thank the following experts for their advice. In addition, the Commission would also like to thank those experts who provided phone consultations throughout the year that helped to clarify clinical issues during the assessment of complaints.

Professor Robert **Adler**
Dr Ion **Alexander**
Dr John **Alexander**
Dr Roger **Allan**
Dr Hugh **Allen**
Dr Stephen **Allnutt**
Dr Anthony **Anker**
Dr Francis **Arnaudon**
Dr Mark **Arnold**
Mr John **Baker**
Dr Michael **Baldwin**
Dr Gary **Banks**
Mrs Susan **Banks**
Professor David **Barnes**
Mrs Jeanne **Barr**
Dr Bruce **Barraclough**
Mr Glen **Barrington**
Dr Philip **Bekhor**
Professor James **Bell**
Dr Lynette **Bellamy**
Dr Warwick **Benson**
Dr Peter **Bentivoglio**
Dr Peter **Berton**
Dr James **Bertouch**
Professor Michael **Besser**
Ms Robin **Billings**
Dr Jules **Black**
Dr Peter **Bland**
Professor Elie Leslie **Bokey**
Ms Kim **Bonnici**
Mr Sam **Borenstein**
Dr David **Bowers**
Professor Bruce **Brew**
Dr George **Bridger**
Professor Henry **Brodaty** AO
Dr Geoffrey **Brodie**
Professor Pat **Brodie**
Dr Andrew **Brooks**
Ms Elspeth **Browne**
Professor Richard **Bryant**
Dr Jeremy **Bunker**
Dr Richard **Burns**
Dr Andrew **Byrne**
Mrs J **Caldwell**
Ms Jann **Capizzi**
Dr Daniel **Challis**
Dr Harry **Champion**
Mr Ian **Chapman**
Professor Richard **Chard**
Miss Kate **Chellew**
Dr Andrew **Child**
Dr Clive **Childs**
Dr Louis **Christie**
Dr Ian **Chung**
Dr David **Church**
Mr Peter **Cleasby**
Professor Geoffrey **Cleghorn**
Professor Paul **Colditz**
Mr Albert **Coleiro**
Mr Mark **Coleman**
Dr Brian **Collits**
Professor Christopher **Commens**
Mr Shaun **Connolly**
Mrs Helen **Cooke**
Ms Anne **Cooper**
Ms Allison **Cummins**
Dr Paul **Curtis**
Professor David **Davies**
Mr John **Davis**
Dr Robert **Day**
Dr Michael **Delaney**
Mr Christopher **Derkenne**
Professor Hugh **Dickson**
Ms Pauline **Dobson**
Dr Glenys **Dore**
Dr Geraldine **Duncan**
Dr Iain **Dunlop**
Ms Maureen **Edgtton-Winn**
Dr Frederick **Ehrlich**
Dr David **Eisinger**
Dr David **Eizenberg**
Dr Ian **Elder**
Ms Jeanette **Eldridge**
Dr Barry **Elison**
Dr John **Ellard**
Mr Colin **Ellis**
Mr Roger **Engel**
Dr John **England**
Ms Ellen **Evans**
Dr Anthony **Eyers**
Dr Gregory **Falk**
Dr Diana **Farlow**
Dr Alan **Farnsworth**
Dr Annabelle **Farnsworth**
Professor Rex **Ferris**
Dr Charles **Fisher**
Professor John **Fletcher**
Dr Anthony **Freeman**
Dr James **Friend**
Ms Julianne **Friendship**
Professor Gordian **Fulde**
Ms Catherine **Fulham**
Mrs Marianne **Gaul**
Dr Rafat **Ghabrial**
Dr Mark **Gianoutsos**
Dr Margaret **Gibbons**
Dr Michael **Giblin**
Dr William **Gibson**
Professor David **Gillett**
Dr Jonathan **Gillis**
Dr Peter **Gillman**
Dr Leslie **Glen**
Mrs Greta **Goldberg**
Dr Philip **Goldstone**
Mrs Alison **Goodfellow**
Ms Amanda **Gordon**
Professor David **Gottlieb**
Professor Kerry **Goulston**
Professor James **Greenwood**
Mrs Sue **Greig**
Ms Ann **Greive**
Mrs Eunice **Gribbin**
Mrs Janine **Haigh**
Dr Neal **Hamilton**
Professor David **Handelsman**
Mr Christopher **Hanna**
Dr Michael **Harding**
Dr John **Harkness**
Dr Keith **Hartman**
Dr Ray **Hayek**
Dr Phillip **Hazell**
Mr Antony **Heath**
Dr Geoffrey **Heithersay**
Dr Paul **Hendel**
Mr Chris **Henderson**
Dr Wilson **Heriot**
Dr Ralph **Higgins**
Dr Anthony **Hobbs**
Dr John **Hogg**
Dr Peter **Holman**
Dr Craig **Hore**
Dr Karel **Hromek**
Dr Kenneth **Hume**
Dr Carole **Hungerford**
Professor James **Isbister**
Dr Allan **James**
Dr Walid **Jammal**
Dr Elizabeth **Jane**
Professor Robert **Jansen**
Professor Richmond **Jeremy**

