HEALTH CARE
COMPLAINTS
COMMISSION

2004-05

Annual Report

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The Hon. John Hatzistergos, MLC
Minister for Health
Parliament House
Macquarie Street
SYDNEY 2000

HEALTH CARE COMPLAINTS COMMISSION

Dear Minister

Report of activities for the year ended 30 June 2005

I am pleased to provide the Annual Report and financial statements of the Health Care Complaints Commission for the financial year ended 30 June 2005 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 sincerely

Kieran Pehm
Commissioner

About us

Contact details

Telephone (02) 9219 7444

Freecall 1800 043 159
from fixed phones in Australia

Facsimile: (02) 9281 4585

Telephone typewriter: (02) 9219 7555

Health Care Complaints Commission
Level 13, 323 Castlereagh Street, Sydney
9 am to 5 pm Mon - Fri

Information about the Commission and publications, including this report, can be viewed at www.hccc.nsw.gov.au

Address correspondence to:

Locked Mail Bag 18, STRAWBERRY HILLS NSW 2012
or
DX 11617 SYDNEY DOWNTOWN NSW
or
hccc@hccc.nsw.gov.au

Complaints Resolution Service *

Lismore / Northern Rivers
Newcastle / Hunter
Northern Sydney
Dubbo / Macquarie
Penrith / Blue Mountains
Western Sydney
Wollongong / Illawarra
South Eastern Sydney
South Western Sydney
Central Sydney

Health Conciliation Registry

From 1 March 2005, the Health Conciliation Registry came under the administrative and managerial responsibility of the Commission. From August 2005 it will be co-located in the Commission's offices.

Tel: (02) 9219 7444
Facsimile: (02) 9280 4375
Email: hcr@hccc.nsw.gov.au

Our vision

In order to reflect the amendments made to the Commission's governing legislation, the *Health Care Complaints Act, 1993*, which came into effect on 1 March 2005, the Commission's vision is:

> *The Health Care Complaints Commission acts independently in the public interest by resolving, investigating and prosecuting complaints about health care to protect the health and safety of the New South Wales public.*

Our charter

Prior to the amendments to the *Health Care Complaints Act 1993*, the Commission's role was to:

- facilitate the maintenance of standards of health services in New South Wales, NSW;
- promote the rights of clients in the NSW health system by providing clear and easily accessible mechanisms for the resolution of complaints;
- facilitate the dissemination of information about clients' rights throughout the health system;
- provide an independent mechanism for assessing whether the prosecution of disciplinary action should be taken against health practitioners who are registered under health registration Acts.

Under the new legislation the Commission's role is to:

- receive and assess complaints relating to health services and health service providers in New South Wales, and
- investigate and assess whether any such complaint is serious and if so, whether it should be prosecuted, and
- prosecute serious complaints, and
- resolve or oversee the resolution of complaints.

In exercising its functions under the Act the Commission is to have as its primary object the protection of the health and safety of the public.

* Known as Patient Support Service prior to 1 March 2005

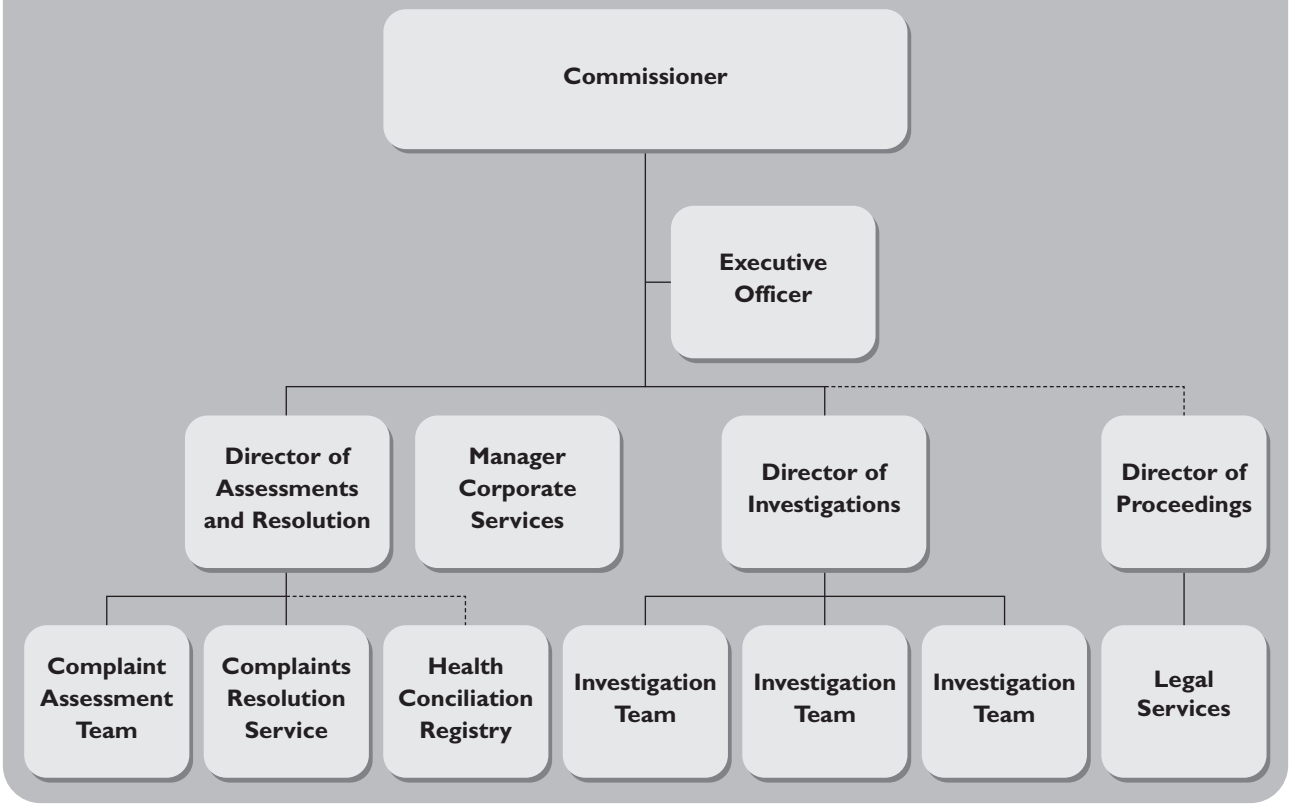
The services provided by the Commission include:

- Receiving and dealing with complaints concerning the care and treatment provided by health practitioners and health services.
- Resolving complaints with the parties.
- Providing opportunities and support for people to resolve their complaints and concerns locally.
- Investigating complaints.
- Prosecuting cases before disciplinary bodies.
- Publishing and distributing information about the Commission's work and activities.
- Advising the Minister and others on trends in complaints.
- Consulting with consumers and other key stakeholders.

Our Stakeholders

- Health Consumers.
- The diverse communities of NSW.
- Parliament of NSW.
- Minister for Health.
- Parliamentary Committee on the Health Care Complaints Commission.
- NSW Department of Health.
- Area Health Services.
- HCCC Consumer Consultative Committee.
- Health professional registration boards.
- Health practitioners and services.
- Health professional, educational and industrial organisations.
- Other government agencies.
- Media.

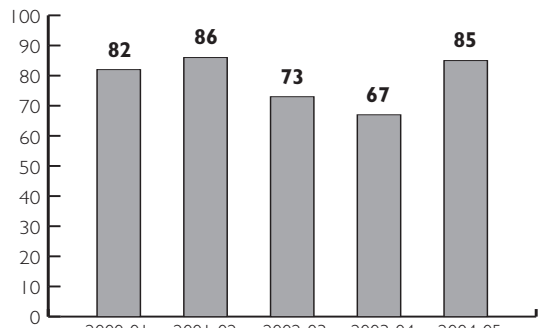
Organisation Chart



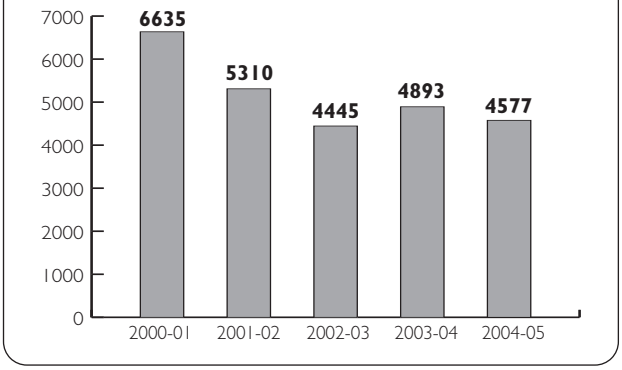
HEALTH CARE COMPLAINTS COMMISSION

Five Years at a Glance

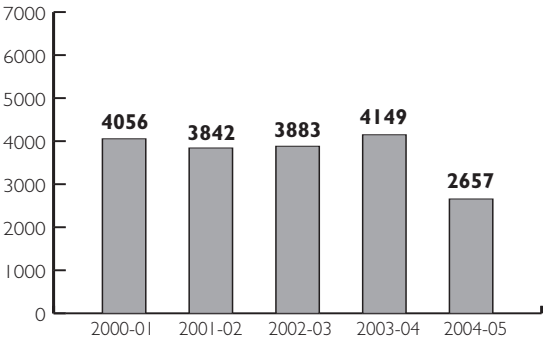
NUMBER OF DISCIPLINARY ACTIONS FINALISED



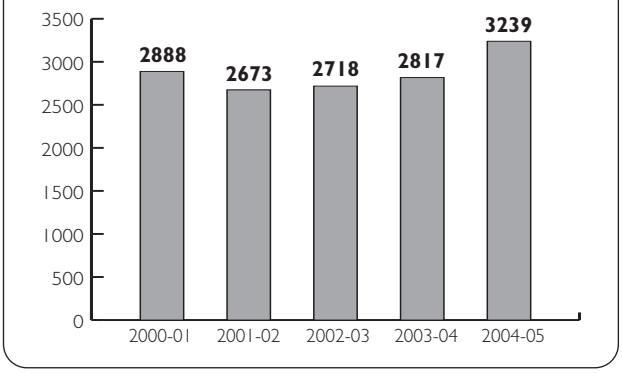
NUMBER OF TELEPHONE INQUIRIES RECEIVED



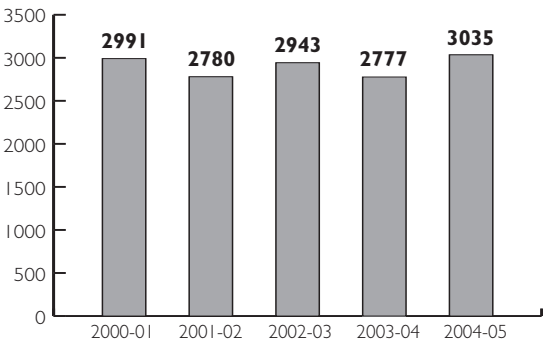
NUMBER OF PATIENT SUPPORT SERVICE* CLIENTS



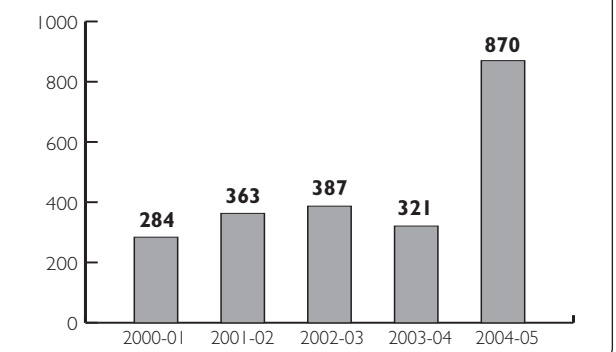
NUMBER OF COMPLAINTS RECEIVED



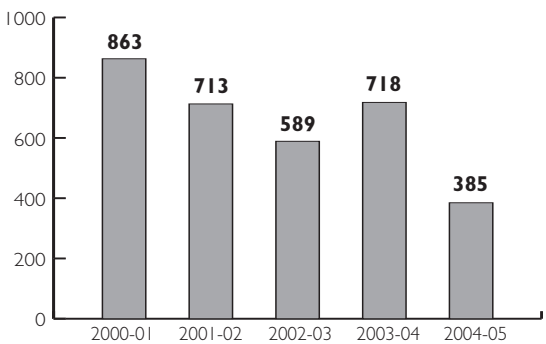
NUMBER OF COMPLAINTS FINALISED



NUMBER OF INVESTIGATIONS FINALISED BY THE COMMISSION



NUMBER OF INVESTIGATIONS OPEN AS AT 30 JUNE**



** Known as Complaints Resolution Service from 1 March 2005.*

*** Including investigations arising out of Campbelltown/Camden Hospitals.*

The year 2004-05 has been one of substantial change and reorganisation at the Health Care Complaints Commission. This report details those changes and highlights the progress of the Commission during the reporting period. There is also a summary of the 2004-05 investigations conducted into the allegations of poor and unsafe patient care at Camden and Campbelltown Hospitals (the Macarthur investigations).

Structural change

A completely new Senior Executive Team is now in place at the Commission. Kieran Pehm was appointed as Commissioner on 29 June 2005 following the completion of a 12 month contract by Judge Kenneth Taylor as Acting Commissioner in March 2005.

Christopher Hanlon was appointed as the Director of Assessments and Resolution in February 2005. Karen Mobbs was appointed Director of Proceedings in March 2005. These appointments follow the appointment of Leena Pradhan to the position of Director of Investigations in August 2004. The new team leads a restructured Commission committed to improving efficiency and accountability.

Under the Director of Assessments and Resolution sits the Complaint Assessment Team and the Complaints Resolution Service (formerly the Patient Support Service). The Health Conciliation Registry, although still independent in its decisions on complaint handling, comes under the administrative supervision of the Director of Assessments and Resolution. During the year, the Commission developed a process of undertaking more thorough assessments of incoming complaints so that the best way of dealing with them is identified at the earliest possible stage. Complainants are now consulted at the outset to clarify their complaints, responses are sought from health practitioners and medical records obtained, where relevant, for assessment by the Commission's internal medical advisers, whose hours were doubled. Through a more thorough and careful assessment process, the Commission plans to substantially increase its resolution of complaints so that only the most serious matters are referred for investigation.

From July 2004 to March 2005, the Investigations Division was divided into six teams, each comprising a team leader and 4 –5 investigators. Since March 2005, investigators from the Macarthur team, having completed most of their investigations, were returned to the general teams of investigators. In June 2005 the five teams were reduced to three following substantial completion of the backlog of investigations and the expiry of the contracts of those investigators who had been brought on for 12 months to clear that backlog. The new team structure in Investigations is designed to increase accountability and provide more effective and consistent supervision of the investigation process. In turn, this has resulted in improved performance and productivity.

The Director of Proceedings leads the Commission's Legal Division. Under recent amendments to the *Health Care Complaints Act*, she is empowered to make decisions, independent of the Commissioner, on whether or not to take disciplinary proceedings against a practitioner. The finalisation of investigations that comprised the Commission's substantial backlog has resulted in more than double the number of matters referred for prosecution by the Legal Division. Extra funding and staff have been allocated to deal with the extra workload.

Complaints performance

Information detailing the numbers of complaints, investigations and prosecutions and the outcomes are contained in the body of the report.

The number of complaints received against providers during the year rose from 2817 to 3239 (15%).

The new, more thorough assessment processes that have been implemented throughout the year have resulted in complaints staying for longer periods in assessment. The number of complaints declined at the assessment stage increased. There were only slightly more requests for review of assessment decisions received. The Commission's procedures and correspondence in this area previously provided very little explanation to complainants. The new Act now requires the Commission to give reasons for its assessments decision corresponding with changed practices and the reframing of procedures in this area. As the Commission's assessment process improves, there should be fewer requests for review. There will also be a greater emphasis placed on conciliation and assisted resolution which should show through in future years and ultimately result in fewer matters being unnecessarily referred for investigation.

The Commission's performance in finalising investigations has been outstanding during the year with 870 investigations finalised compared to an average of 339 for the previous four years. Despite the pressures of the backlog on the Commission, closed

investigations have been dealt with thoroughly and professionally and the outcomes of those investigations have been broadly consistent with those of previous years. As detailed in the last Annual Report, a considerable backlog of investigations was identified by former interim Commissioner Bill Grant in December 2003. When Judge Taylor took over in March 2004, the number of backlog investigations stood at 448. With the assistance of a substantial budget enhancement to allow for the appointment of additional investigators, all backlog matters had been finalised in April 2005.

The delays in finalising investigations have been substantially reduced. While the Commission's corporate goal was to complete 80% all new investigations within 12 months, this proved too ambitious for current capacity. The Commission closed 51% of investigations within 12 months during the year. More detail on the Commission's performance in this area is contained in the section on the Investigations Division. A total of 139 investigations were assessed for investigation in relation to the Macarthur matters. These investigations have been substantially completed.

New legislation

Amendments to the *Health Care Complaints Act 1993* came into effect on 1 March 2005. These amendments refocus the Commission on its principal objectives of resolving, investigating and prosecuting complaints about health service providers.

The Commission has been given powers to require the production of evidence including hospital, medical and practice records during assessment of a complaint and investigation. When the Commission investigates a complaint, it is able to require relevant people to provide documents and information. While that information cannot be used in criminal or civil proceedings it can be used in disciplinary proceedings. Obligations to promptly identify health service providers who are the subject of complaints have been reinforced with appropriate protection for whistleblowers. In addition, an ongoing obligation has been imposed on the Commission to keep under review its assessment of complaints so that complaint issues are clearly identified, the relevant parties properly notified and the complaint is handled in the most appropriate way. The Commission's internal structural adjustments support the effective implementation of the new legislation.

Case management

The Commission's new case management database went "live" on 7 March 2005. Known as Casemate, this system provides greater support and guidance for the complaints handling process as well as more accurate and timely reports on performance. Together with more structured supervision and regular review of cases, the Commission expects to further improve its complaint handling in the coming year.

Consultation

The Commission has re-activated its Consumer Consultative Committee. This Committee meets every three months and provides valuable advice to the Commission on issues affecting health consumers. The Commission will consult with this Committee on the development of a Code of Practice in the coming year.

The Commission also meets regularly with the various health professionals registration boards as part of the co-regulatory scheme of complaint handling and extends its thanks to the Boards for their co-operation and forbearance during what has been a year of change and adjustment to past practices.

The Commission also consulted widely with health interest groups in the lead up to the new legislation and will continue to develop its procedures in consultation with interested parties.

Performance Report

A performance report, highlighting a number of corporate goals achieved by the Commission during the 2004-05 period is contained in the report. Given that the organisation was still undergoing a period of restructure and change to its processes not all the goals were met. The Commission tended to focus on the most pressing priorities such as reducing the backlog of investigations in fairness to both complainants and practitioners who had been left hanging for far too long.

A new corporate plan is currently being prepared and a five-year strategic plan is in development. The focus of the Commission will now be to strengthen its structures and processes to improve internal governance and performance. Business plans for each division have been developed and performance management agreements will be finalised in the coming year.

The Commission is particularly grateful to Judge Taylor for his leadership of the Commission during a period of considerable upheaval. Judge Taylor is to be credited for many of the achievements reached by the Commission for the 2004-05 year and for laying the groundwork for future goals for the next year.

Performance Report for 2004-05

In November 2004 the Health Care Complaints Commission finalised its Corporate Plan for 2004-05. When Mr Bill Grant was appointed as Interim Commissioner in December 2003, the Commission did not have a Corporate Plan. Mr Grant developed a short term Action Plan to guide its operations for the period February – June 2004.

The Action Plan's primary focus was on reducing the backlog of investigations, restructuring the organisation and implementing a suite of urgent changes to policies, procedures and systems of the Commission.

A Corporate Plan was subsequently prepared under the former Acting Commissioner Judge Kenneth Taylor. The 2004-05 Corporate Plan refocuses the Commission on its core business of complaint handling, investigations and prosecutions. It aims to set up sound core business processes that have been neglected in the past; processes which are essential to improving the Commission's efficiency and fairness in complaint handling.

In addition, the Corporate Plan sets out to implement internal governance processes and establish a performance management system in order to develop the Commission as an effective and accountable organisation.

Following on from the reform process of 2003-04, changes to the Commission continued throughout 2004-05. These changes have been introduced to further consolidate the process of concentrating on the investigation of serious, individual cases of poor patient care and seeking to resolve the less serious matters. The 2004-05 Corporate Plan reflects these changes. A longer term strategic plan is currently being developed.

In 2004/05 the Commission worked towards the challenges and goals set out in its Corporate Plan. As already noted, a major priority for the Commission during the reporting period was to eliminate the backlog of investigations and complete the Macarthur investigations.

The Commission was also implementing widespread changes to its internal processes. Consequently, not all of the goals set out in the Corporate Plan were met. Some of these goals required redefinition while others will be met over a longer time scale than first envisaged. The section below outlines the extent to which these goals have been met by the Commission during the period.

The appointment of Executive Directors was not completed until March 2005. A permanent Commissioner was appointed on 29 June 2005. Plans to restructure the Corporate Services division also commenced in the second half of the reporting period. The Commission anticipates that in 2005-06 its goals will be more realistically defined.

The following table summarises the Commission's performance for the reporting period.

Goal 1: Comprehensive and Responsive Complaint Resolution

1.1 Comprehensive complaints resolution to ensure complaints are resolved according to the nature of the complaint and the needs of the parties; promoting fairness, timeliness, compliance and satisfactory resolution.

Measure: 1.1.1. Increase the number/percentage of complaints resolved during assessment.	**Met** 1.1.1 There were 52 complaints resolved during the assessment process. There was no mechanism for capturing the data on this method of resolution so no comparison with previous years is possible. For the next reporting period the Commission will have more accurate data to show the numbers/percentage of complaints resolved during assessment.

1.2 Promote greater use of formal and informal alternate dispute resolution.

Measure: 1.2.1 Number of complaints resolved after assessment.	**Met** 1.2.1 Since February 2005 there has been substantial restructure and change to processes of the Assessments and Resolution Division. The Complaint Assessment Team, Complaints Resolution Service (formerly the Patient Support Service) and the Health Conciliation Registry are all under the direction of the Director of Assessments and Resolution. The CRS no longer accepts informal referrals. All matters are referred following assessment so fewer matters were dealt with through assisted resolution. Since 1 March 2005 the Health Conciliation Registry has been under the administrative responsibility of the Commission. The number of matters resolved through conciliation is lower than in previous years. It is anticipated that the structural changes promoting resolution will be reflected in future years figures.

1.3 To promote complaint resolution services provided to people in rural and regional NSW by the Patient Support Services.

Measure 1.3.1 To promote complaint resolution services provided to people in rural and regional NSW by the Patient Support Service.	**Met** 1.3.1 There are four Complaints Resolution Offices ("CROs" and formerly the Patient Support Officers) which service regional NSW. They are based in Dubbo, Lismore, Wollongong and Newcastle and assist clients in their respective Area Health Services.

1.4 Ensure a best practice approach for all investigations

Measures: 1.4.1 80% of investigations finalised in less than 12 months	**Not met** 1.4.1 For the reporting period the Commission finalised 51% of investigations within 12 months. Although performance in investigations improved substantially on previous years, more work is needed. The Commission will re-evaluate this goal in its plan for the 2005/06 year.
1.4.2 Review investigation processes to ensure that they are fair and transparent to all parties	**Met** 1.4.2 Better case management processes have been implemented, including the restructure of the Investigations Division into small teams headed by an Investigations Manager, and the introduction of Casemate. Respondents are now provided with a fuller disclosure of investigation material to ensure they are afforded procedural.

	fairness. All investigators have been provided with training in appropriate investigation techniques and a comprehensive investigations manual will be finalised in 2005-06. Internal Medical Advisers, the numbers of which have increased, review most investigations and provide expert clinical advice to investigators. The Investigations Review Group, chaired by the Commissioner, meets fortnightly to monitor and review investigations.
1.4.3 Review recruitment and training of peers with emphasis on ensuring adherence to procedural fairness	**Met** 1.4.3 A review of the expert review panel was undertaken. This included written requests being sent to medical colleges requesting they nominate peers to be included on the peer review panel. New peer guidelines and policies are being developed.

1.5 Ensure the conduct of prosecutions is fair and timely.

Measures 1.5.1 Review prosecution guidelines to ensure procedural fairness and process transparency.	**Not met** 1.5.1 The appointment of a Director of Proceedings did not occur until March 2005. Further, the amendments to the Health Care Complaints Act came into effect on 1 March 2005. These factors have meant that a review of the prosecution guidelines has been delayed. The role of the Director of Proceedings is to ensure that prosecutions are conducted in a fair and timely way. Section 90C sets out the criteria that the Director takes into account before making a determination to prosecute.
1.5.2 Directions by disciplinary and appellate bodies are complied with by HCCC within deadlines.	**Partly met** 1.5.2 The Legal Division has inherited a backlog of matters from the Investigations Division. There has been a substantial increase in the workload of the Legal Division and this has impacted on meeting deadlines.

1.6 Development and implementation of efficient and effective complaint case management database

Measure 1.6.1 Casemate system fully implemented by February 2005.	**Met** 1.6.1 The Commission's new database system, Casemate, came into effect on 7 March 2005. Further development will be required in the coming year.

1.7 Establish records management policies and procedures to comply with State Records Act 1998

Measure 1.7.1 Records management policy developed by March 2005.	**Not met** 1.7.1 The Commission's records management has been seriously deficient. A review of the records system has been commissioned and representatives of State Records have been consulted.

1.8 Develop and implement Ethnic Affairs Priority Statement.

Measure 1.8.1 Implemented in compliance with Government policy.	**Not met** 1.8.1 Although an Ethnic Affairs Priority Statement was not done for the reporting period, due to the departure of the Corporate Services Manager and the reorganisation of the Corporate Service Division, a number of initiatives have been undertaken which are detailed in the section on Access to Services. It is anticipated that the Ethnic Affairs Priority Statement will be done in 2005-06.

1.9 Develop and implement Disability Action Plan.

Measure 1.9.1 Implemented in compliance with Government policy.	**Not met** 1.9.1 Although a Disability Action Plan was not done for the reporting period, due to the departure of the Corporate Services Manager and the reorganisation of the Corporate Service Division, a number of initiatives have been undertaken which a detailed in the section on Access to Services. It is anticipated that the Disability Action Plan will be done in 2005-06.

Goal 2: Quality improvement in the health system and promotion of effective complaint resolution practices.

2.1 Promote improvement in both the provision of health care and public awareness of the resolution of complaints about health care.

Measures 2.1.1 Establish an effective liaison with the Clinical Excellence Commission and NSW Department of Health to contribute to improved quality assurance systems.	**Met** 2.1.1 The former Acting Commissioner and Deputy Commissioner have met with the senior staff of the Clinical Excellence Commission. It is anticipated that future meetings will occur during 2005-06. The Director General of NSW Health and the Commissioner have regular meetings and the Commission has an ongoing liaison with the Area Health Services Clinical Governance Units.
2.1.2 Develop a handbook and guidelines to improve the management of complaints by health care services in cooperation with and sponsored by the Australian Council for Safety and Quality in Health Care.	**Met** 2.1.2 The Commission developed a handbook for health care services in 2004. This arose from the project, "Turning Wrongs into Rights" in 2004 which was the report of the project sponsored by the Australian Council for Safety and Quality in Health Care, that was designed to improve the way health care services managed complaints, with emphasis on the link to quality improvement.
2.1.3 Commence development of a Code of Practice under s. 80(1) (i) of the *Health Care Complaints Act 1993.*	**Not Met** 2.1.3 The Commission has re-activated its meetings with its Consumer Consultative Committee. The first meeting was held in March 2005. The Consumer Consultative Committee meets quarterly and will advise the Commission on the development of a Code of Practice. The Commission's internal processes require substantial development before they can be used as a basis for a Code of Practice.

Goal 3: HCCC accountable to its stakeholders for performance.

3.1 Providing timely, accurate advice and relevant reporting to the Minister and NSW Joint Parliamentary Committee.

Measures	**Met**
3.1.1 Develop regular management reports to the Minister on operations and performance commencing from January 2005.	3.1.1 Monthly meetings with the Minister were conducted with the former Acting Commissioner and Deputy Commissioner to report on operations and performance of the Commission. The Minister receives briefing notes arising from Ministerials.
3.1.2 Develop open and meaningful communications with the JPC.	**Met** 3.1.2 The former Acting Commissioner and Deputy Commissioner met with the JPC in May and November 2004 and in March 2005. The Chair of the JPC visited the Commission offices on 27 July 2004.
3.1.3 No major deficiencies identified during JPC hearing into 2003-04 Annual Report.	**Met** 3.1.3 No major deficiencies were identified. The JPC did identify some areas for improvement in the Annual Report.

3.2 Reporting publicly about the work of the Commission

Measures	**Met**
3.2.1 Annual report prepared and submitted to the Minister by 31 October.	3.2.1 Timeframes complied with.
3.2.2 Annual report reflects the key business and operational results and fully complies with legislative requirements.	**Met** 3.2.2 Full compliance with legislative requirements.
3.2.3 Promotion of HCCC messages through various communication channels: •◦◦ Commence website redevelopment •◦◦ Key publications revised •◦◦ Consumer liaison strategy developed.	**Partly Met** 3.2.3 The Commission's website has not yet been redeveloped. The Commission has a revised complaints guide available on its website. New guides relating to the Complaints Resolution Service, a simplified complaints guide and a Rights and Responsibilities guide are currently being developed. The Commission has commenced quarterly meetings with its Consumer Consultative Committee. The Commission also reports publicly about its work to the Minister, Members of Parliament through Ministerials and the media.

Goal 4: Develop as a learning organisation that embraces a culture of continuous improvement, sharing of knowledge and promotes a safe, productive and satisfying workplace.

4.1 Develop and implement a staff performance management system linked to business objectives/goals that includes individual learning and development plans.

Measures	**Met**
4.1.1 Develop performance management policies and procedures by January 2005.	4.1.1 The Commission has developed a policy and planning agreement templates for implementation in 2005-06 as part of the new business planning process for each division.
4.1.2 Review training and competency requirements of all positions by June 2005 as a basis for the provision of staff training and learning opportunities.	**Partly met** 4.1.2 All investigation staff have participated in training on basic investigation techniques. Further staff training will be based on the individual needs of officers, as identified from the performance agreements.
4.1.3 Pilot performance management agreements and performance reviews for the six months ending June 2005.	**Not Met** 4.1.3 The restructure and internal reforms implemented at the Commission for the reporting year and the fact that the appointments of senior staff were not finalised until March 2005 has meant that there has been a delay in piloting the performance management agreements.

