

COMMUNICATION
DEGENERATIVE
BIOPSY

CONDUCT
BOUNDARIES
HYPOT

IMMUNITY
ACCELERATION
EMPATHY

**PROTECTING
PUBLIC
HEALTH AND
SAFETY**

MOTOR NEURON
MUSCULOSKELETAL
NATAL

NUTRITION OBESITY
PALPITATION
RECORDS STANDARDS

LIGAMENT
PACEMAKER
RADIATION

PRESCRIBING
INFUSION
MELANOMA

ACCESS CONSENT
FEVER
AMBULATORY

DEFIBRILLATOR
MULTIDISCIPLINARY
TEAM

20
16—
17

HEALTH CARE
COMPLAINTS COMMISSION

Annual Report



HEALTH CARE
COMPLAINTS
COMMISSION

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Disclaimer – Rounding of statistical figures

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

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Letter of submission



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

Dear Minister

Report of activities for the year ended 30 June 2017

I am pleased to provide the Annual Report and financial statements of the Health Care Complaints Commission and the Health Care Complaints Commission Staff Agency for the financial year ended 30 June 2017 for presentation to the NSW Parliament.

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

Yours faithfully

A handwritten signature in black ink, appearing to read 'Sue Dawson', is located below the 'Yours faithfully' text.

Sue Dawson
Commissioner

Commission at a glance

Our aims and objectives

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

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

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

Our strategy is to do this through:

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

Our values

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

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

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

Stakeholders

The Commission's diverse stakeholders comprise:

- health consumers, including:
 - patients, their families and carers
 - health consumer bodies
 - the diverse communities of NSW.
- health service providers, including:
 - registered and non-registered health practitioners
 - health organisations, such as hospitals and clinics
 - health professional councils and registration bodies
 - colleges and associations
 - universities and other health education providers.
- NSW government stakeholders, including:
 - the Parliament and the Joint Parliamentary Committee on the Health Care Complaints Commission
 - the Minister for Health
 - the Ministry of Health
 - Local Health Districts
 - the Clinical Excellence Commission
 - other public sector agencies.

A message from the Commissioner



It is with great pleasure that I introduce the 2016–17 Health Care Complaints Commission Annual Report. Each year it shows how the Commission makes a difference in our health care system.

Complaints ensure that the health care and treatment experiences of individuals, their families and the community are valued, understood and acted on. A complaint is a potent opportunity for the Commission to take the lessons from consumer experiences and to work with health services and providers to help drive improvements in the quality of care and treatment into the future.

Nationally and internationally, and also in NSW, health care complaints are increasing in number. In NSW the rate of growth in complaints slowed in 2016-17, but the 6,319 complaints received nevertheless represents 53.0% growth over the last five years and a 132.1% growth over the last decade.

Research indicates that this common pattern of growth is attributable to many different factors. The growing and ageing population certainly plays a part, as this leads to more interactions with the health system. Also evident is the impact of broader social trends, including the expectations and choices of health consumers, which are in turn shaped by increasing access to health information and social media. Consumers are rightly empowered and enabled to ask questions and seek solutions when things go wrong or when they do not understand aspects of their treatment and care. Where serious and complex issues are involved, consumers consistently say that they value the ability to rely on an independent body to consider and determine whether there are deficiencies in their health care.

There is a noticeable increase in the complexity of our health care complaints. These complexities may relate to the nature of the complaint (such as where there are multiple complainants, providers, service environments, and/or subjects). The complexity may arise from the position of the complainant or their loved one, as with complaints relating to very vulnerable or disempowered individuals. There may be jurisdictional complexity if it is unclear whether the matter complained of is a health service or not, or if several enforcement or regulatory bodies are involved at the same time. And there may be practical difficulties such as finding and engaging appropriate experts when a complaint relates to a very unusual or new area of health service delivery.

Over the past year the Commission has been building a clearer picture of this complexity. This understanding is helping to streamline our processes, get to the heart of matters quickly, and tailor our scarce assessment and investigation resources in a way that will have the greatest benefit and impact. Unpacking complexity is therefore a focus theme for this annual report.

The Commission has continued to adapt and respond to the high volume and complexity of complaints. With a modest increase in resources for 2016-17 we strengthened our assessment, investigation and legal teams. We have been able to assess, investigate and prosecute a record number of matters: 6,023 complaints assessed; 330 investigations completed; and, 95 prosecutions finalised.

We are conscious that there is more to do. We are acutely aware that we are taking too long to finalise our assessments of complaints and not enough time is set aside to maintain high quality communication with complainants and providers. As resources become available, tackling these issues will be our priority.

We will be accelerating the Business Improvement Project that commenced this year. Through this Project we are making the move to paperless complaints management, fine tuning our triaging function, simplifying assessment actions, improving assessment management tools and increasing staff training.

We will also be establishing a new customer engagement function so that everything we do is seeking to prevent complaints wherever possible and to respond to the preferences and experiences of all parties to the complaints. Our aim is to make the strongest contribution to protecting public health and safety through excellent communication and partnerships.

We also see the potential to more closely analyse our data, to understand, explain and address the patterns in complaints. This analysis would assist us to target our education and outreach activities more effectively and to work across the health system to lift practices in areas of most frequent concern or highest risk.

We fully expect that our operating environment will continue to evolve and we will evolve with it. The coming year will see the introduction of registration of paramedics. It will see a continued emergence of new business models in the health sector, such as web based health assessments

and prescribing. It is inevitable that new types of health services and products will emerge, and with this will come questions relating to the impacts on health consumers.

The Commission continues its close co-regulatory relationship with the health professional councils, as well as a strong rapport with the relevant membership based associations and an open dialogue with the medical insurance industry. We are also building ever stronger relationships with other state based and national health regulation and review bodies, so that our actions are well coordinated and efficient. With all of our partners, our shared objective is to ensure that our decisions are open, transparent and balanced and always directed toward improving the safety and quality of health care in NSW.

I extend my personal thanks to all Commission staff. We are working with patients, their families, providers and health organisations to examine experiences that have typically been difficult and often traumatic for all involved. This is important but challenging. The sensitivity, professionalism and dedication that is shown by our staff is greatly valued.



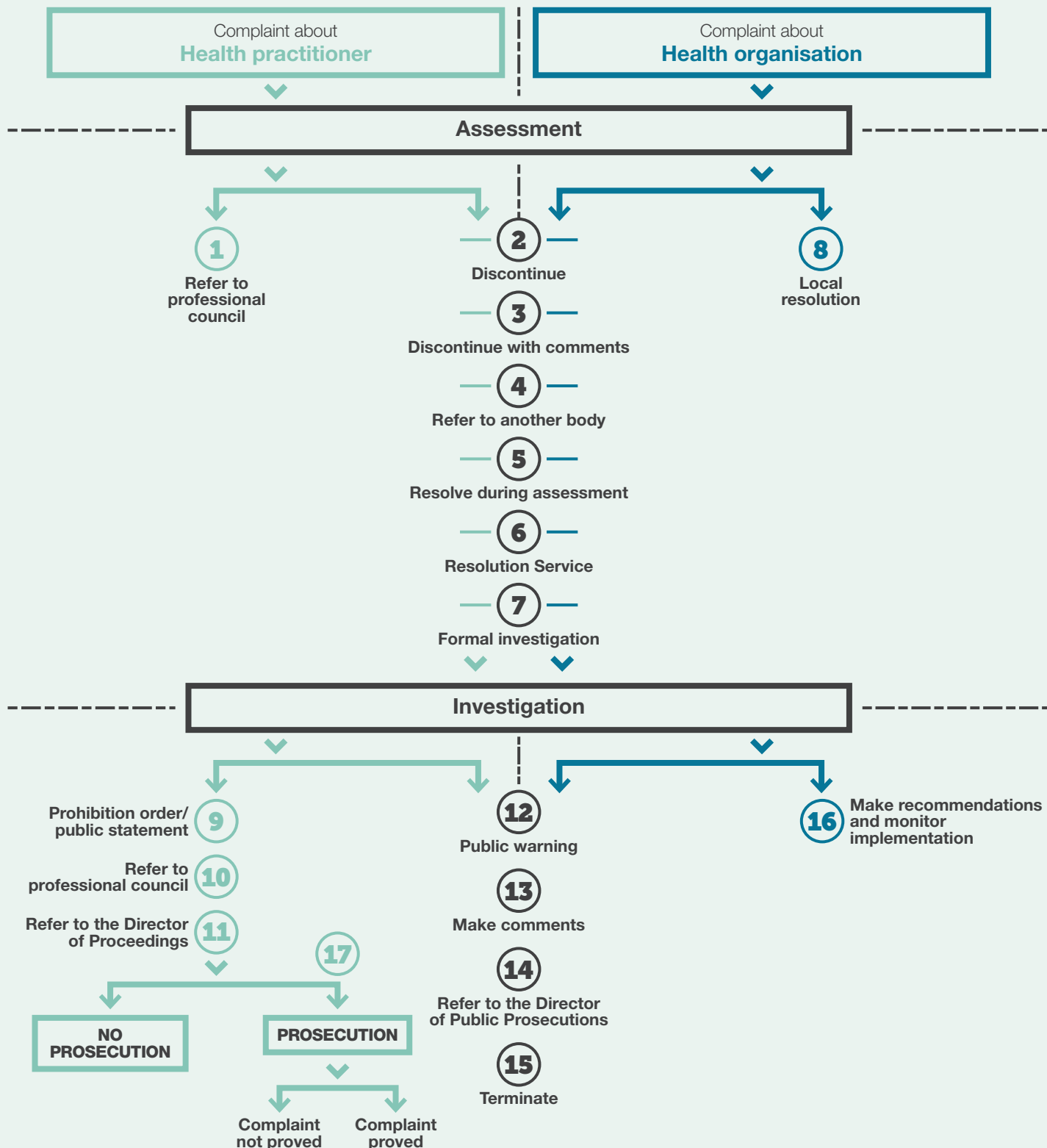
Sue Dawson
Commissioner

Complaints management framework

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

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

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



Possible outcomes of assessment are:

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

Where the Commission investigates a complaint, it may:

- 9 In the case of a non-registered practitioner, **impose a Prohibition Order** to ban or limit the health practitioner from providing health services and issue a public statement about the order.
- 10 In the case of a registered practitioner, **refer the complaint to a professional council** to address poor performance, conduct or health problems.

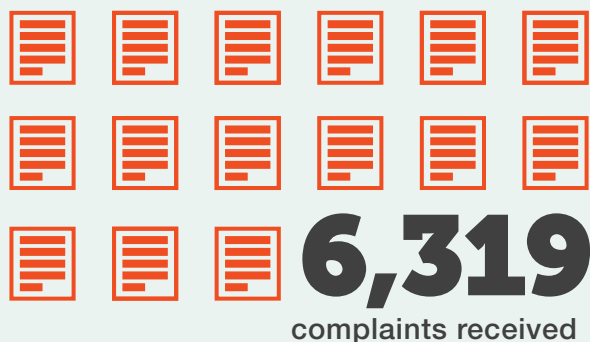
- 11 In the case of a registered practitioner, refer the complaint to the independent **Director of Proceedings**, who determines whether a registered health practitioner should be prosecuted before a disciplinary body based on the risk to the public, the seriousness of the allegation and the prospects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

Where a registered health practitioner has been prosecuted:

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

Performance summary

Assessing and resolving complaints



4.4%

increase

in complaints
assessed

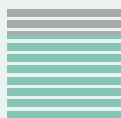


But average assessment time is 60 days
compared to 45 days in 2015-16

2015-16

76.9%

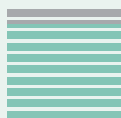
successful resolutions



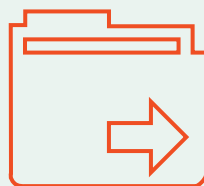
2016-17

85.2%

successful resolutions



More complaints resolved
in assisted resolution



4.4%

complaints review requests
compared to 11.5% in 2005-06

Investigating complaints

More complaints finalised in investigation

2015-16

244



2016-17

330



FINALISED

35.2%

increase



72.4%

investigations
finalised within

12 months

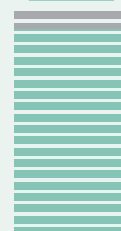
FINALISED



Robust investigations

92.9%

Matters referred for prosecution that
did not need further information



Prosecuting complaints

More complaints referred for prosecution

2015-16

139



2016-17

198



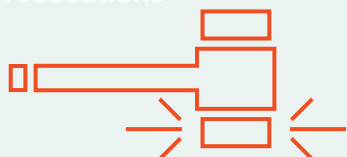
89.2%

complaints considered
within three months



96.2%

success rate in
prosecutions



95

legal matters
finalised



Access and outreach

29.7%

more website visitors



2015-16

366,241

2016-17

475,148

11,365

inquiries received



81.3%

of complainants
were satisfied
with service



Public warning issued about
non-evidence based
weightloss programs



WARNING



Executive summary

The increase in the number of complaints received by the Commission has continued in 2016-17 with 6,319 complaints received.

As well as an increase in volume, complaints to the Commission are also increasing in their complexity and diversity.

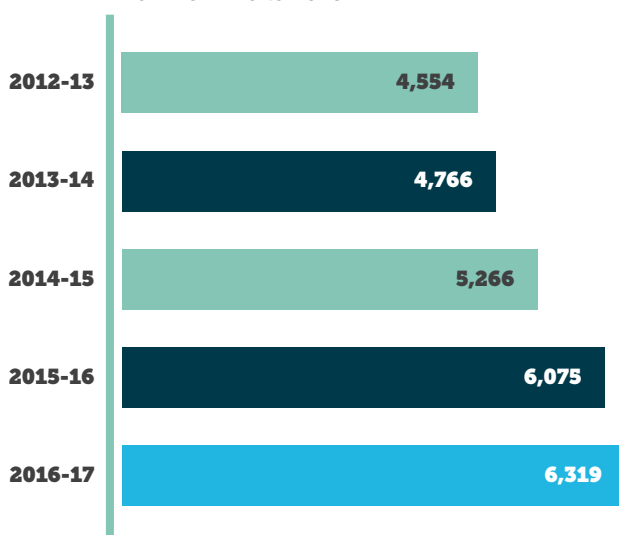
Over the past decade the volume of complaints received by the Commission has risen dramatically. There has been a 132.1% increase in complaints received since 2006-07 with a particular intensification observed over the last four years. This trend is in line with the experience of health care complaints bodies both nationally and internationally. The increase in the volume of complaints is attributed to a range of factors including growing demand for healthcare services, the complexity of the healthcare system, greater consumer expectations of the system and their care providers and increased accountability.

The nature and drivers of complexity of complaints are discussed in greater depth in the Focus Area: Complexity of Complaints, on page 25.

Complaints received

During the year, 6,319 complaints were received, an increase of 4.0% on the previous year. This is a slower rate of annual growth than has been experienced last year, but the overarching picture continues to be one of increasing demand. The overall increase within the period 2012-13 to 2016-17 is 38.8%.

Chart 1 | Number of complaints received from 2012-13 to 2016-17



Counted by provider identified in complaint

The cumulative increase in complaints has prompted the Commission to introduce a number of major efficiency measures, including improvements to systems and processes. These initiatives have enabled the Commission to:

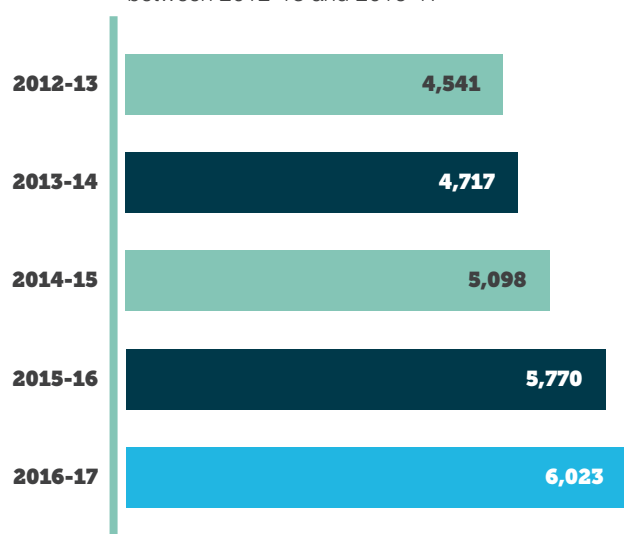
- increase the volume of complaints assessed from 2012-13 by 32.6%.
- increase the number of investigations finalised from 2012-13 by 64.2%.
- increase the number of legal matters finalised between 2012-13 and 2016-17 by 8.0%.

This report also discusses the impacts of the increased volume, complexity and diversity of complaints on service delivery. In particular, it is acknowledged that there has been an unacceptable deterioration in timeliness in completing assessments and investigations and the outreach and education functions that are also important to the work of the Commission have been expanding more gradually than we would like.

Assessing complaints

The Commission assessed a total of 6,023 complaints in 2016-17 compared to the 5,770 complaints assessed in 2015-16. This was a year on year increase of 4.4%, and represents a 32.6% increase since 2012-13.

Chart 2 | Assessments completed between 2012-13 and 2016-17



Counted by provider identified in complaint

The proportion of complaints assessed within the 60 day timeframe has declined with a corresponding increase in the average time taken to assess each complaint. In 2016-17, 64.5% of complaints were assessed within 60 days, compared to 85.8% in 2015-16. The average time taken to assess new complaints was 60 days, a decrease in timeliness from 47 days in 2015-16.

Resolving complaints

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

In the early resolution stream, complaints are amenable to quick, informal intervention to solve misunderstandings and minor problems. Early intervention techniques are applied to resolve the complainant's concerns. In 2016-17, 425 complaints were resolved during assessment and the Commission will be looking to further increase the number of complaints resolved in this way.

In addition to those complaints resolved during assessment, 238 complaints were referred to the Commission's Resolution Service, through which the parties to a complaint are assisted to work through the issues of concern and address them in the most appropriate way.

The Commission's Resolution Service finalised 258 complaints in 2016-17. Of these, 34.5% were finalised within two months of referral, compared with 33.4% in the previous year. 88.7% of complaints were finalised within six months which is consistent with the 88.2% finalised in this timeframe in 2015-16. Of the complaints that proceeded to resolution or conciliation, 85.2% were fully or partially resolved, which compares with 76.9% in 2015-16 and shows an improvement in outcomes.

There is increasing utilisation of the local resolution pathway under the complaints management framework. The Commission has long observed that the best solution is likely to occur when there is a speedy and direct response to issues raised. Local resolution, when operating effectively, offers this. In 2016-17, a total of 549 complaints were referred for local resolution, an increase of 32.3% on the previous year. For the first time, LHDs have been asked to provide feedback on local resolution matters and this system will start to help build a fuller picture of the outcomes for complainants where a matter is referred for local resolution.

More information on the outcomes of assessment and resolution functions can be found in the Chapter, Assessing and resolving complaints.