18 Appendices

Dr Ian **Johnson**
Ms Maren **Jones**
Ms Andrea **Jordan**
Dr Anthony **Joseph**
Dr Stephen **Jurd**
Ms Blanche **Kairies**
Dr Jeffrey **Keir**
Professor Anne-Maree **Kelly**
Ms Fiona **Kendall**
Dr Timothy **Keogh**
Dr Suresh **Khatri**
Mr Raymond **Khoury**
Mr Michael **Kinchington**
Mr David **Kitching**
Professor Leon **Kleinman**
Dr Peter **Klug**
Dr David **Knox**
Ms Penelope **Knudson**
Dr Andrew **Korda**
Dr Beth **Kotze**
Dr Paul **Kovac**
Ms Wendy **Kramer**
Professor Joanne **Kurtberg**
Dr Mary **Langcake**
Dr Kit **Lau**
Mr Vinoo **Lele**
Dr Garth **Leslie**
Dr Michael **Levitt**
Dr Edward **Loughman**
Mr Ashton **Lucas**
Ms Sara **Lucas**
Ms Sue **Lukersmith**
Dr Peter **Lye**
Dr Robert **Lyneham**
Dr Kenneth **Mackey**
Dr Colin **Macleod**
Dr Andrew **MacQueen**
Mr Philip **Major**
Dr Linda **Mann**
Ms Elizabeth Ann **Marsh**
Professor Donald **Marshall**
Dr Lawrence **Mashford**
Ms Susan **Mayhew**
Ms Toni **McCallum Pardey**
Dr Sallyann **McCarthy**
Professor William **McCarthy**
Professor Kevin **McConkey**
Dr Martin **McGee-Collett**
Dr Louis **McGuigan**
Dr Christopher **McMahon**
Mr Bernard **McNair**
Dr Michele **Meltzer**
Ms Rebekkah **Middleton**
Ms Colleen **Mill**
Ms Helen **Miller**
Mr Peter **Moore**
Dr Peter **Morse**
Dr Joy **Mowbray**
Dr Muniswami **Mudaliar**
Dr Raymond **Mullins**
Dr Anne **Murray**
Dr Gregory **Nelson**
Mr Frank **Newman**
Dr Louise **Newman**
Ms Robin **Norton**
Mr Daryl **Nye**
Dr Nicholas **O'Connor**
Dr Wendy **O'Dey**
Professor Lyn Douglas **Oliver**
Dr Matthew **O'Meara**
Dr Julian **Parmegiani**
Dr Gordon **Patrick**
Dr John **Pearman**
Professor Roger **Pepperell**
Dr John **Percy**
Dr Kenneth **Perkins**
Dr Jonathan **Phillips**
Dr Peter **Pigott**
Dr John **Pitkin**
Dr Justin **Playfair**
Dr Alan John **Porter**
Professor Solomon **Posen**
Ms Tracey **Powell**
Professor Joseph **Proietto**
Dr Jennifer **Prowse**
Dr Donald **Pryor**
Professor Carolyn **Quadrio**
Dr Dennis **Raymond**
Ms Patricia **Reynolds**
Dr Shawn **Richards**
Ms Jenifer **Richardson**
Dr Adam **Rish**
Professor Darren **Rivett**
Professor Ivor **Roberts**
Dr Wendy **Roberts**
Dr Patricia **Robertson**
Ms Janette **Robinson**
Dr William **Ross**
Professor Richard **Ruffin**
Dr Robin **Rushworth**
Mrs Fiona **Russell**
Dr Anthony **Samuels**
Mrs Julie **Scott**
Mr Trevor **Scott**
Dr Raymond **Seidler**
Dr Diana **Semmonds**
Mr Stephen **Seymour**
Dr Gabriel **Shannon**
Ms Rosalee **Shaw**
Mr Warren **Shaw**
Ms Agnes **Shea**
Dr John **Sippe**
Dr George **Skowronski**
Dr John **Slaughter**
Dr Denis **Smart**
Ms Catriona **Smith**
Dr Graydon **Smith**
Dr William **Smith**
Dr Velencia **Soutter**
Dr Barbara **Spark**
Professor Kaye **Spence**
Ms Irene L **Stein**
Professor Katharine **Steinbeck**
Dr Michael **Steiner**
Dr Warwick **Stening**
Ms Helen **Stevens**
Dr Janine **Stevenson**
Dr David **Storey**
Dr Marian **Sullivan**
Dr Michael **Suranyi**
Dr Joanna **Sutherland**
Ms Sally **Sutherland-Fraser**
Dr Eric **Taft**
Dr Christopher **Tennant**
Dr Kenneth **Tiver**
Dr Tom **Tseng**
Ms Deborah **Tully**
Dr Robert **Turner**
Mr Andrew **Van Essen**
Dr Christopher **Vickers**
Mr Alyn **Vincent**
Dr John **Vinen**
Mr Christopher **Waite**
Professor Denis **Wakefield**
Mr Anthony **Wallace**
Dr James **Walter**
Dr Stephen **Ward**
Dr Robert E **Ware**
Mr Athol **Webb**
Ms Elvina **Weissel**
Ms Robyn Anne **White**
Mr Lawrence **Whitman**
Professor Ian **Wilcox**
Mr Cearns **William**
Dr Cholmondeley **Williams**
Dr Andrew **Wilson**
Dr Alexander **Wodak**
Professor Robin George **Woods**
Ms Fiona **Wright**
Dr John **Wright**
Mr Theo **Yalouris**