4.2 Undertake an organisation realignment to establish organisation and governance structures that support the delivery of quality performance results.

Measures	**Met**
4.2.1 Establish new Divisional structure by December 2004	4.2.1 A new Divisional structure has been established comprising Assessments and Resolution, Investigations, Legal and Corporate Services.
4.2.2 Establish senior management positions by December 2004	**Met** 4.2.2 All senior management positions were filled by March 2005. Change management processes have been introduced, including changes to the assessment process and to the role of function of the Legal Division, with input from the Workplace Consultative Committee.
4.2.3 Develop a change management program by February 2005 to implement the new organisation structure including the involvement of the Workplace Consultative Committee in the implementation program.	**Partly Met** 4.2.3 The Commission has undergone considerable organisational change during the reporting period. Changes have been made to structures and processes in the assessment, investigations and legal divisions. The Commission is restructuring its Corporate Services and I.T Divisions and this will be finalised in 2005-06 . Regular consultation with the Workplace Consultative Committee has occurred during the period of restructure.
4.2.4 Staff consultation and recruitment action commenced by February 2005.	**Met** 4.2.4 New positions have been created including a new management position in the Investigations division and two grade 5/6 positions in the Complaints Assessment Team that will be responsible for the management of a small team of assessment officers.

Goal 5: Be a lead agency in our governance and corporate infrastructure.

5.1 Develop and implement strategic planning processes that integrate all planning activities, budget preparation and regular performance reporting.

Measures	**Met**
5.1.1 Develop a business framework that links business plans and budgets with individual staff performance agreements.	5.1.1 A business framework was developed in December 2004.
5.1.2 Prepare divisional plans in line with the goals of the Corporate Plan.	**Not met** 5.1.2 The focus on implementing change and restructure as well as the finalisation of the Senior Executive Team occurring in March 2005, has meant that divisional plans were not finalised. New divisional plans will be completed for 2005-06.
5.1.3 Implement quarterly business performance reporting from March 2005.	**Partly Met** 5.1.3 The introduction of Casemate has facilitated the reporting process. Reports are still being refined.
5.1.4 Review and update key corporate performance measures/indicators for implementation in 2005-06.	**Met** 5.1.4 Key corporate performance measures/indicators have been reviewed for implementation in 2005-06.

5.2 Establish internal management groups to plan, review and monitor performance.

Measures	**Met**
5.2.1 Develop terms of reference for key management groups (Investigations Review Panel, Executive Group etc).	5.2.1 The Executive Team meets fortnightly and incorporates a monthly IMT planning meeting. The Investigations Review Group meets fortnightly to monitor and review investigations.
5.2.2 Implement a regular program of meetings from December 2004.	**Met** 5.2.2 As well as the meetings noted in 5.2.1 monthly staff meetings occur.

5.3 Review HCCC's long term information and technology requirements in line with the Commission's business priorities.

Measure	**Not Met**
5.3.1 Review and update IM and T Strategic Plan by February 2005.	5.3.1 IM and T planning has been short term as the Commission has focussed on replacing outdated equipment and implementing Casemate. More long term planning for IT will occur in 2005-06.
5.3.2 Develop Commission's reporting requirement list.	**Partly Met** 5.3.2 The introduction of Casemate has improved the reporting capacity of the Commission. There is still further work to be done in this area.

5.4 Develop internal audit program focusing on high risk areas within the Commission.

Measures 5.4.1 Engage qualified internal audit services provider by December 2004. 5.4.2 Develop a three year audit program based on business risk assessment.	**Partly Met** 5.4.1 and 5.4.2 Deloitte was engaged to identify high risk areas as a basis for a program of internal audit.

5.5 Establish effective workplace relationship management practices involving consultation between management, staff and the union.

Measures 5.5.1 Review and negotiate new HCCC Workplace Agreement 5.5.2 Implement regular meetings of the WCC to discuss staff issues including consultation on the Commission's change management program	**Not Met** 5.5.1 The HCCC workplace agreement will be reviewed and areas for negotiation identified in 2005-06. **Met** 5.5.2 The Workplace Consultative Committee meets with Management on a monthly basis and have been consulted on the change management program.

Amendments to the Health Care Complaints Act, 1993

Amendments to the *Health Care Complaints Act* came into effect on 1 March 2005. The impetus for the amendments to the legislation was the findings contained in the reports of the Special Commission of Inquiry into Campbelltown and Camden Hospitals. Commissioner Bret Walker SC found that many of the shortcomings of the Commission were related not to the statutory framework itself but to the failure of the Commission to properly comply with its statutory obligations. However, he concluded that some changes to the statutory framework of the Health Care Complaints Commission were needed because they could "offer real prospect of improvement".

A major thrust of the amendments has been to refocus the Commission on investigating serious complaints and to improve the operations of the complaints process. The Commission has been given increased powers to achieve these objectives. There are also obligations placed on the Commission regarding notification and review.

The Commission must promptly identify and notify practitioners who are the subject of complaints and the allegations against them. Section 20A imposes a duty on the Commission to keep under review its assessment of a complaint.

Sections 21A and 34A empower the Commission to require the production of hospital, medical and practice records during assessment of a complaint and investigation. In addition, when the Commission investigates a complaint, it can require relevant people to provide documents and information. While that information cannot be used in criminal or civil proceedings it can be used in disciplinary proceedings.

The requirement that a statutory declaration must be provided in support of a complaint has been removed.

Section 85 provides for the inclusion within the Commission of the Health Conciliation Registry. This amendment ensures that all dispute resolution functions are performed by the same body.

To ensure that the conciliation functions of the Registry are kept independent of the Commission there is statutory recognition of the separate role of the Registry, provision that the Registry and conciliators are independent of the Commission when conducting conciliations, offence provisions to prevent the unauthorised disclosure by Registry staff or conciliators of information obtained as part of their duties, and giving the parliamentary joint committee a role in overseeing the operation of the Registry.

The powers of the Director of Proceedings are contained in Part 6A of the Health Care Complaints Act. Section 90B provides the functions of the Director of Proceedings and also confers the power to prosecute complaints. Section 90C sets out the criteria that the Director of Proceedings must consider when determining whether to prosecute a matter. Although co-located in the Commission, the Director of Proceedings makes the decision to prosecute a practitioner independently from the Commissioner.

Assessments & Resolution Division

Overview

The Assessments and Resolution Division comprises the Complaint Assessment Team, the Complaints Resolution Service and the Health Conciliation Registry.

It is fundamental to effective complaint handling that complainants feel that their sense of grievance has been acknowledged and taken seriously.

Complainants want to know that they will be kept informed of how their complaint will be managed and what they can expect from the process. It is important that this commences at the assessment stage when complaints are first received, recorded and assessed by the Commission. It is equally important that this carries through to the final resolution of the complaint. Appropriate referrals play an important role in reassuring complainants that their complaints are being taken seriously and will be handled sensitively and appropriately. Similarly, health services providers, both individuals and institutions, are entitled to some certainty when they are the subject of a complaint being managed by the Commission.

The Commission has made changes to its structure and operations to better meet these expectations.

Figure 1 shows the number of complaints received in the years 2002-03 to 2004-05.

FIGURE 1 - NUMBER OF COMPLAINTS RECEIVED

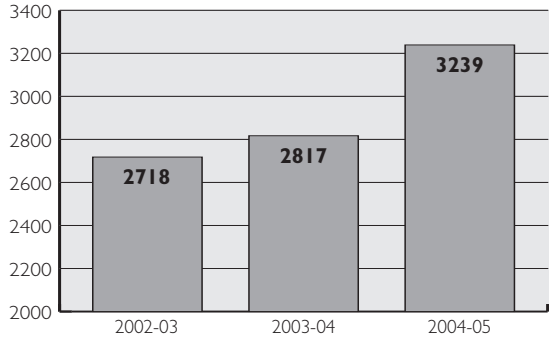


Table 1 shows a summary of the complaints received by category from 2002-2003 to 2004- 2005.

TABLE 1 - SUMMARY OF COMPLAINTS RECEIVED BY CATEGORY 2002-03 TO 2004-05

Category	2002-2003		2003-2004		2004-2005	
	No.	%	No.	%	No.	%
Treatment	1103	40.6%	1154	41.0%	1439	43.3%
Professional Conduct	432	15.9%	457	16.2%	784	23.6%
Communication	315	11.6%	294	10.4%	306	9.2%
Access	210	7.7%	247	8.8%	204	6.1%
Miscellaneous	18	0.7%	121	4.3%	83	2.5%
Cost	123	4.5%	123	4.4%	175	5.3%
Corporate Services	333	12.3%	252	8.9%	120	3.6%
Privacy/Discrimination	93	3.4%	73	2.6%	114	3.4%
Consent	75	2.8%	62	2.2%	80	2.4%
Grievances	16	0.6%	34	1.2%	17	0.5%
Total	**2718**	**100.0%**	**2817**	**100.0%**	**3322 ***	**100.0%**

* This figure differs from the number of complaints received as from 1 March 2005 more than one issue can be recorded against a single provider.

A summary of the breakdown of the categories of complaints is set out in Table 2.

TABLE 2 - BREAKDOWN OF CATEGORY OF COMPLAINTS RECEIVED 2004-05

Issue Category	Issue Name	Count	%
Treatment		**1430**	**43.0%**
	Inadequate Treatment	863	60.3%
	Diagnosis	218	15.2%
	Medication	168	11.7%
	Wrong/Inappropriate Treatment	111	7.8%
	Infection Control	29	2.0%
	Coordination of treatment	21	1.5%
	Rough/Painful Treatment	15	1.0%
	Negligent Treatment	11	0.8%
	Withdrawal/Denial of Treatment	3	0.2%
Professional Conduct		**784**	**23.6%**
	Competence	182	23.2%
	Failure to Complete Annual Declaration	161	20.5%
	Illegal Practices	128	16.3%
	Certificates/Reports	116	14.8%
	Sexual Misconduct	52	6.6%
	Impairment	41	5.2%
	Assault	37	4.7%
	Financial Fraud	32	4.1%
	Accuracy/Inadequacy of Records	29	3.7%
	Breach of Conditions	6	0.8%
Communication		**306**	**9.2%**
	Attitude	200	65.4%
	Inadequate Information	59	19.3%
	Wrong/Misleading Information	47	15.4%
Access		**204**	**6.1%**
	Delay in Admission or Treatment	77	37.7%
	Refusal to Admit or Treat	41	20.1%
	Discharge or Transfer Arrangements	25	12.3%
	Attendance	23	11.3%
	Service Availability	16	7.8%
	Waiting Lists	11	5.4%
	Referral	6	2.9%
	Transport	5	2.5%
Cost		**175**	**5.3%**
	Billing Practices	131	74.9%
	Overcharging	24	13.7%
	Information on Costs	16	9.1%
	Private Health Insurance	2	1.1%
	Government Subsidies	1	0.6%
	Public/Private Election	1	0.6%
Corporate Services		**120**	**3.6%**
	Hotel Services	44	36.7%
	Hygiene/Environmental Standards	42	35.0%
	Administrative Services	34	28.3%
Privacy/Discrimination		**114**	**3.4%**
	Privacy/Confidentiality	53	46.5%
	Access to Records	50	43.9%
	Discrimination	8	7.0%
	Inconsiderate Service	3	2.6%
Legacy Code [1]		**82**	**2.5%**
	Re-Registration (Legacy Code)	52	63.4%
	Prosthetic Devices (Legacy Code)	18	22.0%
	Convictions (Legacy Code)	12	14.6%
Consent		**80**	**2.4%**
	Consent not obtained	43	53.8%
	Consent Invalid	17	21.3%
	Consent not informed/Failure to warn	14	17.5%
	Failure to consult consumer	3	3.8%
	Involuntary Admission	3	3.8%
Grievances		**17**	**0.5%**
	Inadequate/No response to complaint	15	88.2%
	Reprisal/Retaliation	2	11.8%
Other Unethical/Improper Conduct		**1**	**0.0%**
	Other Unethical/Improper Conduct	1	100.0%
Total		**3322 ***	**100.0%**

1 Codes from the database that operated before casemate.
* This figure differs from the number of complaints received as from 1 March 2005 more than one issue can be recorded against a single provider.

All complaints received by the Commission or referred by Registration Boards are assessed by the Complaint Assessment Team. The purpose of assessment is to determine if a complaint should be investigated by the Commission, referred to the Health Conciliation Registry for conciliation, referred to the Complaints Resolution Service for assisted resolution, referred to another body, which could include a Registration Board or an investigative agency, or if the complaint should be discontinued. Assessment decisions of complaints received for the years 2002-03 to 2004-05 is at Table 3.

Where a complaint does not require formal investigation by the Commission under s.23 of the *Health Care Complaints Act* the assessment process (including consultation) should focus on identifying the method of managing the complaint that is, in all the circumstances, most likely to produce a resolution that is fair and equitable to the parties to the complaint.

In deciding what form of resolution should be recommended the Commission has regard to:

- the nature of the complaint;
- the personal circumstances of the complainant;
- the outcomes being sought by the complainant;
- the outcomes that are reasonable in the circumstances;
- the ability of the complainant to effectively represent their own interests in dealing with the provider or providers involved;
- the response (if any) received from the provider or providers; and
- the preparedness or otherwise of the provider or providers to address the complainant's concerns.

During the assessment of a complaint the Complaint Assessment Team makes efforts to contact the complainant to ensure there is a proper understanding of the complaint. The Team also seeks a response from the health service provider about whom the complaint was made and obtains clinical records where necessary. The response and medical records are reviewed by a Commission medical or nursing advisor and/or a peer where this would assist in making the assessment decision. In cases where the complaint relates to a registered practitioner the Commission will consult with the relevant Registration Board prior to making an assessment decision.

The majority of complaints received by the Commission do not warrant formal investigation under s.23 of the Act. Nevertheless, these complaints do indicate a cause for dissatisfaction or concern on the part of the complainant. The Commission attempts to provide means by which these complaints can be resolved. The two most significant forms of resolution are 'in house' in that they are operated by the Commission.

The first of these is the Complaints Resolution Service. Complaints Resolution Officers are able to assist complainants to resolve their complaints by, for example, obtaining additional information for the complainant about why a particular procedure was or was not performed, addressing concerns about poor communication – in many cases the complainant did not have a full understanding of what occurred and why it occurred, ensuring that treatment will continue or assisting the complainant to obtain an acknowledgement from the health service providers involved that the complainant had a poor experience

TABLE 3 - ASSESSMENT DECISION OF COMPLAINTS RECEIVED 2002-03 TO 2004-05

Assessment Decision	2002-2003 No.	2002-2003 %	2003-2004 No.	2003-2004 %	2004-2005 No.	2004-2005 %
Decline	543	20.0%	659	23.4%	936	28.2%
Refer to another body or person	1,118	41.1%	964	34.2%	630	19.0%
Investigation by the Commission	232	8.5%	455	16.2%	523	15.7%
Other resolution	612	22.5%	551	19.6%	399	12.0%
Conciliation consented to or awaiting consent*	202	7.4%	171	6.1%	163	4.9%
Awaiting assessment as at 30 June	11	0.4%	17	0.6%	671	20.2%
Total	**2,718**	**100.0%**	**2,817**	**100.0%**	**3,322**	**100.0%**

* This figure differs from the number of complaints received as from 1 March 2005 more than one issue can be recorded against a single provider. Excludes No Jurisdiction 98, Withdrawal of Drug Authority 4.

while under their care. Additional information about the Complaints Resolution Service, including performance measures, is included below.

The second is conciliation through the Health Conciliation Registry. Conciliation is a more formal process than assisted resolution by a Complaints Resolution Officer. In conciliation an independent conciliator, selected from a panel of conciliators appointed by the Minister, facilitates a meeting of the parties to a complaint in an attempt to achieve an appropriate form of resolution. Conciliation is a voluntary and confidential process. Statements made and documents used in conciliation are not admissible in court or tribunal proceedings. For this reason conciliation provides an appropriate means of complaints resolution in cases where a complainant is seeking compensation or an admission of error or wrongdoing by the providers involved in the complainant's care or treatment as well as more general complaints about poor outcomes or a complainant's dissatisfaction about the services provided. More information about the Health Conciliation Registry, including performance measures, is included below.

Changes to Legislation

The operations of the Health Care Complaints Commission are governed by the *Health Care Complaints Act 1993*. A number of amendments to the Act and other legislation, which came into force on 1 March 2005, have changed the way in which the Commission's assessment process operates.

The more significant changes include:

1. The Commission must advise a health service provider that a complaint has been made concerning them within 14 days of the Commission making its assessment decision in relation to the complaint - the Commission has 60 days to make its assessment decision. Prior to the amendment the Commission was required to notify a provider about a complaint within 14 days of receiving the complaint, see s.16 of the Act.

2. The Commission is required to use its 'best endeavours' to contact the complainant to ensure that the Commission has an accurate understanding of the complaint, see s.20 of the Act.

3. The Commission is obliged to keep its assessment decision under review while it is dealing with a complaint and revise the decision where necessary. The Commission did not previously have the clear authority to revise its assessment decision, see s.20A of the Act.

4. When the Commission is assessing a complaint it can issue a notice to a health service provider, a complainant or any other person to obtain hospital or medical records or information about a health practitioner's practice, see s.21A. Where the Commission is investigating a complaint it can issue a notice to require the production of documents and the provision of information or evidence, see s.34A. These are new provisions and prior to the amendments the Commission did not have 'notice to produce' powers.

5. The Commission may refer a matter to the Director-General of Health, with the Director-General's consent, where the Commission believes that the complaint or part of the complaint could be the subject of an inquiry by the Director-General under the *Public Health Act 1991* or the *Health Services Act 1997*, see s.25A. Where such a referral is made the Commission must discontinue dealing with the complaint unless it concerns the professional conduct of a health practitioner or a health service that affects the clinical management or care of an individual client.

6. The Commission may refer a complaint to a Registration Board, after consultation, if it appears that the complaint should be referred so that the Board can consider taking action, see s.25B. Where a complaint is referred to a Board the Commission must discontinue dealing with it. This is a significant change in practice, prior to the amendment the Commission usually also referred these complaints to a Patient Support Officer (predecessor the Complaints Resolution Officers).

7. The Commission is no longer permitted to refer a complaint to an Area Health Service for their investigation and report back to the Commission. The Commission may refer a complaint to a public health organisation, such as an AHS, for resolution at the local level where the AHS consents to the referral. The Commission may refer a complaint to another body, not being a public health organisation, for its investigation, see s.26.

8. The Complaints Resolution Service is for the first time recognised in the Act (see Division 9 of Part 2 of the Act).

Future Directions

During 2004-05 there has been considerable change at the Commission including the establishment of the Assessments and Resolution Division, changes to the structure of the Commission's complaints assessment program, renaming the Patient Support Service and documenting our assessment and referral processes. The motivation for these changes is to ensure that the Commission can demonstrate that it has a reasonable basis for its assessment decisions and its referral of matters for resolution or other action. The changes also ensure that the Commission obtains sufficient relevant information to make an informed decision in each case and becomes more responsive to the needs and expectations of complainants and practitioners.

The Commission will be consolidating these changes in the coming year as well as strengthening the supervision arrangements in place for the assessment process and developing new information packages, brochures and fact sheets and updating the website to provide information to members of the public to assist them *before* they become complainants. The Commission will be conducting more and more regular training and development activities for Assessment Officers. The Commission will also be confirming the consultation process with each of the Registration Boards and agreeing on appropriate bases for referrals to them.

Operational Activities of the Division

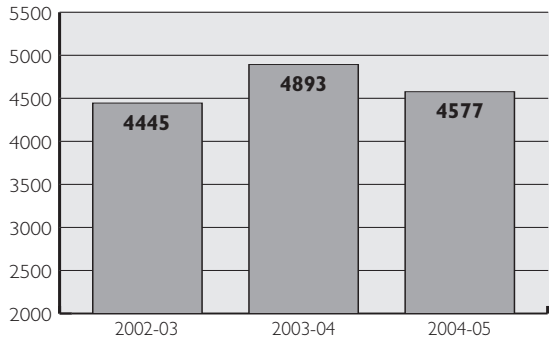
In this section, the operations of the Complaint Assessment Team, the Complaints Resolution Service and the Health Conciliation Registry, including performance measures, are explained in more detail (together with, in the case of the Complaints Resolution Service, some case studies).

1. THE COMPLAINT ASSESSMENT TEAM

The Complaint Assessment Team is the Commission's first point of contact for members of the public. This initial contact may occur in the following ways:

- The Commission's Telephone Inquiry Service is available between 9 am and 5 pm each working day. The purpose of this service is to provide health consumers with an opportunity to obtain information about the complaints process; discuss their concerns so that they are able to put them in some context; obtain information about of other avenues of redress that may be more appropriate to manage their complaint as well as provide assistance in making a complaint to the Commission. During the 2004-2005 reporting period 4577 calls were received. Figure 2 shows the number of telephone inquiries received by the Commission for the years 2002-03 to 2003-05.

FIGURE 2 - NO. OF TELEPHONE INQUIRIES RECEIVED



- The Complaint Assessment Team also deals with members of the public who attend the Commission's offices in person. As with the Telephone Inquiry Service the purpose of this is to provide health consumers with an opportunity to obtain information about the complaints process; discuss their concerns so that they are able to put them in some context; obtain information about other avenues of redress that that may be more appropriate to manage their complaint; and to provide assistance in preparing their complaint.

- The Complaint Assessment Team receives all written complaints directed to the Commission, and is responsible for their management up to the point when an assessment decision is made by the Commission. During the 2004-2005 reporting period the Commission received 3239 written complaints.

Table 4 shows the complaint assessment performance for 2004-05.

TABLE 4 - COMPLAINT ASSESSMENT PERFORMANCE

	2002-2003	2003-2004	2004-2005
% of complaints assessed within 60 days	99.7%	92.3%	87.7%
Average number of days to finalise non-investigation complaints	39 days	39 days	25 days

Tables 5-9 show the assessment decisions of complaints.

TABLE 5 - CATEGORY OF COMPLAINTS ASSESSED AND DECLINED 2002-03 TO 2004-05

Category	2002-2003 No.	2002-2003 %	2003-2004 No.	2003-2004 %	2004-2005 No.	2004-2005 %
Treatment	175	32.2%	181	27.5%	374	40.0%
Professional Conduct	147	27.1%	148	22.5%	163	17.4%
Communication	69	12.7%	79	12.0%	119	12.7%
Cost	35	6.4%	40	6.1%	68	7.3%
Access	20	3.7%	48	7.3%	64	6.8%
Corporate Services	53	9.8%	65	9.9%	59	6.3%
Privacy/Discrimination	27	5.0%	22	3.3%	41	4.4%
Consent	6	1.1%	16	2.4%	24	2.6%
Miscellaneous	3	0.6%	44	6.7%	16	1.7%
Grievances	8	1.5%	16	2.4%	8	0.9%
Total	**543**	**100.0%**	**659**	**100.0%**	**936***	**100.0%**

Excludes: No Jurisdiction 75; Withdrawal of drug authority 9. * Of these 52 were resolved during assessment

TABLE 6 - CATEGORY OF COMPLAINTS ASSESSED FOR DIRECT AND ASSISTED RESOLUTION 2002-03 TO 2004-05

Category	2002-2003 No.	2002-2003 %	2003-2004 No.	2003-2004 %	2004-2005 No.	2004-2005 %
Treatment	245	40.0%	184	33.4%	159	39.8%
Access	57	9.3%	77	14.0%	51	12.8%
Communication	112	18.3%	87	15.8%	49	12.3%
Cost	61	10.0%	46	8.3%	37	9.3%
Professional Conduct	35	5.7%	42	7.6%	30	7.5%
Privacy/Discrimination	29	4.7%	24	4.4%	24	6.0%
Corporate Services	44	7.2%	47	8.5%	22	5.5%
Consent	20	3.3%	14	2.5%	20	5.0%
Miscellaneous	1	0.2%	19	3.4%	0	0.0%
Prosthetic Devices	1	0.2%	2	0.4%	4	1.0%
Grievances	7	1.1%	9	1.6%	3	0.8%
Total	**612**	**100.0%**	**551**	**100.0%**	**399**	**100.0%**

Excludes: No Jurisdiction 16.

TABLE 7 - CATEGORY OF COMPLAINTS REFERRED TO ANOTHER BODY OR PERSON FOR ACTION 2002-03 TO 2004-05

Category	2002-2003 No.	2002-2003 %	2003-2004 No.	2003-2004 %	2004-2005 No.	2004-2005 %
Treatment	478	42.8%	433	44.9%	297	47.0%
Professional Conduct	152	13.6%	143	14.8%	151	24.0%
Communication	101	9.0%	91	9.4%	68	11.0%
Corporate Services	187	16.7%	90	9.3%	29	4.7%
Cost	20	1.8%	33	3.4%	26	4.0%
Access	104	9.3%	87	9.0%	20	3.0%
Privacy/Discrimination	30	2.7%	23	2.4%	16	2.5%
Miscellaneous	9	0.8%	36	3.7%	12	2.0%
Consent	36	3.2%	22	2.3%	10	1.6%
Grievances	1	0.1%	6	0.6%	1	0.2%
Total	**1118**	**100.0%**	**964**	**100.0%**	**630**	**100.0%**

Miscellaneous: Convictions 6; Prosthetic Devices 6. - Excludes: No Jurisdiction 9;

TABLE 8 - COMPLAINTS REFERRED TO ANOTHER BODY 2002-03 TO 2004-05 BY THE TYPE OF BODY REFERRED TO

Body Referred To	2002-2003 No.	2002-2003 %	2003-2004 No.	2003-2004 %	2004-2005 No.	2004-2005 %
Registration Board	453	40.4%	483	50.2%	482	76.5%
AHS	470	42.0%	348	36.1%	94	14.9%
Other body	64	5.7%	62	6.4%	22	3.5%
Director-General	6	0.5%	7	0.7%	19	3.0%
Other Commonwealth government body	8	0.7%	14	1.5%	8	1.3%
Other government department	102	9.1%	45	4.6%	4	0.6%
Private health provider	2	0.2%	1	0.1%	1	0.2%
Private Health Insurance Commission	8	0.7%	4	0.4%	0	0.0%
Awaiting processing as at 30 June 2005	7	0.6%	0	0.0%	0	0.0%
Total	**1,120**	**100.0%**	**964**	**100.0%**	**630**	**100.0%**

Excludes: No Jurisdiction 9.

TABLE 9 - CATEGORY OF COMPLAINTS ASSESSED FOR INVESTIGATION 2002-03 TO 2004-05

Category	2002-2003 No.	2002-2003 %	2003-2004 No.	2003-2004 %	2004-2005 No.	2004-2005 %
Professional Conduct	92	39.7%	119	26.2%	232	44.3%
Treatment	85	36.6%	264	58.0%	196	37.5%
Miscellaneous	5	2.2%	5	1.1%	62	11.9%
Access	12	5.2%	18	4.0%	14	2.7%
Corporate Services	22	9.5%	26	5.7%	11	2.1%
Communication	7	3.0%	9	2.0%	6	1.1%
Privacy/Discrimination	2	0.9%	4	0.9%	2	0.4%
Consent	6	2.6%	6	1.3%	0	0.0%
Cost	1	0.4%	3	0.7%	0	0.0%
Grievances	0	0.0%	1	0.2%	0	0.0%
Total	**232**	**100.0%**	**455**	**100.0%**	**523**	**100.0%**

Miscellaneous: Re-registration 52; Convictions 4.

Preparation of materials for assessment of complaints

The more proactive management of complaints that commenced late in 2003/04 has been further developed during 2004/05. The purpose of this has been to ensure assessment decisions are made based on all of the relevant information.

The steps that the Commission takes when assessing a complaint will usually include:

- ***Contacting the complainant.*** An Assessment Officer will attempt to contact the complainant to discuss the complaint and ensure that the Commission has a proper understanding of the complainant's concerns.

- ***Seeking a response from the health service providers.*** The Commission will usually seek a response from the health service provider or providers identified from the complaint. A copy of the complaint is usually sent to the provider or providers so that they can address the matters of concern.

- ***Accessing health records.*** The Commission will request a copy of relevant health records or clinical notes to assist its assessment in cases where the complaint raises concerns about the clinical aspects of treatment that was or should have been provided. This may, for example, include concerns about the appropriateness of a diagnosis or the effectiveness of treatment. A consent form ensuring that the provider can respond and authorising the Commission to get access to the relevant records is sent to complainants with the Commission's acknowledgement letter.

- ***Clinical advice.*** Where the Commission has a response from the provider or providers involved

and the relevant health records it will, where appropriate, seek clinical advice to assist in making an appropriate assessment decision. The Commission has medical and nursing advisors on staff and these and external peer reviewers are used to assess the appropriateness of the health care or treatment provided to the subject of the complaint.

- ***Board consultation.*** In the case of a health service provider who is registered in New South Wales the Commission is required under s.12 of the Act to consult with the relevant Registration Board as part of the assessment process. Various arrangements are in place to meet this obligation and the frequency and form of consultation varies with individual Boards.

When the Commission has completed its assessment, consulted with the appropriate Board and made its assessment decision the complainant and the providers identified from the complaint are informed in writing.

The results of this more proactive management have been positive. For example, the Registration Boards which the Commission consults about complaints have indicated that they consider that greater amounts of information relating to a complaint has provided the opportunity for more consistent and appropriate assessment decisions to be made.

Strategies to more effectively present a consistent message and information

The Complaint Assessment Team has increased its focus on ensuring that a consistent message and information is given to those who contact the Commission for information, and/or those who place written complaints with the Commission. This has been reflected in a number of ways including:

- Development of a new Complaint Guide which reflects the changes to the Act, and the changes in management and role of the Commission employees.

- Employing an officer, on a term basis, who is dedicated to managing telephone enquiries that are received by the Commission.

- The development of a detailed information-based acknowledgement letter for those who lodge written complaints with the Commission. It is anticipated that early provision of detailed information will increase complainants' understanding of the role of the Commission, the processes associated with managing their complaint, the outcomes available in respect of their complaint, and the reasons why a particular assessment decision may be made in relation to their complaint.

- The preparation of more detailed briefs to assist assessment, and the development of an assessment tool which assists in a consistent approach in the reasons why decisions that are made.