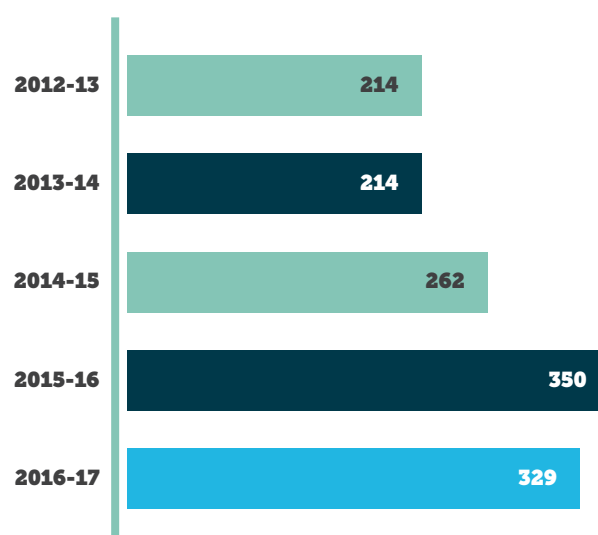
Investigating complaints

In 2016-17, 329 complaints were referred for investigation compared to 350 in the previous year. This decrease of 6.0% is not significant and at this point seems most likely to be related to differences in the nature of matters referred for investigation rather than abatement of the "demand" for investigations.

Some of the key issues and drivers for complaints referred for investigation were:

- a small number of practitioners who are the focus of multiple investigations
- complaints about one particular private health facility and its practitioners resulting in 10 investigations
- issues relating to prescribing medication
- complaints about boundary violations, assault or sexual misconduct.

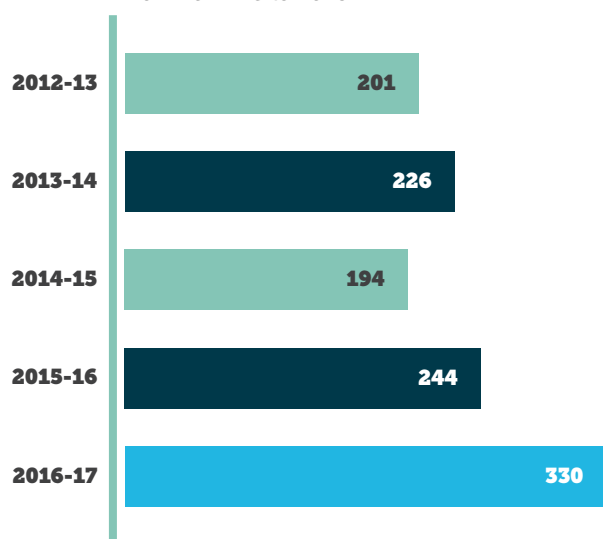
Chart 3 | Investigations received 2012-13 to 2016-17



Counted by provider identified in complaint

The Commission finalised 330 investigations in 2016-17 compared to 244 in 2015-16 which was an increase of 35.2%. This reflects the allocation of an additional resource to the area and streamlined investigation planning and decision making.

Chart 4 | Number of investigations finalised from 2012-13 to 2016-17



Counted by provider identified in complaint

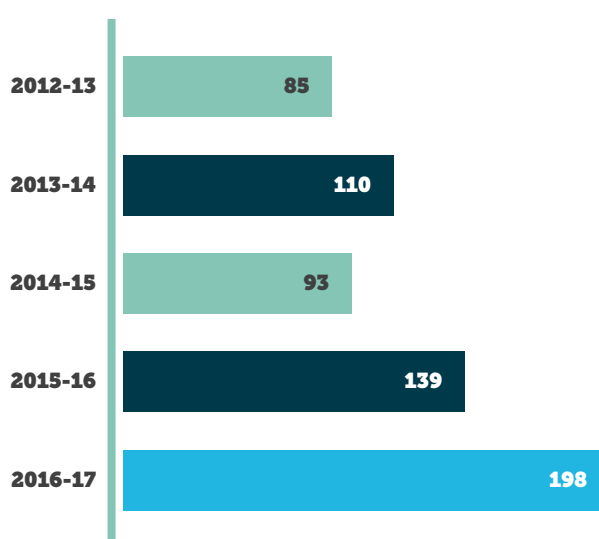
The timeliness of investigations was adversely affected by the increased workload. Overall performance was maintained with investigations finalised on average within 273 days, compared to 275 days in 2015-16. However, fewer investigations were finalised within 12 months (72.5% compared with 84.8% in 2015-16).

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

Prosecuting complaints

The Commission referred 198 investigations to its Legal Division, compared with 139 in the previous year. This is an increase of 42.4%.

Chart 5 | Complaints referred to Director of Proceedings 2016-17

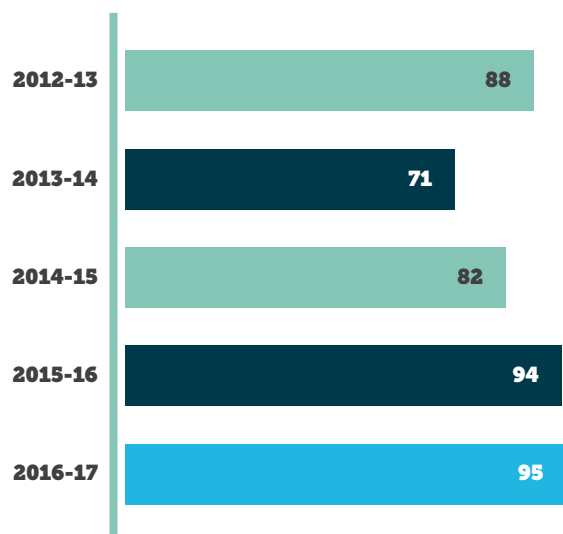


Counted by provider identified in complaint

In the same period, the Director of Proceedings made 104 determinations whether or not to prosecute a complaint, 76 of which recommended prosecution before NCAT and 20 before a Professional Standards Committee. In eight complaints, the Director of Proceedings determined not to prosecute.

As shown in Chart 6, the Legal Division finalised 95 matters in 2016-17. The overall success rate of prosecutions before Professional Standards Committees and NCAT was 96.2%.

Chart 6 | Number of legal matters finalised from 2012-13 to 2016-17



Counted by matter and excludes matters not prosecuted

In 2016-17, the registration of 38 health practitioners was cancelled or disqualified. Three practitioners were suspended and had conditions placed on their registration. A further 31 health practitioners had conditions placed on their registration and were reprimanded or cautioned.

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

Financial summary

The Commission greatly benefited from some additional funding in 2016-17, which increased resourcing for assessments and investigations and enabled commencement of important systems and process improvements.

The Commission's Net Result before capital was a deficit of \$113,000 which was slightly higher than the \$82,000 deficit foreshadowed in the Budget. This was primarily due to higher than budgeted contractor costs associated with the transition to a new corporate services provider and special projects associated with business improvement.

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

The Commission has received an increase to its grant (through the Ministry of Health) for 2017-18. This increase of \$1,129,845 includes capital and recurrent funding. The recurrent component is \$869,845 which will allow the Commission to meet the costs of the new corporate services contract and also to continue to implement business improvement processes and service efficiencies. A particular emphasis will be placed on the development of robust electronic systems and workflows, helping to improve the ability of the Commission to respond to increasing service demand and improve customer engagement and experience.

Corporate goals

The Commission's performance, measured against its corporate goals for 2016-17, is summarised in Appendix B and throughout this report:

- Comprehensive and responsive complaints handling – pages 30-44
- Investigating serious complaints – pages 45-54
- Prosecuting serious complaints – pages 55-59
- Accountability – pages 60-71
- Our organisation – pages 72-87.

Profile of complaints

This section outlines the characteristics of complaints received by the Commission in 2016-17 and since 2012-13.

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

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

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

Volume and nature of complaints received

Complaints received

The Commission received 6,319 complaints in 2016-17 – a 4.0% increase compared to the previous year. This is a slower rate of growth than in previous years. It is of interest to note that while some other complaints jurisdictions also had some signs of a slower rate of growth, others continue to experience significant growth spikes. Notwithstanding fluctuations in the rate of growth in NSW and elsewhere, the overall picture is one of continuing increases in the volume of complaints.

As outlined in last year's Annual Report, there is no single explanation for the rise, but rather a multitude of factors which include:

- An increasing population
- An ageing population, who are more likely to have interactions with the health system
- Increasing consumer choices and expectations
- Greater services offered as medical research and technology combine to deliver treatments that were previously not possible
- Expanding use of complementary therapies
- Greater awareness of complaint management bodies
- Impacts of mandatory reporting requirements.

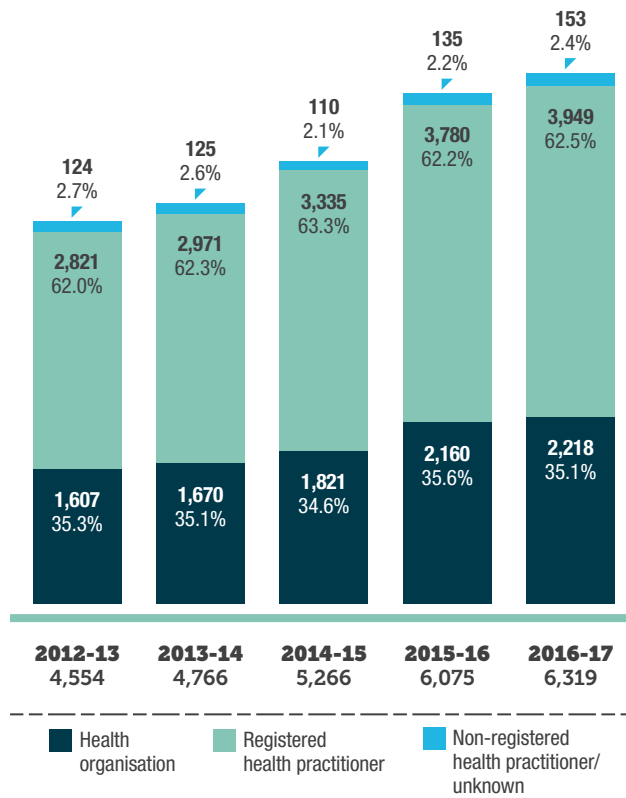
Alongside the increased volume of complaints, is the discernible pattern of increased complexity. The nature and drivers of the complexity are explored in the Focus area: Complexity of complaints (page 25).

Complaints received by type of health service provider

Chart 7 shows the number of complaints received by the Commission since 2012-13 and breaks this down by the type of health service provider complained about.

The proportions of complaints for each category of health service provider have remained consistent during the period. Individual health practitioners continue to make up the highest proportion of all complaints. Over the period 2012-13 to 2016-17 an average of 62.5% were about registered health practitioners, 35.1% of complaints received were about health organisations, and 2.4% were about non-registered health practitioners and practitioners whose registration status was unknown.

Chart 7 | Complaints received by health service provider 2012-13 to 2016-17



Complaints about health practitioners

Chart 8 shows the number of complaints about individual health practitioners received by the Commission in the period covering 2012-13 to 2016-17.

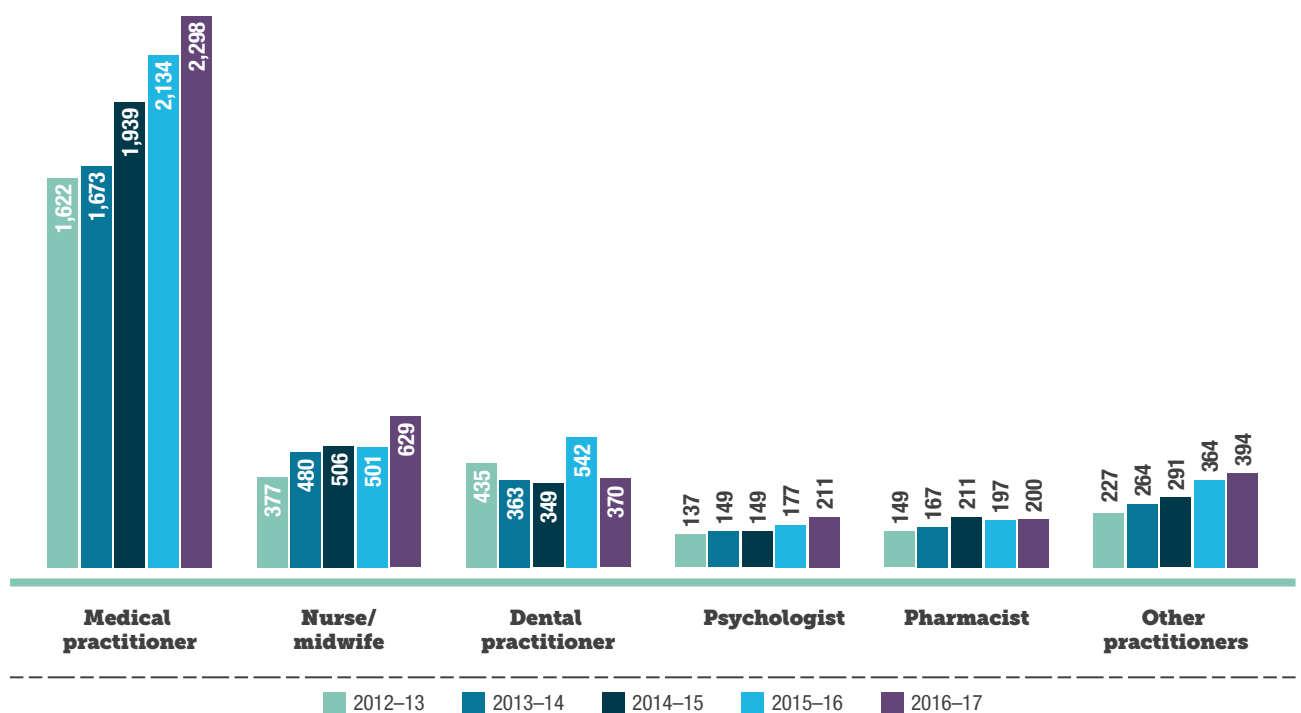
In 2016-17, the Commission received a total of 4,102 complaints about individual registered and non-registered health practitioners, a 4.8% increase on the previous year.

Medical practitioners, nurses and midwives, dental practitioners, pharmacists and psychologists were the health professions most commonly complained about. Complaints about these professions accounted for 94.2% of all complaints received about individual practitioners in 2016-17.

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

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

Chart 8 | Complaints received about health practitioners 2012-13 to 2016-17



Complaints about medical practitioners

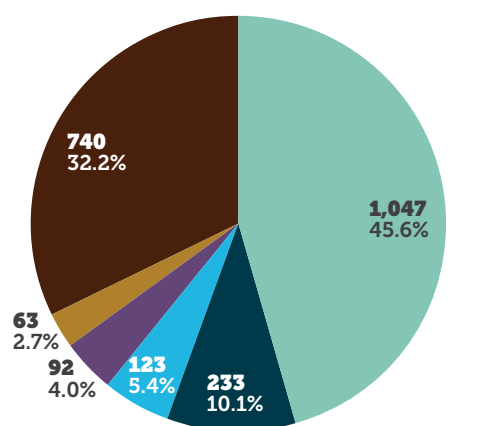
Complaints about medical practitioners continue to be the most common. In 2016-17, the Commission received 2,298 complaints about medical practitioners, a 7.7% increase on the 2,134 received in the previous year. Complaints about medical practitioners made up 56.0% of all complaints about health practitioners in 2016-17.

As shown in Chart 9, in 2016-17, complaints about medical practitioners most commonly related to those in the service areas of general medicine (45.6%; 2015-16: 38.8%), surgery (10.1%; 2015-16: 12.0%), psychiatry (5.4%; 2015-16: 3.4%), mental health care (4.0%; 2015-16: 5.4%) and emergency medicine (2.7%; 2015-16: 4.4%). Complaints about these areas accounted for 67.8% (2015-16: 64.1%) of all complaints received about medical practitioners during the year. The remaining 32.2% of complaints were across a wide range of service areas such as oncology, obstetrics, anaesthesia, aged care, cardiology and drug and alcohol.

The high proportion of complaints relating to general medicine should be seen in the context of the number of patient-practitioner interactions in the primary health care sector – Medicare Australia reported close to 40 million GP attendances in NSW in 2016-17.

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

Chart 9 | Most complained about areas of practice for medical practitioners



General medicine Surgery Psychiatry
Mental health Emergency medicine Other

Counted by provider identified in complaint

HEALTH CARE COMPLAINTS COMMISSION

Complaints about other health practitioners

The Commission received 370 complaints about dental practitioners during 2016-17, a 31.7% decrease on the 542 received in the previous year. While this reduction appears to be in contrast with the overall rise in complaints received against registered health practitioners, it should be noted that the inflated number of complaints against dental practitioners in 2015-16 distorts the overall trend line. The 2015-16 increase was predominantly attributed to one person who made 143 separate complaints about a particular aspect of dental practices' websites. There was also an intensive campaign by the Dental Council of NSW to address infection control in dental surgeries during that year.

In 2016-17, the Commission received 629 complaints about nurses and midwives, 25.5% more than the previous year. This increase is predominantly accounted for by a rise in complaints about professional conduct issues and self reporting of health issues. The majority of professional conduct complaints for nurses/midwives fall into the behaviour category, which includes complaints about nurses and midwives behaving in a manner that is perceived as rough, aggressive or intimidating. The fact that they tend to have longer and more frequent interactions with their patients/clients than the other professions may explain the high proportion of professional conduct complaints received about nurses and midwives compared to other registered health practitioners.

The Commission received 200 complaints about pharmacists in 2016-17, a 1.5% increase on the 197 complaints received in 2015-16. This modest increase is seen in the context of overall growth in complaints about pharmacists of 34.2% between 2012-13 and 2016-17. As previously noted in the Commission's 2015-16 Annual Report, the Commission continues to work with the Pharmacy Council of NSW to identify specific pharmacists involved in complaints about pharmacies and to ensure that timely and effective action is taken.

In addition, 211 complaints about psychologists were received during the year, a 19.2% increase from 2015-16. This continues a pattern of increase in complaints to the Commission about psychologists. The NSW Psychology Council has advised that approximately half of complaints made about psychologists are regarding performance issues, followed by complaints regarding conduct, both of which are reflected in the Commission's data. The number of mandatory notifications received about psychologists is also rising.

Complaints about non-registered health practitioners

The number of complaints about non-registered practitioners in 2016-17 continues to represent a very small proportion of complaints received overall (1.7%). The 107 complaints received was largely consistent with last year (2015-16: 102). As a proportion of all complaints about individual health practitioners, it remained the same as last year (2.6%).

Complaints about counsellors/therapists continue to be the largest proportion of complaints received about non-registered practitioners (17.8%; 2015-16: 16.7%). There was a 6.2 percentage point increase in the proportion of complaints about social workers (15.0%: 2015-16: 8.8%), noting in actual terms, they represent a very small of complaints. The proportion of complaints about massage therapists declined in 2016-17 (from 11.8% to 7.5%). The proportion of complaints about assistants in nursing (12.1%; 2015-16: 12.7%), alternative health providers (11.2%; 2015-16: 11.8%), cosmetic therapists (8.4%; 2015-16: 7.8%), and administrative/clerical staff (8.4%; 2015-16: 8.8%) were consistent with 2015-16.