Appendix E – List of charts

18 Appendices

Appendix F – List of tables

Appendix G – Index of Legislative Compliance

Annual Reports (Statutory Bodies) Act 1984		**Page No.**
Letter of submission		2
Budgets – current and projected		61
Legal change		15, 57
Financial statement		61, 84
Annual Reports (Statutory Bodies) Regulation 2005		
Charter		inside front cover
Aims and objectives		inside front cover
Access		inside front cover
Management and structure		99
Summary review of operations		3
Funds granted to non-government community organisations	The Commission does not allocate funds.	
Factors affecting achievement of operational objectives		throughout
Management and activities		throughout
Research and development	Not applicable.	
Human resources		99
Consultants		107
Equal Employment Opportunity		101
Disability plans		105
Land disposal	The Commission does not own land.	
Promotion		21
Consumer response		97
Guarantee of service	The Commission developed a Code of Practice.	
Payment of accounts		62
Time for payment of accounts	Not applicable.	
Risk management and insurance activities		108
Disclosure of controlled entities		99
Ethnic affairs priorities statements		106
NSW Government Action Plan for Women		105
Occupational Health and Safety		106
Waste	The Commission reports triannually.	
After balance date events having a significant effect in succeeding year	No events have occurred that will effect the Commission finances, operations or community served.	
Annual report production costs and availability		inside back cover
Investment performance	The Commission does not have any surplus funds invested.	
Liability management performance	The Commission does not have debts greater than $20m.	
Exemptions	The Commission will report triannually on EEO, EAPS and cost.	
Performance and numbers of executive officers		99, 102

table continued on next page

18 Appendices

Disability Services Act 1993		**Page No.**
Disability Plans		105

Freedom of Information Regulation 2005		**Page No.**
Annual report of FOI operations		98

Health Care Complaints Act 1993		**Page No.**
The number and types of complaints made during the year		23 – 29
The sources of those complaints		117
The number and types of complaints assessed by the Commission during the year		37 – 38
The number and type of complaints referred for conciliation during the year		37 – 38
The results of conciliations		46 – 47
The number and type of complaints investigated by the Commission during the year		124 – 125
The results of investigations		50 – 52
Summary of the results of prosecutions completed during the year arising from complaints		57 – 59
The number and details of complaints not finally dealt with at the end of the year		126
The time intervals involved in the complaints process		38, 42, 48, 52, 56
The number and type of complaints referred to the Director-General during the year	There were no complaints referred to Director-General under section 25A.	
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 made to the Director-General under section 60.	

Privacy and Personal Information Protection Act 1998		**Page No.**
Privacy management plan		98

Public Sector Employment and Management Act 2002		**Page No.**
Disability Plans		105

Reporting required by Premier or Treasurer		**Page No.**
Disclosure of subsidiaries	The Commission does not have any subsidiaries.	
Departures from *Subordinate Legislation Act*	Not applicable.	
Government Energy Management Policy		107
Electronic service delivery		108
Credit card certification	Not applicable.	
Requirements arising from employment arrangements		61

Health Care Complaints Commission Annual Report 2007-08
Electronic copies of this report are available on the Commission's website www.hccc.nsw.gov.au.
Printed on 100% recycled, Australian made paper.
Production costs $18,710.
Published by the Health Care Complaints Commission 2008
ISBN 978-0-9752390-8-7

Health Care Complaints Commission
Level 13, 323 Castlereagh Street
Sydney NSW 2000

Freecall 1800 043 159
T 02 9219 7444
F 02 9281 4581
E hccc@hccc.nsw.gov.au
W www.hccc.nsw.gov.au