- An increasing focus on providing clearer information to complainants regarding the decisions of the Commission, and the reasons for those decisions

Increased focus on the resolution of complaints during assessment

In the case of less serious complaints, there are significant opportunities to resolve disputes as part of the assessment process. In clarifying the nature of a complaint or seeking more information from a complainant, it may become clear that the issue in dispute can be resolved informally. Assessment staff are being encouraged to explore opportunities for informal resolution where appropriate. Some examples of complaints resolved in this manner are:

- a complaint that relates to the reimbursement of fees for a health service that was inadequately provided was resolved when the service provider became aware of the written complaint to the Commission.

- a health practitioner provided an apology to the complainant relating to the manner of communication that occurred when this was the issue of the complaint.

Assessment Reviews

Section 28 of the *Health Care Complaints Act* provides for the review of a decision made after assessing a complaint at the request of the complainant. The amendments to the legislation require the Commission to undertake the review if the request is made within 28 days after the complainant is notified of the assessment decision.

For the reporting period the Commission received 232 requests for reviews of assessment decisions. This compares to 231 requests for review during 2003-04 and 165 requests during 2002-03.

In 2004-05 the Commission finalised 313 assessment reviews. This is a significant improvement in performance for the last two reporting periods. In

TABLE 10 - OUTCOME OF ASSESSMENT REVIEWS 2002-03 TO 2004-05

Review Result	2002-2003 No.	2002-2003 %	2003-2004 No.	2003-2004 %	2004-2005 No.	2004-2005 %
No further action required	120	86.0%	54	47.8%	297	94.9%
Re-assessment required	13	4.7%	50	44.2%	11	3.5%
Investigation by the Commission	7	0.5%	0	0.0%	5	1.6%
Review not conducted	1	4.1%	9	8.0%	0	0.0%
Total	**141**	**100.0%**	**113**	**100.0%**	**313**	**100.0%**

2003-04 the Commission determined 113 assessment reviews and in 2002-03 the Commission determined 141 assessment reviews.

Table 10 shows the review outcomes for 2004-05.

Continuing improvements in 2005-2006

There is a clear organisational commitment to continue to develop the quality of the work conducted by the Complaint Assessment Team. The importance of the role and function of this Team has been clearly recognised as integral to the effectiveness of the Commission. A number of new initiatives during 2004/05 reflect this:

- Building on the development of an effective branch structure to support the work of the team. This has been reflected in a decision to recruit staff with the skills and expertise to assist in the work of the Complaint Assessment Team. It is envisaged that the inclusion of Team Leaders will provide increased supervision, support and mentoring for Assessment Officers, and will therefore improve the quality of the assessment function.

- A commitment exists to provide development opportunities for staff through internal development and through training purchased from external providers.

- The appointment of a Director of Assessments and Resolution to direct the work of the Complaint Assessment Team, the Complaints Resolution Service and the Health Conciliation Registry.

- Improvement in the quality of work practices associated with the assessment of complaints.

- Increasing the skills of staff in relation to the early resolution of complaints, with an associated increase in the number of matters resolved during the assessment process.

2. COMPLAINTS RESOLUTION SERVICE

The Complaints Resolution Service (CRS), which was previously called the Patient Support Service, helps consumers and providers resolve complaints that have been assessed as suitable for assisted resolution by the Commission.

There are eleven Complaints Resolution Officers in New South Wales. Ten are out-posted in Area Health Services; six within the metropolitan area, based in Central Sydney, Northern Sydney, Penrith, South Eastern Sydney, South Western Sydney and Western Sydney, and four in regional areas, based in Newcastle, Wollongong, Dubbo and Lismore. One Complaints Resolution Officer (CRO) is based in the Commission and provides relief services. The CRS manager is also based at the Commission.

Aims of the Service

The CRS aims to:

- assist in the timely, efficient and effective resolution of health complaints;

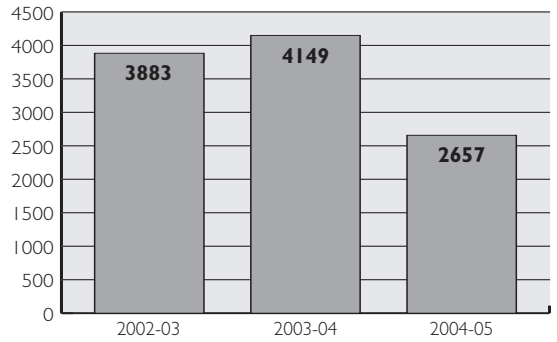
- assist consumers and health providers to understand approaches to local resolution of health concerns;

- equip consumers to take a positive and active role in their health care and to resolve their own concerns in the future; and

- facilitate access to appropriate health care.

Figure 3 shows the number of CRS clients for the years 2002-03 to 2004-05. The decline in the number for 2004-05 is due to the fact that complaints are more thoroughly assessed by the Commission than was previously the case before they are referred to the CRS.

FIGURE 3 - NUMBER OF CRS CLIENTS



Inclusion in the *Health Care Complaints Act 1993*

When the Patient Support Service was established in 1996 the *Health Care Complaints Act 1993* did not address its functions.

The Service had no statutory basis until amendments were made to the *Health Care Complaints Act* which came into effect on 1 March 2005. In Division 9 of part 2 of the amended Act the objects of the Commission, with regard to complaint resolution, are outlined as follows:

(a) to provide an alternate and neutral means of resolving complaints that is independent of the investigative processes of the Commission;

(b) to facilitate the resolution of complaints, including determining the most appropriate means of resolution having regard to the nature of the complaint and the expectations of the parties to the complaint;

(c) to provide information to health service providers and members of the public on the complaints resolution functions of the Commission under this Part.

Since 1996 the Patient Support Service had been resolving complaints but when the Act was amended a decision was made to change the Service's name to Complaints Resolution Service to reflect the clearer role set out in the legislation.

Change to referral source

In 2004 - 2005, the CRS provided a service to 2,657 people with health care concerns. While this is a marked decrease on the previous year it reflects the change in referrals to the Service that have occurred since the Act was amended. Previously the Service received complaints directly from the public or from health services as well as from the Commission. The CRS now deals only with written complaints that have been formally assessed and referred by the Commission.

Community liaison role

The amendments to the Act highlight the role of the Commission in providing information to the community and to health providers about the complaint resolution functions of the Commission. Complaint Resolution Officers are increasing their community liaison to provide such information. They are developing information material that will assist all parties involved in a complaint and will disseminate this material through networking and presentations in the coming year.

How clients found out about the CRS is at Table 11.

Category of concerns raised by CRS clients

CRS clients raise a wide range of concerns about health services. They are categorised using the Commission's complaint categories.

Table 12 shows the types of concerns raised by CRS clients.

TABLE 11 - HOW CLIENTS FOUND OUT ABOUT THE CRS 2002-03 TO 2004-05

	2002-2003		2003-2004		2004-2005	
	No.	%	No.	%	No.	%
HCCC	2872	74.0%	2785	67.1%	1556	58.6%
CRS promotion	466	12.0%	648	15.6%	571	21.5%
Health provider/facility	131	3.4%	246	5.9%	196	7.4%
Other/not known	241	6.2%	207	5.0%	153	5.8%
Directories	44	1.1%	67	1.6%	77	2.9%
Government body	80	2.1%	92	2.2%	47	1.8%
Consumer organisation	37	1.0%	60	1.4%	42	1.6%
Member of Parliament	12	0.3%	44	1.1%	15	0.6%
Total	**3,883**	**100.0%**	**4,149**	**100.0%**	**2,657**	**100.0%**

This total is based on the cases opened during the financial year.

TABLE 12 - TYPE OF CONCERNS RAISED BY CRS CLIENTS 2002-03 TO 2004-05

	2002-2003		2003-2004		2004-2005	
	No.	%	No.	%	No.	%
Treatment	1807	33.6%	2070	36.3%	1156	34.9%
Communication	825	15.3%	794	13.9%	480	14.5%
Access	669	12.4%	711	12.5%	451	13.6%
Miscellaneous	464	8.6%	557	9.8%	304	9.2%
Corporate Services	457	8.5%	394	6.9%	272	8.2%
Cost	368	6.8%	370	6.5%	208	6.3%
Privacy/Discrimination	333	6.2%	347	6.1%	195	5.9%
Professional Conduct	302	5.6%	256	4.5%	145	4.4%
Consent	111	2.1%	115	2.0%	56	1.7%
Grievances	38	0.7%	88	1.5%	42	1.3%
No Jurisdiction	5	0.1%	7	0.1%	6	0.2%
Total *	**5379**	**100.0%**	**5709**	**100.0%**	**3315**	**100.0%**

* This total is based on the 2657 cases opened during the financial year. It differs from the total number of clients because some clients raised more than one concern.

Miscellaneous: Information regarding health services, CRS or complaints mechanisms 268; Prosthetic devices 31; Health Insurance Commission 4; Convictions 1.

Treatment received from a health service or provider was the major source of concern. It has remained the major category of concern of CRS clients for the past three years and this year accounted for 34.9% of all concerns.

This category of complaint includes issues such as inadequate or incorrect diagnosis, inadequate or incorrect treatment, infection control or the quality of medical records. Most people sought explanations about what went wrong and assurances that it would not happen to others.

Communication issues were the second largest category of concern (14.5%). This category includes insensitive or rude communication, the provision of wrong or misleading information or the failure to communicate. People regularly complain that health professionals do not provide enough information or do not explain issues clearly enough. Some providers were said to be dismissive or rude when further information is sought.

The third largest category of concern was access to health care (13.6%). This category includes refusal to admit or treat, discharge or transfer arrangements as well as patient transport issues.

CRS concerns by location and service sector

Table 13 breaks down the concerns raised with the CRS by health service location and type of service (public, private, non-government or other).
The number of complaints handled fell for all Area Health Services. This was mainly due to the fact that informal complaint referral stopped at the time of the implementation of the amendments to the Act in March 2005. CRS concerns by location and sector is at Table 13. The Area Health Services were restructuredon 1 January2005.

Type of service provided by the Complaints Resolution Service

The services provided and recorded by the CRS are the provision of information, support and assisted negotiation. The CRS works with both the consumer and the provider to tailor a resolution strategy that will work for both parties. The flexibility of the model is critical to its acceptance and success. Table 14 shows the type of service provided to clients for the past three years.

80% of clients, whose issues were finalised during the year, were provided with either support or assisted advocacy services. 'Support' means listening, clarifying issues and assisting people to identify the most appropriate option for resolution. Complaint Resolution Officers aim to empower people to take action for themselves.

'Assisted negotiation' may include arranging and/or attending resolution meetings between the consumer and the health service, negotiating directly with the health service/provider on the consumer's behalf, assistance with writing a letter, locating health services that address the client's needs other means of facilitating local resolution. When resolution meetings are organised, the Complaint Resolution Officer works with both parties to clarify issues and desired

TABLE 13 - CRS CONCERNS BY LOCATION AND SERVICE SECTOR 2002-03 TO 2004-05

AHS	2002-2003 Total No.	2003-2004 Total No.	2004-2005 Public [1]	Private [2]	Other [3]	Total No.
Central Coast AHS	135	143	42	45	2	89
Central Sydney AHS	329	316	95	77	11	183
Corrections HS	158	286	233	2		235
Far West AHS	23	28	9	4	1	14
Greater Murray AHS	85	90	25	16	2	43
Hunter AHS	331	316	83	105	3	191
Illawarra AHS	147	298	138	64	12	214
Interstate/Out of State	4	9	3	6		9
Macquarie AHS	44	141	65	15	1	81
Mid North Coast AHS	146	144	39	40	4	83
Mid Western AHS	57	52	32	24	1	57
New England AHS	52	41	14	14		28
Northern Rivers AHS	129	207	66	57		123
Northern Sydney AHS	458	448	123	166	16	305
Not known	100	65	7	17	9	33
South Eastern Sydney AHS	612	556	158	188	12	358
South Western Sydney AHS	416	506	139	133	3	275
Southern AHS	80	69	21	12		33
Wentworth AHS	131	127	41	36	3	80
Western Sydney AHS	504	461	119	130	23	272
Total *	**3,941**	**4,303**	**1,452**	**1,151**	**103**	**2,706**

* This total is based on the 2657 files opened in the financial year. It differs from the total number of clients because some clients raised concerns about more than one health provider.

[1] Public: all public health services including public hospitals, public nursing homes and community health services.

[2] Private: all private health services including private hospitals and nursing homes, private practitioners e.g. GPs, specialists, dentists etc.

[3] Other: all Non Government Organisation (NGO) health services and concerns about system wide issues, access to services that involve all sectors.

Note: Private and NGO health services are located within the geographical boundaries of an Area Health Service but are not under its control.

TABLE 14 - TYPE OF SERVICE PROVIDED BY CRS 2002-03 TO 2004-05

	2002-2003 No.	2002-2003 %	2003-2004 No.	2003-2004 %	2004-2005 No.	2004-2005 %
Information only	808	20.9%	861	19.9%	705	21.0%
Support & Assisted Negotiation	3,059	79.1%	3,469	80.1%	2,645	79.0%
Total *	**3,867**	**100.0%**	**4,330**	**100.0%**	**3,350**	**100.0%**

* This total is based on the 3250 files closed during the financial year. It differs from the total number of clients because some clients raised concerns about more than one provider.

outcomes. In complex cases, an issues paper is prepared and sent to the provider or health organisation prior to the meeting. More than one meeting may be required to reach resolution.

A minority of clients (20%) were either provided with information or were clients who could not be contacted after referral. When information was provided it assisted them to: obtain health or community services; exercise their health rights; find out how to contact consumer support groups or the appropriate person with whom to discuss their health issues.

Data collected from the Complaints Resolution Service's satisfaction survey show that 25.9% of clients had one or two contacts with the Service, 29.6% had three to four contacts and 40.0% had five or more contacts. 4.6% of survey respondents did not indicate the number of times they contacted the CRS.

Outcomes achieved 2004 - 2005

The various outcomes of the CRS for the past three years are noted in Table 15. The total for 2004 – 2005 reflects the number of outcomes recorded on the

3,350 files that were closed in the reporting year. More than one outcome is possible for each client eg an apology and a change in procedure. The number of outcomes therefore does not match the total number of clients or concerns.

Outcomes of complaints for consumers are known where Complaints Resolution Officers have been involved in the resolution of the concerns. These known outcomes are recorded under 'resolved', 'partially resolved', 'not resolved' and 'unable to be resolved'. Outcomes are generally not known where the client pursued the concerns with another body or where the client declined CRS involvement.

Where Complaints Resolution Officers were directly involved in the resolution of concerns, 86.3% of matters were resolved or partially resolved compared with the performance target of 80%. CRS outcomes are at Table 15.

TABLE 15 - CRS OUTCOMES 2004-05

Category	Count	%
No contact or patient declined involvement	**125**	**3.5%**
No contact or patient declined involvement	125	3.5%
Client pursued with another body/person	**992**	**27.6%**
HCCC	433	12.0%
Health facility/provider	291	8.1%
Other Government Body	108	3.0%
Legal advisor	94	2.6%
Other (Specify)	66	1.8%
Resolved	**1598**	**44.4%**
Explanation/Information	858	23.8%
Received service	424	11.8%
Apology provided	117	3.3%
Refund/expenses paid	95	2.6%
System/practice change	67	1.9%
Other (Specify)	37	1.0%
Incomplete Resolution	**544**	**15.1%**
Explanation/Information	397	11.0%
Received service	50	1.4%
Apology provided	44	1.2%
System/practice change	23	0.6%
Other (Specify)	16	0.4%
Refund/expenses paid	14	0.4%
Not Resolved	**251**	**7.0%**
Client did not proceed	141	3.9%
Parties unable to agree on facts/resolution	82	2.3%
Other (Specify)	16	0.4%
Provider - refusal to participate	12	0.3%
Unable to be Resolved	**89**	**2.5%**
Lost contact with party/ies	65	1.8%
Other (Specify)	14	0.4%
Information not available	10	0.3%
Total	**3599**	**100.0%**

* This total is based on the 3250 cases closed during the financial year.

Types of Outcomes

- ***Total /partial resolution***

59.5% of outcomes recorded indicate total or partial resolution of client concerns. The provision of information or an explanation resolved client concerns in over half of those cases (1255). For example, clients were able to understand: what actually happened to them when something went wrong; why and how decisions were taken during treatment; or what the doctor or dentist meant when using medical jargon.

Approximately a quarter of the cases (474) were resolved when clients received services as a result of raising their concerns. For example clients were able to access health services; they were offered another operation/alternate service or received a copy of the medical records that had previously been refused. An apology resolved concerns in 161 cases and refunds or waived fees in 109 cases. Practice/system changes were recorded in 90 cases and clients were reassured that what had gone wrong would be avoided in future.

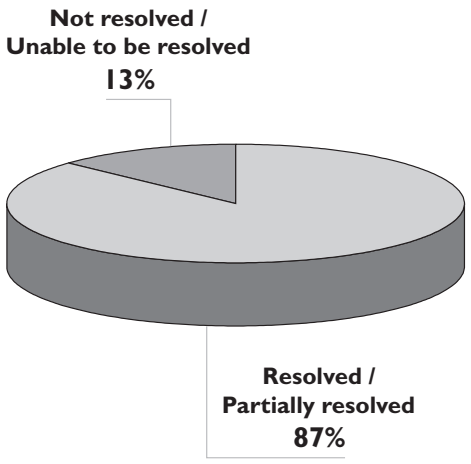
- ***Not resolved/unable to be resolved***

A relatively small percentage (7.0%) of concerns were recorded as 'not resolved' due to a range of reasons including: client expectations were unable to be met; there was disagreement on facts; the options for resolution were not acceptable to the client or provider. In some cases grief prevented complainants accepting reasonable explanations given by health providers.

Two and a half percent (2.5%) of matters were unable to be resolved because of lost contact with parties or the client was unwilling to pursue the matter after the resolution process commenced. There were 3.5% of matters where no contact was made with the CRS. The total matters that were not resolved or were unable to be resolved was 13%.

Figure 4 shows the CRS outcomes for 2004-05.

FIGURE 4 - CRS OUTCOMES 2004-05



Clients pursued with another body/person

In other matters, the Complaints Resolution Officer may have assisted the consumer to develop a resolution strategy that they carried out. In these matters the Complaints Resolution Officer rarely knows the outcome for the consumer. Where this occurs, the Complaints Resolution Officer involvement is categorised as 'client pursued with another body/person'. This outcome was recorded in 27.6% of cases.

Four hundred and thirty three clients pursued their concerns with the Commission. Many were assisted to lodge a formal complaint while others requested a review of the Commission's original assessment decision. Two hundred and ninety one pursued their concerns directly with a health provider or facility without further assistance from a Complaints Resolution Officer. Ninety four indicated that they would pursue their issues with a legal representative. It may be reasonable to assume that many of these concerns were resolved as no further contact was made with the Complaints Resolution Officer.

No contact

96.5% of people who were offered the CRS used the service. In a small number of cases (3.5%), the Complaints Resolution Officer could not locate the client or the client decided against using the services of the CRS when contacted.

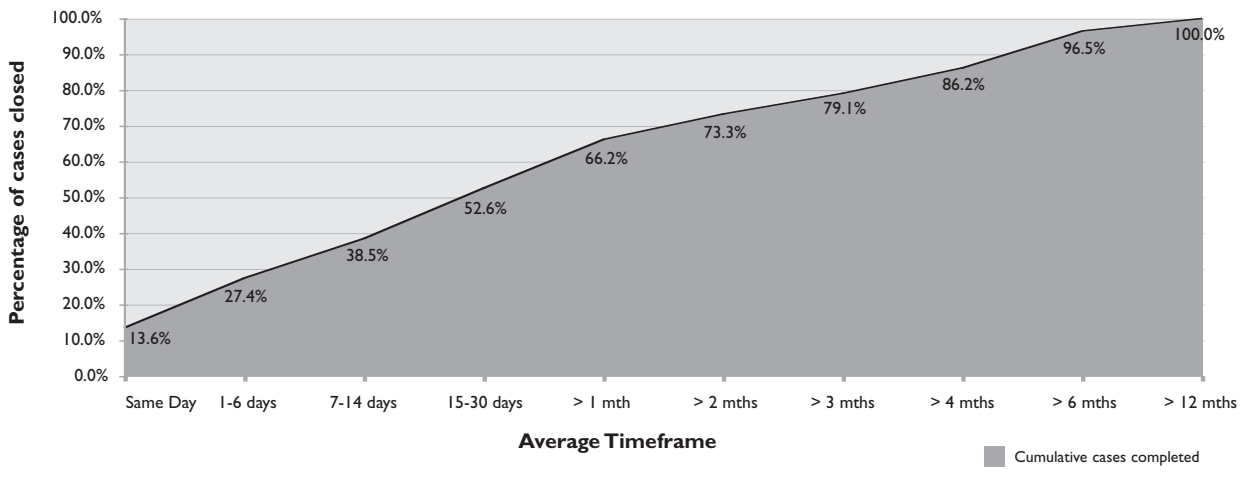
Timeliness of Complaints Resolution Service

CROs offer prompt service but can progress at the pace desired by the client. Grief, for example, can require that issues progress slowly whereas incidents demanding immediate response can be dealt with speedily. Sometimes when written responses are sought from health providers the resolution process can be delayed.

Figure 5 indicates how long it took to complete CRS cases in 2004 – 2005.

27.4% of cases were completed within a week; 52.6% within a month; 79.1% within three months and 96.5% within a year. The small number of cases (3.5%) that took more than a year were delayed because of various reasons; including the complexity of the issues and the multiple activities required before completion; difficulties in contacting and getting responses from providers; time taken by clients to decide when/how to proceed.

FIGURE 5 - COMPLAINT RESOLUTION SERVICE: TIMEFRAME TO COMPLETE CASES



Results of the CRS Satisfaction Survey 2004 – 2005

The Complaints Resolution Service seeks client feedback after service provision through a satisfaction survey. Surveys were posted to clients together with a reply paid envelope. The survey included questions about the accessibility, timeliness and responsiveness of the service as well as overall satisfaction. The CRS received 240 completed surveys from a total of 891 surveys (27% response rate).
Key results include:

- 85.4% thought complaint resolution officers were responsive to their concerns;
- 82.1% found complaint resolution officers were prompt in returning their calls;
- 74.2% were satisfied with the service they received.

Clients' feedback from the satisfaction survey

Following are some quotes from the surveys:

- "The CRO's advice gave me the strategies to deal with my complaint in a practical way. During our conversations she was very responsive and supportive and showed excellent communication skills."
- "The CRO was very easy to talk to – didn't force any opinions – was quick to respond to myself and the other party. She made a difficult task relatively easy."
- "The CRO's willingness to accompany myself and family when facing the staff and management at the hospital we had concerns about, and meeting us prior to the meeting with them was very useful."
- "Although the service was unable to come up with the result I wanted, alternate options were given and I felt I was listened to."
- "Prior to the CRO's intervention I was being ignored. She helped elicit an admission, an apology and further testing with no charge."
- "Impartiality, promptness, empathy and professionalism were useful."
- "The CRO was very understanding of my problem. Her replies were prompt and her advice was to the point and accurate."
- "The CRO put me in contact with the deputy manager of NSW department of births, deaths and marriages and paved the way for me to pursue an amendment to my son's birth certificate. Previously I had made seven attempts myself to no avail."
- "My complaint took so long to be resolved I most likely would have let it go and forgotten about it. However the CRO kept at it and helped me see it through and I am glad that I did as it needed to be addressed."
- "What was most helpful was that the CRO was so ready to assist us in drawing up and printing in a simple format our concerns and the hoped for outcomes and accompanying us to the final meeting with the hospital representatives."
- "The CRO followed through from beginning to end. The matter was finally resolved and laid to rest. The CRO was excellent to deal with."

Additional performance monitoring measures

The Complaints Resolution Service monitors the quality of service provided by CROs in various ways. The manager reviews all client files to ensure that service standards have been met, appropriate complaint resolution options identified and adequate support provided to consumers to resolve their health complaints. The manager also conducts monthly on-site supervision sessions and provides guidance and advice in complex matters.

CRS Case Studies 2004-2005

Elements of effective resolution

A man presented to the Emergency Department of a private hospital and was admitted for a diagnostic procedure. After taking a medicine in preparation for the procedure the man became distressed by the effects of the medication. He reported that he tried to refuse further medicine but felt pressured by nursing staff to take it. The patient stated that he did not understand what the medicine was for and he discharged himself when he thought the nursing staff were not responding appropriately to his distress. He wrote a lengthy and detailed complaint to the Commission and the matter was assessed for resolution with the assistance of a CRO.

The CRO spoke with the complainant and the Acting Director of the facility. The complainant wanted acknowledgement that he had not been given clear information about the proposed procedures and that this had lead to him being distressed. The Acting Director was offended by some of the remarks made about staff in the complaint and felt there were no issues for the facility to respond to. To facilitate resolution the CRO offered to identify key points from the complaint that might be able to be addressed. Following further phone discussions with the complainant the CRO sent a list of the issues to the Acting Director. The Acting Director replied to the complainant however, he was not satisfied that the letter stated that hospital staff had behaved appropriately. The complainant sent back another long letter as he continued to feel that his concerns had not been recognised.

The CRO recontacted the hospital and discussed the matter with a newly appointed General Manager. The General Manager telephoned the CRO after reading the letters of complaint and offered information to be passed onto the complainant. The information included a verbal apology for the distress the man had experienced and acknowledgement that patients admitted via Emergency may not receive the same detail about a procedure as patients booked for an elective procedure. The General Manager explained that there was a review process in place where complaints assisted the hospital to identify ways to improve services. There was now a plan to write a brochure for patients outlining the procedure and the effects of the medication and provide staff with an education session to raise awareness of the information and emotional needs of people in an emergency admission.

When the CRO provided this information the complainant was satisfied that his complaint had been heard and that the proposed brochure and training would make a difference for future patients. The complainant considered his concerns to be resolved.

Listening to families

A family wrote to a private hospital with concerns about the care provided to their mother during the last few days of her life. When the family was not satisfied with the response from the hospital they made a complaint to the Commission. The matter was referred to the CRS to assist with resolution of the issues.

The concerns related to the emergency admission of an older woman to a private hospital for palliative care. The woman had advanced cancer and was not expected to live long. The treating oncologist had previously had discussions with the family about the mother's deteriorating health and the family was anxious that the mother be kept comfortable. The family ensured that someone was with the mother during her hospitalisation.

After some days in hospital a family member heard an audible alarm and alerted the staff. There was a problem with the mother's syringe driver. A nurse checked the machine and consulted a senior nurse as it was thought that the syringe driver had not been loaded properly. When the nurse reloaded the syringe driver it was discovered that it was not functioning correctly. The machine had not been operational for 17 of the past 24 hours. Only one nurse had charted the volume of the syringe driver up until that time.

During this time the mother had been distressed and uncomfortable and the family asked the nursing staff to contact the oncologist. The staff delayed calling the doctor until the next morning so as not to disturb the doctor at night. On another occasion the staff refused to contact the doctor despite the woman being very distressed. Whilst the mother was in hospital the family had expressed concern with the care provided but felt that the hospital did not attempt to address the concerns.

The CRO was able to negotiate a written response to the family that addressed all the issues of concern. An apology was offered for the distress experienced by the family and their mother. The hospital provided further education to nursing staff on the use of syringe drivers and a chart was developed that included a column to record the remaining fluid volume. Staff training was also given about being sensitive and responsive to the needs of palliative care patients and their families.

Improving continuity of care

A woman wrote to the Commission concerned that a public hospital wanted to send her daughter home when she was unwell. The eighteen year old daughter has a severe physical disability, is wheelchair bound and cannot speak. There had been three recent presentations to the Emergency Department with vomiting, low blood pressure and lethargy. The woman stated that she had to fight for her daughter to be kept in hospital.

Following assessment the CRO became involved to assist in the resolution of the issues raised. The CRO discussed the situation with the complainant. It seemed that the episodes of vomiting had been occurring over several years and when under the care of a children's hospital such episodes had always resulted in admission and outpatient follow up by the treating specialist. Now that the daughter was a patient of the adult services a different system of care was in place.

The complainant wanted the hospital to guarantee that her daughter would be admitted to hospital until the symptoms ceased as she was not able to look after her daughter when the symptoms were present. The complainant wanted follow up care to investigate the cause of the episodes and to monitor her daughter's condition.

After talking with the complainant the CRO suggested discussing the issues in a face-to face meeting with the hospital. As there were outstanding medical issues a meeting was arranged as soon as possible with the Director of Emergency and the Clinical Services Director.

At the meeting a number of arrangements were agreed to which would improve the continuity of care for both the complainant and her daughter. This included liaison with the previous specialist so that the daughter's treatment history and management plans would be included on the adult files. Referral to a specialist for review would be arranged. The Emergency Department Director would discuss the daughter's treatment needs with the Emergency Department staff and develop an individual management plan so that when the daughter presented all staff would be aware of the daughter's needs. The mother would be given a specified contact person in the Emergency Department to notify when they were coming to hospital.

The complainant was invited to attend a staff in-service to give feedback to staff about the needs of carers of people with disabilities in the Emergency Department setting. When another presentation to hospital occurred and an admission was necessary, the complainant was satisfied with the care provided.

Involving families in discharge planning

The complainant's wife was admitted to a private hospital for a surgical procedure. At the time of her admission the woman was mobile. She was living at home with her husband who was her primary carer as she suffered from dementia. Following surgery the woman spent some time in the coronary care unit and then returned to the ward. Her husband visited the hospital twice each day.

The complainant was told that his wife was ready to go home. It was alleged that there was no discussion of any assistance being needed at home. On the day of discharge the complainant found that his wife could not stand upright. He told the nurse in charge that he was concerned that his wife could not walk and he was going to need assistance with getting her into the car. The nurse in charge observed the wife briefly and arranged for another nurse to obtain a wheelchair and escort her to the car.

As the complainant was attempting to assist his wife into the car she fell. The nurse who had brought her to the car had already left. The husband subsequently realised that he should have gone back into the hospital but at the time he assumed that since his wife was considered ready for discharge she must be well enough. This couple had a difficult time at home until they were able to organise community nursing care for wound dressings.

The complainant wrote to Commission and the complaint was referred to a CRO. In a letter to the complainant the private hospital acknowledged that there had been inappropriate discharge planning. The wife had fallen in hospital the evening before her discharge and should have been reassessed. The hospital offered to meet with the complainant and the CRO.