Complaints about health organisations

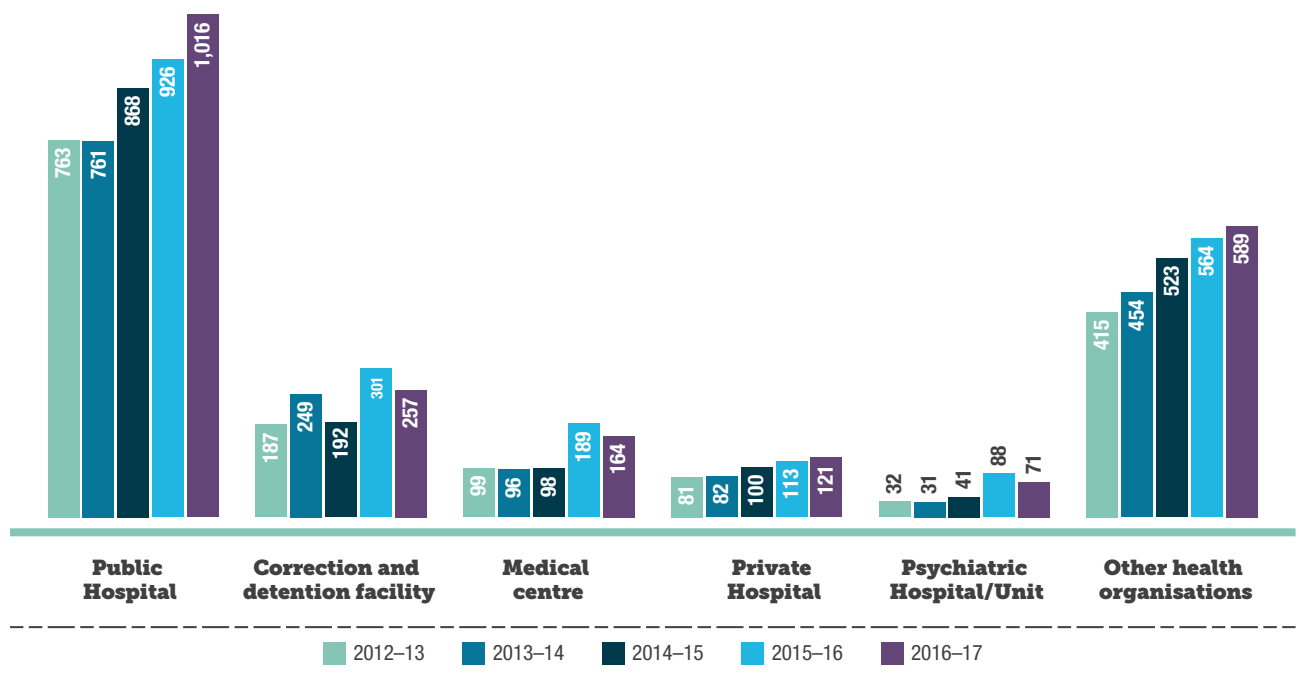
Chart 10 shows the number of complaints received about health organisations in the period 2012-13 to 2016-17.

In 2016-17, the Commission received 2,218 complaints about health organisations, a 2.7% increase on the previous year. A 38.3% increase in complaints about health organisations has been observed within the period between 2012-13 and 2016-17, in line with the overall 38.8% increase in complaints over this period.

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

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

Chart 10 | Complaints received about health organisations 2012-13 to 2016-17



Counted by provider identified in complaint

Complaints about public hospitals

In 2016-17, the 1,016 complaints about public hospitals constituted an increase of 9.7% on the previous year and accounted for 45.8% of all complaints against health organisations, compared to 42.9% in 2015-16 and 47.7% in 2014-15.

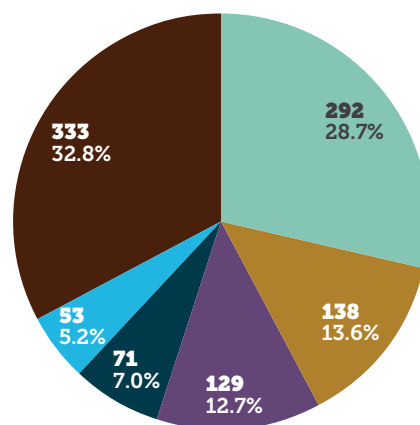
The number of complaints about public hospitals should be seen in the context of the increasing number of services provided. In 2016-17 there were 2,781,852 emergency department attendances in NSW public hospitals (2015-16: 2,733,853), 1,953,706 discharges from hospital (2015-16: 1,885,913) and 13,617,485 outpatient services provided (2015-16: 13,478,446).

Chart 11 shows the public hospital service areas that were subject to the most complaints in 2016-17. The complaints most commonly related to emergency medicine (28.7%; 2015-16: 20.5%), surgery (13.6%; 2015-16: 10.0%) mental health care (12.7%; 2015-16: 10.9%), obstetrics (7.0%; 2015-16: 6.7%) and general medicine (5.2%; 2015-16: 19.7%).

Complaints about these areas accounted for 67.2% (2015-16: 67.8%) of all complaints about public hospitals during the year. The high proportion of complaints about emergency medicine and surgery is largely attributed to the fact that these are health services associated with high risk, where complications and unexpected treatment outcomes can be more prevalent. It is noted that there are significant fluctuations across years in relation to the proportion of complaints relating to general medicine.

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

Chart 11 | Most complained about service area in public hospitals



Emergency medicine Surgery Mental health
Obstetrics General medicine Other Service Areas

Counted by provider identified in complaint

Complaints about other health organisations

Complaints about health organisations other than public hospitals were a higher proportion of the total number of complaints received about health organisations in 2016-17, accounting for 54.2% of complaints about health organisations.

Complaints about correction and detention facilities decreased from 301 in 2015-16 to 257 in 2016-17. Complaints about pharmacies rose 34.3% from 67 in 2015-16 to 90 in 2016-17. Many of these complaints related to compounding that was not compliant with the Pharmacy Guild regulations and were received from both consumers and pharmaceutical companies. Complaints about dispensing errors were also common.

The number of complaints about private hospitals also increased with 121 received in 2016-17, an increase of 7.1% from the previous year. The number of complaints about psychiatric hospitals decreased slightly, from 88 in 2015-16 to 71 in 2016-17, a decrease of 19.3%.

In 2016-17, the Commission received 164 complaints about medical centres compared to 189 in 2015-16, a decrease of 13.2%.

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

Issues raised in complaints

A single complaint will often raise a number of issues. Chart 12 shows the issues raised in complaints over the last five years. In 2016-17, 6,319 complaints received raised 11,694 issues – an average of 1.9 issues per complaint, which is consistent with the previous year.

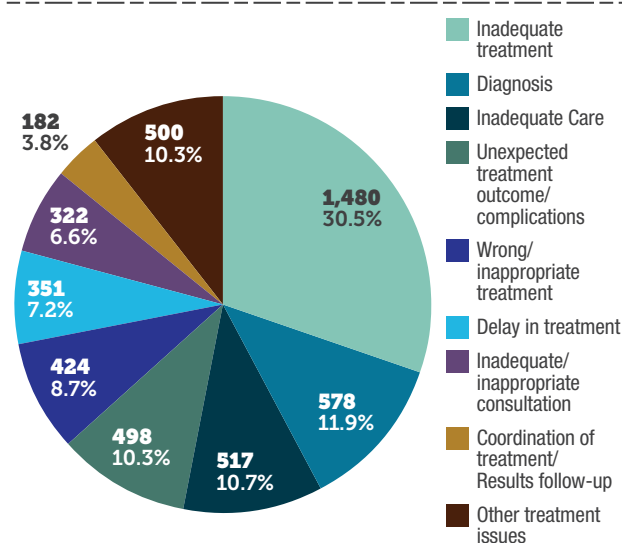
In 2016-17, the three most common issue categories were treatment (41.5%; 2015-16: 42.3%), the professional conduct of the health service provider (16.4%; 2015-16: 14.9%) and communication (15.9%; 2015-16: 17.2%). This is the first year that the number of complaints regarding professional conduct issues have surpassed those regarding communication issues. This is not unexpected as the Commission has observed a gradual but clear year on year increase in the number and proportion of complaints received regarding professional conduct issues.

Complaints about treatment

As shown in Chart 13, the most common issues raised in the treatment category were inadequate treatment (30.5%; 2015-16: 34.8%), diagnosis (11.9%; 2015-16: 11.7%) and inadequate care (10.7%; 2015-16: 11.6%).

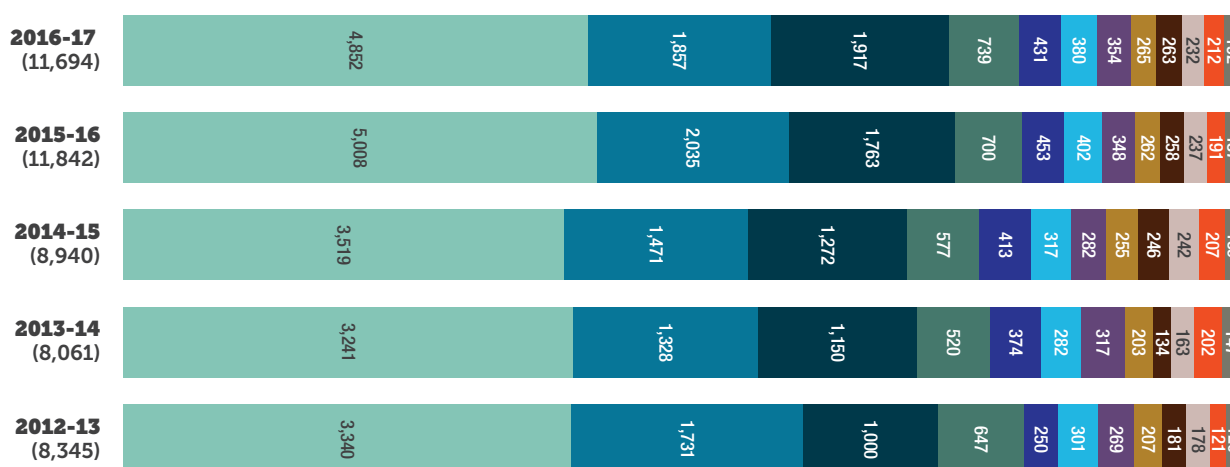
Other common treatment-related issues were unexpected outcome (10.3%; 2015-16: 14.6%), wrong/inappropriate treatment (8.7%; 2015-16: 2.5%), delay in treatment (7.2%; 2015-16: 6.6%), inadequate or inappropriate consultation (6.6%; 2015-16: 5.3%) and coordination of treatment or follow up of results (3.8%; 2015-16: 2.9%).

Chart 13 | Most common treatment issues raised in complaints received 2016-17



Counted by issue raised in complaint

Chart 12 | Issues raised in all complaints received 2012-13 to 2016-17



Treatment Communication/information Professional conduct Medication
 Environment/management of facilities Fees/costs Access Reports/certificates Consent
 Medical records Grievance processes Discharge/transfer arrangements

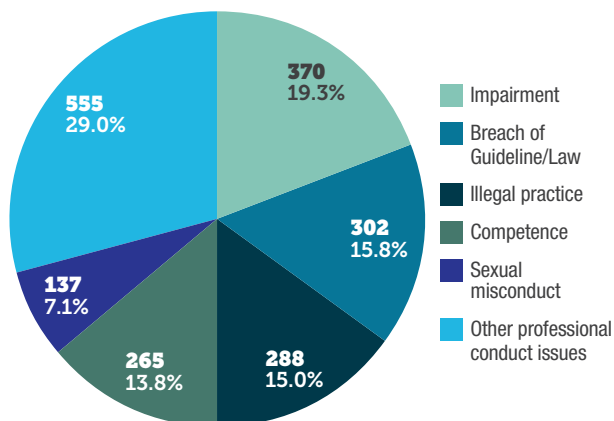
Counted by issue raised in complaint

Complaints about professional conduct

As shown in Chart 14, where the complaint related to professional conduct, most complaints related to a practitioner possibly suffering from an impairment (19.3%; 2015-16: 14.2%), a breach of guidelines or law (15.8%; 2015-16: 19.1%) or illegal practice (15.0%; 2015-16: 12.6%). The practitioner's competence accounted for 13.8% of complaints in this category (2015-16: 17.8%), followed by sexual misconduct (7.1%; 2015-16: 6.9%). Other professional conduct-related issues (such as misrepresentation of qualifications, inappropriate disclosure of patient information, boundary violations and financial fraud) accounted for 29.0% of all complaints raising a professional conduct concern.

The Commission receives a proportion of complaints about impairment, which may negatively impact upon a health practitioner's ability to carry out their professional duties. In most of these cases, unless there is also evidence of departures in conduct and/or a significant risk of harm the complaint would be referred to the relevant professional council which can assist these practitioners through their Health Program, to ensure they receive the necessary treatment and support.

Chart 14 | Most common professional conduct issues raised in complaints received 2016-17



Counted by issue raised in complaint

Complaints about communication

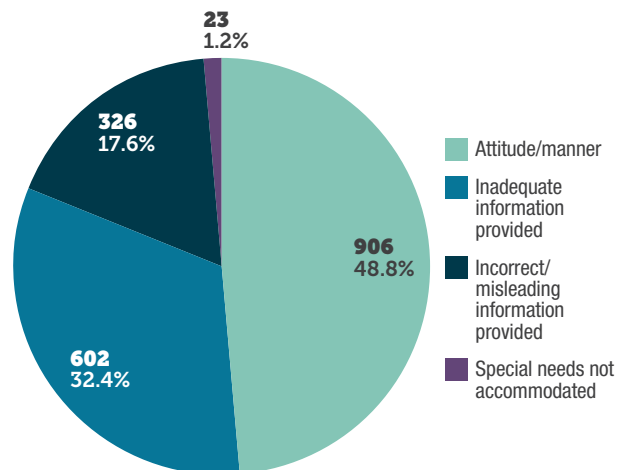
As shown in Chart 15, nearly half of communication and information-related issues concerned the attitude and manner of the health practitioner. This is a decreased proportion compared to the previous year (48.8%; 2015-16: 57.6%). Other issues in this category related to inadequate information (32.4%; 2015-16: 31.2%) or incorrect/misleading information (17.6%; 2015-16: 9.9%) from the health service provider. The increases in these two categories may reflect health consumer's greater access to health information and a desire to receive fuller information from the provider on treatment options and risk.

In a small number of cases (1.2%; 2015-16: 1.3%), the complaint was about the failure to accommodate the special needs of a patient.

The Commission is acutely aware that sound communication between a health care provider and consumers is instrumental to quality treatment. Many complaints can be prevented by a practitioner making the effort to discuss treatment options and decisions, obtain and record informed consent and ensure that no ambiguity remains. This message will continue to be the cornerstone of our advice to health service providers.

A detailed breakdown of all issues in complaints received in 2016-17 is included in Table A.2 in Appendix A.

Chart 15 | Most common communication/information issues raised in complaints received 2016-17



Counted by issue raised in complaint

Issues raised about health practitioners

Chart 16 sets out the types of issues raised in complaints about medical practitioners, dental practitioners, nurses and midwives, psychologists and pharmacists, compared to all practitioners in 2016-17.

Communication issues were common in complaints across all professions, however, were more prominent in complaints about medical practitioners and nurses, and less prominent in complaints about pharmacists. Communication issues are often coupled with treatment issues in complaints.

As in the previous two years, treatment issues were most prominent in complaints about medical practitioners (44.0%, 2015-16: 49.1%) and dental practitioners (56.8%, 2015-16: 44.6%). The proportion of treatment-related complaints about nurses and midwives remained relatively low (24.3%, 2015-16: 27.2%).

Pharmacists attracted the same proportion of complaints about professional conduct this year compared to last year (42.8%; 2015-16: 42.8%) which include complaints relating to illegal practice, breaches of guidelines or laws, and impairment. Medication issues were the second most frequently raised, at 39.5% (2015-16: 41.8%).

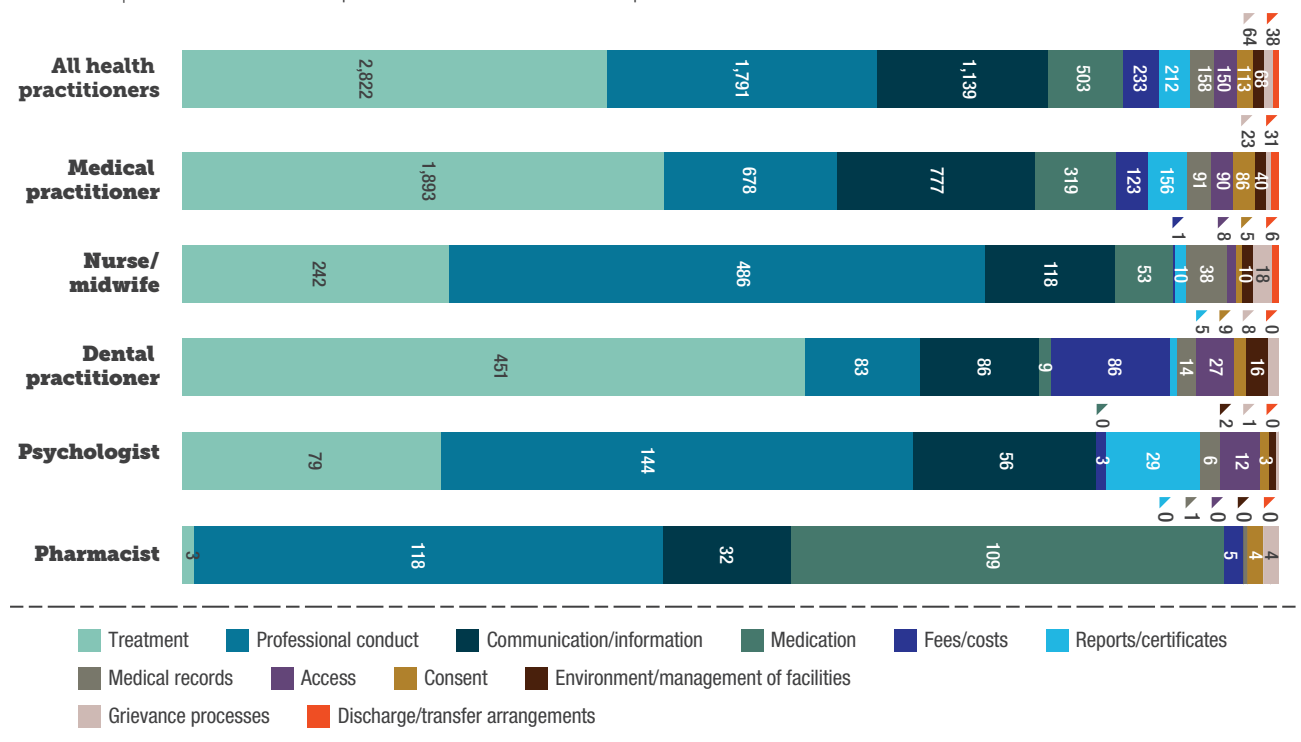
The proportion of complaints about the professional conduct of nurses and midwives was also high (48.8%; 2015-16: 41.9%).