The CRO assisted the complainant to list his outstanding questions in preparation for the meeting. The complainant wanted a change in the discharge process to avoid the situation he and his wife had experienced. At the meeting there was open acknowledgement of the complainant's concerns and a genuine apology about the distress that had been caused. It was agreed that a new discharge care plan would be developed at the hospital. The plan would include a signature from the patient or carer to indicate that they were informed about the discharge plan.

After three months the CRO recontacted the private hospital. A copy of the new discharge plan and a report on the implementation was provided to the complainant.

Turning negatives into positives

A pregnant woman who was due to have her second child in a few months, sought assistance from a CRO in relation to the hospital where she was to give birth. Four years earlier the woman delivered her first baby in that hospital and her experience was traumatic. As the complainant lived in a regional area she had to return to this hospital. She approached the CRO wanting to raise her concerns about the first delivery with the hospital. The CRO assisted the woman to document the specific issues about the hospital care and make a complaint to the Commission.

In talking with the CRO the woman acknowledged that part of the healing for her would be achieved by the second birth being a better experience. The CRO contacted the Nursing Unit Manager in Maternity who agreed to speak with the obstetrician and arrange a meeting with the woman. The CRO helped the woman prepare some questions so that the medical and nursing staff could address each in turn and identify strategies to address her fears about returning to the hospital. The second birth became a positive experience for the woman and the hospital.

Hospital management later wrote to the woman in response to her complaint about the first delivery. This included an apology and a list of five practical changes that had been made in the Maternity Unit. Due to the responsiveness of hospital staff, the bravery of the woman and the assistance of the CRO a wounding grievance had been transformed into a very positive outcome.

Misunderstanding

A man made a complaint to the Commission about a general practitioner (GP) who he alleged had refused to see his three week old son who had recently had surgery. The complainant said that the doctor had not seen his son because he could not pay money up front for the consultation. The man explained that the baby was not yet included on his Medicare card and he was told that the doctor said he would need to pay an amount in advance. The man took his son to see another doctor.

The man wanted to meet with the GP to discuss his concerns. He and the GP had differing recollections about what had happened and what had been said. The GP did not believe he had refused to see the baby. The CRO contacted the GP who was initially reticent about a meeting saying that he did not think that it would achieve anything. The GP decided he would consult his medical defence organisation and take its advice.

The GP then agreed to meet with the complainant, his wife and the CRO. The meeting was very successful. The areas of dispute were clarified and resolved and the complainant accepted the apology offered by the doctor. The GP advised that as a result of the complaint he had prepared a written document for his practice explaining to patients the fees and the use of Medicare cards.

Accessing obstetric services in rural areas

A CRO assisted a complainant to make a complaint about the difficulties she experienced trying to access obstetric services in a rural area. The woman was 41 weeks pregnant and she believed she was having mild contractions. A family member rang the small local hospital to get some advice and was told that the woman would have to travel to a larger hospital for any advice.

The complainant was reluctant to make a two hour car trip which would be uncomfortable and costly if she was sent home as she was not in labour. She rang a friend who advised her that a mid-wife was rostered on at the small local hospital that afternoon.

The complainant decided to go to the small hospital and ask to see the midwife. On arrival at the hospital a nurse responded to the complainant by allegedly saying that the complainant had been told what to do and if the doctor saw her there he would be annoyed. The complainant also alleged that the nurse made some inappropriate comments to her leaving her distressed.

The complainant did not understand why the nurse would not listen to the baby's heartbeat, take her blood pressure, perform an examination and advise her what stage labour she was in. The complainant was hoping the nurse would help decide whether the woman should drive or go by ambulance to the larger hospital.

The Area Health Service examined the issues raised by the complainant and advised that the doctor had forewarned the hospital about the call from the relative and it was his advice that if she presented at the hospital she should be told to go to the larger hospital. The Area and the staff member apologised for not being courteous in their manner. The Area also recognised that for a more co-ordinated obstetric service was needed and a working group was established to make recommendations about skill development for staff, increased community awareness of services, and suggestions for innovative models of service.

Improving care

A carer for an elderly, frail woman wrote to the Commission with concerns about the nursing care provided in a public hospital. The elderly woman had been hospitalised for some weeks and during this time she sustained extensive bruising on her legs, did not eat well and her general condition deteriorated. The complainant believed that the patient had been seriously neglected.

The Commission sought a response from the Area Health Service and following assessment referred the matter to the CRS. A CRO contacted the complainant who was keen to meet with the hospital to discuss the outstanding concerns. The CRO developed a list of the issues to be addressed and negotiated with the hospital to set up a meeting.

The meeting was attended by the carer, the Director of Nursing, the Public Guardian for the patient and the CRO. The carer was given the opportunity to express his concerns. The Director of Nursing (DON) listened and apologised for the lapses in care that had occurred. She thanked the complainant for bringing the problems to her attention and explained that staff training had already been undertaken in response to the complaint. The DON said that further training was planned to ensure that staff pay close attention to food intake and dietary management as well as taking extreme care in the movement of frail older patients to avoid the severe bruising that this patient had sustained.

The meeting ended on a positive note with the carer feeling that he had been heard and that changes were being made to ensure that other patients did not suffer similar adverse outcomes from hospital care.

Insensitive communication

The Commission received a complaint with HCCC regarding allegations of insensitivity by a General Practitioner (GP) during a consultation. The Commission assessed the complaint as suitable for assisted resolution and referred the matter to a Complaints Resolution Officer.

The CRO contacted the complainant and doctor to inform both parties of the resolution process and to generate strategies for resolution of the concerns. Issues for the client related to the doctor's alleged rudeness and her lack of knowledge about an appropriate specialist referral. There had been a consequent delay in treatment for the complainant. The complainant had tried to raise his concerns with the practice manager but had not received a timely response.

The complainant wanted the opportunity to meet face to face with the doctor to be sure the doctor understood how he had felt following the unsatisfactory consultation. The CRO set up a meeting with the doctor and practice manager within three days.

At the meeting the doctor acknowledged that at the time of the consultation she was finding it difficult to concentrate and give her full attention to patients due to a recent death in her family.

The doctor and practice manager apologised to the complainant and agreed to put the apology in writing. The practice manager undertook to review staffing arrangements to allow for relief when a staff member needs time away from direct patient care.

The CRO contacted the complainant, doctor and practice manager after the meeting. The complainant was satisfied his concerns had been heard and with the written response to his complaint. The doctor and practice manager commented it had been helpful to receive feedback directly from the complainant and that they had found the resolution process positive.

3. THE HEALTH CONCILIATION REGISTRY

Conciliation is a formal process in which an independent conciliator facilitates a meeting to assist parties to reach a resolution of their complaint. Conciliation is one of the dispute resolution processes available for the Commission to use where a complaint does not warrant investigation by the Commission.

Where the Commission decides that conciliation is the preferred option for handling a complaint, the Commission refers the matter to the Health Conciliation Registry (the Registry). The Commission must consult with the Registrar prior to referring a complaint for conciliation.

Conciliation is voluntary and there is no compulsion for parties to participate if they choose not to do so.

The Act provides that conciliation is confidential. Anything said or done in conciliation or documents produced for the purpose of conciliation cannot be used as evidence if a matter subsequently proceeds to any court, tribunal or other body. This protection exists to encourage parties to speak as freely to each other as they are able, with a view to resolving a complaint. This confidentiality provision also provides an opportunity for parties to resolve complaints on the basis of refunds or other financial compensation if that is appropriate.

The types of complaints that the Commission will assess as suitable for conciliation are likely to meet at least one of the following criteria:

- a breakdown in communication between the parties;
- insufficient information provided to the complainant;
- inadequate explanation for poor outcome or an adverse event;
- inadequate service;
- an ongoing patient/provider relationship;
- a complainant who is seeking a refund or financial compensation as an outcome.

A complaint will not be assessed as suitable for conciliation if:

- the complainant has made it clear that they do not want to meet or interact with the provider again, and do not see this as a means to resolve the complaint;

it is apparent that the issue may be resolved more efficiently or less formally by another process;
a complainant has a particular support need which may require a more tailored form of resolution – eg. a person with ongoing mental health issues or major unresolved grief issues.

Conciliators

The Minister appoints the conciliators who facilitate conciliations for the Registry. The conciliators are appointed to a panel and work on a sessional basis. They are appointed for terms of up to three years and the recruitment process is publicly advertised and competitive. The conciliators who are on the current panel are highly experienced and skilled in conciliation and other dispute resolution processes.

Up until 1 March 2005, the Registry was an entirely separate body from the Commission, and was administered by the Department of Health. However as part of the legislative amendments the Registry became part of the Commission, although it retains independence from the Commission in the performance of its conciliation function.

In addition to becoming part of the Commission, the legislation brought other changes to the work of the Registry. Prior to the amendments, the Commission was responsible for obtaining the consent of parties to participate in conciliation.

This changed with the amendment, and the Registry is now responsible for obtaining the consent of parties to participate in conciliation.

This has affected the numbers of complaints referred to the Registry since March 2005, but it is currently too early to determine whether it will affect the number of complaints that proceed to conciliation.

Table 16 shows the category of complaints received and originally assessed for conciliation.

Table 17 details the results of conciliation.

TABLE 16 - CATEGORY OF COMPLAINTS RECEIVED & ORIGINALLY ASSESSED FOR CONCILIATION 2002-03 TO 2004-05

Category	2002-2003 No.	2002-2003 %	2003-2004 No.	2003-2004 %	2004-2005 No.	2004-2005 %
Treatment	239	55.8%	177	47.6%	90	54.9%
Communication	58	13.0%	62	16.7%	26	15.9%
Access	33	7.4%	32	8.6%	15	9.1%
Corporate Services	48	10.8%	39	10.5%	11	6.7%
Professional Conduct	6	1.3%	16	4.3%	10	6.1%
Consent	13	2.9%	9	2.4%	8	4.9%
Cost	23	5.2%	11	3.0%	2	1.2%
Prosthetic Devices	1	0.2%	2	0.5%	2	1.2%
Grievances	2	0.4%	5	1.3%	0	0.0%
No Jurisdiction	0	0.0%	17	4.6%	0	0.0%
Privacy/Discrimination	13	2.9%	2	0.5%	0	0.0%
Total	**436**	**100.0%**	**372**	**100.0%**	**164**	**100.0%**

TABLE 17 - RESULTS OF CONCILIATION HELD DURING THE YEAR 2002-03 TO 2004-05

Outcome	2002-2003 No.	2002-2003 %	2003-2004 No.	2003-2004 %	2004-2005 No.	2004-2005 %
Agreement reached/Partial reached	133	78.7%	113	83.7%	85	84.2%
No agreement reached	36	21.3%	22	16.3%	16	15.8%
Total	**169**	**100.0%**	**135**	**100.0%**	**101**	**100.0%**

Investigation of complaints

In the reporting period, the Commission assessed 3322 complaints. Of these, 523 were assessed as suitable for investigation (see Table 9). This number represented 15.7% of the total number of complaints received at the Commission in the reporting period. These complaints were about individual health practitioners and health organisations.

The number of complaints under investigation as at 30 June 2005 is at Table 18.

TABLE 18 - COMPLAINTS UNDER INVESTIGATION AS AT 30 JUNE 2005

Year	No.	%
2002-03	2	0.5%
2003-04	73	19.0%
2004-05	310	80.5%
Total	**385**	**100.0%**

870 investigations were finalised by the Commission during the year, an increase of 549 from the previous year. This increase is substantially due to the additional resources of the Investigation Division (see the 'Backlog' section below).

Tables 19 and 20 show the outcomes of finalised investigations about health services and health practitioners respectively.

Conducting an investigation

Under s.23 of the *Health Care Complaints Act*, the Commission must investigate certain types of complaints.

These are cases where:

- the registration health authority (such as the Medical Board or Nurses and Midwives Board) is of the opinion the complaint should be investigated;
- the complaint raises a significant issue of public health or safety; or
- the complaint raises a significant question as to

TABLE 19 - OUTCOMES OF HEALTH SERVICE INVESTIGATIONS 2002-03 TO 2004-05

Investigation Result	2002-2003 No.	2002-2003 %	2003-2004 No.	2003-2004 %	2004-2005 No.	2004-2005 %
Terminated by the Commission	28	56.0%	39	73.6%	99	79.2%
Make comment or recommendation	22	44.0%	14	26.4%	26	20.8%
Total	**50**	**100.0%**	**53**	**100.0%**	**125**	**100.0%**

TABLE 20 - OUTCOME OF FINALISED INVESTIGATIONS ABOUT HEALTH PRACTITIONERS 2002-03 TO 2004-05

Outcome	2002-2003 No.	2002-2003 %	2003-2004 No.	2003-2004 %	2004-2005 No.	2004-2005 %
Terminated by the Commission	191	56.7%	156	58.2%	408	53.8%
Prosecute a complaint before a disciplinary body	74	22.0%	46	17.2%	131	17.2%
Make comments to the practitioner about the complaint	38	11.3%	29	10.8%	81	10.7%
Refer to a registration authority for disciplinary action	33	9.8%	37	13.8%	76	10.0%
Referred to Director of Proceedings	0	0.0%	0	0.0%	62	8.2%
Refer to Director of Public Prosecutions	1	0.3%	0	0.0%	1	0.1%
Intervene in any proceedings before a disciplinary body	0	0.0%	0	0.0%	0	0.0%
Total	**337**	**100.0%**	**268**	**100.0%**	**759**	**100.0%**

the appropriate care or treatment of a client by a health service provider; or

- if the complaint were to be proven, it would provide grounds for disciplinary action against a health practitioner; or

- if the complaint were to be proven, it would involve gross negligence on the part of a health practitioner.

In making decisions about whether to investigate a complaint, the primary object of the Act is the protection of the health and safety of the public.

For advice on general clinical issues, the Commission has a number of internal medical and nursing advisers. However, when conducting an investigation, the Commission obtains a report from an independent expert who is sufficiently qualified and experienced to give advice on the subject matter of the complaint. When selecting the expert, the Commission obtains a declaration from that person to ensure there are no financial, personal or other conflicts of interest with any party in the complaint that may influence them. The list of expert advisers used by the Commission as is Appendix One.

In conducting an investigation, the Commission has certain powers. Those powers are stipulated within the *Health Care Complaints Act* and are only used when they are deemed necessary and when requests for information are unsuccessful and the information is essential to the investigation.

The amendments to the *Health Care Complaints Act* have conferred additional powers on the Commission. If the Commission is investigating a complaint and is of the opinion that a person is capable of giving information, producing documents (including medical records) or giving evidence that would assist, the Commission may by notice in writing request the person to do the following:

- to give the Commission any such information of which the person has knowledge;

- to produce any such documents;

- at a reasonable time and place, provide evidence in writing or orally.

At the end of an investigation into a registered health practitioner, the Commission may refer the complaint to the Director of Proceedings.

The Commission may also take the following action:

- refer the complaint to the Director of Public Prosecutions for consideration of criminal charges.

- refer the complaint to the appropriate registration authority to take action under the relevant health registration Act. In some cases, the health registration authority may have the power to refer the practitioner for performance or impairment assessment. Most often, the health registration authority may decide to counsel the practitioner about the conduct which is the subject of the complaint.

- To make comments to the health practitioner. Such comments are kept on the record at the Commission and with the relevant health registration authority.

- To take no further action.

Where the practitioner is not registered with a registration authority (such as a social worker, an acupuncturist or alternative health provider), the Commission is only able to make comments to the practitioner regarding the outcome of an investigation. In istances where criminal activity is alleged, the Commission may refer the matter to the Director of Public Prosecutions.

The complainant is able to seek a review of the action taken by the Commission if they are not satisfied with the outcome. That review is conducted by an Investigation Manager who was not involved in the original investigation and the outcome is determined by the Commissioner.

At the end of an investigation into a health organisation (such as a hospital), the Commission may:

- Make comments to the health organisation;

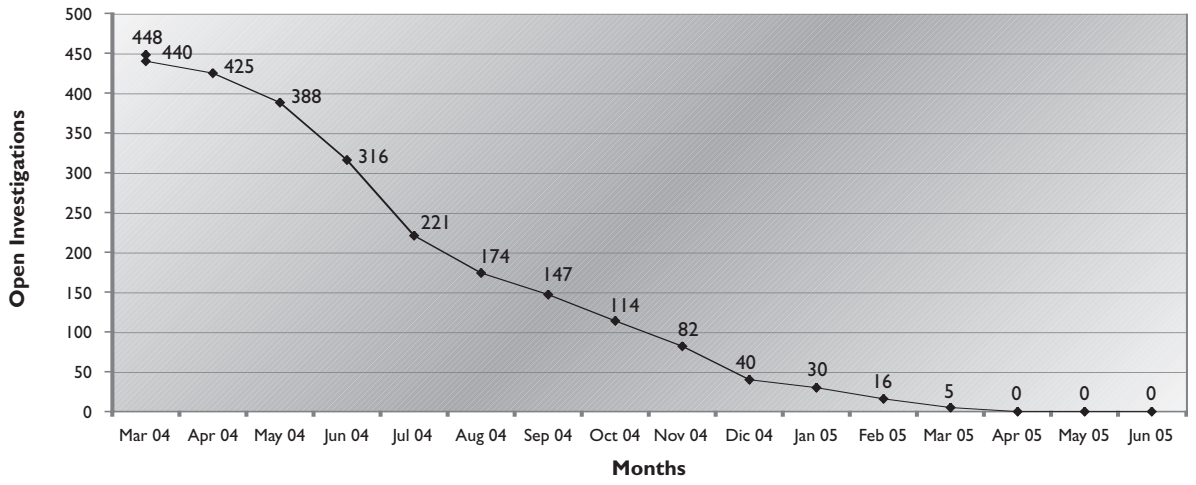
- Make recommendations to the health organisation;

- Take no further action.

Backlog of Investigations

When Mr Bill Grant, was appointed as interim Commissioner in December 2003 the Commission had an extensive and unacceptable backlog of investigations. Mr Grant identified all investigations open prior to 1 August 2003 as forming part of the "backlog" of investigations.

FIGURE 6 - BACKLOG INVESTIGATIONS FINALISED



A budget enhancement of $5.7 million to overhaul the Commission allowed for the appointment of additional investigators to concentrate on completing the backlog investigations.

The Commission employed additional temporary investigators to work exclusively on those matters. Additionally, a Commission legal officer was seconded to the Investigations Division to advise on legal issues arising from the backlog investigations.

As reported in the Commission's Annual Report of 2003-04, the backlog stood at 448 open investigations at the end of March 2004. At 30 June 2004, the number was 315. By January 2005 the backlog had reduced to 30 investigations. The backlog was eradicated in April 2005. The elimination of the backlog is shown in Figure 6.

The outcomes for the backlog investigations were proportionately similar to those of previous years. That is, a comparable proportion resulted in no further action or disciplinary action. Although there was a large increase in the number of investigations finalised in the reporting period compared to the previous period, the number of request for reviews did not proportionately increase.

This is shown in Table 21.

During the reporting period, the majority of investigations (58% of complaints about health practitioners and 62% of complaints about health organisations) were completed within 18 months of receipt of the complaint.

In the previous year, only 30% of complaints about health practitioners and 24% of complaints about health organisations were completed within 18 months of receipt. The average length of time taken to complete investigations for the years 2002-03 to 2004-05 is shown in Table 22.

Many of the investigations finalised were more than 3 years old (114 investigations) as a result of extra resources being used to address the backlog. At the end of the reporting period, there were 4 investigations older than 2 years.

One of those matters was waiting on the outcome of a police investigation before proceeding.

With the elimination of the backlog the contracts of the temporary investigators were completed on 30 June 2005.

TABLE 21 - OUTCOME OF INVESTIGATION REVIEWS 2002-03 TO 2004-05

Outcome	2002-2003		2003-2004		2004-2005	
	No.	%	No.	%	No.	%
No further action	5	100.0%	13	100.0%	23	95.8%
Reopen for investigation	0	0.0%	0	0.0%	1	4.2%
Refer to another body	0	0.0%	0	0.0%	0	0.0%
Total	**5**	**100.0%**	**13**	**100.0%**	**24**	**100.0%**

TABLE 22 - AVERAGE LENGTH OF TIME TAKEN TO COMPLETE INVESTIGATIONS 2002-03 TO 2004-05

Outcome	2002-2003				2003-2004				2004-2005			
	Health Service		Health practitioner		Health Service		Health practitioner		Health Service		Health practitioner	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
less than 6 months	2	4%	23	6.8%	5	9.4%	45	16.8%	14	12%	176	22%
6 - 12 months	1	2%	33	9.8%	3	5.7%	15	5.6%	24	21%	171	22%
12 - 18 months	5	10%	35	10.4%	9	17%	31	11.6%	33	29%	112	14%
18 - 24 months	8	16%	66	19.6%	3	5.7%	26	9.7%	13	11%	73	9%
24 - 30 months	10	20%	56	16.6%	2	3.8%	32	11.9%	10	9%	65	8%
30 - 36 months	6	12%	50	14.8%	6	11.3%	31	11.6%	8	7%	57	7%
36 months or more	18	36%	74	22%	25	47.2%	88	32.8%	9	8%	105	13%
Total	**50**	**100%**	**337**	**100%**	**53**	**100%**	**268**	**100%**	**111**	**100%**	**759**	**100%**

Future Directions - Improving Investigations

As previously reported, the Commission has required substantial changes and improvement in order to ensure that the backlog and delays do not recur. The processes for investigations have been reviewed to ensure that they are compliant with legislative requirements.

New procedures are being implemented to ensure that investigations are timely and proportionate.

A new procedures manual is being prepared in to ensure consistency in practice throughout the division. Investigators had training in basic investigation skills (July 2004). The training plan for 2005-6 includes additional training for statement taking and interview skills for investigation officers.

Casemate

The implementation of the new computer system, Casemate, has allowed for a more systematic method of allocating and monitoring the performance of the investigation team. Performance targets have been set and investigators are held to account for the timely completion of investigations, the quality of those investigations and ensuring that parties are kept informed of their progress.

Casemate enables consistent data entry about complaints and allows for the development of management reporting throughout the Commission. Casemate was implemented throughout the Commission on 7 March 2005.

There were 22 separate databases held throughout the Commission. Much of the essential data used to monitor performance was kept on manual systems. All databases have now been migrated into a new case management system, Casemate. The issues with regard to data migration are ongoing and an analysis of the old databases has shown that there was little consistency in the entry of much of the data. In order to provide greater consistency, the complaint categories have been brought into line with those being used across the state and nationally.

Case Studies

Case Study 1

The Commission received a complaint from the Private Health Care Branch of the Department of Health regarding the care and treatment provided to a patient who underwent surgical excision of four third molar teeth at a private hospital. The patient had a past history of chronic renal failure and underwent renal dialysis three times a week. Post operatively the patient was prepared for transfer to a public hospital for follow up care and dialysis as prearranged.

At the time of transfer, hospital staff noted that the patient was unresponsive and with no pulse and was immediately transferred to the recovery room for active resuscitation. Resuscitation was unsuccessful and the patient died. The incident was referred to the Private Health Care Branch of the NSW Department of Health (PHCB) as a reportable incident. PHCB then investigated the matter and referred their report to the Commission which raised concerns regarding the death of the patient following the dental surgery, for which anaesthetic services were provided.

The conduct of the anaesthetist (the respondent) in relation to this complaint was originally referred to the NSW Medical Board for action pursuant to s.26 of the *Health Care Complaints Act*. However, following a review of the respondent's response to the issues associated with the care of the patient, the Board requested that the Commission investigate the conduct of the anaesthetist as his clinical management of the patient may constitute unsatisfactory professional conduct.

The patient presented for a general anaesthetic as a high risk patient. He had existing renal failure and ongoing dialysis requirements. He was at risk of hyperkaleamia and cardiac arrhythmias and has a history of hypertension and hypertension induced seizures. Pre, intra and post-operative monitoring and treatment by the anaesthetist was required to ensure the patient faced as little risk as possible throughout this period.

An expert review by an anaesthetist identified several areas of concern in relation to the respondent's practice with criticism ranging from moderate to severe. The respondent's conduct demonstrated a lack of adequate knowledge, skill, judgement or care as described by s36(1)(a) of the *Medical Practice Act 1992* and as such constitutes unsatisfactory professional conduct.

The Commission, in consultation with the Medical Board concluded that the matter be placed before a Professional Standards Committee for determination.

Case Study 2

The Commission received a complaint regarding the prescribing practices of a doctor. The nature of the complaint was that the complainant's daughter was addicted to pethidine/morphine and the doctor (respondent) gave her daily injections of these drugs for her migraines.

The issues raised in the complaint resulted in an investigation by the NSW Health Department's Pharmaceutical Services Branch (PSB) that included collecting and examining dispensing records of pharmacists and conducting an interview with the respondent. The subsequent report of the PSB identified a number of irregularities relating to the respondent's prescribing history of drugs (that required authority to prescribe) to a number of people including the complainant's daughter and members of the doctor's family. As a consequence, a broadened complaint was referred by the PSB to the NSW Medical Board which in turn laid the complaint with the Commission. The new complaint, based on the PSB investigation, was investigated by the Commission.

An expert's opinion was sought on the evidence gathered during the investigation. The expert expressed severe criticism for the respondent prescribing and administering of drugs to members of his own family. The expert was also severely critical of the management of the excess ampoules of pethidine for the complainant's daughter.

The Commission, in consultation with the NSW Medical Board determined that there was sufficient evidence for prosecution of the complaint on the basis of inappropriate prescribing.

Case Study 3

The Commission received a complaint from a health service regarding a disclosure by a former patient of a psychiatric clinic that she had a sexual relationship with her former treating nurse. During the investigation, it was found that the nurse did pursue a personal relationship with the patient and her family. The personal relationship was pursued by the nurse after the patient had already made allegations of a sexual nature about him when she was an inpatient.

In choosing to pursue a personal relationship outside of work with the family the nurse placed himself in a position where he became the subject of allegations of professional misconduct. In pursuing a personal relationship with the patient, the nurse placed himself in a position where he was alone with a female patient who according to her family, had made a number of allegations of a sexual nature. The nurse also placed the complainant in a situation where she was unclear about the professional boundaries of health professionals.

Although the Commission was unable to determine the veracity of the allegations it found, following advice from a expert reviewer, that the nurse failed to maintain professional boundaries in his dealings with a former patient. In consultation with the NSW Nurses and Midwives Board, the Commission determined that disciplinary action was warranted and agreed that the nurse should undergo counselling by the Board. The purpose of the counselling was to provide the nurse with the opportunity to develop strategies to maintain professional boundaries as a nurse.

Case Study 4

The complainant was involved in a motor vehicle accident and was taken to a District Hospital. At the time it was uncertain whether she had sustained a fracture to one of the vertebrae in her neck. The complainant was subsequently transferred to a larger Hospital (the respondent) where she underwent repeat scans and assessment by a neurosurgical registrar. The registrar was of the understanding that the repeat scans were clear. After several hours, and on the basis of the scan and assessment results, the complainant was discharged home. The following day the complainant's CT scan was seen by a radiologist. A report was prepared suggesting the possibility of an undisplaced fracture. A copy of the report was sent to the accident and emergency department.

One month after her initial presentation the complainant was contacted and instructed to return to the hospital for another scan (MRI). This followed a quality check by the hospital which involved an emergency department physician reviewing reports received from the Medical Imaging department. When a positive finding is identified, the scan and report are checked against the patient notes, the diagnosis and treatment plan. The complainant immediately returned to the hospital and underwent a MRI. The complainant subsequently sought an opinion from a private neurosurgeon. She then underwent surgery for pain relief. The Commission considered that the delay of one month between presentation and recall of the patient for the MRI to be unacceptable in a teaching hospital where it would be reasonable to expect quality checks to occur on a daily basis. The Commission also found that when the patient was recalled, one month after the accident there was no co-ordinated approach by hospital staff

The Commission wrote to the Area Health Service advising it of the findings of the investigation. The Chief Executive of the Area Health Service advised the Commission that the Hospital has initiated changes in line with the Commission's recommendations. The Chief Executive advised of increased frequency of quality checks in the emergency department and changes to the protocols relating to patient recall. The Chief Executive advised that these changes are being formalised through the development of policy to support the changes. The Chief Executive also advised that an area-wide policy is being developed to provide guidelines on the waiting time for surgical review.

Case Study 5

The Commission received a complaint from a woman who went to see a social worker at a community health centre for counselling. The complainant alleged that the social worker had been inappropriate during the counselling session. It was alleged that the social worker told the client about her own sexual relationships and that she had relationships outside her own marriage. It was also alleged that the social worker showed the complainant inappropriate and explicit material on a website.

Following an investigation, the social worker admitted to the conduct. Given the nature of the conduct, a registered health practitioner would be referred to the Director of Proceedings for consideration of action before a disciplinary body. However, as social workers are not registered, and the particular social worker was not a member of a professional body, no disciplinary action is possible under the *Health Care Complaints Act*. The most severe option available to the Commission is to provide comments to the health service provider. Those comments were made to the social worker in this case.

Background

In December 2003, the Commission finalised a report of its investigation into Campbelltown and Camden hospitals in the Macarthur Health Service. This investigation commenced after the Director-General of NSW Health referred a complaint to the Commission on 18 November 2002 about practices at the two hospitals following disclosures by "whistleblower" nurses. Specifically, the complaint contained numerous allegations of poor clinical, management, performance and process issues and provided some evidence regarding specific incidents at Campbelltown and Camden Hospitals in the Macarthur Health Service.

The 2003 Investigation Report concentrated primarily on identifying systemic deficiencies within Campbelltown and Camden Hospitals and the South Western Sydney Area Health Service (SWSAHS). Whilst the Investigation Report did not squarely address complaints of individual conduct it acknowledged at p.29.9: *"...The investigation has, however, raised questions about the performance of individual registered health providers. The Commission is assessing those to determine if further action is warranted in the public interest."*

Following release of the Report the Government established a Special Commission of Inquiry (SCI), headed by Senior Counsel, Mr Bret Walker to examine allegations of inadequate patient care or treatment at Campbelltown or Camden Hospitals and to identify any further action to be taken, including referral of any matter to any other person or body for prosecution or disciplinary or other investigative action.