Issues raised about non-registered health practitioners

The issues raised in complaints about non-registered health practitioners follow a different pattern to those raised in complaints about registered health practitioners. Non-registered health practitioners are far more likely to be the subject of a complaint about professional conduct issues (45.5%; 2015-16: 50.5%). Treatment issues are the second most common area complained about, rising 9.2 percentage points compared to last year (24.5%; 2015-16: 15.3%). The proportion of communication complaints received about non-registered health practitioners remained relatively stable at 16.5% (2015-16: 17.4%).

These three issues were the most commonly raised for complaints about counsellors/therapists, social workers, cosmetic therapists, alternative health practitioners and assistants in nursing.

Chart 16 | Issues raised in complaints received about health practitioners 2016-17



Issues raised in complaints about health organisations

Chart 17 shows a breakdown of the issues raised in complaints about public and private hospitals and other specific health organisations compared to all health organisations in 2016-17.

Issues relating to treatment accounted for over half of all complaints about public hospitals (53.8%, 2015-16: 53.5%), and 44.4% of all complaints about private hospitals (2015-16: 42.7%).

Communication and information-related issues were the second most commonly complained about issue in relation to both public and private hospitals, and also medical centres. Communication and information-related issues accounted for 17.9% (2015-16: 20.1%) of complaints about public hospitals, 13.5% of complaints about private hospitals (2015-16: 21.1%) and 22.8% of complaints about medical centres (2015-16: 23.5%).

In 2016-17, complaints about the environment and management of the facility accounted for 13.2% of complaints about private hospitals (2015-16: 9.5%) and 5.8% of complaints about public hospitals (2015-16: 5.9%).

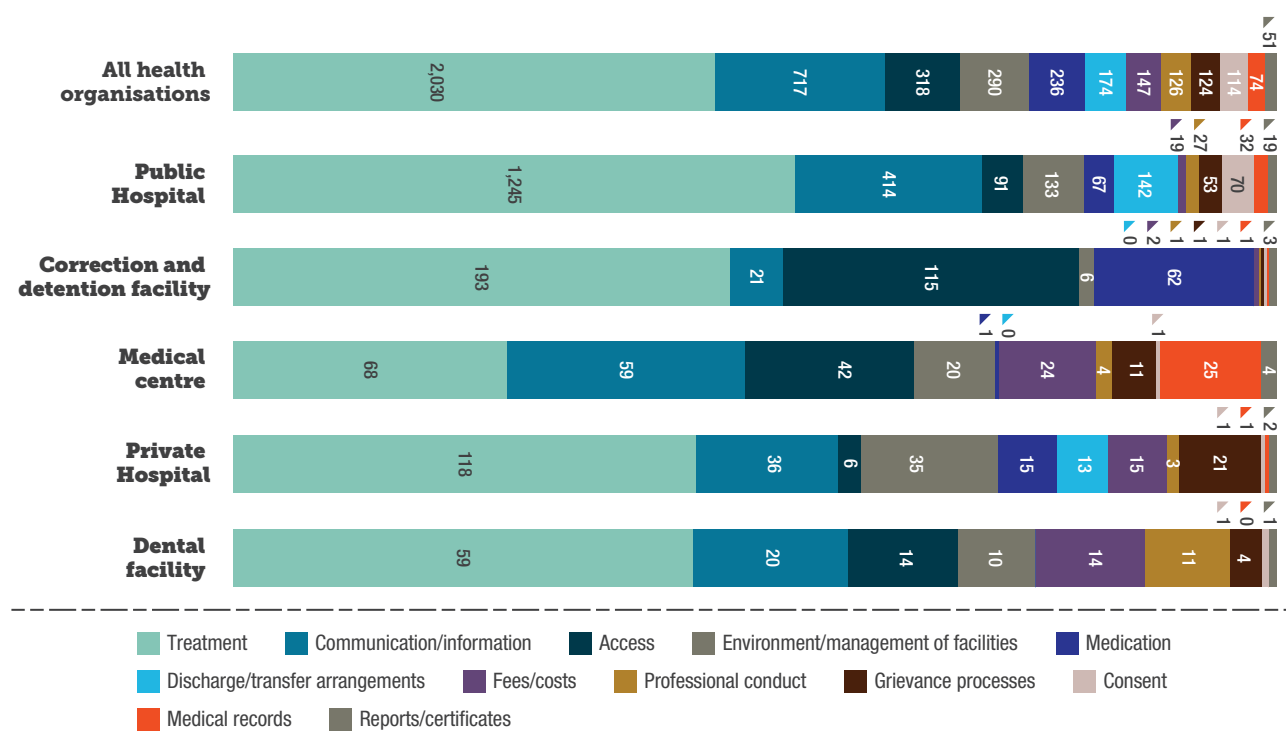
As in the previous two years, treatment issues were less prominent in complaints about medical centres, with only 26.3% raising this issue (2015-16: 25.5%). This may reflect that patients at medical centres present with less serious conditions or more likely to involve continuity of care for chronic conditions.

Complaints about medical records were more likely to be received about medical centres than to any other health organisation, with 9.7% of complaints about medical centres raising this issue (2015-16: 11.6%). These complaints mainly concerned access to, or transfer of records.

Consistent with previous years, correction and detention facilities attracted a higher proportion of complaints about access than other health organisations (28.3%; 2015-16: 30.0%), mostly relating to waiting lists and service availability. Medication issues were also raised in a large proportion of complaints about correction and detention facilities (15.3%; 2015-16: 17.0%).

In contrast with 2015-16, complaints about fees and costs were higher in medical centres (9.3%) and dental facilities (10.4%) than in complaints about private hospitals (5.6%; 2015-16: 9.5%), although the small numbers in this issue category overall is noted.

Chart 17 | Issues raised in complaints received about health organisations 2016-17



Complaints by location

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

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

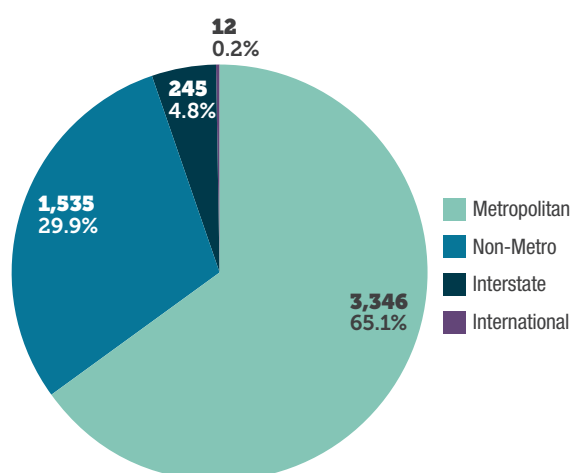
In relation to analysis of LHD by LHD data, the significant differences in the volume and types of services provided need to be recognised.

Location of complainants

Chart 18 shows breakdown of complaints received by the location of complainants. In 2016-17 location details were not provided by 1,256 complainants. The Commission received 3,346 complaints from complainants who indicated that they were located in metropolitan NSW. This represents 65.1% (2015-16: 60.3%) of all complaints where the complainant location was known. 1,535 complaints were received from complainants located in regional NSW, accounting for 29.9% (2015-16: 33.9%) of all complaints with location details. 245 complaints were received from interstate complainants (4.8%, 2015-16: 5.5%) and 12 from international complainants (0.2%, 2015-16: 0.2%).

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

Chart 18 | Location of complainants



Counted by complainant

Location of providers

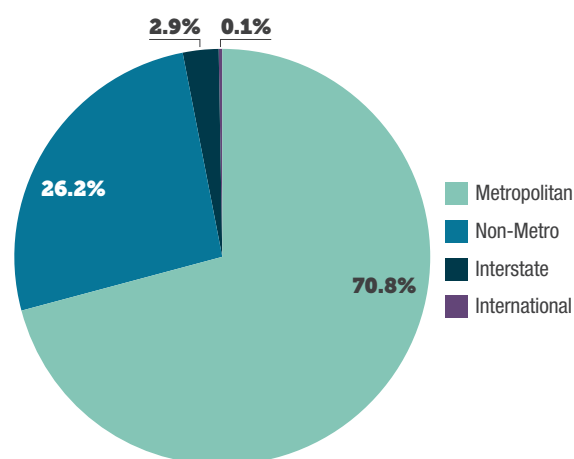
In 2016-17 location details were not able to be identified for 164 providers.

Chart 19 shows the breakdown of complaints received by the location of health service providers. In 2016-17, the Commission received 4,358 complaints about health service providers in metropolitan NSW, which was 70.8% of all complaints with a known provider location. This is consistent with the previous year's figure of 70.2%.

1,614 complaints (or 26.2%) were about health service providers in regional areas, which is marginally below the previous year's figure of 26.6%. A small number of providers were from interstate (176, or 2.9%) and only seven were international (0.1%). These are consistent with last year's figures of 3.1% and 0.1% respectively.

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

Chart 19 | Location of providers



Counted by complainant

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

Issues raised in complaints from metropolitan and regional complainants

Chart 20 shows the issues raised by individual complainants located in metropolitan and regional NSW, excluding complaints made by organisations.

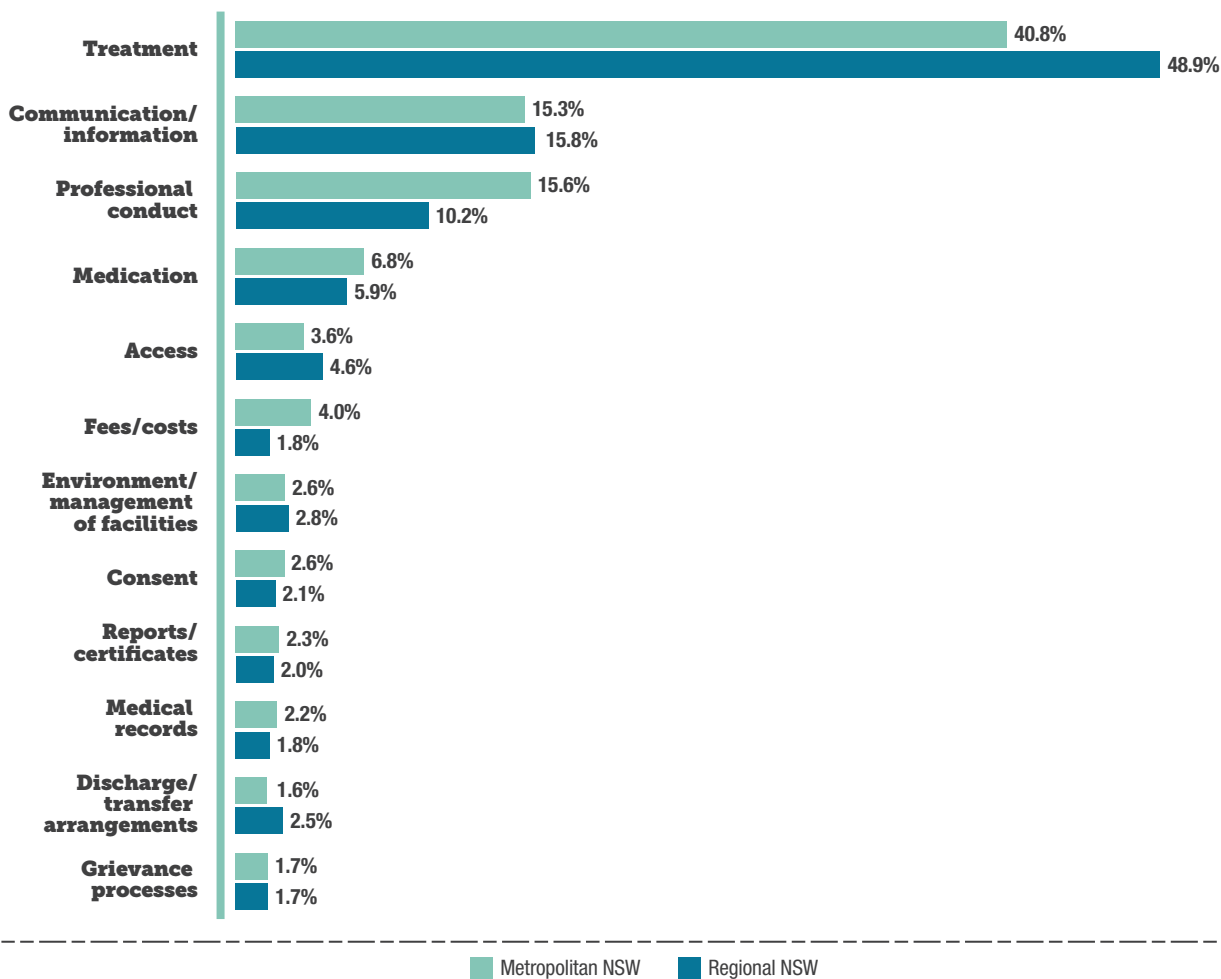
The chart shows some areas of difference in the issues raised.

Unlike 2015-16, in which the percentage of complaints where treatment issues were raised was similar for both metropolitan and regional complainants (44.7%

and 45.0% respectively), the proportion of complaints regarding treatment dropped in metropolitan areas (40.8%) while climbing slightly in regional areas (48.9%).

Professional conduct issues were more likely to be raised by metropolitan complainants (15.6%; 2015-16: 10.6%) than regional complainants (10.2%; 2015-16: 14.2%). Other differences in issues raised were consistent with the differences previously observed, in that access and discharge/transfer matters arise more frequently in regional context while fees and costs continue to be a more common issue for metropolitan than regional complainants.

Chart 20 | Issues raised by metropolitan and regional complainants



Counted by issue raised in complaint

Focus area – complexity of complaints

The Commission has identified for some years now that, in addition to the pattern of growth in complaints, these complaints are also becoming more complex. Volume and complexity combine to become key drivers of the challenges that face health care complaints management now and into the future.

The Commission has undertaken some initial analysis of our complaints to look at the dimensions of the complexity that we are observing.

It is, of course, difficult to measure complexity, but by looking at the features of our complaints we have an emerging picture of what the complexity looks like.

The Commission has been able to categorise complexity in four ways and understanding these dimensions and the interactions between these four areas has helped to steer adjustments to the way we work.

Four dimensions of complexity

Complex complaints

A single complaint itself may be inherently complex and this is increasingly the case. Furthermore one complaint may be connected to other complaints in a range of ways, such that these complaints all need to be considered together and managed in a consistent way.

There are many manifestations of this type of complexity:

- A complaint with a single patient who has been treated by multiple individual providers. This scenario may be further complicated by the delivery of this treatment in a range of different service types of locations.
 - For example, a patient who is receiving multi-disciplinary care and treatment; or, a patient who was admitted in an Emergency Department, then required surgery, which may have occurred in the same hospital as the emergency presentation or another hospital, which may in turn have been a private or a public hospital. Rehabilitation may then have occurred at a different facility.
- A complaint may relate to a single patient in a single location, but may nevertheless involve complex interplays between system wide issues and the care and treatment provided by an individual practitioner.

- One example may be where a practitioner is alleged to have provided substandard care, but it is also apparent that policies about the required responses to certain clinical scenarios were not up to date, or were up to date but not implemented by personnel.

- A complaint where a single provider is alleged to have departed from standards or care in relation to multiple patients, over a long period and over multiple locations.

There is evidence of an increasing incidence of single providers generating multiple complaints and subsequent lines of investigation over the last five year period.

- In 2012-13, there were 28 providers who had two or more investigations, and these investigations accounted for 31.7% of all investigations. By 2016-17, there were 68 providers whose investigations constituted 61.4% of all investigations.
- The 28 providers in 2012-13 constituted 16.1% of all providers involved in investigations; whereas in 2016-17, the 68 providers accounted for more than double that proportion (being 34.8% of all providers involved in investigations).
- This trend is also reflected in the fact that the number of investigations rose by 53.7% (from 214 to 329) between 2012-13 and 2016-17, but the number of providers involved in the investigations rose by only 12.1% (from 174 to 195).
- For example, a recent Commission investigation involved a medical practitioner with over 150 patients, treated over more than a decade, across three locations and with multiple different types of illnesses. In these cases multiple streams of investigation are required to arrive at a view about whether disciplinary action is warranted and if so, which patients, in which timeframe and/or location and which treatment decisions provide evidence to ground the disciplinary action.

- A suite of complaints may relate to a particular form of treatment that has been delivered to multiple patients by multiple providers.
 - For example, another recent Commission investigation has involved the care and treatment of dozens of women, all of whom had undergone multiple surgeries conducted by several specialist practitioners that resulted in poor outcomes and, at times, irreversible life changing injuries.
- Particular complexities arise in complaints relating to emerging areas of health service delivery, where treatments and protocols are still evolving and being tested.
 - Examples could be novel treatments or new applications of rapidly expanding treatment such as stem cell therapy.



Case Study – Complexity arising from a range of issues in an emerging area of treatment

A complaint was received about a thoracic physician, Dr Samuel Tae-Kyu Kim concerning his care and treatment of a patient with a persistent cough and respiratory problems over a three year period.

It was alleged that Dr Kim recommended the patient see a non-registered complementary health practitioner for 'esoteric lung massage'. This was a form of treatment that the Commission had not previously come across and the Investigation Officer was required to conduct research into its use and its purported health benefits. Dr Kim also failed to disclose to the patient that this non-registered practitioner was his fiancée. He also recommended or referred the patient to a number of other esoteric healing practitioners connected to a commercial practice to which he belonged.

During the investigation it appeared that the physician did not explain the distinction between conventional and complementary treatment to Patient A and did not disclose his own connections to the esoteric practitioners. It also appeared that he had acted contrary to the Medical Council of NSW's Complementary Health Care Policy and the Medical Board of Australia's Good Medical Practice: A Code of Conduct for Doctors in Australia.

The complaint was referred to the Director of Proceedings for consideration of prosecution, which was ultimately prosecuted before a Professional Standards Committee. The physician was found guilty of unsatisfactory professional conduct, with the Committee criticising his referrals to the complementary practitioners and finding that he recommended treatments (such as esoteric lung massage and chakra puncture) in full knowledge there was insufficient evidence for their efficacy as treatment for the patient's lung condition.

The Committee reprimanded Dr Kim and imposed conditions on his registration, including that he must practice under supervision and obtain a second opinion and approval from a thoracic physician before making any referrals for complementary therapies and treatment.

Complex complainant scenarios

Complainant complexity may arise in scenarios such as those where the complainant or the subject of the complaint is in a vulnerable position.

- For instance the subject or complainant could possibly be physically or mentally unwell while the complaints process is underway.
- A third person (or more than one person) may raise a complaint about the treatment of someone other than themselves, but it may be unclear whether there is knowledge about the complaint or consent for access to medical information on the part of the person whose treatment is being questioned.
- In some instances, the care and treatment of a person without decision making capacity may be raised by others, but the issues in the complaint may be unclear or there may be disagreement about core issues such as guardianship, powers of attorney, and consent to access records. This disagreement may be between the third party complainant or between two or more third party complainants in relation to a single subject.
- There are also cases where the person who has received treatment from a practitioner may not be concerned or complaining about the treatment received, but another person may be critical of that treatment.

This category also includes complexities that may also arise from other scenarios, such as vexatious complainants. These can be difficult as, on face value, there may appear to be substance to a complaint, but upon closer assessment there are factors which lead to legitimate questions about the bona fides of the complaint.

- Examples include complaints made under the identity of others who, when contacted, have no knowledge of the complaint.

Complex jurisdictional questions

Questions may arise as to whether the Commission has jurisdiction to manage a complaint.

These issues typically arise where there is a question as to whether the matter complained of relates to the delivery of a health service. This can be a grey area in fields such as beauty treatments, which may not involve any interventions under the public or private health statutes but do involve interventions or personal care of some kind.

Another example is home based care where a person is provided with support to deal with day to day needs, but this may or may not be provision of a health service depending on what this support involves.

There may also be a question as to whether a provider is delivering a service as a registered or non-registered practitioner. This is a particularly important question as the actions that can be taken throughout the complaints handling process, the powers of the Commission and the possible outcomes vary between these two categories.

Complex complaints processes

The final category relates to managing the interdependencies between the Commission's own processes and the processes and priorities of other entities and sourcing all of the information and evidence that is required to finalise a matter.

Within the Commission's own processes, complexities may relate to factors such as: who owns the relevant medical records and how they can be accessed; difficulties locating and securing responses from practitioners; gathering evidence where the allegations relate to historical matters and relevant evidence – including medical records – are not available. In an investigation context, sourcing appropriately skilled, respected and non-conflicted experts is a particular issue, particularly where the clinical field in question may have a small number of subject experts within NSW or even nationally, or where the treatment in question is in a novel or evolving area of practice.

Externally, and particularly in more serious matters, it is not uncommon for other investigations to be running in parallel. These may be at state level such as those by NSW Police, the NSW Coroner's Court, the Pharmaceutical Regulation Unit and Public Health Units. They may be at national level, for example through Australian Health Practitioner Regulatory Agency, Australian Competition and Consumer Commission, the Therapeutic Goods Administration or Australian Sports Anti-Doping Authority. These complaints can only be satisfactorily progressed through coordinated processes (including effective exchange of information and data) across regulatory agencies.



Case study – Complexity relating to multiple patients, multiple practitioners and multiple processes

The Commission investigated Dr Mengyi Chen, a general practitioner who practised two days a week in a group practice in Telopea. She also practiced three days a week at another group practice.

The complaint related to Dr Chen's inappropriate prescribing of Schedule 4D and Schedule 8 drugs, without an authority, to 15 patients over a period of about three years, as well as her poor record keeping in relation to each of those patients. Each of the patients were drug-dependent and some had current or prior history of treatment under the supervision of the NSW Opioid Treatment Program.

Dr Chen's inappropriate prescribing was in breach of the *Poisons and Therapeutic Goods Act 1966* and the *Poisons and Therapeutic Regulation 2008*.

Dr Chen first came to the attention of the Pharmaceutical Services Unit ('PSU') in 2013 following advice that a pharmacy in Telopea was the fourth highest dispenser of Oxycontin (a Schedule 8 drug) in NSW. The Commission needed to work in close cooperation with the PSU. The PSU traced the scripts back to the practice that Dr Chen was working at. The investigation into Dr Chen also ran in parallel with two other practitioners at the practice who were also prosecuted by the Commission. This was a complex investigation given the number of patients, many of which were shared patients among the three practitioners, and the number of years that the inappropriate prescribing had occurred. The seriousness of inappropriately prescribing Schedule 8 drugs, especially in combination with Schedule 4D drugs, was identified by the expert witness obtained by the Commission. The reckless prescribing of these drugs can have very serious harmful effects including impairment of memory, cognitive impairment and fatal opioid overdoses.

The investigation resulted in a prosecution before the NSW Civil and Administrative Tribunal. On 28 November 2016, the Tribunal found all of the complaints proven and found Dr Chen guilty of professional misconduct. The Tribunal found that Dr Chen's failings were a result of laziness and a non-caring attitude which was also reflected in Dr Chen's attitude to the recording of clinical notes. They found that the professional misconduct was of a very serious nature and they had grave doubts about Dr Chen's ability to practice medicine safely. The Tribunal also commented that Dr Chen's disdain for any obligation to keep proper records at the practice was "tantamount to a deliberate disregard for her statutory obligations and created risk to the health and safety of her patients because of the inability of another practitioner to fully understand what treatment had been afforded to a patient, and importantly, why".

Upon making a finding of professional misconduct, the Tribunal cancelled Dr Chen's registration and ordered that she not be able to apply for review of that order for a period of 18 months.

Working with complexity

Our analysis of the way in which complexity manifests in the health care complaints environment is informing decisions about how we redesign of our operational processes and complaints handling approaches and helping us to use our resources most effectively.

The central point is that complaints need to be dealt with differently depending on their complexity. The Commission is therefore introducing a risk-based triaging and assessment planning approach which takes complexity into account. Where a complaint is about a single, lower level matter it would typically be classified as an early resolution matter and more informal and immediate actions would be taken in an effort to achieve resolution.

Where a complaint is more complex, however, the nature of the complexity needs to be understood and early decisions need to be made about how to deal with this complexity. For instance, if a matter is clinically complex, there is a need for early involvement of medical advisors so that there is a clear articulation of the specific clinical questions that arise, the records and responses that are required to consider those questions, and the earliest possible identification of the need for specialist advice.

In the past, there has been limited focus on identifying and linking related complaints, with the possibility that multiple complaints about a single provider could be allocated and assessed by a number of different assessment officers. The triaging processes now involve more active consideration of other related complaints, with the intention that Managers and Senior Assessment Officers would coordinate and manage all of the related matters in an efficient and consistent way.

This upfront consideration of related complaints is also assisting to identify circumstances where there is good cause to conclude that a complaint should be considered vexatious or not made in good faith, which will assist in making a determination before extensive and potentially unnecessary assessment activity is undertaken.

In some of these complex cases, there is an early apprehension that the matter may be more than likely to require fuller investigation. In these cases the information gathered during the assessment process needs to provide the best possible platform for later activity, with streamlined processes for transferring matters to investigation as soon as they are assessed to avoid delay.

Similarly, where a new investigation relates to matters already being investigated, or to a complaint that has already been referred for consideration of disciplinary action, monitoring the investigations and where appropriate linking up those processes is important.

If a complaint relates to a matter that is already under investigation, for instance by police or the subject of a Coronial inquiry, then immediate consideration of the relationship between those processes and the actions taken by the Commission needs to occur. Clear Memoranda of Understanding to support immediate requests for information through designated personnel become essential in this context, so that the actions of all bodies can be aligned and to avoid duplication of effort.

Increasingly, the Commission is also looking to strengthen its partnerships and undertake joint operations with other regulators, so that information that is secured by any of the regulatory bodies can be utilised for the purposes of a Commission investigation. This collaboration is being assisted by Commission involvement in the NSW Health Regulators Forum and the Consumer Health Regulators Group, which is a coalition of regulators across Australia meeting quarterly to share information on emerging issues and concerns, and to ensure a coordinated and consistent application of regulatory functions.

Assessing and resolving complaints

The nature and purpose of the assessment process

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

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

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

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

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

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

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

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

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

The Commission is mindful of the importance of ensuring that complaints that are referred to professional councils or to health service providers are managed in an effective and timely way and the focus is on getting the best possible resolution for the consumer at the end of the process. During 2016-17 Commission began establishing more structured arrangements for provision of feedback on the outcome to the Commission where complaints that have been referred to a professional council or a health service provider for action. For 2017-18 and beyond, the Commission will place a greater focus on analysis of this feedback, to determine trends and patterns, and gain greater insight into these processes which fall outside the formal jurisdiction of the Commission, but which nevertheless play a critical role in ensuring the public health and safety of the NSW community.

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

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

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

A proportion of complaints raise lower level issues (such as practitioner rudeness, poor information or long waiting times). These issues are of understandable concern to the consumer but do not raise more significant issues of risk to public health and safety. In these cases, the priority for the Commission is to provide guidance to the practitioner or service about necessary improvements in practice. In 2015-16, the outcome of "discontinue with comments" was introduced for this purpose. Determining to "discontinue with comments" enables this guidance to be provided, whereas previously the complaint would simply have been assessed for no further action.

A complaint will be discontinued where:

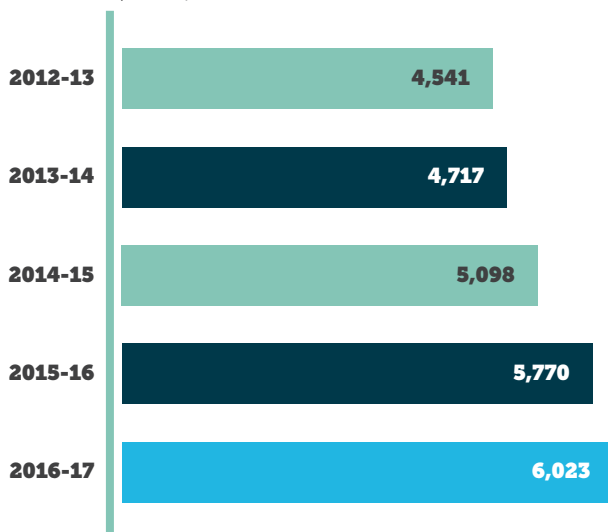
- assessment uncovers information that corrects misapprehensions in a complaint and indicates that there has not been inferior treatment or care or unsatisfactory conduct.
- a clinical expert examines all relevant records and responses and does not find that there were any departures in the treatment and care provided.
- the complaint is found to be made in bad faith.

A complaint may also be withdrawn by the complainant.

Complaints assessed

In 2016-17 there were 6,023 complaints assessed by the Commission – a 4.4% increase from the previous year. This shows an increase in the Commission's productivity, indeed the volume of complaints assessed is unprecedented. It is clear however that the cumulative impact of year on year increases in complaints and their complexity will require more intensive effort on significant systems enhancements, automation of key processes, streamlined complaints handling processes and resourcing decisions.

Chart 21 | Complaints assessed from 2012-13 to 2016-17



Counted by identified in complaint

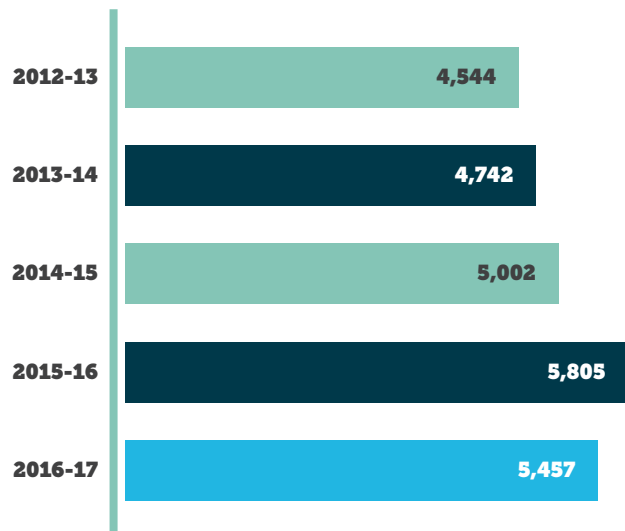
Assessments finalised

The Commission also records the number of assessment files finalised and closed, to monitor the completion of all necessary steps to achieve file closure. Once a matter is assessed the remaining steps are to undertake consultation, prepare decision letters and audit and close the case file.

In total, there were 5,457 assessments files finalised and closed in 2016-17, which is a minor 6.2% decrease from 2015-16. This reinforces that the systems for finalising all steps for close of a file require increased focus as part of the 2017-18 automation and systems upgrade project.

It should be noted that the 'assessments finalised' figure is used as the basis for the analysis of assessment outcomes that follows (as per standard practice for previous Annual Reports), as the final outcome of a complaint may change after the assessment recommendation is made through consultation with the professional council.

Chart 22 | Assessments finalised from 2012-13 to 2016-17



Counted by provider identified in complaint

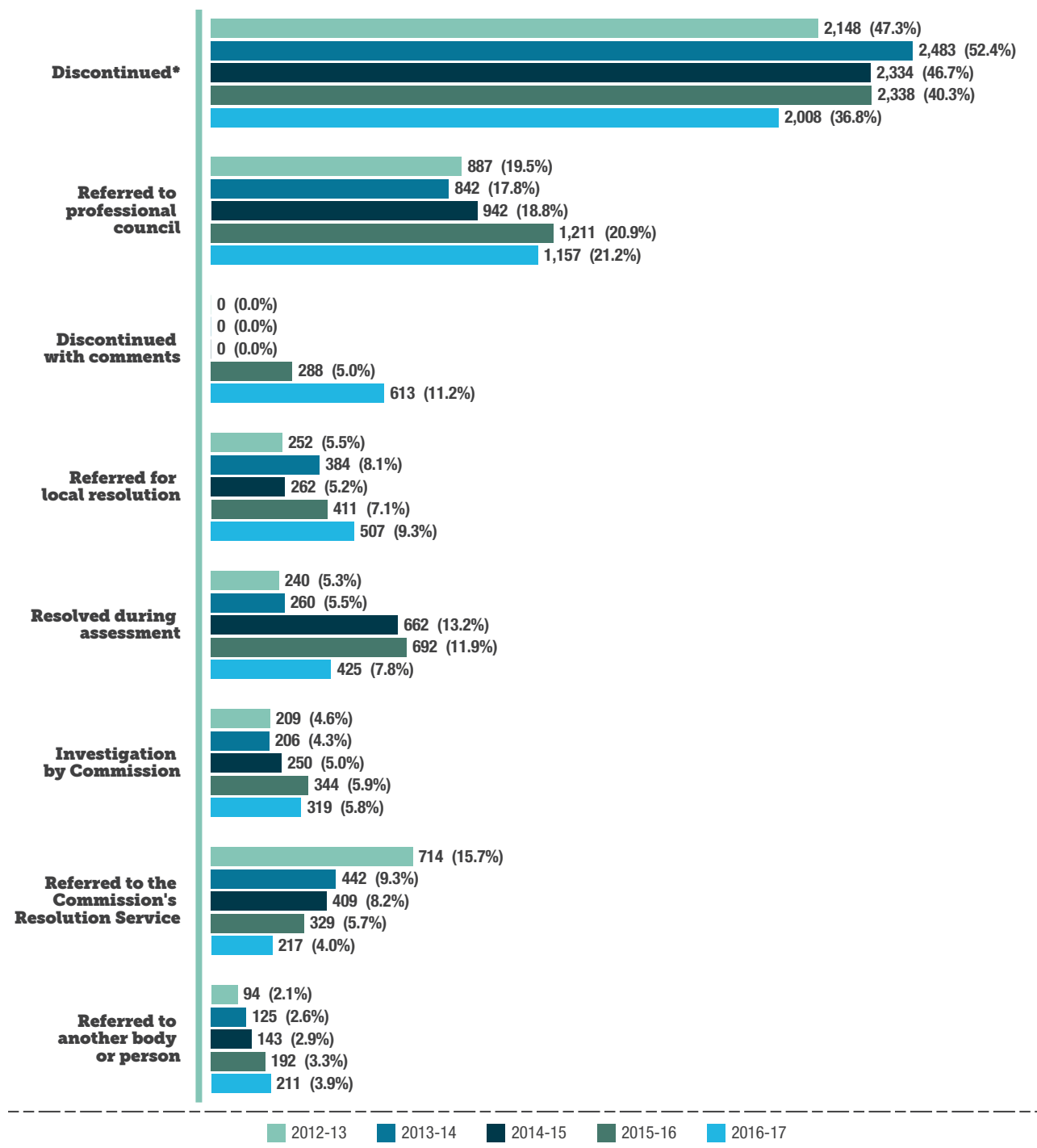
Assessment outcomes

Chart 23 shows the Commission's assessment outcomes for complaints for 2016-17 compared to the previous four years.

Chart 23 shows that:

- The proportion of matters resolved during assessment has declined in 2016-17. Review of this indicates that the increased volume of complaints has meant fewer resources for early resolution functions. The early resolution resources have been increased for 2017-18.
- The 5.8% of complaints referred for investigation in 2016-17 is generally in line with the proportion referred in 2015-16.
- The proportion of complaints discontinued without any further action continues to decline and is significantly less than three years ago (36.8% compared to 52.4% in 2013-14).

This is a desirable trend and primarily explained by the introduction of the category "discontinue with comments" in 2015-16, which constitutes 11.2% of assessment decisions for this period. As noted earlier, this category was introduced to address complaints that raise lower level issues (such as poor communication by a practitioner, poor information or long waiting times). In these cases, the priority for the Commission is to provide guidance to the practitioner or service about necessary improvements in behavior or practice.

Chart 23 | Outcome of assessment of complaints 2012-13 to 2016-17

Counted by provider identified in complaint

- One in five complaints was referred to a professional council (21.2%) for their action in relation to identified concerns about poor performance, conduct or possible health issues for the practitioner. This proportion is slightly higher than previous years.
- More assessments were referred for local resolution (9.3%) than in previous years. The ability to more confidently refer matters to local resolution with the expectation of improved understanding and resolution of concerns is reflective of the focus across the health system through the Australian National Safety and Quality Health Service Standards to increasing capacity and systems for managing complaints within all Local Health Districts.
- The proportion of matters referred to the Commission's Resolution Service has declined, 5.7% in 2015-16 to 4.0%. This is primarily a reflection of

the effort to direct the most complex, sensitive and contentious matters to the Resolution Service so that more time and effort is available to deliver successful outcomes. As will be noted later in the Chapter, with a smaller number of matters, the performance of the Resolution Service had significantly improved. That said, there is a need to examine the capacity to take more matters through the Resolution Service and this will occur during 2017-18.

- A small proportion of complaints (3.9%) was referred to another body or person for consideration, which is higher than previous years and to some extent reflects the establishment of other relevant regulatory bodies, such as the transition to a fully independent Aged Care Complaints Commissioner at national level.



Comments provided to correct treatment practices

The Commission received a complaint from a mother raising concerns about the care and advice a medical practitioner provided to her 13 year old son. They attended the medical practitioner concerning a birthmark.

The complainant stated that the medical practitioner examined the birthmark and advised that it should be removed and that this could be done by laser treatment.

Following this advice, the complainant's son attended a dermatologist for an opinion. The dermatologist advised that the birthmark could not be removed by laser therapy and that it did not in fact need to be removed. In his referral letter back to the GP, the dermatologist advised: *'This is not amenable to any laser intervention. Rather the treatment of choice if active therapy were to be pursued, is with surgery. This was discussed. He is happy to leave it alone'*.

As part of the assessment process, the Commission obtained a response and the consult records from the medical practitioner. The medical practitioner stated to the Commission that he examined the birthmark and diagnosed it as benign. He stated that did not provide advice that the birthmark should be removed, rather the complainant and her son sought advice on its removal. In response to this request, he suggested laser treatment as he felt excision would be too invasive and unnecessary.