The Special Commission was also required to examine the role of the Commission and recommend appropriate changes to the way it operated. The SCI found that the Commission's investigation was deficient in its focus on systemic issues and in its failure to comply with legislative requirements to investigate the conduct of individual practitioners involved in the incidents of patient care which were the subject of complaint.

The New Investigation

With the establishment of a new administration at the Commission in December 2003, a separate investigation team ("the Macarthur team") was set up to specifically review each incident of patient care described in the original report. The team included Commission investigators and medical and nursing advisers who had not been involved in the previous investigation, and was advised by Senior Counsel, and solicitors from the Crown Solicitors Office.

The Macarthur investigation team initially reviewed 48 incidents of patient care, comprising the 47 incidents described in the Commission's investigation report where the patient's details were known and a further matter added to the Special Commission of Inquiry's terms of reference in March 2003. The team reviewed the medical notes and obtained other information to determine whether the conduct of any doctor, nurse or other health professional involved in providing that care should be investigated by the Commission. Initially this review involved the actions of some 150 health care providers.

The Special Commission of Inquiry

Operating independently of the Commission, the Special Commission of Inquiry also reviewed the same 48 incidents. Amendments were made to the *Health Care Complaints Act* to require the Commission to investigate any matter concerning the conduct of an individual practitioner referred to it by the Special Commission of Inquiry. Similar obligations required the Commission to refer individual medical practitioners to the NSW Medical Board for Performance Assessment under Part 5A of the *Medical Practice Act 1992* if the SCI required it.

The SCI initially referred 27 doctors and 23 nurses to the Commission for investigation following its review of the 48 incidents.

Subsequently, a further 11 incidents of patient care, arising from 67 additional allegations brought to the SCI were referred to the Commission by the SCI. This referral involved investigations of 24 doctors, 17 registered nurses, and one physiotherapist.

Further Referrals to the Commission

Further complaints from the public were also referred to the Macarthur team throughout 2004. The investigations arising from original, 2002 complaint, together with the referrals from the SCI totalled 133. Combined with the additional complaints from the public, the Macarthur investigations finally totalled 139.

Assessment Process undertaken by Macarthur Team

The initial task undertaken by the Macarthur team was the assessment of the Director General's complaint under the provision of the Act, the purpose being to decide whether or not any practitioner should be investigated, some other action taken (eg. conciliation, referral to the Director General, referral to another person/body for investigation, such as the Medical Board, Nurses and Midwives Registration Board or employer) or the complaint discontinued.

Attention was given to identifying firstly, the individual practitioners who fell within the terms of the complaint (i.e. those involved in the incidents the subject of the Commission's previous systemic investigation where no practitioners had been specifically identified) and secondly, identifying the nature of the allegations in relation to each practitioner and the specific concerns held about their respective involvement.

As the various individual respondents to the Director General's complaint were identified, they were notified in writing of the complaint, the nature of the complaint and the identity of the complainant. The relevant registration boards were also duly notified and consulted with as requested.

Assessments were undertaken of 60 incidents in total (comprising 48 incidents from the 2003 investigation, one matter referred to the Commission in March 2004 and a further 11 matters referred by the SCI) and detailed assessment reports were prepared in relation to each incident. The factual and/or clinical complexity of the incidents varied significantly.

Each assessment report:

- identified the practitioners involved;
- set out the facts of the clinical incident;
- detailed any concerns, issues and/or allegations raised by the Clinical Review Panels and/or the SCI; and
- made recommendations as to appropriate action to be taken against practitioners whose conduct warranted investigation or some other form of action.

The material considered in the assessments included:

- copies of the patient's clinical records;
- prior clinical reviews undertaken by Clinical Review Panels (CRP's) established for the previous systemic investigation by the Commission.
- responses from SW/SAHS on behalf of the hospitals and in some cases, the practitioners, as to the concerns raised by CRP's;
- some limited responses from individual health practitioners concerning their respective roles in a particular patient's care;
- advice in some cases from the Commission's in house medical and nursing advisors who were requested to provide their view in relation to particular incidents in the course of the Commission's previous (systemic) investigation;
- advice from the medical and nurse advisors who formed part of the Team;
- legal advice from solicitors and counsel advising the Team;
- expressions of expert opinion obtained by the SCI concerning which medical and accredited nurses should be the subject of investigation by the Commission; and
- notes and transcripts of interviews with the medical and nursing experts who were engaged by the SCI to assess all of the incidents and the roles of a number of the practitioners involved.

At the end of the assessment stage, the Macarthur Team:

- determined that there should be 139 investigations of individual practitioners. This number included 104 respondents, 35 of which were involved in more than one incident. The respondents included:
  - 50 Medical Practitioners
  - 51 Nurses
  - 3 Physiotherapists
- referred 18 matters relating to doctors to the NSW Medical Board for investigation under s.26 of the *Health Care Complaints Act*. These referrals ended the Commission's involvement in these matters; and
- referred 8 groups of nurses to the SWSAHS.

At the end of each assessment the complainant, the respondent practitioner and the SWSAHS (as employer) and the Director General (being the complainant) were notified of the Commission's

assessment decision. Patients and families were also informed of the assessment outcomes (practitioners' identities withheld) in relation to their specific clinical incident.

Investigation Process

During the investigations further information was obtained in order to determine what action, if any, ought be taken concerning each practitioner in respect of the complaint. The first part of this process involved notifying each practitioner that their conduct was the subject of investigation, particularising those aspects of their alleged conduct which were being investigated and inviting them to provide their account of the circumstances surrounding their care and treatment of the patient. Some of the investigations required further medical records and/or other information to be provided by the SWSAHS. In other cases interviews were undertaken with witnesses.

In the course of the investigations, independent medical experts were used to identify the particular standard of care expected of an individual practitioner and whether there had been a departure from the standard. The experts were asked to review relevant documentation and advise whether in their opinion, the care provided by the practitioner was adequate and appropriate. The experts was also asked to identify aspect of care which fell below the acceptable standard, to state whether the departure from the standard would attract criticism and if so, the level of criticism.

The options available to the Commission at the end of an investigation and prior to 1 March 2005, when the amendments to the legislation came into effect, included:

- prosecuting a complaint before a disciplinary body (either a Professional Standards Committee or a Medical Tribunal)*;
- referring the complaint to the appropriate health registration authority for action under the relevant health registration Act (such as counselling);
- making comments to the practitioner;
- taking no further action.

During the investigation each practitioner was given the opportunity to make submissions. The Macarthur team gave full consideration to these submissions before making a final recommendation about the appropriate outcome of the investigation. A decision was then made by the Commissioner, following in consultation with the relevant health registration board, as to the appropriate action to be taken.

The Macarthur team also sought to keep the patients and, where appropriate, their families informed of the progress of the investigations.

Outcomes

There have been 139 investigations in relation to the Macarthur matters.

The following sets out the outcomes of the investigations:

- Five doctors are to be prosecuted before a Medical Tribunal.
- Three doctors are to be prosecuted before Professional Standards Committees.
- Four registered nurses are to be prosecuted before Professional Standards Committees.
- Eight doctors have been referred for counselling by the NSW Medical Board.
- Four registered nurses have been referred for counselling by the NSW Nurses and Midwives Registration Board.
- Fourteen doctors, nine registered nurses and one physiotherapist have been the subject of written comments.
- The remaining investigations have been terminated as warranting no further action.

In some cases systemic issues also needed addressing. These matters were referred to the SWSAHS with a request that the SWSAHS investigate the matters and introduce further appropriate measures to ensure that the various needs for, say, nursing observations of patients, were met by all nursing staff. In the event that particular deficiencies on the part of individual nurses were confirmed it was requested that the SWSAHS ensure appropriate supervision was in place to avoid future failures.

** Since the commencement of the amendments to the Health Care Complaints Act, 1993, on 1 March 2005, investigations that may result in disciplinary action are now referred to the Director of Proceedings.*

Advice from the SWSAHS is that a number of changes have been made to address systemic deficiencies. Among these are:

- the appointment of a clinical nurse consultant at Campbelltown Hospital to provide leadership and to improve the clinical skills of the nurses,
- the development of an on-call policy to ensure the timely attendance of senior medical clinicians for critically ill patients,
- the establishment of a Clinical Reference Group (and proposed Clinical Case Review Group) to review deaths at Campbelltown Hospital to ascertain whether they warrant referral to the Coroner.
- The introduction of a dedicated transport system for patient transfer between Camden and Campbelltown Hospitals.
- The networking of Campbelltown Hospital's Intensive Care Unit (ICU) to Liverpool Hospital's ICU,
- A CT scanning service now provides 24-hour diagnostic capability at Campbelltown Hospital,
- More than 30 new clinical staff have been recruited including 5 clinical nurse consultants, an additional staff specialist in obstetrics, 2 additional senior emergency doctors, 3 additional registered nurses to the Cancer Therapy Centre, junior doctors in emergency and cardiology medicine.
- There are now 7.4 medical registrars working at the hospital which is more than double the number in 2003.
- A new registrar training network between St Vincents, Liverpool, Campbelltown and Wagga Wagga Base Hospitals has been established resulting in more registrars being appointed at Campbelltown Hospitals.
- The networking of the Emergency Department with Liverpool Hospital and the appointment of a joint Director of the two Departments has commenced.
- The establishment of the Sydney Children's Hospital Macarthur Unit at Campbelltown Hospital which offers paediatric surgery and enhanced paediatric emergency medicine,
- A paediatric staff specialist on site, based in the Emergency Department until 10pm Monday to Friday,
- The development of a 20 bed non-acute mental health facility at Campbelltown,
- New programs for continuing education for all nursing staff.

In addition to these changes, the Government closed the Camden Hospital Maternity unit in February 2005.

Conclusion

There remains some debate among health service providers as to the relative responsibility of individual conduct or systems issues as the cause of incidents of poor patient care.

The Commission's first investigation concentrated on systemic issues at the expense of individual responsibility. This approach was roundly criticised, most tellingly, by the SCI findings that the Commission failed to observe the requirements of the *Health Care Complaints Commission Act*. The Commission subsequently investigated the conduct of individual practitioners and amendments to the Act reinforced its responsibilities in this regard.

Where systemic issues play a significant role in poor patient care they can be taken into account in assessing the extent of individual responsibility. If systemic issues appear to predominate, the Act provides mechanisms for those issues to be reported by the Commission and recommendations made for change.

Legal Division and the Director of Proceedings

Background and Process

Since the amendments to the *Health Care Complaints Act* came into effect the Legal Division operates under the supervision of the Director of Proceedings. The Director of Proceedings determines whether a complaint should be prosecuted and if so, whether it should be prosecuted by the Commission or referred to another body. Complaints may involve allegations of impairment, unsatisfactory professional conduct or professional misconduct.

The decision to prosecute is made independently from the Commissioner.

The position of Director of Proceedings was created to address perceptions that the Commission lacked objectivity in its decisions to take disciplinary action against a practitioner. Such a perception became evident during the consultations with key stakeholders when the idea of a Director of Proceedings was first proposed. It was clear that there was a widespread concern, particularly among practitioners, that as the Commissioner was responsible for the conduct of investigations and prosecutions, decisions to institute disciplinary proceedings were not perceived as independent and fair.

The Director of Proceedings makes her decisions independently from the assessment and investigation processes. To ensure that the co-regulatory nature of the system is preserved, the Director of Proceedings is required to consult with the relevant registration board about its views prior to determining whether or not to institute disciplinary proceedings.

The powers of the Director of Proceedings are contained in Part 6A of the *Health Care Complaints Act*. Section 90B sets out the functions of the Director of Proceedings and also confers the power to prosecute complaints. Section 90C sets out the criteria that the Director of Proceedings must consider when determining whether to prosecute a matter. These criteria are:

- The protection of the health and safety of the public;
- The seriousness of the alleged conduct the subject of the complaint;
- The likelihood of proving the alleged conduct;
- Any submissions made under s.40 by the health practitioner concerned.

If the Director of Proceedings considers that a matter does not meet the threshold for prosecution the matter will be referred back to the Investigations Division to gather further evidence or for the Commissioner to determine the outcome in line with statutory requirements.

The independence of the Director of Proceedings is codified in s.90D. That section provides that:

> *" the Director of Proceedings is not subject to the direction and control of the Commissioner in relation to dealing with any particular complaint that has been referred by the Commission to the Director for consideration".*

Generally, complaints which may lead to a finding of unsatisfactory professional conduct are referred to a Professional Standards Committee ("PSC"). The practitioner is entitled to be accompanied by either a barrister or solicitor or another adviser, but is not entitled to be represented at the inquiry.

A PSC is not empowered to de-register or suspend a practitioner but may issue a caution or reprimand, impose a fine or impose conditions on the registration of the practitioner. PSC hearings are conducted in private and the findings are not made public.

Prosecutions for professional misconduct are generally heard before a Tribunal, which has the power to suspend or de-register a practitioner. Tribunal matters are usually open to the public and a practitioner is able to be legally represented in such hearings.

Disciplinary and other legal cases

There was a considerable increase in the number of cases referred to the Legal Division for disciplinary proceedings. In 2003-04, some 80 matters were referred to Legal and this number rose to 207 throughout 2004-05. A number of additional legal officers have been employed on a temporary basis to assist with the increased workload.

At the end of 2004-05, the Commission had finalised 85 cases, including 73 disciplinary cases, 8 review or re-registration applications and 4 appeals and applications. In 7 cases, the complaints were withdrawn and inquiries were not held for various reasons including that the complainant no longer wanted to give evidence, the death of the practitioner and the fact that the practitioner was no longer practising. Two cases were dismissed as the

disciplinary body was not satisfied that the complaint was proved. There was a 27% increase in the disciplinary and other cases finalised compared to last year (85 as against 67).

2004-05 saw an enormous increase in the work of the Legal Division. This was primarily due to Investigations finalising many of the backlog matters and the matters being referred to Legal for disciplinary action. The impact of the increase in cases will continue to be felt into 2005-06 as many of the matters have yet to be listed and heard.

Table 23 shows the number and percentage of complaints about health practitioners referred for disciplinary proceedings at the end of an investigation.
The outcomes of disciplinary cases determined by Professional Standards Committees is at Table 24.
Table 25 shows the outcomes of disciplinary cases determined by Boards of Inquiry.
The outcomes of disciplinary cases determined by Tribunals is at Table 26.

The creation of the position of Director of Proceedings has meant that the decision to prosecute has devolved from the Commissioner to the Director of Proceedings. As a consequence, the Legal Division has now assumed responsibility for reviewing investigation files **prior** to a decision to prosecute being made. This allows for a rigorous analysis of the evidence to be undertaken by the Legal Division, which can then be considered by the Director of Proceedings in making the decision whether or not to prosecute.

Where necessary, matters can be referred back to Investigations for further evidence to be obtained. Where a decision to prosecute is made by the Director of Proceedings, the Legal Division is now responsible for drafting the formal Complaint that commences the disciplinary proceedings.

The introduction of new systems and processes at a time in which the Legal Division is already subject to a heavy workload presents a number of challenges. However, it is anticipated that the resulting prosecution cases will be of a higher quality and will ultimately lead to reduced legal costs and shorter listing times.

TABLE 23 - COMPLAINTS ABOUT HEALTH PRACTITIONERS REFERRED FOR DISCIPLINARY PROCEEDINGS AT THE END OF AN INVESTIGATION 2002-03 TO 2004-05

Disciplinary Body Referred To	2002-2003		2003-2004		2004-2005	
	No.	%	No.	%	No.	%
Medical Tribunal	28	26.2%	22	27.5%	48	23.2%
Nurses Tribunal	14	13.1%	13	16.3%	33	15.9%
Medical Board	23	21.5%	11	13.8%	32	15.5%
Nurses Board	9	8.4%	4	5.0%	26	12.6%
Nurses Profess. Standards Committee	5	4.7%	9	11.3%	22	10.6%
Medical Profess. Standards Committee	18	16.8%	10	12.5%	19	9.2%
Pharmacy Board Inquiry	1	0.9%	0	0.0%	9	4.3%
Psychologists Tribunal	0	0.0%	1	1.3%	6	2.9%
Dental Board Inquiry	1	0.9%	0	0.0%	3	1.4%
Pharmacist Tribunal	0	0.0%	0	0.0%	2	1.0%
Physiotherapists Board Inquiry	0	0.0%	2	2.5%	2	1.0%
Dental Technicians Board	2	1.9%	0	0.0%	1	0.5%
Pharmacist Board	0	0.0%	0	0.0%	1	0.5%
Pharmacist Profess. Standards Committee	0	0.0%	0	0.0%	1	0.5%
Psychologists Board	5	4.7%	1	1.3%	1	0.5%
Psychologists Board Inquiry	1	0.9%	0	0.0%	1	0.5%
Chiropractors & Osteopaths Tribunal	0	0.0%	2	2.5%	0	0.0%
Chiropractors Board	0	0.0%	1	1.3%	0	0.0%
Chiropractors Board Inquiry	0	0.0%	2	2.5%	0	0.0%
Optometrist Board Inquiry	0	0.0%	2	2.5%	0	0.0%
Podiatrists Profess. Standards Committee	0	0.0%	0	0.0%	0	0.0%
Psychologists Profess. Standards Committee	0	0.0%	0	0.0%	0	0.0%
Total	**107**	**100.0%**	**80**	**100.0%**	**207**	**100.0%**

TABLE 24 - OUTCOMES OF DISCIPLINARY CASES DETERMINED BY PROFESSIONAL STANDARDS COMMITTEES 2004-05

			No.
Medical Professional Standards Committee	*Proved*	Reprimand	1
		Reprimand and conditions	10
		Conditions	2
		Caution and conditions	2
		Caution	2
	Not proved/Inquiry not held	Withdrawn and dismissed	1
Nurses Professional Standards Committee	*Proved*	Reprimand	3
		Reprimand and conditions	10
		Conditions	0
		Caution and conditions	0
	Not proved/Inquiry not held		0
TOTAL			**31**

TABLE 25 - OUTCOMES OF DISCIPLINARY CASES DETERMINED BY BOARDS OF INQUIRY 2004-05

			No.
Chiropractors Board of Inquiry	*Proved*	Reprimand and conditions	1
Dental Board of Inquiry	*Proved*	Reprimand and conditions	1
	Not proved/Inquiry not held	Withdrawn and dismissed	1
Pharmacy Board of Inquiry	*Proved*	Reprimand and conditions (Ton)	1
		Reprimand, Fine and conditions (Barone)	1
Physiotherapists Board of Inquiry	*Proved*	Caution and conditions	1
	Not proved/Inquiry not held	Heard and dismissed	1
Psychologists Board of Inquiry	*Proved*	Reprimand and conditions	1
TOTAL			**8**

TABLE 26 - OUTCOMES OF DISCIPLINARY CASES DETERMINED BY TRIBUNALS 2004-05

Tribunals			No.
Chiropractors Tribunal	*Proved*	Suspension (Arnold)	1
Medical Tribunal	*Proved*	De-registered (Jones, Rivera, Lindsey, Michael, Prakash, Reeves)	6
		Reprimand and conditions (Ma, Barratt, Hamad)	3
		Reprimand (Tse, Corbett, Lindsay)	3
		Reprimand, fine and conditions (Devsam)	1
		Conditions (Roehrich, Tsouroutis)	2
		Reprimand and fine (Chatterjee, Cheng)	2
	Not proved/Inquiry not held	Heard and dismissed (Bills)	1
		Withdrawn (Joseph)	1
Nurses and Midwives Tribunal	*Proved*	De-registered (Uskovic, Kerr, Moore)	3
		Reprimand and counselling (Hunt)	1
		Reprimand and conditions (Proctor)	1
		Conditions (Practitioner D-name suppressed)	1
	Not proved/Inquiry not held	Withdrawn (Bernoth, Harb, Craig)	3
Psychologists Tribunal	*Proved*	De-registered (Dow, Practitioner-name suppressed)	2
		Reprimand and conditions (Pinto, Kelly)	2
	Not proved/Inquiry not held	Withdrawn (Ramster)	1
TOTAL			**34**

FIGURE 7 - LEGAL CASES 2004-05

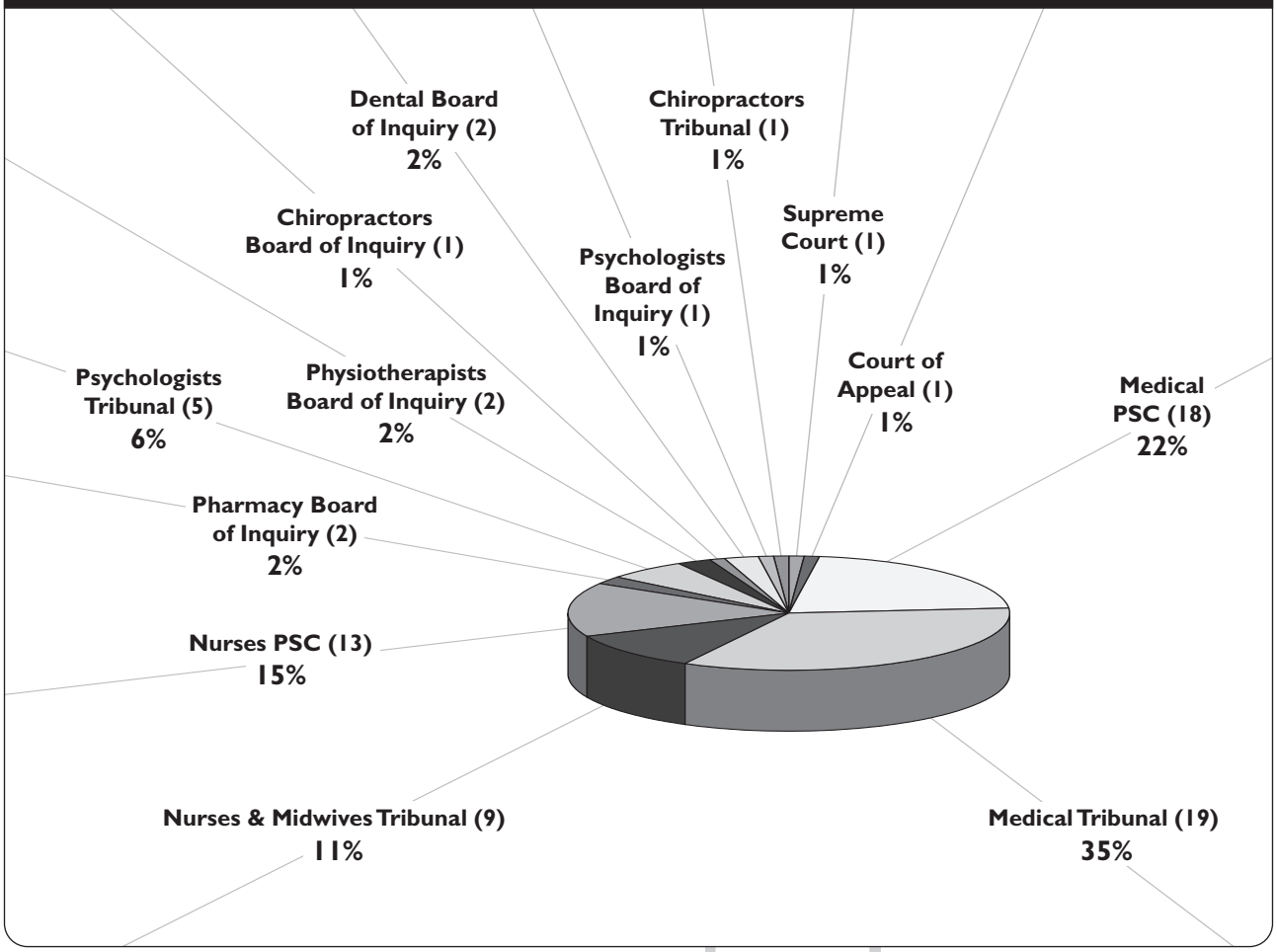
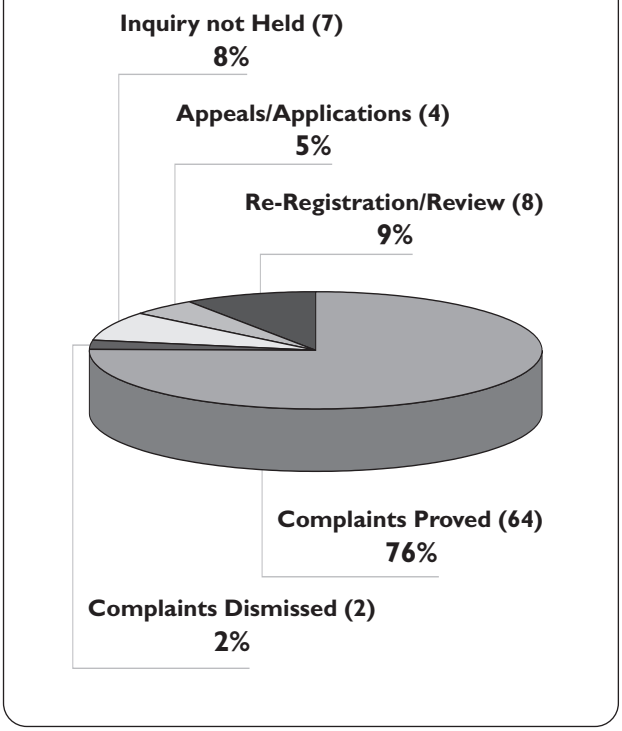


FIGURE 8 - OVERVIEW OF CASES 2004-2005



Case Studies

The following is a summary of some of the complaints the Commission has prosecuted before the Tribunals and Professional Standards Committees.

MEDICAL TRIBUNAL

Dr Jones – Sexual Misconduct

The Commission made a complaint against Dr Roger Jones of unsatisfactory professional conduct and professional misconduct.

The matter was first heard in 2003 but as a consequence of one of the Medical Tribunal members hearing the matter becoming ill and subsequently retiring, the Tribunal did not make a determination in relation to the complaint. The matter was subsequently re-heard before a differently constituted Tribunal. The Commission alleged that the practitioner engaged in a sexual relationship with Patient A whilst she was a patient. It was also alleged that the practitioner engaged in an inappropriate personal relationship with Patient B as well as using the title "Psychiatrist" when not entitled to do so.

Patient A first came under the care of the practitioner as an in-patient and the practitioner continued to treat her after her discharge from hospital. The practitioner subsequently commenced a sexual relationship with Patient A, who claimed to have entered into the relationship only after the practitioner threatened to have her locked up in an institution where he could administer shock treatment. Patient A and the practitioner continued to have a sexual relationship for a number of years. During the relationship Patient A took a series of photographs of the practitioner lying naked on a bed and recorded a number of telephone conversations between herself and the practitioner as well as making contemporaneous diary entries in relation to their meetings.

The practitioner initially denied the allegations and suggested that Patient A had suffered under the disability of a severe mental disorder causing her to be paranoid and deluded. However, he later admitted to the relationship with Patient A, claiming that it was for a very limited period. In 2003, the practitioner removed his name from the Register of Medical Practitioners.

The practitioner did not attend the Inquiry before the Tribunal but made written admissions confirming his relationship with Patient A, albeit for a very brief period and acknowledging that he had had an inappropriate personal relationship with another patient, Patient B. The Tribunal was satisfied that each of the particulars of the complaint had been made out. The Tribunal found that "*despite the fact that Patient A has a history of significant psychiatric disability, where there is a conflict between her version of events and the practitioner's versions of events that Patient A's version is to be preferred. The Tribunal regards the practitioner as being an unreliable historian and that the practitioner lied to the Commission and to the Tribunal about his sexual activities with patient A*".

The Tribunal was particularly critical of the practitioner's dealings with Patient A and found "*that the practitioner abused the position of trust which was reposed in him by virtue of the medical practitioner/patient relationship. The practitioner must have known how vulnerable Patient A was at the time he so callously commenced the sexual relationship with her for his own sexual gratification. Further, the practitioner must have known the degree of affection Patient A held for him and that Patient A was likely to be damaged by his illicit social and sexual dealings with her.*"

The Tribunal gave credit to the practitioner for his admissions regarding his sexual conduct with Patient A and for not requiring either patient to give evidence before the Tribunal. The Tribunal also gave credit to the practitioner for removing his name from the Register of Medical Practitioners. However, the Tribunal found that the conduct was of a "s*ufficiently serious nature to justify suspension of the practitioner from practising medicine or the removal of the practitioners name from the register*." The Tribunal found that the conduct of the practitioner amounted to professional misconduct and ordered that the practitioner not be re-registered and that he not be permitted to make an application for registration for a period of 5 years.

MEDICAL TRIBUNAL

Dr Chatterjee – Sexual misconduct

The Commission made a complaint against Dr Chatterjee of unsatisfactory professional conduct and professional misconduct.

Dr Chatterjee, a general practitioner, first saw the female patient when she was a young child and she continued to consult him into adulthood. After a break in treatment, the patient returned to the practitioner and sought treatment for depression, anxiety and panic attacks. The complaint alleged that during a consultation, the practitioner gave the patient a massage without clinical justification, embraced her and touched her breast and buttocks beneath her clothing.

Whilst the practitioner claimed to have a clear recollection of the consultation, he denied the alleged conduct. The practitioner attempted to establish that the patient was either mentally unsound or a person of such character that she should not be believed. The Tribunal noted that there were no witnesses to what occurred other than the practitioner and the patient and accordingly that there was no corroborative material to support the evidence of either of them. Following a detailed review of the evidence, the Tribunal accepted the patient's evidence, finding that it was given in a clear and straightforward manner. The Tribunal found that "*there was plausibility in her evidence that, because the practitioner has always previously treated her with kindness and professionalism, she trusted him, notwithstanding indicators which suggested that his conduct on 9 June 2000 was unusual. In these circumstances, the Tribunal finds that the inconsistencies in her evidence are not such that it should not accept her evidence*".

In contrast, the Tribunal found that parts of the practitioner's evidence were not credible and "*that he was not a witness of credit*". The Tribunal found the Complaint proved and having "*regard to the nature of the conduct involved, the vulnerable condition of [the patient] at the time of the incident and the severe criticism of the peer reviewer, the Tribunal finds the practitioner guilty of professional misconduct.*

The Tribunal took into account that there was little or no evidence of insight on the part of the practitioner into his conduct, no admissions and no contrition. This absence of insight was found to be compounded by the fact that the practitioner chose to conduct himself unacceptably with the patient, "*who at the time was a young woman, vulnerable by reason of her psychological condition, who trusted and relied upon him*". The Tribunal regarded as particularly reprehensible the manner in which the practitioner dealt with the patient in his response to the complaint. The Tribunal also had regard to the practitioner's previously unblemished record and the references provided. The Tribunal severely reprimanded the practitioner and fined him $13,750.