While the versions of events differed with respect to who suggested/requested the birthmark be removed, the evidence did indicate concern that laser treatment had been suggested, when excision would have been required if the removal of the birthmark were pursued.

As the matter related to the conduct of a medical practitioner, the Commission was required to consult with the Medical Council of NSW. Both the Commission and Council agreed that it was appropriate to advise the medical practitioner in formal comments that his advice regarding the laser treatment was incorrect and he should exercise greater caution in providing advice of this nature.

Assessment decisions by type of health practitioner

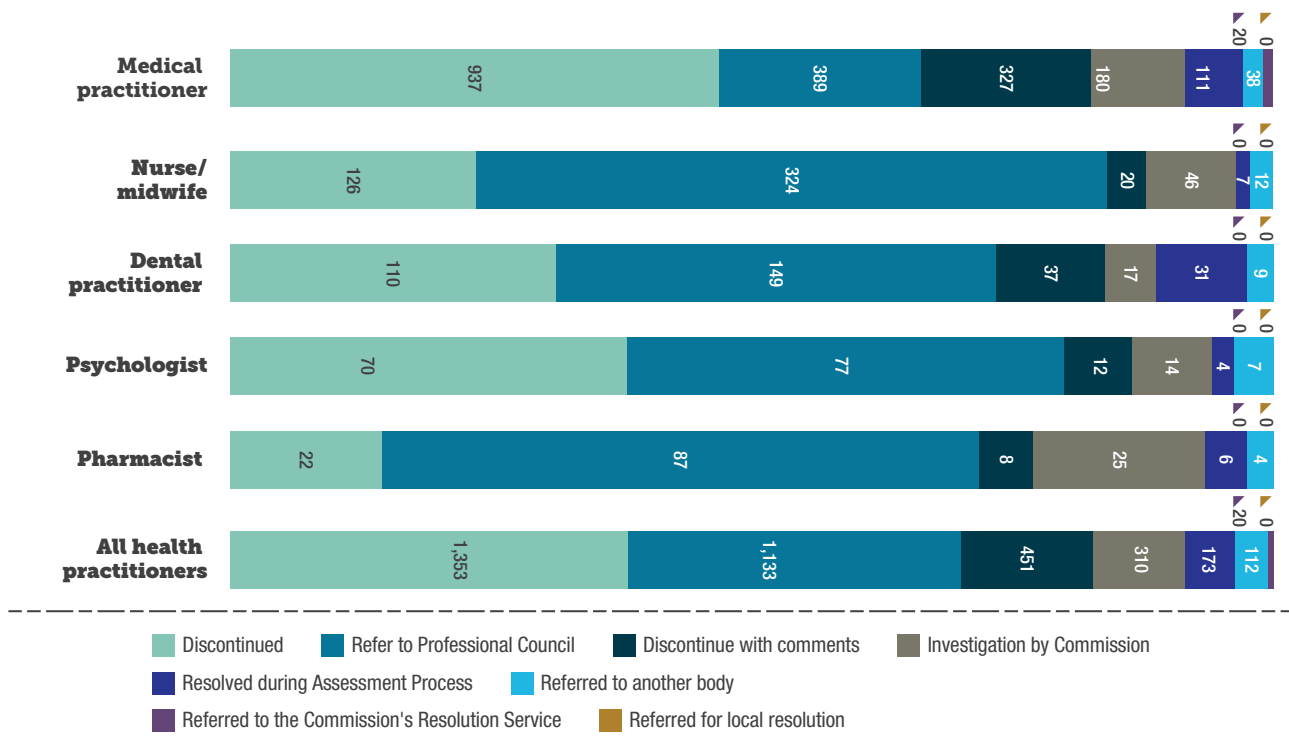
Chart 24 below sets out how the Commission dealt with complaints in 2016-17, by the type of health practitioner involved. The chart compares the assessment decisions for each of the top five most complained about health practitioners to the assessment decisions for all complaints about health practitioners.

In 2016-17, fewer complaints about medical practitioners were discontinued (46.8% compared to 49.6%, 2015-16). An increased number and proportion were referred to the Medical Council of NSW (19.4% as compared to 16.4% in 2015-16). The proportion of complaints resolved during assessment declined by 5.1 percentage points (from 10.6% to 5.5%) which highlights the need to continue efforts to strengthen the Commission's focus on early resolution of complaints.

The rise in the proportion of complaints about medical practitioners that were discontinued with comments, from 8.4% in 2015-16 to 16.3% this year, reflects the fact that there is an important opportunity to achieve improvements in practice through highly specific suggestions to practitioners about improvements that would most likely avoid future complaints.

The most likely outcome for complaints about dental practitioners, nurses and psychologists was referral to the relevant professional council. This is due to the fact that effective consideration of clinical issues is frequently central to addressing the concerns raised in complaints. In addition, highly technical subject expertise is able to be accessed through these councils which allows thorough exploration of concerns by the relevant experts. The proportion of complaints about nurses/midwives in this category was slightly higher than last year (60.6% to 55.6% in 2015-16). Conversely, the proportion of complaints discontinued for nurses and midwives decreased slightly, from 27.1% to 23.6% this year.

Chart 24 | Outcome of assessment of complaints by health practitioner



Counted by provider identified in complaint

The proportion of complaints referred to the Dental Council declined significantly, from 58.6% in 2015-16 to 42.2% this year. This is largely due to the Council undertaking a proactive infection control campaign last year. The corresponding increase was largely seen in the discontinued with comments (up from 2.2% in 2015-16 to 10.5%) and discontinued (from 26.9% to 31.2%) categories.

The proportion of psychologists referred to the professional council was consistent with last year (41.8%; 2015-16: 40.1%), as was the proportion discontinued (38.0% compared 38.3% in 2015-16). The proportion of complaints referred for investigation for psychologists saw a small decline of 3.5 percentage points in 2016-17, from 11.1% in the previous year to 7.6%.

Complaints about pharmacists continued to be most likely to be referred to the Pharmacy Council (57.2%), which is a decrease from last year's result (64.1%). The proportion of complaints referred for investigation increased in 2016-17, from 13.0% to 16.4% reflecting an increase in matters about both inappropriate and over prescribing of medications, as well as compounding matters. This proportion of complaints investigated

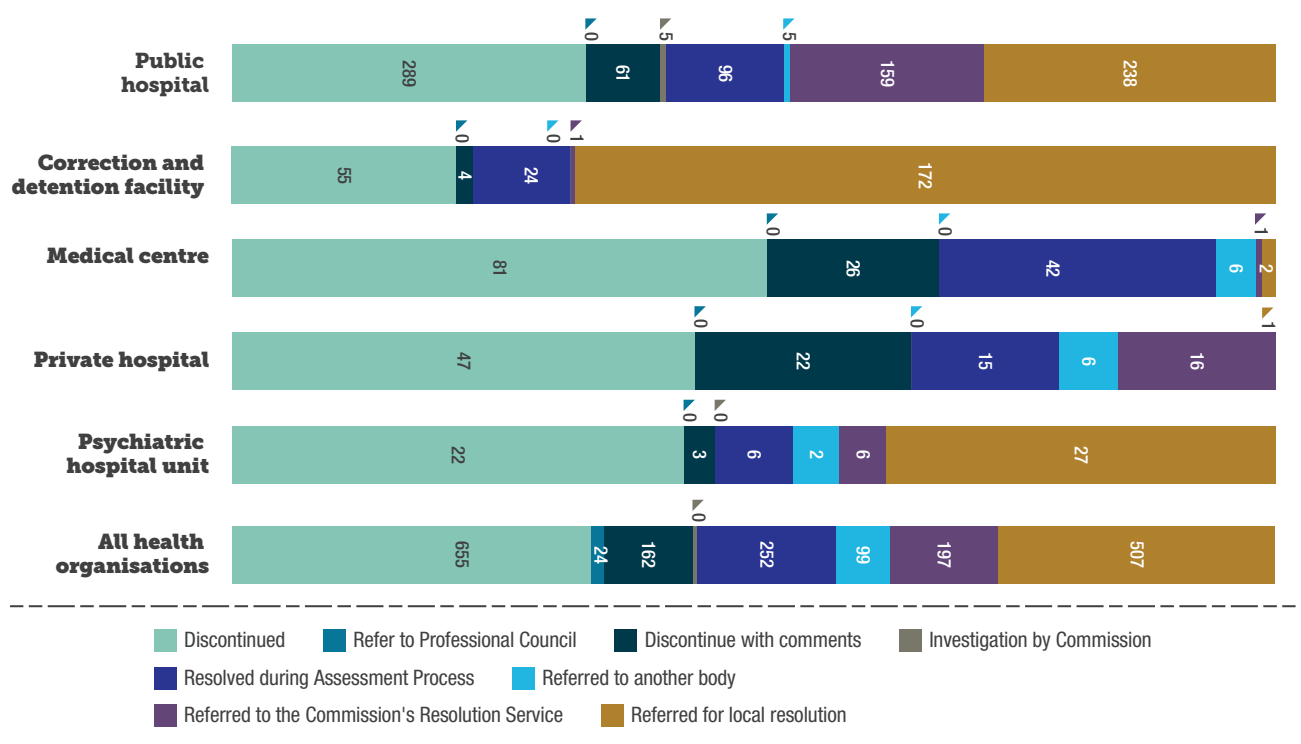
is the highest across all health practitioners by some margin (the next highest is medical practitioners at 9.0%) and is just under twice the proportion for all health practitioners (8.7%). Conversely, pharmacists have the lowest proportion of complaints discontinued across the health professions (14.5%; 2015-16: 17.9%) and around two and half times less than the proportion for all health practitioners (38.1%).

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

Assessment decisions by type of health organisation

Chart 25 below sets out how the Commission dealt with complaints in 2016-17, by the type of health organisation. The chart compares the assessment decisions for each of the top five most complained about types of health organisations to the assessment decisions for all complaints about health organisations.

Chart 25 | Outcome of assessment by health organisation



Counted by provider identified in complaint

In 2016-17 complaints about public hospitals were less likely to be discontinued compared to 2015-16 (33.9%, down from 37.8%). More of these complaints are being referred to local resolution (27.9%) compared to last year (17.0%) and as a result the proportion of complaints about public hospitals referred to the Commission's Resolution Service declined, from 24.1% to 18.6%.

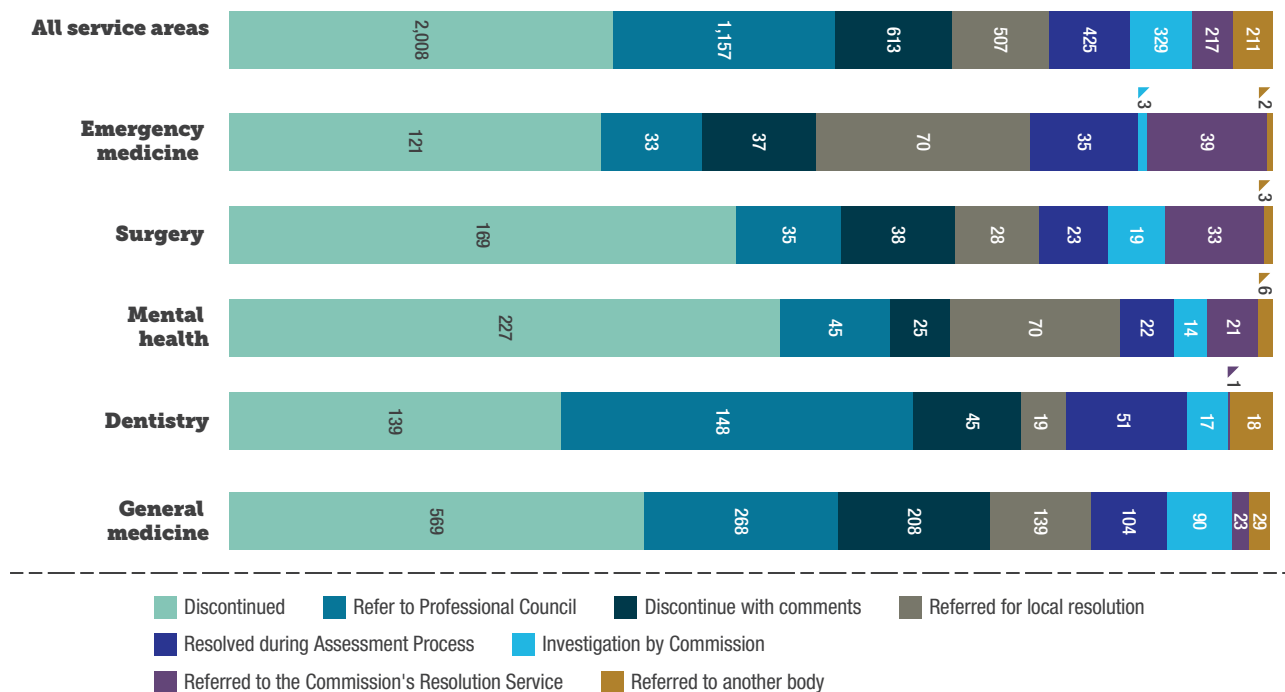
The most likely outcome for complaints about private hospitals is also discontinued (44.3%), followed by discontinued with comments (20.8%). It is noted that local resolution is currently not available as an outcome for complaints about private health facilities and these facilities are typically less inclined to agree to assisted resolution (15.1%). The Commission recognises the need for a concerted effort on working more closely with private health organisations to strengthen their understanding of the Resolution Service as a source of expert advice and assistance in the management of difficult or complex complaints.

Complaints about medical centres were most likely to be discontinued (51.3%; 2015-16: 54.3%). Commission staff are often able to resolve a higher proportion of complaints about medical centres while assessing the complaint, and this was the outcome achieved in over 25% of these complaints. This reflects the type of complaints about these facilities which typically involve a dispute about fees and costs associated with treatment; access to medical records or waiting times, which could be clarified with assistance from the Assessment Officer.

The majority of complaints about correction and detention facilities (67.2%, 2015-16: 71.0%) were referred for local resolution to Justice Health, the provider of health services in most of these facilities. For security reasons, assisted resolution is not commonly used in that context. Local resolution has proved to be an effective outcome in the correctional setting as it provides immediate visibility of the problem for the clinical service providers. Furthermore many of the complaints received related to healthcare policy changes within the corrections system, such as access to the methadone program and non-smoking policies and issues like these are best communicated, explained and addressed directly by the service provider.

The most likely outcome for complaints about psychiatric hospitals in 2016-17 was referral to local resolution (40.9%). This is the first year that the proportion of complaints about psychiatric hospitals referred to local resolution has outstripped the proportion that were discontinued. The data also shows a decline in the proportion of complaints about psychiatric hospitals that were managed by the Commission's Resolution Service. The Commission is reviewing its processes for assessing complaints relating to mental health services, to ensure closer consideration of whether those matters could be more likely to be achieve a better outcome with the support of an independent resolution officer from the Commission's Resolution Service.

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

Chart 26 | Outcome of assessment of complaints by most common service area 2016-17

Counted by provider identified in complaint

Assessment decisions by service area

Chart 26 looks at the assessment decisions for complaints in 2016-17 by the type of health service that was provided. The chart compares the assessment decisions for each of the top five most complained about service areas to the assessment decisions for all service areas.

In 2016-17, a higher proportion of complaints was referred for local resolution for mental health (16.3%; 2015-16: 12.1%) and this issue has been discussed above. The proportion of complaints about mental health that were discontinued remained relatively stable (52.8%; 2015-16: 49.7%). There were fewer matters resolved during assessment in 2016-17 compared to last year as a proportion of all complaints in this service area (5.1% to 8.8%).

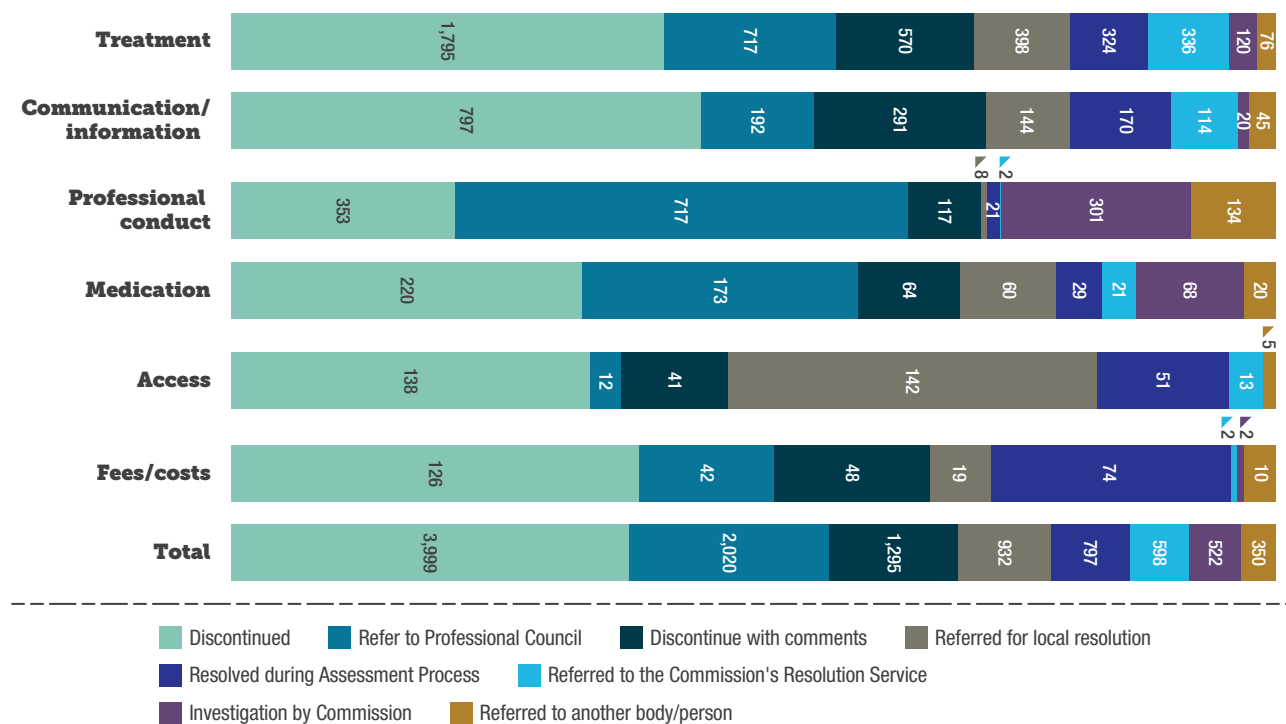
For complaints relating to emergency medicine there was a significant increase in the proportion referred for local resolution in 2016-17 (20.6%; 2015-16: 10.1%) consistent with the overall pattern of referring complaints that can be addressed more quickly and directly at the point of service delivery.

A decline was observed in the proportion of complaints resolved during assessment for emergency medicine (from 17.0% to 10.3%) and general medicine (from 16.6% to 7.3%). As noted above redoubled efforts to resolve these sorts of matters quickly is a key operational priority for 2017-18.