MEDICAL TRIBUNAL

Dr Corbett - Complaint and re-registration application

Two applications were before the Tribunal in respect of the medical practitioner, Dr Paul Corbett.
The first was a complaint brought by the Commission alleging that the practitioner had been convicted of offences and made the subject of criminal findings for offences in New South Wales and further that he suffered from an impairment, namely "a *physical and/or mental conditions or disorders; as defined in DSM-IV-TR alcohol abuse or dependence and cognitive disorder, not otherwise specified – which detrimentally affects, or likely to detrimentally affect, his mental capacity to practice medicine*". The second matter was an application by the practitioner for the lifting or variation of the conditions imposed on his right to practice medicine.

Background
In June 1990, the Medical Tribunal ordered the removal of the practitioner's name from the Register following a finding of professional misconduct arising from his convictions in relation to numerous offences of Medicare fraud. Following his convictions, the practitioner was ordered to repay $556,762.52 to Medicare and served a four year prison term prior to being released on parole. The practitioner twice applied for a review of the Tribunal's decision to remove his name from the Register and his application was refused on both occasions. In September 2000, following an extensive hearing for review, the Tribunal ordered that the practitioner's name be reinstated on the Register. His registration was subject to a number of conditions, including that he work under supervision for two years in a public hospital.

Some time after 1992, the practitioner developed a significant alcohol addiction. He was convicted of mid-range prescribed concentration of alcohol offences in April 1994 and June 1995, and high-range offences in April 1997 and August 1998. These offences were taken into account by the Tribunal when the practitioner was given the right to re-register. The practitioner told the Tribunal at that time that he had given up drinking after the 1998 offence and had undergone treatment for his alcoholism. However, in 2000 and again in 2002 he continued to drink alcohol. In 2001, the practitioner worked between January and July as an employee of the Western Sydney Area Health Service prior to being dismissed for unsatisfactory performance.
From that time, the practitioner has been unable to find other work in the public hospital system.

Further convictions
In June 2001, the practitioner was convicted of two further drink driving offences. In October 2001, he was convicted of driving whilst disqualified, using an unregistered vehicle on a road area and using an uninsured vehicle. In December 2003, following a rehearing in the District Court of a summary prosecution for the offences of indecent assault and common assault, the judge found the offences proved and imposed a s.10 bond with conditions on the practitioner. Late in 2001 the practitioner was dealt with for breach of a bond imposed on him by the Local Court. These were the matters on which the Commission relied in relation to the complaint.

Tribunal Inquiry
The practitioner did not contest that criminal findings had been made against him but did contest the complaint in relation to impairment. Additionally, by reason of his difficulty in finding work in the hospital system and the recent offer of work in a general practice, the practitioner sought to be relieved from further compliance with the condition requiring him to work for two years in the public hospital system. The Commission opposed his application. The Tribunal considered the evidence and the submissions but was of the view that the practitioner's application ought be dismissed. "*While there have been some changes in his circumstances for the good and there have been some improvements in his health, the Tribunal is not persuaded that the interests of the public would have adequate protection if it did as asked".*

Whilst the Tribunal expressed sympathy for the practitioner's position, and noted that there was support in the evidence for his capacity to work in general practice on certain conditions and there was available work in the practice, it must consider other matters. "*First, it has been 15 years since Dr Corbett last practised as a GP. Indeed in his whole career, he was only in general practice for about five years. Secondly, since the orders made in 2000, he has continued to commit breaches of the criminal law, leading to sentences of imprisonment, to be served by periodic detention or which were suspended. Thirdly, after the year 2000 hearing, he continued to drink alcohol. He committed offences whilst under the influence of alcohol. Fourthly, he was dishonest with the board-appointed psychiatrist...and then with the Commission. The Tribunal sees there being a necessity for honest dealings by him with the Board in any ongoing relationship that he has with it. Although he says that he has not had alcohol for two years and three months, he told the tribunal before which he gave evidence in 2000 that he was not then drinking. This tribunal has concerns about the possibility that he might continue to drink."*

The Tribunal also took into account the difficulties experienced by the practitioner when he did return to work and his continuing need for supervision. Whilst the Tribunal felt that a case could be made out for supervised general practice, it found that is was not made out in this application and accordingly dismissed it. The Tribunal found that both complaints brought by the Commission were made out and ordered that the practitioner be reprimanded and pay the Commission's costs in each of the matters.

NURSES AND MIDWIVES TRIBUNAL

Mr D - Criminal Conviction

Mr D is a registered nurse who at the time that the complaint was heard, had been practicing for a period exceeding 20 years. In 2001, following a criminal trial, Mr D was found guilty of three sexual offences that occurred between 1972 and 1975 at which time Mr D was aged between 19 and 22. The victim of these sexual offences was his younger sister, Ms D who was then aged between 12 and 14. Criminal charges were not brought against Mr D until 1999. Following the guilty verdicts, Mr D was sentenced to a term of imprisonment of 2½ years with a non-parole period of 18 months. Mr D did not at any stage advise his employer that he had been charged with these offences or that he had been found guilty at trial.

The Commission firstly alleged that, having been convicted of these criminal offences, the circumstances of the offences rendered Mr D unfit in the public interest to practice nursing. Secondly, it was alleged that as a consequence of the convictions and the conduct itself that Mr D was not of good character. In relation to the first complaint, the Tribunal examined the circumstances of the offence as well as Mr D's obligation to report to his employers that he had been charged with sexually assaulting his sister. The Tribunal found that all of the offences would, at the time they were committed, render Mr D unfit in the public interest to practice nursing. In relation to the second complaint, the Tribunal noted that the finding that a person is not of good character must be as at the time of the Inquiry. The Tribunal stated, "*we are obliged to take into account the persons behaviour under adverse as well as under better circumstances. We are obliged to take into account the actions of the person in making moral and other judgements. The mere effluxion of time does not indicate reformation of character.*"

The Tribunal noted that the nature of the sexual assaults committed were serious and had a serious impact on the victim and that it was perturbed by Mr D's continued refusal to admit his guilt in relation to the offences he committed. The Tribunal had regard to a psychiatric report indicating that there was a low risk of Mr D re-offending. The Tribunal found that the complaint alleging that Mr D was not of good character was not proved. Consequently, the Tribunal was of the view that *"the public interest and protection of the public does not require the removal of [Mr D's] name from the Register of Nurses. However, because of the serious nature of the convictions as the convictions were recorded in only 2001 and because he has recently been released from jail having served a sentence of imprisonment, the Tribunal is of the view that conditions on his registration are required*".

The Tribunal was satisfied that Mr D was fit to practice as a registered nurse in regard to specific categories of adult patients. While Mr D remains a "prohibited person" he should not provide nursing care to children or young persons. He should also not provide nursing care to categories of patients who may be particularly vulnerable, for example because of mental disability. The Tribunal ordered that the registration of Mr D be subject to a condition that he practice in the field of Aged-Care and in an Aged-Care facility. A number of other conditions were placed on his registration and an order made that he not practice as a registered nurse in areas which are prohibited to him pursuant to his status as a prohibited person under the *Child Protection (Prohibited Employment) Act* 1998.

PSYCHOLOGISTS TRIBUNAL

Mr Dow - Inappropriate relationship

The Commission made a complaint against Mr Bill Dow (aka William Royals), a registered psychologist, of unsatisfactory professional conduct and professional misconduct.

The Commission alleged that the psychologist had treated a male patient for a period of time and had held himself out to various practitioners as having treated or counselled the patient. It was claimed that for the majority of this period, the client lived in the same premises as the practitioner and that the practitioner engaged in and maintained a relationship with the client. During the hearing the psychologist made admissions that his conduct amounted to professional misconduct. He admitted to having treated the male client between January 2002 and April 2002 and between May and July 2002 to having held himself out to various health practitioners as treating and/or counselling the client. He admitted that from mid-January 2002 the client lived in the same premises as himself and at all relevant times that the practitioner had engaged in a personal relationship with the client. The client was aged 17 years at the commencement of the period.

The Tribunal accepted and agreed with the comments made by the peer reviewer in the matter, namely, that "*Mr Dow's behaviour fell seriously below accepted professional standards at the level of his training, his clinical skills, his ethical standards and his alleged behaviours reflected incompetence in each of these areas...Not only did he fail in his duty of care to a supposed client but his professional ignorance and/or incompetence also exposed an already vulnerable youth to further psychological risk, eg increased hallucinations*".

The peer reviewer further stated, "*...the giving of free treatment/ counselling would remain ethically and professionally inappropriate for Mr Dow and dangerously confusing if (the client) were to be considered his friend... It would remain ethically and professionally inappropriate for Mr Dow to occupy the dual role of friend or counsellor. From the viewpoint of patient care there is a serious neglect of the duty of care owing by the counsellor to the client who is being subjected to the boundaries confusion of a dual role relationship. In the particular case of a previously abused client such as [this client] the neglect of care is even more serious.*" The peer noted that "*the provision of ongoing (free) counselling while living with the counselling client incurs my severe disapproval and, I believe, that of my colleagues*".

The Tribunal referred to the Code of Ethical Conduct of the NSW Psychologist Registration Board, a document by which all Psychologists are bound. The Tribunal found that "*a therapeutic relationship existed between [the client] and the Psychologist, the Psychologist did not seek the advice of a senior colleague before beginning the personal relationship with [the client] or at any time.*"

The Tribunal found that the conduct amounted to professional misconduct. It noted that the psychologist agreed that his name be removed from the Roll of Registered Psychologists and that he had made an undertaking to the Tribunal that he never reapply for registration. The Tribunal formally removed the name of the psychologist from the Register and accepted his undertaking and ordered him to pay the costs of the Commission.

PROFESSIONAL STANDARDS COMMITTEE

Dr Z - Medication Errors

The Commission made a complaint against Dr Z of unsatisfactory professional conduct in relation to his treatment of Patient A and Patient B.

Patient A presented after hours to the emergency department. In the course of his treatment, Patient A told the practitioner that he required his daily dose of 500 mg of Methadone. Only 470 mg of Methadone was available in the hospital and accordingly the practitioner prescribed a dose to Patient A in that amount. He was questioned twice by a nurse in relation to the dose but did not re-check it. The dose was subsequently administered to Patient A and the practitioner failed to issue particular instructions to nursing staff concerning the need to monitor the patient's vital signs overnight.

MIMS (April – May 2001 edition) indicates that the maximum dosage of Methadone should be 80mg per day. Evidence was brought by the Commission that a dose in the amount of 500 mg was unheard of and exceptionally the dose may approach 200 mg. Patients presenting to emergency departments do not always give an accurate account of their Methadone dosage and the evidence was that the practitioner should have checked the dose against the guidelines. The fact that 500 mg of Methadone was not available in the hospital, with the total amount available being 470 mg should have triggered alarm and the practitioner should have consulted a reference or an expert. He should have looked for signs of withdrawal and queried the truth of the dose requested by Patient A. Given the questioning from the nursing staff, it would have been even more important to check the dose. Following the dose of Methadone, Patient A should have been closely monitored.

Patient B was a three year old child who presented to the emergency department with an alleged overdose of paracetamol. Paracetamol overdose is a common presentation at emergency departments and morbidity is low. N-acetylcysteine (NAC) is the antidote for paracetamol overdose and the correct dose is calculated according to a patient's weight and age by reference to a nomogram that has been in use for some 20 years. Anaphylactoid reaction to NAC can occur in between 10% to 15% of patients and is dose related. Practitioner Z miscalculated both the initial and follow up doses of NAC to Patient B by misplacing the decimal point, thereby causing the patient to be administered ten times the recommended dose of the drug. The practitioner failed to recognise the inappropriateness of the dose ordered for a child, failed to check the dose when he was informed of the patient's adverse reaction and failed to seek the advice of a more experienced practitioner. He also failed to review the patient before transfer to a ward.

The practitioner made a number of admissions in relation to the complaint. He stated that he was suspicious of the daily dose advised by Patient A but because the event occurred after hours he could not verify the dose with the prescriber. He said that his judgment was clouded by the possibility that the patient might suffer withdrawal symptoms if not prescribed Methadone. By the time of the hearing the practitioner had undertaken the NSW Methadone Prescribers Accreditation Course and noted that he was aware of the appropriate dose of Methadone and the manipulative behaviour of addicts. In relation to Patient B, the practitioner admitted that he had incorrectly calculated the dosage of NAC and misplaced the decimal point.

The Committee found that unsatisfactory professional conduct had been made out and reprimanded the practitioner. It also placed a number of conditions on his registration including that he not work in an emergency department in any hospital where he is the senior member in charge and must at all times work when there is a properly qualified senior medial officer with whom he can consult when faced with difficult clinical problems.

PROFESSIONAL STANDARDS COMMITTEE

Nurse Z – Criminal Convictions

The Commission made a complaint against Nurse Z of unsatisfactory professional conduct arising out of his stealing $273 from eight separate patients and his subsequent criminal convictions for these thefts.

Police were investigating a number of reported thefts of money from patients at a hospital. After comparing the dates and times of the thefts with the roster of employees, the police interviewed Nurse Z. Nurse Z made full admissions to the offences and told police that he had used the money to purchase fuel for his car, which he used to travel to and from work. He stated that he was driving considerable distances for work and that he only took the money when he did not have enough to pay for the petrol required for the trip. Nurse Z was charged with eight counts of larceny. He was subsequently convicted and placed on a 12 month bond. He was ordered to pay compensation and court costs.

Nurse Z gave evidence that he had repaid all of the monies and had not breached his bond. In evidence before the PSC were two reports from psychologists who Nurse Z had consulted after the detection of the thefts and a number of testimonials. Nurse Z gave evidence that he had consulted a financial advisor which had led to a refinancing of his mortgage and that he had made a number of changes to his financial situation. Nurse Z indicated his extreme regret at his behaviour and expressed shame and humiliation.

The Committee found that the conduct amounted to unsatisfactory professional conduct. It found that in the circumstances of Nurse Z's case that the conduct did not amount to professional misconduct but noted that it would only be in exceptional cases that a conviction for larceny where the victims were patients under the care of a nurse would not result in a finding of professional misconduct. The Committee accepted that at the time of the commission of the offences, Nurse Z was under extreme financial pressures and was working exceptionally long hours. His life was out of control and his judgment impaired. It accepted his contrition as sincere and noted that he had put in place appropriate measures to ensure that he would not re-offend. The Committee found that Nurse Z had made restitution, co-operated with police, admitted his guilt, asked for forgiveness, and apologised. In the event of any further offences of this nature, Nurse Z was advised that any resulting complaint would likely result in an Inquiry before a Tribunal. Nurse Z was then reprimanded.

Disability Action Plan

As reported in the last Annual Report the induction module for staff which covers disability access issues has been reviewed and expanded. This module highlights those features in the building, in which the Commission is located, which assist the access of people with a disability. Improved lighting and signage, including signage in Braille is available in the foyer to the common areas of the Commission's building.

The Commission has appointed an officer to work exclusively as the Telephone Inquiry Officer to provide assistance to callers wanting to lodge a complaint. That officer identifies as a person with a disability. There is an emphasis in respect of the position on providing assistance to callers with disabilities or who are from a non-English speaking background (NESB).

The Commission has developed a five-step process to provide assistance to any person, and in particular callers with disabilities or from a NESB, who wish to lodge a complaint with the Commission. This includes preparing the complaint for the person and sending it to them for review or arranging to meet with the person and obtain the details of the complaint.

Through the Consumer Consultative Committee the Commission sought advice from disability support organisations about the content and presentation of Commission brochures and other information material for particular target audiences including persons with disabilities.

The Commission had anticipated reviewing and updating its existing action plan in this reporting period. The complexity of the operational and structural changes that have occurred this year have meant that this process is delayed until 2005-06.

Ethnic Affairs Priorities Statement

During the year the Commission's complaint guide was reviewed and costings are being sought regarding the translation of the guide into community languages.

The Commission makes regular use of the Telephone Interpreter Service to assist complainants who are not conversant in the English language.

The Commission spent $6000 on translation and interpreting services in the reporting period. These services ensure that consumers are able to express their complaints in the languages in which they are most confident.

Bilingual skills of staff are utilised on an informal basis to assist complainants. Three staff members receive payment of an allowance under the Community Languages Allowance Scheme to provide interpreting/translation services in languages other than English. The languages are Spanish, Italian and Filipino.

A review of the Commission's Ethnic Affairs Priority Statement forward plan has commenced and it was anticipated that it would be completed for this reporting period. The complexity of the operational and structural changes that have occurred this year have meant that this process is delayed until 2005-06.

Electronic Service Delivery

The Commission is committed to providing electronic services aligned to NSW Government guidelines.

The Commission's website has a range of publications, including the new complaints guide. This new guide provides information on the complaints handling process and incorporates the legislative changes which came into effect on 1 March 2005.

The Commission has rewritten the content of its website and is planning a major overhaul of the site. It is anticipated that the newly designed website will go live in 2005-06.

The Commission can be contacted via email through its website.

The website also provides links to a range of other bodies, including the NSW Health Department, the registration boards, consumer organisations and other watchdog agencies.

A secure Citrix Gateway facility has been installed at the Commission as a component of the Casemate project implementation. This facility is intended to provide secure online remote access to Casemate, email and other corporate systems for remote officers, management and other Commission users via laptops or remote computers.

TABLE 27 - SECTION A: NUMBER OF NEW FOI REQUESTS

FOI Requests	PERSONAL * 2003/04	PERSONAL * 2004/05	OTHER # 2003/04	OTHER # 2004/05	TOTAL 2003/04	TOTAL 2004/05
A1 New	53	47	5	1	58	48
A2 Brought forward	0	0	0	0	0	0
A3 Total to be processed	53	47	5	1	58	48
A4 Completed	53	47	5	1	58	48
A5 Transferred out	0	0	0	0	0	0
A6 Withdrawn	1	3	0	0	1	3
A7 **Total processed**	**52**	**44**	**5**	**1**	**57**	**45**
A8 Unfinished (carried forward)	0	0	0	0	0	0

* Personal requests are those made by individuals
\# Other requests are those made by organisations

Freedom of information

As at 1 March 2005 the Health Care Complaints Commission became an exempt body under Schedule 2 of the FOI Act (s.9) in relation to its complaint handling, investigative, complaints resolution and reporting functions (including any functions exercised by the Health Conciliation Registry).

TABLE 28 - SECTION B: WHAT HAPPENED TO COMPLETED REQUESTS

Results of FOI	PERSONAL 2003/04	PERSONAL 2004/05	OTHER 2003/04	OTHER 2004/05
B1 Granted in full	15	12	2	1
B2 Granted in part	29	22	0	0
B3 Refused	8	13	3	0
B4 Deferred	0	0	0	0
B5 Completed	52	47	5	1

Section C: Ministerial Certificates
None issued during this or the previous reporting period.

TABLE 29 - SECTION D: FORMAL CONSULTATIONS

	ISSUED 2003/04	ISSUED 2004/05	TOTAL 2003/04	TOTAL 2004/05
D1 - Number of requests requiring formal consultations	6	5	6	5

TABLE 30 - AMENDMENT OF AGENCY RECORDS - NO. OF REQUESTS FOR AMENDMENT PROCESSED DURING THE PERIOD (S.43)

Results of Requestes	2003/04	2004/05
Agreed	0	1
Refused	0	0
Total	**0**	**1**

TABLE 31 - SECTION G: FOI REQUESTS GRANTED IN PART OR REFUSED. BASIS OF DISALLOWING ACCESS - NUMBER OF TIMES EACH REASON CITED IN RELATION TO COMPLETED REQUESTS WHICH WERE GRANTED IN PART OR REFUSED

Basis of allowing or restricting access	PERSONAL 2003/04	PERSONAL 2004/05	OTHER 2003/04	OTHER 2004/05
G1 s.19 (application incomplete, wrongly directed)	0	0	0	0
G2 s.22 (deposit not paid)	0	1	0	0
G3 s.25 (1) (a1) (diversion of resources)	0	0	0	0
G4 s.25 (1) (a) (exempt)	28	0	0	0
G5 s.25 (1) (b), (c), (d) (otherwise available)	0	0	3	0
G6 s.28 (1) (b) (documents not held)	4	25	0	0
G7 s.24 (2) (deemed refused, over 21 days)	0	0	0	0
G8 s.31 (4) (released to Medical Practitioner)	0	0	0	0
G9 Schedule 2 (complaint being processed by HCCC)	5	2	0	0
G10 Section 9 (exemption from operation of FOI Act.)	0	7	0	0
Totals	**37**	**35**	**3**	**0**

Section E: Amendment of personal records
No requests for notation were made during this or the previous reporting period.

Section F: Notation of personal records
No requests were made for notation during this or the previous period.

TABLE 32 - SECTION H: COSTS AND FEES OF REQUESTS PROCESSED DURING PERIOD

	ASSESSED COSTS		FOI FEES RECEIVED	
	2003/04	2004/05	2003/04	2004/05
H1 All completed requests	$1,235	$1,036	$1,235	$1,036

TABLE 33 - SECTION I: DISCOUNTS ALLOWED

Type of Discount Allowed	PERSONAL		OTHER	
	2003/04	2004/05	2003/04	2004/05
I1 Public interest	0	0	0	0
I2 Financial hardship - pensioner / child	12	10	0	0
I3 Financial hardship - non-profit organisation	0	0	0	0
I4 **Totals**	**12**	**10**	**0**	**0**
I5 Significant correction of personal records	0	0	0	0

TABLE 34 - SECTION J: DAYS TO PROCESS

Elapsed Time	PERSONAL		OTHER	
	2003/04	2004/05	2003/04	2004/05
J1 0 - 21 days	44	30	4	1
J1 22 - 35 days	3	8	1	0
J1 Over 35 days	5	9	0	0
J1 **Totals**	**52**	**47**	**5**	**1**

TABLE 35 - SECTION K: PROCESSING TIME

Processing Hours	PERSONAL		OTHER	
	2003/04	2004/05	2003/04	2004/05
K1 0 - 10 hours	48	41	5	1
K2 11 - 20 hours	3	6	0	0
K3 21 - 40 hours	1	0	0	0
K4 Over 40 hours	0	0	0	0
K5 **Totals**	**52**	**47**	**5**	**1**

TABLE 36 - SECTION L: REVIEWS AND APPEALS NUMBER FINALISED DURING PERIOD

	2003-04	2004-05
L1 Internal reviews finalised	1	1
L2 Ombudsman reviews finalised	0	1
L3 District Court reviews finalised	0	0
L4 ADT appeals finalised	0	0

TABLE 37 - BASES OF INTERNAL REVIEW. GROUNDS ON WHICH INTERNAL REVIEW REQUESTED

Outcome	PERSONAL				OTHER			
	UPHELD		VARIED		UPHELD		VARIED	
	2003-04	2004-05	2003-04	2004-05	2003-04	2004-05	2003-04	2004-05
L5 Access refused	0	0	0	0	0	0	0	0
L6 Deferred	0	0	0	0	0	0	0	0
L7 Exempt matter	0	0	1	1	0	0	0	0
L8 Unreasonable charges	0	0	0	0	0	0	0	0
L9 Charge unreasonably incurred	0	0	0	0	0	0	0	0
L10 Amendment refused	0	0	0	0	0	0	0	0
L11 **Totals**	**0**	**0**	**1**	**1**	**0**	**0**	**0**	**0**

Privacy Management Plan

The review undertaken of the Commission's Privacy Management Plan for the last reporting period has enabled the Commission to continue to ensure that its policies and practices comply with the requirements of the *Privacy and Personal Information Protection Act 1998*.

Two new applications under the *Privacy and Personal Information Protection Act 1998* for internal reviews were received during the reporting period. One of these matters relating to access of documents was resolved and the other has been referred to the Administrative Decisions Tribunal.

Promotion

Publications

Commission publications as at 30 June 2005 are as follows:

- Annual Report:
  - 2004-05
  - 2002/03
  - 2001/02
  - 2000/01
  - 1999/2000
  - 1998/1999
- Corporate Plan 2004/05.
- The Complaint Guide.
- Case Study Booklet Vol 1.
- Breast Cancer life after diagnosis brochure.
- Cosmetic Surgery Report 1999.
- How to get help for a health concern – A brochure for Aboriginal people.
- How to get your records brochure.
- Report into Impotency Treatment Services.
- Report on an investigation of incidents in the operating theatre at Canterbury Hospital.
- Report into adverse outcomes following cataract surgery at Dubbo Base Hospital.

All the above publications are available on the Commission's website: ***www.hccc.nsw.gov.au***
The Commission is updating a range of documents that will be available in the next reporting year. These include a simplified version of the complaints guide, translation of the complaints guide into a range of languages and a guide on the Complaints Resolution Service.

Commission Policy Documents

The Commission's range of policy documents are:

- Code of conduct and ethics for staff.
- Complaint referral agreement.
- Consumer Consultative Committee – Terms of Reference and code of conduct.
- Guidelines for professional reviewers and advisers.
- Information sharing agreement.
- Investigation policy.
- Memorandum of Understanding with the NSW Department of Health.
- Privacy Management Plan.
- Prosecution policy and guidelines.

Complaints by Consumers

The Commission received a considerable number of complaints regarding delay in processing the matters that came to be identified as the backlog of matters. The Commission acknowledges that these delays were unacceptable and has since put in a range of measures to clear those investigations in April 2005.

In previous years the Commission did not keep accurate data on the complaints it received about its service. It will do so for the next reporting year.

When a complainant is dissatisfied with a decision of the Commission in relation to either an assessment or investigation outcome he or she is entitled to a seek a review of the matter. Assessment reviews are undertaken pursuant to s.28 of the *Health Care Complaints Commission Act*. Reviews of investigation outcomes concerning individual practitioners are undertaken pursuant to s.41.

Consumers are also entitled to complain to the NSW Ombudsman and the Independent Commission Against Corruption (ICAC) about the Health Care Complaints Commission. For the reporting year the Ombudsman received 12 formal complaints about the Commission. It finalised 11 and of those all were declined for investigation. One complaint was received by the ICAC.

HUMAN RESOURCES

Commissioner

The Commission consists of a Commissioner appointed by the Governor. In the reporting period the following people have occupied this role:

- Kenneth V Taylor, AM, BA, LLB, RFD Judge of the District Court of NSW, appointed by the Minister as Acting Commissioner on 22 March 2004 for a year.

- Kieran Pehm, BA, LLB, LLM, appointed by Minister as Acting Commissioner from 22 March 2005 with Commissioner's delegations effective from 8 March 2005 and confirmed as Commissioner on 29 June 2005.

TABLE 38 - SENIOR EXECUTIVE SERVICE

	CURRENT	2003/04
Number of female executive officers	two	nil
Number of executive positions at each level	Level 6 - one Level 5 - one Level 2 - two Level 1 - one	Level 5 - one Level 2 - one

Senior Executive Service

In the 2004 – 2005 reporting period the Commission had five SES positions. The positions are:

Commissioner
Deputy Commissioner
Director of Proceedings
Director, Assessments and Resolution
Director, Investigations

The position of Commissioner, SES 6, was filled up to 21 March 2005 by a Judge, who is a Judicial Officer, not an SES Officer.

The appointed occupant of the position of Deputy Commissioner, SES 5 was Mr Kieran Pehm, BA, LLB, LLM. When Judge Taylor proceeded on leave on 8 March 2005 in the period immediately prior to the completion of his appointment on 21 March 2005, Mr Pehm assumed the responsibilities of the role of Commissioner and was subsequently appointed by the Minister as Acting Commissioner from 22 March 2005 following the departure of Judge Taylor.

Mr Pehm was appointed by the Governor as Commissioner on 29 June 2005. Mr Pehm is SES 6 and has a remuneration package of $228,651.

TABLE 39 - NUMBER OF STAFF AS AT 30 JUNE (EFFECTIVE FULL TIME)

Category		2001	2002	2003	2004	2005
Executive	*Senior Executive Officers*	1	1	1	1	4
	Senior Officer	1	1	2	1	1
Clerk	*Grade 11/12*	1	3	5	4	1
	Grade 10	4	3	5	5	4
	Grade 7/8	32.53	32.9	35.07	50.89	35.28
	Grade 5/6	4	2.6	1.8	0.6	--
	Grade 3/4	7	10	9	8	7
	Grade 2	--	--	--	--	--
	Grade 1	1	1	1	1	1
Clerical Officer	*Grade 3/4*	8	7	8	8	9
	Grade 1	2	1	1	1	1
Trainee		1	--	--	--	--
Legal Officer	*Grade VI*	1	1	1	1	1
	Grade III-IV	4	4	5	5	7
	Grade II	2	1	--		--
Medical Advisers		0.2	0.8	0.8	1.8	1.2
Total		**69.73**	**69.27**	**75.67**	**91.29**	**72.48***

* As this figure was calculated at 30 June 2005 it does not include those temporary staff employed for the purpose of clearing the backlog and assisting with completing the Macarthur investigations. The figure also does not include the agency staff employed by the Commission who have assisted in the processing of complaints and providing administrative support to operational areas.

During his period as Deputy Commissioner, Acting Commissioner and Commissioner, Mr Pehm has carried out his duties in an excellent manner. He has either overseen or worked in conjunction with Judge Taylor on the overhaul and restructure of the Commission and the improved performance of the staff.

Ms Karen Mobbs commenced duty on 21 March 2005 in the newly created position of Director of Proceedings, SES 2.

Ms Leena Pradhan, commenced duty on 26 July 2004 in the newly created position of Director of Investigations, SES 2.

Mr Chris Hanlon commenced duty on 14 February 2005 in the newly created position of Director of Assessments and Resolution, SES 1.

Commission Staff

The number of employees, by category for the years 2001 to 2005 is at Table 39.

Consultants

During the reporting period consultants were engaged at a total cost of $227,526. Table 40 sets out the type of consultants used by the Commission and the cost for their service.

Committees

The Commission has reconvened its Consumer Consultative Committee and holds meetings every three months. The Committee is made up of the following members:

- Kath Brewster, Council on the Ageing.
- Sam Choucair, Ethnic Communities Council.
- Alanna Clohesy, People With Disabilities NSW Inc.
- Denele Crozier, Women's Health NSW.
- Ann Cutler, Association for the Welfare of Child Health.
- Samantha Edmonds, NCOSS.
- Lola Edwards, Aboriginal Health and Medical Research Council.
- Geoff Honor, People Living With HIV/AIDS.
- Ann Maclochlainn, Mental Health Coordinating Council.
- Tim Marchant, Carers NSW.
- Susan Mitchell, Rural and Remote Health Consumers of Australia.
- Anna Saminksy, Health Consumer Network.
- Pauline Shepherd, Alzheimer's Association.
- Kim Walker, NSW Council of Intellectual Disability.
- Barbara Wright, Combined Pensioners and Superannuants Association.

The Committee provides valuable advice to the Commission on issues affecting health consumers. The Committee will be advising the Commission on the development of its Code of Practice for the next reporting year.

TABLE 40 - CONSULTANTS

Category of Consultancy	No. of Engagements	Total Cost
Clinical advice to investigators	451	$199,421
Review of information technology services	1	$6,000
Business Risk Assessment	1	$14,850
Review of budget management, financial controls and other accounting advice	1	$4,630
Job evaluation and classification advice	2	$2,625

Equal Employment Opportunity (EEO)

The Commission continued to promote the principles of equity and EEO as well as recognise the varying needs of its staff members. This was done through:

- provision of training and developmental opportunities for staff;
- accommodating the requirements of staff with (temporary or permanent) disabilities;
- support for staff using flexible work practices to balance work and family responsibilities;
- usage of the Community Language Allowance Scheme;
- opportunities for staff to gain experience through the provision of relief in more senior and responsible positions;
- Continuation of a TTY telephone service for the hearing impaired.

Trends in the distribution of EEO groups

The distribution index for women employed by the Commission is 99. A distribution index of 100 indicates that the distribution of the EEO group across salary levels is equivalent to that of other staff. Values less than 100 mean that the EEO group tends to be more concentrated at lower salary levels than is the case for other staff. The more pronounced this tendency is, the lower the index will be.

The distribution index is automatically calculated by the software provided by the Office of Equal Opportunity in Public Employment. The distribution index is not calculated where EEO group or non-EEO group numbers are less than 20. Women are the only EEO group employed at the Commission with more than 20 members. Last year the index was 96. The increase reflects the fact that more women have been employed in the Commission at higher levels whilst the gender mix of the lowest level staff has remained constant.

Industrial Relations

The Commission has a workplace agreement which provides for a workplace consultative committee as a formal framework for the conduct of cooperative industrial relations.

Commission representatives

- Commissioner or his nominee;
- Director of Investigations;
- Director of Assessment and Resolution;
- Manager of Corporate Services.

Public Service Association representatives

- the General Secretary or nominee;
- two representatives nominated by PSA members on the Commission staff.

The current workplace agreement is scheduled for review in the next reporting period.

On 24 May 2005 the Industrial Relations Commission made the Crown Employees (Health Care Complaints Commission, Medical Advisers) Award. The Award is effective from 24 May 2005 and applies to Medical Advisers employed by the Commission.

TABLE 41 - TRENDS IN THE REPRESENTATION OF EEO GROUPS 2002 - 2005

	% OF TOTAL STAFF AT 30 JUNE 2005				
	Benchmark or Target %	2002	2003	2004	2005
Women	50	71	67	69	70
Aboriginal people and Torres Strait Islanders	2	1.4	1	2.7	1.3
People whose first language was not English	20	14	14	15	15
People with a disability	12	8	9	3	8
People with a disability who require a work-related adjustment	7	--	--	--	--

Personnel policies and practices

Commission staff are either members of the Senior Executive Service or Officers appointed under the *Public Sector Employment and Management Act 2002* (PSE and M Act). Officers' salaries are set by awards and agreements. A 4% pay rise, being the second instalment of a 16% pay increase provided for by the Crown Employees (Public Sector - Salaries 2004) Award was implemented for staff in July 2005.

As noted above, on 24 May 2005 the Industrial Relations Commission made the Crown Employees (Health Care Complaints Commission, Medical Advisers) Award. The Award is effective from 24 May 2005 and applies to Medical Advisers employed by the Commission.

Staff conditions of service are principally set by the PSE&M Act 2002 and the Crown Employees (Public Service Conditions of Employment) Award 1997 and are managed according to the guidelines set by the Premier's Department in the *NSW Personnel Handbook*. Follow the "publications" links on www.premiers.nsw.gov.au for access to the Handbook and other relevant information.

Staff Education and Development

Commission staff participated in a range of education and development programs. Staff attended a half day training session at the Independent Commission Against Corruption on EEO, Grievance and Diversity Training.

Legal staff attended a series of seminars throughout the reporting period. Topics covered included:

- Recent Developments in Privacy laws.
- Working with Statutes.
- New Subpoena rules.
- Solicitor-Advocate Skills.
- Drafting Documents for use in Court: Affidavits and Witness Statements.
- Witnesses: Statements of Evidence of Lay Witnesses and Reports of Expert Witnesses.
- The Role of Solicitor at Trial.
- Occupational Health and Safety Law.

Other courses undertaken by Commission staff included:

- Measurement in the Public Sector.
- Job Application and Interviewing Skills.
- Understanding Mental Illness.
- English Grammar.
- Specialised ICT courses.

All assessment, CRO, investigation and legal staff participated in training on amendments to the legislation.

Investigation staff have also undertaken training in investigative techniques throughout the year.

ENVIRONMENTAL IMPACT

Waste Reduction And Purchasing Policy

The Commission continued its commitment to the Government's Waste Reduction and Purchasing Policy during the reporting period.

- The Commission returns all toner cartridges used in its printers, photocopiers and facsimile machines to the suppliers for the purpose of recycling. The toner cartridges purchased for use by the Commission are constructed of recycled components.
- During the reporting period the Commission purchased 4,050 reams of paper with 3,600 reams of that paper containing recycled content.
- All photocopying performed in the Commission is on recycled paper and the Commission's Annual Report is printed on recycled paper.
- The Commission sent 11.5 tonnes of used paper for recycling, during the reporting period.

Energy Management

The Commission continues to be committed to the NSW Government Energy Management Policy as part of the National Greenhouse Strategy.

In line with Government policy, the Central Square premises occupied by the Commission have obtained a four star accredited Australian Building Greenhouse Rating issued by the Department of Energy, Utilities and Sustainability.

Energy data for the reporting period 2004 – 2005 is at Table 42.

TABLE 42 - ENERGY USE

Energy Use	2003 to 2004 Office	2003 to 2004 Cars	2003 to 2004 CO2	2004 to 2005 Office	2004 to 2005 Cars	2004 to 2005 CO2
Electricity (k Wh)	284,887	-	272	304,432	-	291
Greenpower (k Wh)	5,842	-	-	19,340	-	
Petrol (L)	-	3,665	8	-	4060	9

Normalisation Factors	2003 to 2004	2004 to 2005
Occupancy (No. of people)	86	79
Area (m2)	1,790	1,790
Distance travelled (km)	35,405	35152

Energy Utilisation Index	2003 to 2004 Office	2003 to 2004 Cars	2004 to 2005 Office	2004 to 2005 Cars
Mj / person / annum	12,170	-	14,754	-
Mj / M2 / annum	585	-	651	-
Mj / Km	-	3.5	-	4

Outline Budget

In 2003-04, the government committed an extra $5.7 million to the Commission, $2.6 million in 2003-04 and $3.1 million 2004-05, to refocus the organisation on its core business of investigating complaints and to complete the investigation of complaints against the Macarthur Area Health Service and to clear the backlog of outstanding investigation cases.

TABLE 43 - COMPARISON OF FINANCES 2001-05

Actual	2000-01 $0	2001-02 $0	2002-03 $0	2003-04 $0	2004-05 $0
Total expenses	6,674	6,872	9,183	10,416	11,080
Total retained revenue	223	1,538	1,114	865	373
Gain/(loss) on sale of non-current assets	11	-	- 23	-	-
Net Cost of Services	**6,440**	**5,334**	**8,092**	**9,551**	**10,707**

During 2004-05 an assessment and identification of accounting policy changes arising from the full adoption of the Australian equivalents to international financial reporting standards (AIFRS) was completed. Only minor changes in financial reporting are expected in preparing the Commission's financial statements for 2005-06 under AIFRS, such as the disclosure of computer software as intangible assets.

TABLE 44 - OUTLINE BUDGET FOR 2005-06 FINANCIAL YEAR

	2005/06 $0
Expenses	
Operating Expenses	
• Employee related	7,084
• Other operating expenses	3,043
Maintenance	4
Depreciation and amortisation	339
Total expenses	**10,470**
Less	
Retained revenue	
Sales of goods and services	16
Investment income	42
Other revenue	279
Total retained revenue	**337**
NET COST OF SERVICES	**10,133**

A detailed 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 of the budget for the 2005-06 financial year is as in Table 44.

Account Payment Performance

The Commission's Accounts Officer is the Manager, Corporate Services and accounts are processed in accordance with the provisions of the *Public Finance and Audit Act 1983.*

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 Department of Gaming and Racing as part of the Commission's Shared Corporate Service arrangement.

The payment performance analysis is as follows:

TABLE 45 - AGED ANALYSIS AT THE END OF EACH QUARTER

Quarter	Current (ie 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	1,403,517	62,335	1,646	1,799	15,591
December	767,616	106,271	18,722	1,722	11,138
March	998,098	69,023	112,632	27,856	19,895
June	1,293,505	142,190	47,316	1,279	3,756

TABLE 46 - ACCOUNTS PAID ON TIME WITHIN EACH QUARTER

Quarter	TOTAL ACCOUNTS PAID ON TIME Target %	Actual %	$	TOTAL AMOUNT PAID $
September	85	94.52	1,403,517	1,484,888
December	85	84.78	767,616	905,469
March	85	81.31	998,098	1,227,504
June	85	86.93	1,293,505	1,488,046

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

Risk Management, Insurance And Occupational Health And Safety

There were no prosecutions lodged against the Commission under the *Occupational Health and Safety Act 2000* in this reporting period.

TABLE 47 - OCCUPATIONAL HEALTH AND SAFETY INCIDENTS, INJURIES AND CLAIMS 2004 - 2005

	No.
No. of New Claims	2
No. of Workers Comp Claims Accepted	2
Fall, Trip, Slip Outside Workplace	1
Work Practice/Setup Related	1
Total Injuries 2004-2005	2

There has been a decrease in the number of work related injuries from the previous reporting period. Last reporting period, 6 workers compensation claims were accepted compared to only 2 for this period.

The Commission has a fleet of 3 motor vehicles and there were 3 claims for damage to the vehicles in the current reporting year compared to nil claims in the previous reporting year. There were no claims for personal injury relating to the claims.

TABLE 48 - MOTOR VEHICLE CLAIMS 2004 - 2005

	No.
No. of New Claims	3
No. of Claims Accepted	3
Collision Involving Another Vehicle	2
Collision With Property	1
Total Motor Vehicle Claims 2004-2005	3

GPO BOX 12
Sydney NSW 2001

INDEPENDENT AUDIT REPORT

Health Care Complaints Commission

To Members of the New South Wales Parliament

Audit Opinion

In my opinion, the financial report of the Health Care Complaints Commission

(a) presents fairly the Health Care Complaints Commissions financial position as at 30 June 2005 and its financial performance and cash flows for the year ended on that date, in accordance with applicable Accounting Standards and other mandatory professional reporting requirements in Australia, and

(b) complies with section 41B of the *Public Finance and Audit Act 1983* (the Act).

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

The Commissioner's Role

The financial report is the responsibility of the Commissioner of the Health Care Complaints Commission. It consists of the statement of financial position, the statement of financial performance, the statement of cash flows and the accompanying notes.

The Auditor's Role and the Audit Scope

As required by the Act, I carried out an independent audit to enable me to express an opinion on the financial report. My audit provides *reasonable assurance* to Members of the New South Wales Parliament that the financial report is free of *material* misstatement.

My audit accorded with Australian Auditing and Assurance Standards and statutory requirements, and I:

- evaluated the accounting policies and significant accounting estimates used by the Commissioner in preparing the financial report, and
- examined a sample of the evidence that supports the amounts and other disclosures in the financial report.

An audit does *not* guarantee that every amount and disclosure in the financial report is error free. The terms 'reasonable assurance' and 'material' recognise that an audit does not examine all evidence and transactions. However, the audit procedures used should identify errors or omissions significant enough to adversely affect decisions made by users of the financial report or indicate that Commissioner had not fulfilled their reporting obligations.

My opinion does *not* provide assurance:

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

Audit Independence

The Audit Office complies with all applicable independence requirements of Australian professional ethical pronouncements. The 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 are not compromised in their role by the possibility of losing clients or income.

P K Brown, FCPA
Director, Financial Audit Services

Health Care Complaints Commission

Financial Statements For The Year Ended 30 June 2005

CERTIFICATE OF ACCOUNTS

Pursuant to s.41C(1B) of the Public Finance and Audit Act 1983 "the Act", I declare on behalf of the Health Care Complaints Commission that:

(i) the financial statements of the Health Care Complaints Commission for the year ended 30 June 2005 have been prepared in accordance with the requirements of applicable Australian Accounting Standards and the Urgent Issues Group Consensus Views, the requirements of the *Public Finance and Audit Act 1983* and Regulations, the Financial Reporting Directions published in the Financial Reporting Code for Budget Dependent Agencies or issued by the Treasurer under s.9(2)(n) of the Act.

Where there are inconsistencies between the above requirements, the legislative provisions have prevailed.

Statements of Accounting Concepts are used as guidance in the absence of applicable Accounting Standards, Urgent Issues Group Consensus Views and legislative requirements.

(ii) the financial statements present fairly the financial position and transactions of the Health Care Complaints Commission.

(iii) there are no circumstances which would render any particulars in the accounts to be misleading or inaccurate.

Kieran Pehm
Commissioner

Date 20 / 10 / 2005

Statement of Financial Performance
for the Year Ended 30 June 2005

	Notes	Actual 2005 $'000	Budget 2005 $'000	Actual 2004 $'000
Expenses				
Operating Expenses				
Employee Related	*2(a)*	8,179	8,390	7,039
Other Operating Expenses	*2(b)*	2,766	3,486	3,271
Maintenance		12	4	5
Depreciation	*2(c)*	123	158	101
Total Expenses		**11,080**	**12,038**	**10,416**
Less:				
Retained Revenue				
Sale of Goods and Services	*3*	1	15	60
Investment Income	*3*	54	20	25
Grants and Contributions	*3*	-	-	491
Other Revenue	*3*	318	303	289
Total Retained Revenue		**373**	**338**	**865**
Net Cost of Services	*17*	**10,707**	**11,700**	**9,551**
Government Contributions				
Recurrent Appropriations	*4*	10,418	10,569	9,669
Capital Appropriation	*4*	691	-	-
Acceptance by the Crown Entity of employee benefits and other liabilities	*5*	952	604	655
Total Government Contributions		**12,061**	**11,173**	**10,324**
SURPLUS/(DEFICIT) FOR THE YEAR FROM ORDINARY ACTIVITIES		**1,354**	**(527)**	**773**
TOTAL CHANGES IN EQUITY OTHER THAN THOSE RESULTING FROM TRANSACTIONS WITH OWNERS AS OWNERS		**1,354**	**(527)**	**773**

The accompanying notes form part of these statements

Statement of Financial Position
as at 30 June 2005

	Notes	Actual 2005 $'000	Budget 2005 $'000	Actual 2004 $'000
ASSETS				
Current Assets				
Cash	*7*	1,712	390	1,370
Receivables	*8*	348	473	364
Other		109	5	27
Total Current Assets		**2,169**	**868**	**1,761**
Non-Current Assets				
Plant and Equipment	*9*	1,096	611	368
Total Non-Current Assets		**1,096**	**611**	**368**
Total Assets		**3,265**	**1,479**	**2,129**
LIABILITIES				
Current Liabilities				
Payables	*10*	171	814	365
Provisions	*11*	492	514	542
Total Current Liabilities		**663**	**1,328**	**907**
Non-Current Liabilities				
Provisions	*11*	95	110	69
Total Non-Current Liabilities		**95**	**110**	**69**
Total Liabilities		**758**	**1,438**	**976**
Net Assets		**2,507**	**41**	**1,153**
EQUITY				
Accumulated Funds	*12*	2,507	41	1,153
Total Equity		**2,507**	**41**	**1,153**

The accompanying notes form part of these statements

Statement of of Cash Flows
for the Year Ended 30 June 2005

	Notes	Actual 2005 $'000	Budget 2005 $'000	Actual 2004 $'000
CASH FLOWS FROM OPERATING ACTIVITIES				
Payments				
Employee Related		(7,671)	(8,009)	(6,869)
Other		(3,032)	(3,652)	(3,625)
Total Payments		**(10,703)**	**(11,661)**	**(10,494)**
Receipts				
Sale of Goods and Services		83	15	551
Interest Received		36	15	47
Other		246	465	351
Total Receipts		**365**	**495**	**949**
Cash Flows from Government				
Recurrent Appropriation		10,418	10,569	9,669
Capital Appropriation		691	-	-
Cash Reimbursements from Crown Entity		404	604	325
Net Cash Flows from Government		**11,513**	**11,173**	**9,994**
NET CASH FROM OPERATING ACTIVITIES	*17*	**1,175**	**7**	**449**
CASH FLOWS FROM INVESTING ACTIVITIES				
Purchase of Plant and Equipment		(833)	(200)	-
NET CASH FLOWS FROM INVESTING ACTIVITIES		**(833)**	**(200)**	**-**
NET INCREASE IN CASH		**342**	**(193)**	**449**
Opening Cash and Cash Equivalents		1,370	583	921
CLOSING CASH AND CASH EQUIVALENTS	*7*	**1,712**	**390**	**1,370**

The accompanying notes form part of these statements

Summary of Compliance with Financial Directives
for the Year Ended 30 June 2005

	2005				2004			
	RECURRENT		CAPITAL		RECURRENT		CAPITAL	
	Recurrent Appropriation $'000	Expenditure/ Net Claim on Consolidated Fund $'000	Capital Appropriation $'000	Expenditure/ Net Claim on Consolidated Fund $'000	Recurrent Appropriation $'000	Expenditure/ Net Claim on Consolidated Fund $'000	Capital Appropriation $'000	Expenditure/ Net Claim on Consolidated Fund $'000
Original Budget Appropriation / Expenditure								
Appropriation Act	10,569	10,346	-	-	7,213	7,118	-	-
Additional Appropriations	-	-	-	-	-	-	-	-
s21A PF&AA - special appropriations	-	-	-	-	-	-	-	-
s24 PF&AA - transfer of functions between departments	-	-	-	-	-	-	-	-
s26 PF&AA - Commonwealth specific purpose payments	-	-	-	-	-	-	-	-
	10,569	10,346	-	-	7,213	7,118	-	-
Other Appropriation / Expenditure								
Treasurer's Advance	-	-	428	428	2,551	2,551	-	-
Section 22 – expenditure for certain works and services	-	-	-	-	-	-	-	-
s27 of the Appropriation Act	72	72	263	263				
	72	72	691	691	2,551	2,551	-	-
Total Appropriation / Expenditure (includes transfer payments)	10,641	10,418	691	691	9,764	9,669	-	-
Drawdowns from Treasury		10,418		691		9,669		-
Total 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)

1. Summary of Significant Accounting Policies

(a) Reporting Entity

The Health Care Complaints Commission (HCCC) is a budget dependent general government sector agency, responsible for protecting the public from substandard health services and incompetent and unethical health practitioners.

The HCCC was established as a body corporate under s.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.

(b) Basis of Accounting

The HCCC's financial statements are a general-purpose financial report, which has been prepared on an accrual basis and in accordance with:

- applicable Australian Accounting Standards
- other authoritative pronouncements of the Australian Accounting Standards Board (AASB)
- Urgent Issues Group (UIG) Consensus Views
- 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 under s.9(2)(n) of the Act.

Where there are inconsistencies between the above requirements, the legislative provisions have prevailed.

In the absence of a specific Accounting Standard, other authoritative pronouncement of the AASB or UIG Consensus View, the hierarchy of other pronouncements as outlined in AAS 6 "Accounting Policies" is considered.

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. The accounting policies adopted are consistent with those of the previous year.

(c) Revenue Recognition

Revenue is recognised when the entity has control of the good or right to receive, it is probable that the economic benefits will flow to the agency, and the amount of revenue can be measured reliably. Additional comments regarding the accounting policies for the recognition of revenue are discussed below.

Parliamentary appropriation and contributions from other bodies

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

(ii) Sale of Goods and Services
Revenue from the sale of goods and services comprises revenue from the provision of products or services i.e. user charges. User charges are recognised as revenue when HCCC obtains control of the assets that result from them.

(iii) Investment Income
Interest revenue is recognised on a time proportionate basis as it accrues that takes into account the effective yield on the cash balance.

(d) 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 and vesting sick leave are recognised and measured in respect of employees' services up to the reporting date at nominal amounts based on the amounts expected to be paid when the liabilities are settled.
Unused non-vesting sick leave does not give rise to a liability as it is not considered probable that sick leave taken in the future will be greater than the entitlements 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) Accrued salaries and wages - reclassification
As a result of the adoption of Accounting Standard AASB 1044 "Provisions, Contingent Liabilities and Contingent Assets", accrued salaries and wages and on-costs have been reclassified to "payables" instead of "provisions" in the Statement of Financial Position and the related note disclosures, for the current and comparative period. On the face of the Statement of Financial Position and in the notes, reference is now made to "provisions" in place of "employee entitlements and other provisions". Total employee benefits (including accrued salaries and wages) are reconciled in Note 11 "Provisions".

(iii) Long Service Leave and Superannuation
The Commission's liabilities for long service leave and superannuation are assumed by the Crown Entity. The Commission accounts for the liability as having been extinguished resulting in the amount assumed being shown as part of the non-monetary revenue item described as "Acceptance by the Crown Entity of employee benefits and other liabilities".
Long service leave is measured on a present value basis. Adoption of this methodology was mandated by NSW Treasury for budget dependent agencies whose long service leave liability is assumed by the Crown. Factors used for the present value calculations were derived by the Government Actuary and advised in Treasury Circular 03/08.
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 (ie Basic Benefit and First State Super) is calculated as a percentage of the employees' salary. For other superannuation schemes (ie. State Superannuation Scheme and State Authorities Superannuation Scheme) the expense is calculated as a multiple of the employees' superannuation contributions.

(e) Insurance

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

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

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

(g) Acquisition of Assets

The cost method of accounting is used for the initial recording of all acquisition of assets by the Commission. Cost is determined as the fair value of assets given as consideration plus the costs incidental to the acquisition.
Assets acquired at no cost, or for nominal consideration, are initially recognised as assets and revenues at their fair value at the date of acquisition.
Fair value means the amount for which an asset could be exchanged between a knowledgeable, willing buyer and a knowledgeable, willing seller in an arm's length transaction.

(h) Plant and Equipment

Plant and Equipment costing at least $5,000 is capitalised except for grouped assets (assets with inter-related functions, such as the computer network) where all additions regardless of amount are capitalised.

i) Revaluation of Physical Non-Current Assets

Physical non-current assets are valued in accordance with the "Guidelines for the Valuation of Physical Non-Current Assets at Fair Value " (TPP 03-02). This policy adopts fair value in accordance with AASB 1041 from financial years beginning on or after 1 July 2002.
The Agency holds non-specialised assets with short useful lives and these are measured at depreciated historical cost, as a surrogate for fair value.

(j) Depreciation of Non-Current Physical Assets

Depreciation is provided for on a straight line basis for all depreciable assets so as to write off the depreciable amount of each asset as it is consumed over its useful life to the HCCC.
The useful life of the various categories of non current assets is as follows:

Asset Description	*Depreciation Life in years*
Computer Hardware	5
Software	5

(k) Maintenance and repairs

The costs of 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.

(l) Leased assets

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

(m) Receivables

Receivables are recognised and carried at the original invoice amount less a provision for any uncollectable debts. An estimate for doubtful debts is made when collection of the full amount is no longer probable. Bad debts are written off as incurred.

(n) Payables

These amounts represent liabilities for goods and services provided to the agency and other amounts, including interest. Interest is accrued over the period it becomes due.

(o) Budgeted amounts

The budgeted amounts are drawn from the budgets as formulated at the beginning of the financial year with any adjustments for the effect of additional appropriations under s 21A, s 24 and/or s 26 of the *Public Finance and Audit Act 1983*.
The budgeted amounts in the Statement of Financial Performance and the Statement of Cash Flows are generally based on the amounts disclosed in the NSW Budget Papers (as adjusted above). However, in the Statement of Financial Position, the amounts vary from the Budget Papers, as the opening balances of the budgeted amounts are based on carried forward actual amounts i.e. per the audited financial statements (rather than carried forward estimates).

2. Expenses

	2005 $'000	2004 $'000
(a) Employee related expenses comprise the following specific items:		
Salaries and wages (including recreation leave)	6,775	6,051
Superannuation	561	476
Workers compensation insurance	32	32
Long service leave	358	138
Payroll tax and fringe benefit tax	453	342
	8,179	**7,039**
(b) Other operating expenses		
Auditor's remuneration - audit of the financial reports	17	21
Bad and doubtful debts	-	-
Consultancy	234	217
Equipment and plant	59	78
Equipment leasing	112	145
Fees for services rendered	693	669
Legal fees and adverse costs*	399	699
Other	61	239
Printing	14	115
Rental expenses relating to operating leases	836	701
Stores	131	99
Telephone, postal and internet	148	157
Travelling	62	131
* Includes an amount of $364,402.35 which represents a reversal of a prior year accrual	**2,766**	**3,271**
(c) Depreciation		
Computer hardware/software	28	7
Office furniture and equipment	9	8
Leasehold improvements	86	86
	123	**101**

3. Revenues

	2005 $'000	2004 $'000
Rendering of services	1	60
Investment income - interest	54	25
Grants and contributions	-	491
Other revenue - legal cost recoveries	318	289
	373	**865**

Notes to and Forming Part of the Financial Statements for the Year ended 30 June 2005

4. Appropriations

	2005 $'000	2004 $'000
Recurrent appropriation		
Total recurrent drawdown from Treasury (per Summary of Compliance)	10,346	7,118
Treasurers advance	-	2,551
s27 of the Appropriation Act	72	-
Recurrent appropriation (per Statement of Financial Performance)	**10,418**	**9,669**
Capital appropriation		
Treasurers advance	691	-
Capital appropriation (per Statement of Financial Performance)	**691**	**-**

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

The following liabilities and/or expenses have been assumed by the Crown Entity or other government agencies

	2005 $'000	2004 $'000
Payroll tax	33	29
Superannuation	561	476
Long service leave	358	150
	952	**655**

6. 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.

7. Current Assets - Cash

	2005 $'000	2004 $'000
Cash on hand - petty cash float	1	1
Cash at bank	1,711	1,369
	1,712	**1,370**

For the purpose of the Statement of Cash Flows, cash includes cash on hand and cash at bank. Cash assets recognised in the Statement of Financial Position are reconciled to cash at the end of the financial year as shown in the Statement of Cash Flows as follows:

Cash (per Statement of Financial Position)	1,712	1,370
Closing cash and cash equivalents (per Statement of Cash Flows)	**1,712**	**1,370**

8. Current Assets - Receivables

	2005 $'000	2004 $'000
Debtors	495	676
less		
Provision for doubtful debts	(147)	(312)
	348	**364**

9. Non Current Assets - Plant and Equipment

	2005 $'000	2004 $'000
Plant and Equipment		
At fair value	107	86
Less accumulated depreciation	76	67
	31	**19**
Computer Equipment		
At fair value	407	72
Less accumulated depreciation	94	66
	313	**6**
Computer Software		
At fair value	494	-
Less accumulated depreciation	-	-
	494	**-**
Lease Improvements		
At fair value	430	429
Less accumulated depreciation	172	86
	258	**343**
Total Plant and Equipment		
At Net Book Value	**1,096**	**368**

Reconciliations

Reconciliation of the carrying amounts of each class of plant and equipment at the beginning and end of the current and previous financial year are set out below.

	Plant and Equipment $'000	Computer Equipment $'000	Computer Software $'000	Leased Improvements $'000	Total $'000
2005					
Carrying amount at start of year	19	6	-	343	368
Additions	22	335	494	-	851
Disposals	-	-	-	-	-
Write off	-	-	-	-	-
Depreciation expense	(9)	(28)	-	(86)	(123)
Carrying amount at end of year	**32**	**313**	**494**	**257**	**1,096**
2004					
Carrying amount at start of year	27	13	-	429	469
Additions	-	-	-	-	-
Disposals	-	-	-	-	-
Write off	-	-	-	-	-
Depreciation expense	(8)	(7)	-	(86)	(101)
Carrying amount at end of year	**19**	**6**	**-**	**343**	**368**

10. Current Liabilities - Payables

	2005 $'000	2004 $'000
Accrued salaries, wages and on-costs	51	114
Creditors	106	29
Other	14	222
	171	**365**

11. Current/Non-Current Liabilities - Provisions

	2005 $'000	2004 $'000
Employee benefit and related on-costs		
Recreation leave	482	535
Payroll tax on long service leave	67	49
Long service leave on-costs	38	27
Total provisions	**587**	**611**
Aggregate employee benefits and related on-costs		
Provisions - current	492	542
Provisions - non-current	95	69
Accrued salaries, wages and on-costs (Note 10)	51	114
	638	**725**

12. Changes in Equity

	2005 $'000	2004 $'000
ACCUMULATED FUNDS		
At 1 July 2004	1,153	380
Total Changes in Equity other than those resulting from Transactions with owners as owners		
Surplus/(Deficit) for the year from ordinary activities	1,354	773
At 30 June 2005	**2,507**	**1,153**

13. Commitments for Expenditure

	2005 $'000	2004 $'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	5	-
Later than one year not later than five years	-	-
Later than five years	-	-
Total (including GST)	**5**	**-**
b. Operating Lease Commitments Future non-cancellable operating lease rentals not provided for and payable		
Not later than one year	1,139	1,170
Later than one year not later than five years	3,420	2,870
Later than five years	828	966
Total (including GST)	**5,387**	**5,006**

Total Commitments above included input tax credits of $489,721 ($455,000 2003-04) that are expected to be recovered from the Australian Taxation Office.

14. Contingent Assets

These are legal costs awarded in favour of the Commision arising from the 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 $808,506.25.