In terms of complaints referred to the Resolution Service, complaints about emergency medicine (11.5%), surgery (9.5%) and mental health (4.9%) were more likely to be referred than complaints about other service areas.

A smaller proportion of complaints relating to dentistry were referred to the relevant professional council for appropriate action (33.8%, 2015-16: 49.6%). It appears that this is due largely to the introduction of the ability to make comments to practitioners where departures are very minor, with this category up 7.8 percentage points. This trend will be monitored.

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

Chart 27 | Outcome of assessment of complaints by issues raised 2016-17

Counted by issues raised in complaint

Assessment decisions by type of issue raised

Chart 27 compares the assessment decisions made by the Commission in 2016-17 by the type of issue raised in the complaint. By comparing the assessment decisions for all complaints, to the assessment decisions for the different types of issues raised the analysis can indicate whether particular assessment decisions are more or less likely to be made, across different issue categories.

Complaints concerning the treatment provided to a patient were less likely to be referred to the Commission's Resolution Service than last year (7.7%, 2015-16: 11.0%) or resolved during assessment (7.5%; 2015-16: 11.3%). A slightly higher proportion of complaints were referred to the professional council (16.5%; 2015-16: 14.2%) and referred to local resolution (9.2%; 2015-16: 6.0%).

This year, the outcomes of matters relating to professional conduct were generally in accord with last year. Where a complaint raises significant issues of public health and safety arising from the treatment or where there appears to be evidence of gross negligence or a significant departure from relevant professional standards, the Commission

investigates the complaint. Where the issues do not reach this threshold, which is set out in s23 of the Health Care Complaints Act, the complaint may be referred to the relevant professional council to take appropriate action. Professional conduct was only slightly less likely to be referred for investigation by the Commission (18.2%, 2015-16: 20.3%) or referred to the relevant professional council (43.4%, 2015-16: 44.3%). Slightly more were likely to be referred to another body (8.1%; 2015-16: 7.3%). The only category of real change was discontinued with comments (7.1%; 2015-16: 3.5%) which reflects the increasing use of this outcome to provide guidance to practitioners in areas such as the importance of maintaining professional boundaries, careful management of sensitive information and improved attitude. The proportion of complaints about professional misconduct that were discontinued was consistent with last year (21.4% compared to 21.0%).

Complaints about communication typically result in lack of understanding or a misunderstanding on the part of the patient or their family about the health service they received. The prompt facilitation of correct and fuller information and provision of scope for an apology by direct interaction with the service provider is the preferred outcome. To this end, the proportion of complaints about communication issues that were referred for local resolution increased to 8.1% compared to 6.7% in 2015-16. There were decreases in the proportion of complaints that were referred to the Commission's Resolution Service (6.4%, 2015-16: 9.1%).

A higher proportion of complaints about access are referred to local resolution (35.3%; 2015-16: 31.4%) with the expectation of a direct and timely response to improving access.

The most likely outcomes for complaints about medication were discontinue (33.6%; 2015-16: 32.7%), followed by referral to a professional council (26.4%; 2015-16: 28.9%).

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

Assessment timeliness

Timeliness remains the key pressure for the Commission. Reduced timeliness is a direct by-product of the cumulative impact of year-on-year increases in the volume and complexity of complaints. The Commission is also heavily dependent on responses from practitioners and health services who are also subject to competing demands.

Further more, where a complaint and the information and records that are gathered relate to complex clinical issues, the Commission ensures that expert clinical advice is received. This is necessary to ensure high quality decisions but it does add time to the process.

The average time taken to assess a complaint is increasing – it is now at 60 days compared to 47 days in 2015-16. For 2016-17, 64.5% of assessments were completed within the 60 day timeframe which is less timely compared to 2015-16 (85.8%).

The Commission records the reasons as to why it is unable to complete its assessment of a complaint within the 60 day statutory timeframe. For 2016-17, in 46.5% of complaints the Commission was waiting for a response from the provider, copies of medical records or further information. In 48.4% of complaints, the assessment team was waiting for specialist or expert medical/nursing advice regarding clinical issues that required expert review.

There is also a decline in timeliness of advising the outcome of a complaint and its reason to complainants and providers within 14 days. The 62.7% compliance with the statutory timeframe in 2016-17 compares with 88.7% in the previous year.

The reduction in timeliness is an undesirable trend and one that requires immediate action. Some additional funding was received for 2016-17 and this allowed two more assessment officers to be recruited and commenced in September/October 2016. As for all new staff, intensive training and development has been required and much of this needs to involve existing staff to promote consistency across assessments. The full year impact of the additional resources is yet to be experienced but should deliver an uplift in 2017-18.

The focus over recent years on additional complaints management staff has been critical to managing increasing complaints volumes, but it is clear that it must be matched by investment that makes our work more efficient. The 2016-17 Business Improvement Project has identified that opportunities lie with improvements to how we do our business. The most significant benefits will arise from automating steps in our complaints handling to eliminate cumbersome administrative steps such as the manual entry of complaints information, manual document scanning and storage, assembling physical files, etc for all complaints received.

Direct access to the details of provider registration details held by the Australian Health Practitioner Regulation Agency was negotiated during 2016-17 and has significantly reduced the time required to commence assessment of complaints.

Significant resources are now being directed to the development of a "beginning to end" electronic complaints management system. This move towards automation will allow the Commission to refocus our scarce resources on the provision of timely and high quality services.

A triage or “risk based” approach towards assessing incoming complaints is also being implemented, ensuring that the most serious or complex complaints are promptly identified and escalated to the correct management pathway. Complaints that are suitable for early resolution or that should be forwarded to the appropriate professional council immediately are also identified through this process, allowing staff in the assessment teams to focus their efforts appropriately and limiting duplication of work.

Work is also continuing on projects to provide a modern, responsive and increasingly user friendly experience for both complainants and providers. The Commission’s Inquiry Service is being reviewed and changes are underway which will improve access to quality information and timely support, including empowering callers to resolve less serious issues that do not necessitate a complaint.

Reviews

Complainants are provided with the opportunity to request a review of the Commission’s assessment decision. The proportion of review requests received is a key measure of quality for the Commission.

For 2016-17, the Commission received 238 requests for a review of an assessment decision. This is far less than

the 307 received in 2015-16 (a decrease of 22.5%). This represents 4.4% of all assessments finalised for 2016-17 and is less than the year end results for 2015-16 (5.3%) and 2014-15 (5.5%). Indeed it is by far the lowest review rate in over a decade, noting that the rate was 11.5 % in 2005-06 and 7.5% in 2010-11.

The Commission continues to be pleased with this positive outcome and it is a tangible reflection of a sustained focus on the quality of decision making and the customer focus for decision letters. Priority continues to be placed on ensuring that decisions are well supported by the evidence and there is also a good understanding of the reasons for decisions by complainants.

Of the reviews completed this year the original decision made by the Commission was confirmed in 89.3% of reviews. This is consistent with the result of 91.2% in 2015-16.

The timeliness of reviews, however, remains an issue. The reviews requested are typically of the more complex and sensitive matters and the reviews have been increasingly tailored to the remaining issues of concern and to thorough reconsideration of all previous material in addition to any new materials. While this is improving the quality of reviews it is more time consuming. Further strategies to improve timeliness are being considered.



Case Study – Facilitating improvements in paediatric care service delivery

Mrs A complained to the Commission that her infant son has an illness that requires him to attend hospital for regular MRI scans. She was concerned that he usually has to fast from early morning and then wait until late in the afternoon to have the procedure. She expressed concern that the protracted fasting is upsetting for her son and the family, as he does not manage well without food given his young age.

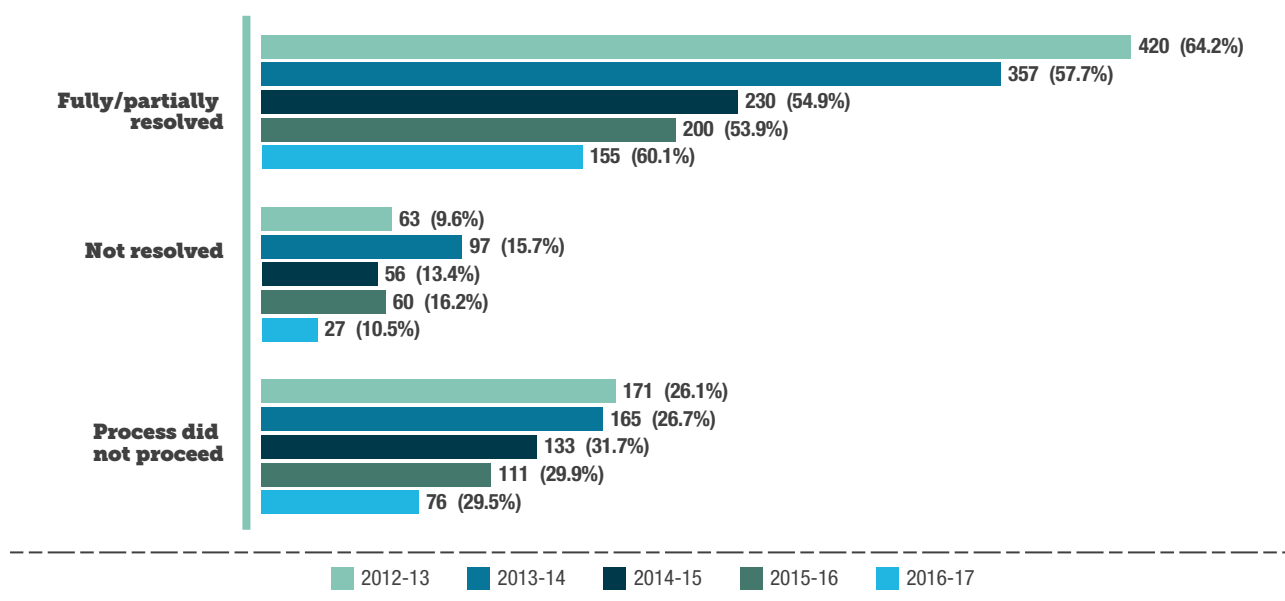
The complaint was referred to the Commission’s Resolution Service.

It was identified that the paediatric MRI list had often been scheduled in the afternoon as result of competing priorities and staff availability. The hospital acknowledged the difficulties experienced by children who have had to spend long periods without food while awaiting procedures. Through negotiation with key stakeholders, arrangements were able to be put in place for the Paediatric MRI list to be moved to a morning session going forward.

Resolution service

Chart 28 shows the outcome of resolution and conciliation processes over the past five years.

Chart 28 | Outcome of resolution processes 2012-13 to 2016-17



Counted by provider identified in complaint

There has been an emphasis on forward planning and priority setting for the Resolution Service within an environment of significant increases in complaints volume and complexity and in the context of significant changes in clinical governance structures and processes across health organisations. This is to ensure that it is well equipped to work on the more complex matters it receives. It is pleasing that positive results have arisen from this focus.

While the total number of matters referred to the Resolution Service has decreased, there has been a marked rise in the number of complaints resolved or partially resolved, with just over three quarters of complaints resolved or partially resolved (85.2%) in 2016-17 once the parties consent to participate.

In 2016-17, 27 complaints (10.5%) were not resolved. Typically the reasons that complaints do not get resolved include irreconcilable disagreements over key facts central to the complaint; an irretrievable breakdown in relations between the parties; and/or one or both parties withdraw from a meeting or the process entirely.

In 2016-17, of all complaints referred to the Resolution Service, nearly one in three (29.5%) did not proceed, which is broadly consistent with the results of previous years. Resolutions do not proceed largely due to one or both parties withdrawing their consent to participate in the process. For example, the complainant determines that the outcome they are seeking cannot be delivered through the process. They may have a change in their personal circumstances, or health or wellbeing issues preclude them from participating.

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

There has been a general improvement in the timeliness of resolutions matters. 34.5% of matters were resolved within four months compared to 33.4% in 2015-16. The number of complaints closed within six months has also improved to 88.8%, as compared with 88.1% in the previous financial year.



Case Study – Resolution focused on continuity of patient care

Dr A wrote a letter of complaint to the Commission explaining she was a general practitioner who had taken over the treatment of a number of patients who had been attending a nearby medical practice that had closed quite suddenly. Dr A was concerned that she, and several other doctors at her practice, had been unsuccessful in obtaining the clinical records from the closed practice and that this would have a negative impact on the patients.

The Resolution Service managed the complaint. It was established that the medical practice had closed quite suddenly as the doctor who owned the practice had been diagnosed with a terminal illness and was unable to continue working. The doctor authorised his adult daughter to communicate with the Commission on his behalf.

The resolution officer obtained a list of the patients who had attended the medical practice of Dr A. Arrangements were made for the records to be provided to Dr A.

The resolution officer also initiated plans for the remainder of the records, in electronic format, to be provided to a nearby medical centre that had compatible computer software. This was to ensure that all of the patient records could be more easily accessed in future so that no additional patients were disadvantaged.

Investigating complaints

The nature and purpose of investigations

The Commission may refer a complaint for investigation where:

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

Investigations may be of individual practitioners (be they registered in one of the 14 registered professions or non-registered) or they may be about a health organisation (which may be one of many different types of organisations – a public or private hospital, pathology service, a general practice medical centre, etc).

In relation to non-registered health practitioners, the Commission investigates complaints when a two-stage test is met. Firstly, the alleged conduct must breach the NSW Code of Conduct for non-registered health practitioner (the Code). Secondly, the conduct of the practitioner may pose a risk to the health or safety of members of the public.

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

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

There are several possible outcomes from an investigation process:

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

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

A complaint may be **referred to the relevant professional council** if a review of all available evidence showed that the alleged care and treatment or misconduct did not meet the threshold for disciplinary action, however, were still of significant concern to warrant further action which was within the professional council's jurisdiction. Complaints may also be **referred to the relevant professional council under section 20A** which is during the course of an investigation, rather than awaiting to the end of an investigation.

Unlike investigations into registered health practitioners, the Commission may decide to impose a **prohibition order** on the non-registered health practitioner. Such an order would be made where the Commission finds that the non-registered health practitioner poses a risk to the public. Prohibition orders may prevent a non-registered health practitioner from providing a health service or specific health services for a period of time or permanently. On rare occasions, **breaches of a prohibition order may be found which are referred to the Commissioner** for the consideration of appropriate action.

The Commission may also cause a public statement to be issued in the form of a **public warning under section 94A** of the *Health Care Complaints Act 1993*. Public warnings are reserved for situations where the Commission is of the view that a particular treatment or health service poses a risk to public health or safety, and cannot be issued about particular practitioners.

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

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

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

In addition to making recommendations, the Commission is also implementing a program of follow up visits to public hospitals, to audit continued compliance with recommendations previously made. Commission audits are carried out by Commission staff and clinicians who

have been trained by the NSW Clinical Excellence Commission. These audits also offer the Commission and LHD staff the opportunity to share ideas around best practice and drive systemic improvements. The Commission's audit reports are provided to the Chief Executive team of the LHD and the Secretary of the Ministry of Health.

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

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

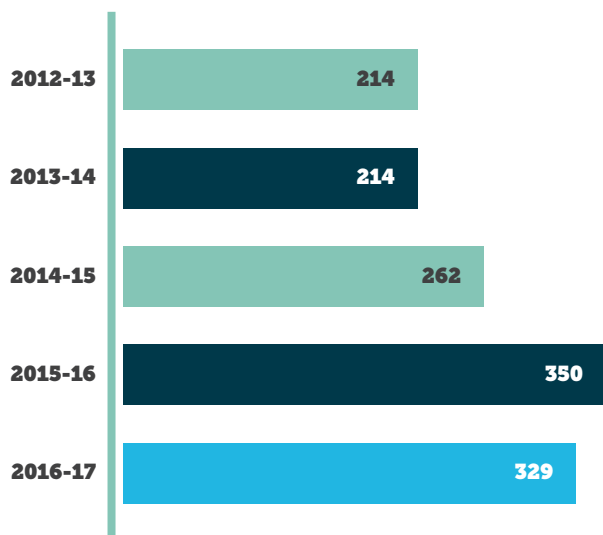
In some instances the **National Board is informed** (eg. where the registered practitioner has retired or removed themselves from the register) so that the matters covered in the investigation can be considered if the practitioner seeks to re-register or change their registration status.

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

Investigations referred

In an environment of continued complexity and demand, the Commission must, more than ever, be innovative and agile in its approach to investigations. Resources will continue to be focused on those investigations that go to the very heart of the integrity of the state's health service, leveraging off the lessons learned from specific incidents and complaints to facilitate improvements to treatment quality, systems and procedures that will benefit all health consumers.

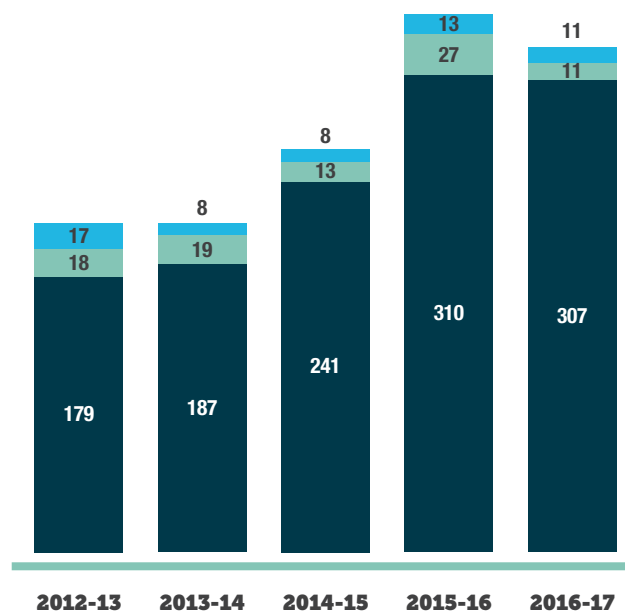
In 2016-17, 329 complaints were referred for investigation. As shown in Chart 29, this represents a minor 6.0% decrease on the 350 complaints referred in 2015-16, but care should be taken in interpreting this decrease or drawing conclusions from it, as the 2015-16 investigation numbers had some known particular drivers. These included the knock on effect of a campaign to tackle infection control in dental practices as well as a small number of very aberrant practitioners generating a large number of complaints and investigations.

Chart 29 | Investigations received 2012-13 to 2016-17

Counted by provider identified in complaint

Chart 30 shows that there are fluctuations over time in the number and proportions of practitioners and services which form the basis of investigations. The 2016-17 investigations data show that:

- Individual registered practitioners remain the most frequent focus of investigations although they are declining as a proportion of all investigations.
- There is a trend towards individual practitioners who generate multiple investigations – 15 individual practitioners generated 85 investigations (25.8% of all complaints referred for investigation) in 2016-17. One individual practitioner alone generated 16 investigations.
- A significant decrease (-59.3%) in investigations about non-registered practitioners, noting, however that the numbers are small in this category, and in the previous year complaints about two practitioners generated a spike which is unlikely to be repeated.
- Complaints relating to one particular private health facility and its practitioners generated 10 investigations.
- There were fewer complaints about dental practitioners within the individual practitioner category – from 26 in 2015-16 to 17 in 2016-17 (a decrease of 34.6%).
- Hospitals referred for investigation remain a very minor proportion of overall investigations.