15. Contingent Liabilities

Adverse costs awarded against the Commission, across a range of cases, are estimated to be $492,265.00 at 30 June 2005 (2003-04 $585,970.00), estimates have been provided by the Commission's Chief Legal Officer.

16. Budget Review

Net Cost of Services
The Net Cost of Services was lower than Budget by $993,000. This follows lower than expected employee related and other operating expenses and increased legal cost recoveries.

Assets and Liabilities
Current Assets were higher than Budget following an increase in the balance of cash on hand as at 30 June 2005 and in non-current assets. The NSW Treasury made a s27 appropriation that enables HCCC to change from leasing arrangements for computer hardware and software to the purchase of "Casemate" software and to purchase replacement computers.
Current Liabilities were lower than Budget and close to 2004-05 actuals.

Cash Flows
Cash Flows from Government and investing activities were higher than Budget following the provision of additional funds by the NSW Treasurer to support additional expenditure on computer hardware and software.

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

	2005 $'000	2004 $'000
Net cash from operating activities	1,175	449
Depreciation	(122)	(101)
(Increase)/Decrease in provisions	22	96
Acceptance by the Crown Entity of employee benefits and other liabilities	(952)	(655)
Cash flows from Government/Appropriations	(11,109)	(9,669)
Increase/(Decrease) in receivables and other	7	7
(Increase)/Decrease in payables	272	322
Net Cost of services	**(10,707)**	**(9,551)**

18. Financial Instruments

Classes of financial instruments recorded at cost and their terms and conditions at balance date are as follows:

Cash
Cash comprises cash on hand and bank balances within the Treasury Banking System. Interest is earned on daily bank balances at the monthly average NSW Treasury Corporation (Tcorp) 11am unofficial cash rate adjusted for a management fee to Treasury.
Terms and Conditions - Monies on deposit attract an average interest rate of approximately 4.33%.

Receivables
All trade debtors are recognised as amounts receivable at balance date. Collectability of trade debtors is reviewed on an ongoing basis. Debts which are known to be uncollectable are written off. A provision for doubtful debts is raised when some doubt as to collection exists. The credit risk is the carrying amount (net of any provision for doubtful debts). No interest is earned on trade debtors. The carrying amount approximates net fair value. Sales are made on 30 day terms.

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

Interest Rate Risk
Interest rate risk affects cash at bank and investments where the value of these instruments is subject to fluctuations due to changes in market interest rates.
The Commission's consolidated exposure to interest rate risk and the effective interest rates of financial instruments at year end are:

	2005 $'000	2004 $'000	
Cash	1,712	1,370	all at floating interest rates
Receivables	348	364	all non-interest bearing
Creditors	171	251	all non-interest bearing

All amounts are carried in the accounts at net fair value.

Credit rate risk affects receivables where there is a risk of a trade debtor of the Commission failing to meet their obligations as and when they fall due.

There are no unrecognised financial instruments.

19. The Impact of Adopting Australian Equivalent to AEIFRS

The Health Care Complaints Commission will apply the Australian Equivalents to International Reporting Standards (AEIFRS) from 2005-06.

The following strategy has been implemented to manage the transition to AEIFRS:

a. an officer from the Department of Gaming and Racing has been designated to have responsibility for the implementation of AEIFRS

b. the scope and impact assessment was carried out with the assistance of the Internal Audit Bureau

c. NSW Treasury's implementation plan and timetable were followed to direct AEIFRS implementation for the Department.

The Health Care Complaints Commission has determined the key areas where changes in accounting policies are likely to impact the financial report. Some of these impacts arise because AEIFRS requirements are different from existing AASB requirements (AGAAP). Other impacts are likely to arise from options in AEIFRS. To ensure consistency at the whole of government level, NSW Treasury has advised agencies of options it is likely to mandate for the NSW Public Sector. The impacts disclosed below reflect Treasury's likely mandate (referred to as "indicative mandates").

The Health Care Complaints Commission does not anticipate any material impacts on its cash flows. The actual effects of the transition may differ from the estimated figures below because of pending changes to the AEIFRS, including the UIG Interpretations and/or emerging accepted practice in their interpretation and application. The Health Care Complaints Commission's accounting policies may also be affected by a proposed standard to harmonise accounting standards with Government Finance Statistics (GFS). However, the impact is uncertain because it depends on when this standard is finalised and whether it can be adopted in 2005-06.

No change has been made to the Opening AEIFRS Balance Sheet as there are no changes of a material nature in the accounting policies arising from the adoption of AEIFRS.

20. After Balance Date Events

No after balance date events have occured.

END OF AUDITED FINANCIAL STATEMENTS

Appendix 1: List of Expert Advisers

Abbott, Dr Richard
Adler, Professor Robert
Alexander, Dr Ion
Allen, Dr Hugh
Andrews, Dr Williams
Anker, Dr Anthony
Anthony, Dr Hobbs
Arnaudon, Mr Francis
Arnold, Dr Mark
Baker, Mr John
Baker, Professor Arthur
Baldwin, Dr Michael
Banks, Dr Gary
Banks, Mrs Susan
Barnes, Professor David
Barr, Mrs Jeanne
Barraclough, Dr Bruce
Barrington, Mr Glen
Beckenham, Dr Edward
Bekhor, Dr Phillip
Bell, Professor James
Bellamy, Dr Lynette
Benson, Dr Warwick
Bentivoglio, Dr Peter
Berton, Dr Peter
Bertouch, Dr Jim
Besser, Professor Michael
Billings, Ms Robin
Black, Dr Jules
Bland, Dr Peter
Borenstein, Mr Sam
Bowers, Dr David
Brazier, Dr David
Bridger, Professor Patrick
Brodaty, Professor Henry
Brodie, Dr Geoffrey
Bruce, Professor Brew
Bryant, Professor Richard
Bunker, Dr Jeremy
Caldwell, Mrs J
Chard, Professor Richard
Child, Dr Andrew
Childs, Dr Clive
Christie, Dr Louise
Chung, Dr Ian
Chung, Dr Rhoderic
Cleghorn, Professor Geoffrey
Colditz, Professor Paul
Coleiro, Mr Albert
Coleman, Mr Mark
Commens, Dr Christopher
Cooke, Mrs Helen
Cooper, Ms Anne
Cummins, Ms Allison
Curtis, Dr Paul
Davies, Professor David
Day, Dr Robert
Derkenne, Mr Christopher
Dickson, Professor Hugh
Dore, Dr Glenys
Duncan, Dr Geraldine
Dunlop, Dr Iain
Eisinger, Dr David
Eizenberg, Dr David
Elder, Dr Ian
Elison, Dr Barry
Ellard, Dr John
England, Dr John
Erlich, Professor Frederick
Evans, Ms Ellen
Fagan, Professor Paul
Falk, Dr Gregory
Farlow, Dr Diana
Farnsworth, Dr Alan
Farnsworth, Dr Annabelle
Ferrier, Dr Alan
Fletcher, Professor John
Friendship, Ms Julianne
Ghabrial, Dr Rafat
Gibbons, Dr Margaret
Giblin, Dr Michael
Gibson, Professor William
Gillett, Professor David
Gillis, Dr Jonathan
Goldberg, Mrs Greta
Goldstone, Dr Philip
Goodfellow, Mrs Alison
Gordon, Ms Amanda
Gottlieb, Professor David
Goulston, Professor Kerrie
Greenwood, Professor James
Greig, Mrs Sue
Greive, Ms Ann
Gruenewald, Dr Simon
Hanna, Mr Christopher
Harding, Dr Michael
Harland, Ms Jennifer
Hartman, Dr Keith
Hazell, Dr Phillip
Heithersay, Dr Geoffrey
Hendel, Dr Paul
Higgins, Dr Ralph
Hoekstra, Dr Margaretha
Hogg, Dr John
Holman, Dr Peter
Hore, Dr Craig
Hume, Dr Kenneth
Hungerford, Dr Carole
Isbister, Professor James
James, Dr Allan
Jane, Dr Elizabeth
Jansen, Professor Robert
Jeremy, Professor Richmond
Jordan, Ms Andrea
Joseph, Dr Anthony
Jurd, Dr Stephen
Kennedy, Dr Michael
Keogh, Dr Timothy
Khatri, Dr Suresh
Kirby, Ms Narelle
Klienman, Dr Leon
Klug, Dr Peter
Knox, Dr David
Korda, Dr Andrew
Kotze, Dr Beth
Kovac, Dr Paul
Ku, Dr Hilary Chi
Kurtberg, Professor Joanne
Lau, Dr Kit
Lele, Mr Vinoo
Lenehan, Dr John
Leslie, Dr Garth
Levitt, Dr Michael
Loughman, Dr Ed
Lukersmith, Ms Sue
Lye, Dr Peter
Lyneham, Dr Robert
Mackey, Dr Kenneth
Macleod, Dr Colin
Macqueen, Dr Andrew
Mann, Dr Linda
Marsh, Ms Elizabeth Ann
Marshall, Professor Donald
Mayhew, Ms Susan
McCarthy, Professor William
McConkey, Professor Kevin
McGee-Collett, Dr Martin
McMahon, Dr Christopher
McNair, Mr Bernard
Meltzer, Dr Michelle
Middleton, Ms Rebekkah
Mill, Ms Colleen
Morse, Dr Peter
Mowbray, Dr Joy
Nelson, Dr Gregory
Newman, Dr Louise
North, Mr David
Oates, Mrs Rosemary
O'Connor, Dr Nicholas
O'Dey, Dr Wendy
Oliver, Professor Lyn Douglas
O'Meara, Dr Matthew
Pepperell, Professor Roger
Percy, Dr J P
Perkins, Dr Kenneth
Phillips, Dr Jonathan
Pigott, Dr Peter
Pitkin, Dr John
Playfair, Dr Justin
Pond, Dr Constance
Porges, Dr Stuart
Porter, Dr Alan John
Posen, Professor Solomon
Proietto, Professor Joseph
Prowse, Dr Jennifer
Pryor, Dr Donald
Quadrio, Professor Carolyn
Richards, Dr Shawn
Rish, Dr Adam
Rivett, Professor Darren
Roberts, Ms Wendy
Robinson, Ms Janette
Ross, Dr William
Royle, Professor John
Rushworth, Dr Robin
Russell, Mrs F
Seidler, Dr Raymond
Semmonds, Dr Diana
Shannon, Dr Gabriel
Shaw, Ms Rosalee
Shields, Ms Elizabeth
Sippe, Dr John
Skowronski, Dr George
Slaughter, Dr John
Smart, Dr Denis
Smith, Dr Graydon
Soutter, Dr Valencia
Spark, Dr Barbara
Spence, Professor Kaye
Steinbeck, Prof. Katharine
Steiner, Dr Michael
Stening, Dr Warwick A
Stewart, Dr Ian
Storey, Dr D
Sullivan, Dr Marian
Suranyi, Dr Michael
Sutherland, Dr Joanna
Taft, Dr E
Taylor, Dr Roy
Tennant, Professor C
Tish, Dr Keith
Tseng, Dr Tom
Tully, Ms Deborah
Vickers, Dr Christopher
Vinen, Dr John
Waite, Mr Christopher
Wakefield, Professor Denis
Wallace, Mr Anthony
Walter, Dr J
Ward, Dr Stephen
Ware, Dr Robert E
Webber, Dr Mary
Weissel, Ms Elvina
White, Ms R A
Wilkinson, Dr E John
Williams, Dr Cholm
Wilson, Dr Andrew
Wodak, Dr Alexander
Woods, Prof. Robin George
Wright, Dr Murray
Wright, Ms Fiona

Appendix 2: Statistics

TABLE 49 - COMPLAINTS OPEN AS AT 30 JUNE BY ASSESSMENT DECISION 2002-03 TO 2004-05

Assessment Decision	2002-2003 No.	2002-2003 %	2003-2004 No.	2003-2004 %	2004-2005 No.	2004-2005 %
Commission investigation underway	589	59.4%	718	74.8%	435	35.4%
Awaiting assessment	171	17.3%	87	9.1%	506	41.2%
Decline to deal with	42	4.2%	17	1.8%	101	8.2%
Assisted Resolution	0	0.0%	9	0.9%	64	5.2%
Resolved during assessment process	0	0.0%	0	0.0%	51	4.1%
Referred to another body for investigation	66	6.7%	16	1.7%	18	1.5%
Conciliation	91	9.2%	57	5.9%	52	4.2%
Direct resolution	30	3.0%	3	0.3%	2	0.2%
Resubmit	0	0.0%	53	5.5%	0	0.0%
Consultative resolution	2	0.2%	0	0.0%	0	0.0%
Total	**991**	**100.0%**	**960**	**100.0%**	**1229**	**100.0%**

TABLE 50 - COMPLAINTS RECEIVED ABOUT HEALTH SERVICES 2002-03 TO 2004-05

Facility	2002-2003 No.	2002-2003 %	2003-2004 No.	2003-2004 %	2004-2005 No.	2004-2005 %
Public hospital	396	43.9%	484	51.4%	519	45.8%
Other*	82	9.1%	83	8.8%	93	8.2%
Private hospital	71	7.9%	59	6.3%	83	7.3%
Corrections Health Service	32	3.5%	29	3.1%	58	5.1%
Nursing home	47	5.2%	40	4.2%	50	4.4%
Community Health Service	32	3.5%	32	3.4%	49	4.3%
Pharmacy	14	1.6%	36	3.8%	46	4.1%
Medical centre	35	3.9%	41	4.4%	43	3.8%
Area Health Service	25	2.8%	20	2.1%	40	3.5%
Private medical practice	10	1.1%	7	0.7%	31	2.7%
Dental unit - public	8	0.9%	7	0.7%	20	1.8%
Optometrist Practice	5	0.6%	3	0.3%	18	1.6%
Ambulance Service	17	1.9%	15	1.6%	15	1.3%
Radiology practice	17	1.9%	14	1.5%	14	1.2%
Dental surgery - private	1	0.1%	4	0.4%	12	1.1%
Psychiatric hospital	62	6.9%	34	3.6%	10	0.9%
Health Fund - Private	1	0.1%	3	0.3%	6	0.5%
Drug & alcohol service	1	0.1%	2	0.2%	7	0.6%
Pathology centres/labs	19	2.1%	13	1.4%	6	0.5%
Nursing Agency - District/Community	4	0.4%	0	0.0%	5	0.4%
Women's health centre	2	0.2%	1	0.1%	4	0.4%
Day procedure centre	13	1.4%	9	1.0%	3	0.3%
Hostel - aged	8	0.9%	6	0.6%	1	0.1%
Total	**902**	**100.0%**	**942**	**100.0%**	**1133**	**100.0%**

* **Other: 2004-2005:** Alternative health service 2; Blood Bank 2; Sexual Assault 2, Group home - mental health 2; Hostel - other 2; Methadone clinic 2; Physiotherapy clinic - private 2; Public Development Disability Hospital 2; Boarding house 1; Chiropractic practice 1; DD Hospital 1; Early childhood clinic 1; Family planning clinic 1; Group Home - Development Disablility 1; Health Fund - Public; Multi Purpose Service 1; Other, no code available 69.

TABLE 51 - COMPLAINTS RECEIVED ABOUT PUBLIC HOSPITALS BY AREA HEALTH SERVICE 2002-03 TO 2004-05

Region	2002-03 No.	2002-03 %	2003-04 No.	2003-04 %	2004-04 No.	2004-04 %	2003-04 Admissions	2003-04 Non-Admitted Patient Services	2003-04 Emergency Dep't Attendance
Greater Southern AHS	33	7.2%	19	3.7%	19	3.6%	91,614	1,425,110	260,401
Greater Western AHS	23	5.0%	31	6.1%	41	7.8%	79,833	1,183,203	200,625
Hunter/New England AHS	28	6.1%	48	9.4%	46	8.7%	171,520	2,535,562	313,524
Interstate/Other**	3	0.7%	3	0.6%	1	0.2%	N/A	N/A	N/A
North Coast AHS	44	9.6%	41	8.0%	47	8.9%	122,651	1,683,166	134,132
Northern Sydney/ Central Coast AHS	61	13.3%	77	15.0%	72	13.7%	178,217	2,909,126	209,920
South Eastern Sydney/ Illawarra AHS	104	22.7%	79	15.4%	109	20.7%	273,975	4,810,245	323,772
Sydney South West AHS	78	17.0%	131	25.6%	100	19.0%	255,113	3,361,703	255,347
Sydney West AHS	84	18.3%	83	16.2%	92	17.5%	186,593	3,212,458	196,570
Total	**458***	**100.0%**	**512***	**100.0%**	**527***	**100.0%**	**1,359,516**	**21,120,573**	**1,894,291**

* Includes Psychiatric hospitals. ** Includes The Children's Hospital, Westmead, Hawkesbury Hospital, and Port Macquarie Base Hospital.

TABLE 52 - COMPLAINTS RECEIVED ABOUT PUBLIC AND PRIVATE HOSPITALS ANALYSED BY SERVICE AREA 2004-05

Service Area	PUBLIC No.	PUBLIC %	PRIVATE No.	PRIVATE %
Other/Unknown*	135	26.0%	39	47.0%
Accident and Emergency	109	21.0%	4	4.8%
Mental Health	37	7.1%	4	4.8%
Obstetrics	30	5.8%	2	2.4%
General Medicine	27	5.2%	4	4.8%
Surgery - General	25	4.8%	12	14.5%
Psychiatry	24	4.6%	0	0.0%
Cardiology	13	2.5%	0	0.0%
Gerontology	12	2.3%	2	2.4%
Intensive Care	12	2.3%	2	2.4%
Public Health	10	1.9%	1	1.2%
Palliative Care	9	1.7%	2	2.4%
Administration - General	7	1.3%	2	2.4%
Surgery - Orthopaedic	6	1.2%	0	0.0%
Gastroenterology	5	1.0%	1	1.2%
Neurology	5	1.0%	2	2.4%
Non Health Related	5	1.0%	1	1.2%
Paediatric Medicine	5	1.0%	0	0.0%
Gynaecology	4	0.8%	0	0.0%
Neonatology	4	0.8%	0	0.0%
Oncology - Medical	4	0.8%	1	1.2%
Opthalmology	4	0.8%	0	0.0%
Renal Medicine	4	0.8%	0	0.0%
Rehabilitation Medicine	3	0.6%	2	2.4%
Respiratory	3	0.6%	0	0.0%
Waiting Lists	3	0.6%	0	0.0%
Anaesthesia - Other	2	0.4%	0	0.0%
Dentistry	2	0.4%	0	0.0%
Drug & Alcohol Services	2	0.4%	1	1.2%
Infectious Diseases	2	0.4%	0	0.0%
Midwifery	2	0.4%	0	0.0%
Podiatry	2	0.4%	0	0.0%
Radiography	2	0.4%	1	1.2%
Total	**519**	**100.0%**	**83**	**100.0%**

* Other: **Public hospital:** Administration - Medical Records 1; Community Health 1; Counselling 1; Developmental Disability 1; Haematology (Clinical) 1; Oncology - Radiation 1; Personal Care 1; Physiotherapy 1; Radiology 1; Social & Welfare Work 1; Surgery - Hand and Upper Limb 1; Surgery - Oral (Maxillo Facial) 1; Surgery - Vascular 1; Urology 1; Code not available 125. **Private hospital:** Physiotherapy 5; Radiology 1; Urology 1; Hydrotherapy 1; Nuclear Medicine 1; Surgery - Plastic and Reconstructive 1; Code not available 29.

TABLE 53 - COMPLAINTS RECEIVED ABOUT REGISTERED AND NON-REGISTERED HEALTH CARE PROVIDERS 2002-03 TO 2004-05

Health Practitioner	2002-2003 No.	2002-2003 %	2003-2004 No.	2003-2004 %	2004-2005 No.	2004-2005 %
Medical practitioner	1,222	67.4%	1,227	65.5%	1,131	56.5%
Nurse	213	11.7%	286	15.3%	477	23.8%
Dentist	156	8.6%	157	8.4%	169	8.4%
Psychologist	53	2.9%	43	2.3%	66	3.3%
Other*	49	2.7%	52	2.8%	44	2.2%
Pharmacist	28	1.5%	13	0.7%	23	1.1%
Dental technician and prosthetist	16	0.9%	16	0.9%	16	0.8%
Chiropractor	14	0.8%	21	1.1%	15	0.7%
Physiotherapist	16	0.9%	21	1.1%	13	0.6%
Optometrist	18	1.0%	7	0.4%	12	0.6%
Podiatrist	7	0.4%	10	0.5%	10	0.5%
Natural Therapist	0	0.0%	2	0.1%	8	0.4%
Assistant in nursing	1	0.1%	2	0.1%	6	0.3%
Counsellor/therapist	11	0.6%	5	0.3%	4	0.2%
Osteopath	3	0.2%	1	0.1%	4	0.2%
Social worker	7	0.4%	10	0.5%	4	0.2%
Total	**1,814**	**100.0%**	**1,873**	**100.0%**	**2,002**	**100.0%**

* **Other, 2004-2005:** Radiographer 3; Naturopath 2; Psychotherapist 2; Residential care worker 2; Traditional Chinese Medicine 2; Acupuncturist 1; Ambulance personnel 1; Dietitian/Nutritionist 1; Health Education Officer 1; Speech pathologist 1; Occupational therapist 1; Optometrical Dispenser 1; Previously registered Med Practitioner 1; Struck off health practitioner 1; Welfare Officer 1; No code available 23.

TABLE 54 - COMPLAINTS RECEIVED ABOUT REGISTERED PROFESSIONS BY CATEGORY 2004-05

Category	MEDICAL PRACTITIONER No.	NURSE No.	DENTIST No.	PSYCHOLOGIST No.	PHYSIOTHERAPIST No.	CHIROPRACTOR No.	DENTAL TECHNICIAN AND PROSTHETIST* No.	PHARMACIST No.	PODIATRIST No.	OPTOMETRIST No.	OSTEOPATH No.	OPTICAL DISPENSER No.
Access	58	6	4	0	2	1	0	0	0	0	0	0
Communication	141	11	18	13	2	0	1	2	2	0	0	0
Consent	40	3	8	0	0	0	0	1	0	1	0	0
Corporate Services	12	2	2	2	0	0	3	1	0	0	0	0
Cost	67	0	32	2	1	2	2	1	2	4	0	0
Grievances	2	2	0	1	0	0	0	0	0	0	0	0
Legacy Code*	3	63	8	0	1	7	0	0	1	0	0	0
No Jurisdiction	19	5	1	0	1	0	0	0	0	0	0	0
Privacy/ Discrimination	50	6	1	12	2	0	1	0	1	0	0	0
Professional Conduct	247	315	20	33	9	2	3	5	1	0	2	0
Treatment	579	74	97	7	7	7	7	5	5	6	2	1
Total	1131	477	169	66	23	16	15	13	12	10	4	1
Total practitioners registered in NSW as at 30.6.2005	**26,864**	**116,760**	**4,300**	**8,636**	**6,454**	**1,306**	**723**	**7,583**	**783**	**1,654**	**508**	**1,436**

* Codes that operated before Casemate was introduced.

TABLE 55 - SOURCE OF COMPLAINTS 2002-03 TO 2004-05

Source	2002-2003 No.	2002-2003 %	2003-2004 No.	2003-2004 %	2004-2005 No.	2004-2005 %
Consumer	1,520	55.9%	1,366	48.5%	1,125	44.2%
Registration Board	492	18.1%	500	17.7%	684	26.8%
Family or friend	359	13.2%	475	16.9%	430	16.9%
Department of Health (State & Cwth)	91	3.3%	243	8.6%	63	2.5%
Health professional	29	1.1%	40	1.4%	57	2.2%
Parliament/Minister	56	2.1%	66	2.3%	46	1.8%
Government department	70	2.6%	51	1.8%	45	1.8%
Other	13	0.5%	27	1.0%	41	1.6%
Legal representative	37	1.4%	25	0.9%	20	0.8%
Courts	6	0.2%	7	0.2%	17	0.7%
Consumer organisation	31	1.1%	9	0.3%	16	0.6%
Professional association	2	0.1%	1	0.0%	4	0.2%
Non-government organisation	12	0.4%	7	0.2%	0	0.0%
Total	**2,718**	**100.0%**	**2,817**	**100.0%**	**2,548**	**100.0%**

TABLE 56 - COMPLAINANT PROFILE 2004-05

		No.
Age Group	0-15	2
	16-24	3
	25-34	24
	35-44	28
	45-59	60
	60+	35
	Unknown	3790
	Total	**3,942**
Aboriginal or Torres Strait Islander	No	3,937
	Yes	5
	Total	**3,942**
Disability	No	1008
	Yes	0
	Unknown	2934
	Total	**3,942**
Interpreter required	No	3923
	Yes	19
	Total	**3,942**
Gender	Female	1993
	Male	1586
	Unknown	363
	Total	**3,942**

Appendix 2

TABLE 57 - INVESTIGATIONS FINALISED ABOUT HEALTH SERVICES 2002-03 TO 2004-05

Description	2002-2003 No.	2002-2003 %	2003-2004 No.	2003-2004 %	2004-2005 No.	2004-2005 %
Public hospital	37	74.0%	37	69.8%	99	79.2%
Nursing home	6	12.0%	3	5.7%	7	5.6%
Private hospital	4	8.0%	3	5.7%	5	4.0%
Prison Medical Service	0	0.0%	0	0.0%	3	2.4%
Private Medical Practice	0	0.0%	1	1.9%	3	2.4%
Other	0	0.0%	2	3.8%	2	1.6%
Women's Health Centre	0	0.0%	0	0.0%	2	1.6%
Ambulance Service	0	0.0%	0	0.0%	1	0.8%
Multi Purpose Service	0	0.0%	0	0.0%	1	0.8%
Radiology Practice	0	0.0%	0	0.0%	1	0.8%
Area Health Service	0	0.0%	0	0.0%	1	0.8%
Drug & Alcohol Service	0	0.0%	0	0.0%	0	0.0%
Psychiatric hospital	1	2.0%	2	3.8%	0	0.0%
Community Health Service	0	0.0%	2	3.8%	0	0.0%
Medical centre - private	1	2.0%	1	1.9%	0	0.0%
Optometrist Practice	0	0.0%	1	1.9%	0	0.0%
Pathology Centres	0	0.0%	1	1.9%	0	0.0%
Hostel	1	2.0%	0	0.0%	0	0.0%
Total	**50**	**100.0%**	**53**	**100.0%**	**125**	**100.0%**

TABLE 58 - INVESTIGATIONS FINALISED ABOUT HEALTH PRACTITIONERS 2002-03 TO 2004-05

Description	2002-2003 No.	2002-2003 %	2003-2004 No.	2003-2004 %	2004-2005 No.	2004-2005 %
Nurse	80	23.7%	73	27.2%	438	49.8%
Medical practitioner	216	64.1%	148	55.2%	375	42.7%
Pharmacist	2	0.6%	4	1.5%	20	2.3%
Psychologist	15	4.5%	7	2.6%	16	1.8%
Dentist	1	0.3%	4	1.5%	14	1.6%
Physiotherapist	8	2.4%	5	1.9%	9	1.0%
Osteopath	1	0.3%	0	0.0%	3	0.3%
Chiropractor	4	1.2%	6	2.2%	2	0.2%
Dental technician and prosthetist	4	1.2%	0	0.0%	1	0.1%
Chiropodist/podiatrist	1	0.3%	6	2.2%	1	0.1%
Unregistered (Counsellor/Therapist)	0	0.0%	1	0.4%	0	0.0%
Traditional Medicine	0	0.0%	1	0.4%	0	0.0%
Social worker	1	0.3%	0	0.0%	0	0.0%
Other	1	0.3%	0	0.0%	0	0.0%
Optometrist	1	0.3%	7	2.6%	0	0.0%
Naturopath	0	0.0%	2	0.7%	0	0.0%
Natural Therapist	0	0.0%	2	0.7%	0	0.0%
Health practitioner de-registered	2	0.6%	0	0.0%	0	0.0%
Assistant in Nursing	0	0.0%	1	0.4%	0	0.0%
Administrative or Clerical Staff	0	0.0%	1	0.4%	0	0.0%
Total	**337**	**100.0%**	**268**	**100.0%**	**879**	**100.0%**

TABLE 59 - CATEGORY OF OPEN INVESTIGATIONS 2002-03 TO 2004-05

Category	2002-2003 No.	2002-2003 %	2003-2004 No.	2003-2004 %	2004-2005 No.	2004-2005 %
Treatment	265	44.3%	404	55.4%	235	46.8%
Professional Conduct	197	32.9%	193	26.5%	209	41.6%
Access	21	3.5%	16	2.2%	17	3.4%
Communication	14	2.3%	19	2.6%	13	2.6%
Corporate Services	50	8.4%	44	6.0%	13	2.6%
Consent	10	1.7%	9	1.2%	4	0.8%
Cost	5	0.8%	4	0.5%	4	0.8%
Miscellaneous	19	3.2%	22	3.0%	4	0.8%
Privacy/Discrimination	8	1.3%	4	0.5%	3	0.6%
Grievances	0	0.0%	3	0.4%	0	0.0%
Total	**589**	**100.0%**	**718**	**100.0%**	**502**	**100.0%**

Miscellaneous: Re-registration 4;

TABLE 60 - OUTCOMES OF APPEAL CASES AND OTHER APPLICATIONS COMPLETED 2004-05

Appeals	Outcome	No.
Court of Appeal		
Appeal against Medical Tribunal decision refusing re-registration application (Bannister)	Dismissed	1
Supreme Court		
Application by Commission re: constitution of Nurses and Midwives Tribunal (Practitioner D-name suppressed)	Dismissed	1
Medical Tribunal		
Appeal by practitioner against PSC interlocutory audit order	Discontinued	1
Appeal by practitioner against PSC decision not to disqualify	Upheld	1
District Court		0
High Court		0
Total		**4**

TABLE 61 - OUTCOMES OF RE-REGISTRATION/REVIEW APPLICATION CASES COMPLETED 2004-05

Re-Registration/Review Application	No.
Medical Tribunal	
Re-registered with conditions (Dalley, Mehta, Annetts)	3
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Review of conditions allowed (Bentley, Rohatgi)	2
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Health Care Complaints Commission
Level 13, 323 Castlereagh Street
Sydney NSW 2000
Freecall 1800 043 159
T *(02) 9219 7444*
F *(02) 9281 4585*
E *hccc@hccc.nsw.gov.au*
W *www.hccc.nsw.gov.au*