Chart 30 | Investigations received by health service provider 2012-13 to 2016-17

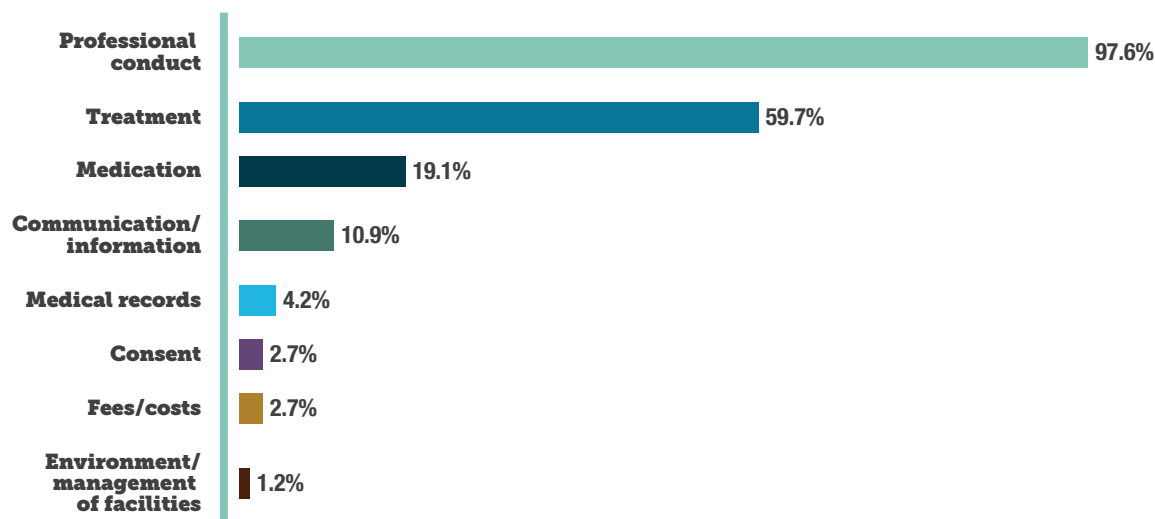
Counted by provider identified in complaint

Issues raised in investigations

Chart 31 outlines the issues raised in all investigations finalised in 2016-17, noting that more than one issue will generally be raised in an investigation.

Nearly all investigations (97.6%) raise professional conduct as an issue, which reflects the fact that professional conduct issues are more serious in nature, and those types of complaints are more likely to be investigated. Treatment is raised in over half of all investigations (59.7%), noting that these treatment issues would be particularly serious and complex, as matters of a more straight forward clinical nature are typically managed by the relevant professional council.

Nearly one in five investigations (19.1%) raise medication as an issue. Other issues such as communication (10.9%), medical records (4.2%) and consent (2.7%) are also raised, which tend to be ancillary elements of the complaint, but may still form a critical part of the complaint. For example, a poor outcome of a medical procedure may also reveal poor record keeping or raise concerns around informed consent.

Chart 31 | Issues raised in investigations finalised

Counted by issue raised in complaint

Investigation outcomes

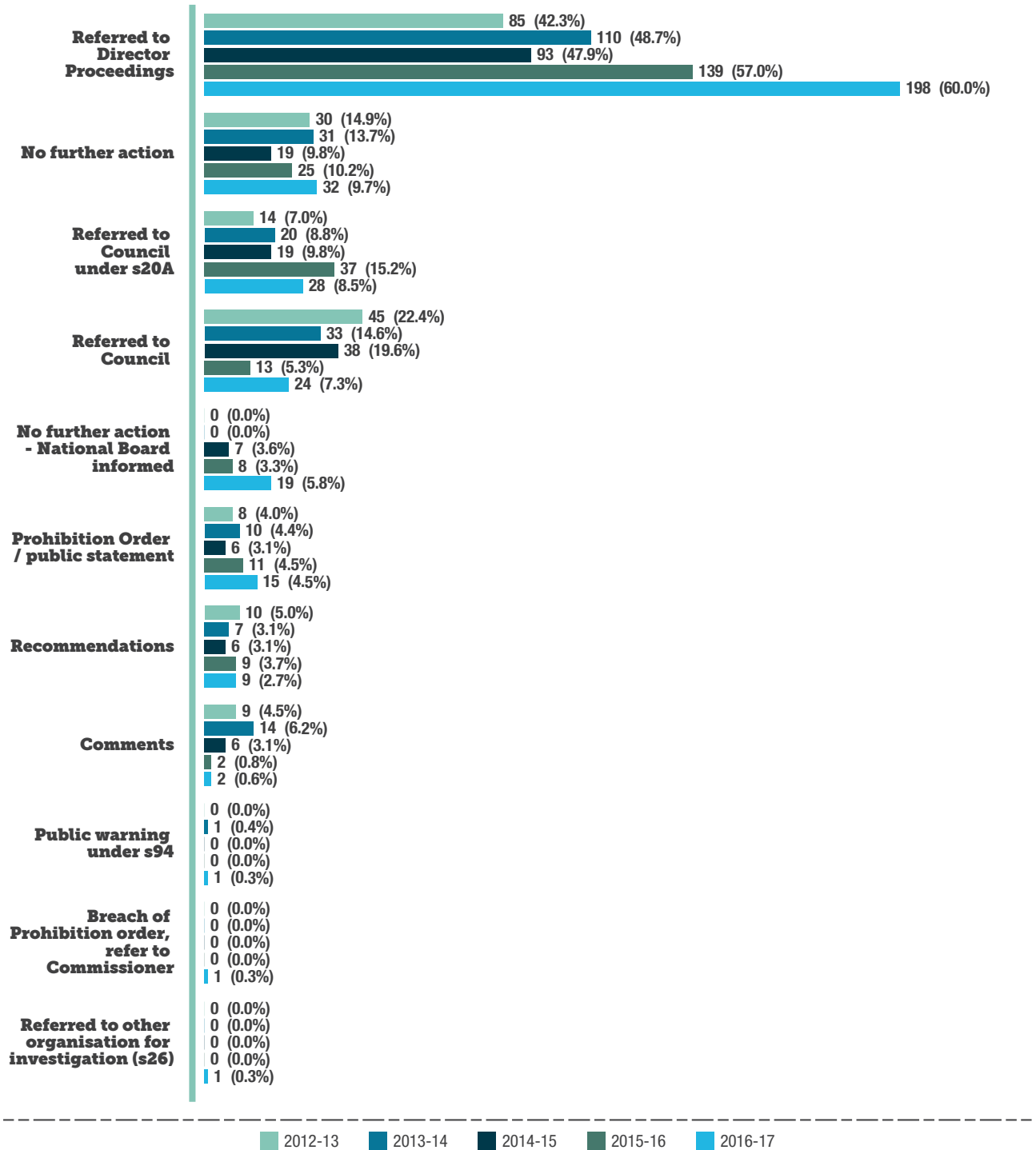
The number of investigations finalised during the year was 330 – a significant 35.2% increase compared to 2015-16.

This increase has been possible as a result of a number of enhancements in our investigation practices – including additional resources allocated to investigations; improved practices in working with other regulatory bodies to conclude common matters effectively; and the continuous improvement in investigative techniques adopted across the dedicated investigation teams.

Chart 32 shows the outcomes for the investigations finalised in 2016-17 compared to the previous four years.

It is important to note that not all investigations reveal serious issues. In 2016-17:

- 15.8% of all investigations finalised by the Commission in 2016-17 were not significantly serious enough to warrant disciplinary proceedings and they were referred to the relevant council for management under their health, performance or conduct processes.
- 9.7% of investigations led to no further action being taken by the Commission, primarily because no allegation in a small number of cases (26 or 8.8%; 2015-16: 9.6%) no further action was taken as the investigation did not generate sufficient evidence to warrant further action could be substantiated.

Chart 32 | Outcomes of investigations into health practitioners and health organisations 2012-13 to 2016-17

Counted by provider identified in complaint



Case Study – Poor infection control posing health risk

The Commission prosecuted a complaint before the New South Wales Civil and Administrative Tribunal ('the Tribunal') against Dr Robert Starkenburg, a dentist practising in Bondi Junction.

The complaint alleged that in 2014, during an inspection by a Dental Council of NSW inspector, Dr Starkenburg had failed to maintain proper infection control at his surgery in numerous respects including by failing to:

- have in place appropriate procedures for surface cleaning and decontamination between patients;
- maintain separate clean and contaminated zones within the treatment room or instrument reprocessing area;
- observe proper standards for the safe transfer of used instruments and materials;
- have adequate cleaning aids or facilities;
- ensure that instruments were sterile at point of use;
- have an ultrasonic cleaner that was appropriately tested or contained appropriate cleaning solution;
- have an autoclave that was tested or calibrated on an annual basis;
- maintain adequate batch control identification or maintain and store instruments in a hygienic manner;
- observe appropriate practice and procedure in relation to hand hygiene;
- maintain and make available appropriate information relating to infection control policies and procedures; and
- had failed to keep proper clinical records.

This complaint arose against a history of similar complaints and concerns about Dr Starkenburg and a failure to correct the deficiencies in his practice. The Tribunal noted that in 2015, the NSW Ministry of Health conducted an inquiry and attempted to make contact with up to 800 of Dr Starkenburg's current and past patients. A public alert was issued and a dedicated telephone hotline established with the Ministry recommending that all of Dr Starkenburg's patients be tested for blood-borne viruses.

The Tribunal also heard that Dr Starkenburg did not routinely take a medical history from patients to identify any health conditions or chronic illness which could place them at risk and that he had told the Dental Council of NSW that he could tell by "the appearance of patients" whether they were in good health.

The Tribunal found that Dr Starkenburg had engaged in professional misconduct and ordered that his registration be cancelled.

Outcome of investigations into registered health practitioners

In 2016-17, there has been a further increase in the proportion of investigations into registered health practitioners that were referred to the Director of Proceedings – 66.7% compared to 63.8% in 2015-16. This follows the significant increase from 2014-15, from 53.4%.

28 investigations were referred to the relevant professional council as a result of reviewing the matter during investigation. In these cases review of all available evidence showed that the alleged misconduct did not meet the threshold for disciplinary action or other factors had removed the perceived risk to public health or safety. Reassessing complaints is in accordance with the Commission's legislative obligation to keep its assessment of a complaint under review, including during an investigation.

The Commission referred 24 complaints (8.1%; 2015-16: 6.0%) to the relevant professional council following investigation and generally after an expert report indicated that any identified departures in skill, knowledge, judgment or care exercised were not significant enough to amount to professional misconduct or unsatisfactory professional conduct. Action by the professional council was seen to be the most appropriate response.

In 19 cases (6.4%; 2015-16: 3.7%), the National Board was informed and no further action was taken by the Commission, typically because the practitioners involved were no longer registered and on the basis that further action would be triggered if at any time in the future re-registration is sought.

Outcome of investigations into non-registered health practitioners

In 2016-17 there were 22 investigations finalised regarding non-registered health practitioners (2015-16: 17). In over two thirds (68.2%) a prohibition order or public statement was made (2015-16: 64.7%). In five cases, there was no further action (2015-16: four) and in one case, corrective comments were made (2015-16: two). One matter concerned a breach of a prohibition order and was referred to the Commissioner for consideration of taking action under the Public Health Act 2010 and it was determined to pursue charges under section 102(3) of the Act in the Local Court.

The practitioner pleaded guilty and was fined \$2,000 and ordered to enter into a good behaviour bond pursuant to section 9 of the Crimes (Sentencing Procedure) Act 1999 (NSW) for two years.

Outcome of investigations into health organisations

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

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

Eleven investigations have related to health organisations (2015-16: nine). Recommendations for improvements to organisational practices and systems were made in nine cases, with only one having no further action. This is broadly consistent with the previous year where of the nine investigations made into health organisations, all resulted in recommendations being made. In 2016-17, the Commission made a total number of 23 recommendations to improve the future provision of services in all of these matters. A public warning was issued as a result of one investigation, concerning non-evidenced based weight loss programs.

The Commission continues to develop its program of auditing compliance with recommendations it has made to health organisations. In 2016-17 the Commission undertook audits of two separate health facilities, Brewarinna District Hospital and Shellharbour Hospital. This is critical work, given the importance of drawing lessons from individual investigations to drive system wide improvements. This improvement was found in both audits, noting the recommendations that had been implemented had continued to be consistently applied in practice, leading to increasing patient care and safety. It was also noted that it had driven wider improvements in the respective Local Health Districts.



Case study – Misrepresentations by a non-registered health practitioner

The Commission received a number of complaints about Sean Kirsten, an unregistered health practitioner practising as a dietitian. Patients of Mr Kirsten included those with cancer, significant eating disorders, and endocrine disorders. Mr Kirsten offered patients a course of treatment which comprised a meal plan and individual consultations, for a considerable fee.

The complaints raised concerns that Mr Kirsten was falsely purporting to have qualifications and extensive experience in the treatment of complex health concerns, which he did not possess.

The Commission's investigation found that Mr Kirsten made false and misleading representations to his prospective and existing patients, including that he:

- is a qualified dietitian, attaining a PhD in the discipline;
- is willing or is able to cure cancer;
- attained a range of bachelor qualifications in nutrition and health science disciplines;
- was employed in a clinical capacity at major Sydney hospitals including in the 'eating disorders units' and 'obesity wards'; and
- was employed as a dietary / nutritional advisor by internationally recognised sporting teams, and reality television shows.

The investigation found no evidence available that Mr Kirsten holds any qualifications, or that he is sufficiently experienced to provide any dietitian or nutritional services. The Commission found that the practitioner's conduct in misrepresenting his qualifications and experience and his treatment of patients, was unethical and breached the Code of Conduct for non-registered health practitioners. It was determined that he posed a risk to the health and safety of the public. The Commission prohibited Mr Kirsten from providing any health services in any discipline for two years, and from providing any dietitian or nutrition services until such time as he gains recognised qualifications.

Investigation timeliness

The average time taken to complete investigations for 2016-17 compared with the previous year did not increase, notwithstanding the significantly higher number of matters finalised. Investigations took an average of 273 days to complete (excluding the time a Commission investigation may be suspended while the complaint is being investigated as part of a coronial inquest or where there are related criminal proceedings). This compares with 275 days in the previous year.

As seen in Table A.32 in Appendix A, the breakdown by timeframe shows a more complicated picture and the need to monitor timelines closely.

On the one hand, a higher proportion of investigations is being completed within three or six months. This is a very positive situation and a reflection of the improvements in investigation planning and triaging. This includes earlier determination of matters where initial evidence gathering shows less serious issues than originally thought (and referral to a professional council is most appropriate) and also matters that can be managed more efficiently by collaborating with regulatory partners (such as NSW Police or the Pharmaceutical Regulation Unit).

On the other hand, many more investigations exceeded a 12 month timeframe. This is largely attributable to a very high level of investigative complexity and significant challenges that are involved in sourcing and commissioning appropriate subject experts on cases that are always serious but also often unusual or novel (e.g. in new frontiers of medicine like compounding pharmaceuticals such as peptides; stem cell therapy; and appearance surgery). Whilst these figures compare unfavourably to the results in previous years, it is noteworthy that a significant number of the most complex investigations ever handled by the Commission were finalised in this period.

Ongoing use of preventative techniques and partnerships

To build on the work that is done in response to individual complaints and to deliver the best outcomes for the community, the Commission continues to use a broad range of strategies to influence systemic improvements in health service delivery. Placing increased emphasis on preventing on consumer exposure to identified risks is also very important.

The Commission works closely with its co-regulatory partners- including the Ministry of Health's Pharmaceutical Regulation Unit and Public Health Units, NSW Police and increasingly national regulators to ensure that operational intelligence is combined to gather evidence which ensures that there is the most efficient, effective and timely approach to protecting the health and safety of the public.

The ability to use public warnings about unsafe treatment or services, under s94A of the Act, is one important feature of this work. The Commission is able to make such warnings during its investigation, in cases where any further delay in issuing the statement poses a risk to an individual or to public health or safety. In 2016-17 such a warning was issued in regard to non-evidence based weight loss programs, which claimed to offer rapid weight loss to its participants without the need for consideration of diet and exercise. The details of the warning issued are explained in the Access and Outreach Chapter. Essentially, the Commission found there was no basis to such programs, and urged those individuals considering programs and products for weight loss to be vigilant in their research prior to proceeding, and to discuss a weight control plan with their GP.

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



Co-ordinated investigation of a health facility

The Commission received multiple complaints concerning a doctor not registered in Australia performing cosmetic procedures at a beauty clinic and that the clinic was using foreign injectable products that were not on the Australian Register of Therapeutic Goods (ARTG).

An investigation was commenced and this was conducted in collaboration with the Pharmaceutical Regulatory Unit (PRU) of the NSW Ministry of Health and a Public Health Unit (PHU). Inspections of the clinic found numerous non-ARTG products such as hyaluronic acid injections.

The Commission's investigation found that the clinic was carrying out skin penetration practices, but was not registered as a skin penetration premises as required under the Public Health Act 2010. The PHU also discovered that the clinic had very unsatisfactory infection control. For instance:

- No autoclave for sterilising reusable skin penetration implements.
- Equipment (tattoo pen) used in connection with skin penetration procedures was not cleaned and dried after use and not kept in a clean condition.
- Reusable articles that may be used to penetrate a person's skin were not sterilised.
- Articles used in skin penetration procedures and manufactured for single use were not disposed of immediately after the procedures in an appropriate sharps container.
- Single use of ink/pigment containers used in cosmetic tattooing were stored with non-sterile products.

The investigation concluded that the clinic lacked management and had poor arrangements for operational accountability. The clinic had failed to understand its regulatory responsibilities and it operated without relevant registration and without adequate infection control. The numerous non-ARTG products found on the premises were reportedly there without the knowledge of the owner.

The Commission made numerous recommendations to the clinic under section 42 of the *Health Care Complaints Act 1993*, with the aim of ensuring full compliance with relevant legislative requirements. The clinic was required to provide the Commission with evidence of existing protocols in use that ensured only ARTG approved products are used and only appropriately Australian registered medical practitioners are responsible for the ordering and prescribing of scheduled medications to clients. Further, the Commission stated that if no such protocols exist, the clinic was to establish these.

The Commission also required the clinic to provide all staff with training in infection control protocols and standards and ensuring their awareness that only ARTG products can be used when providing health services and the health risks associated with using non-ARTG products. Evidence of the content of the training and evidence of the training having been delivered was also required.

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

Prosecuting complaints

The nature and purpose of prosecutions

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

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

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

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

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

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

NCAT can cancel or suspend the registration of a practitioner and may also make a prohibition order that bans or limits the practitioner from practising in another area of health service. For example, a psychiatrist whose registration is cancelled can be banned from working as a counsellor.

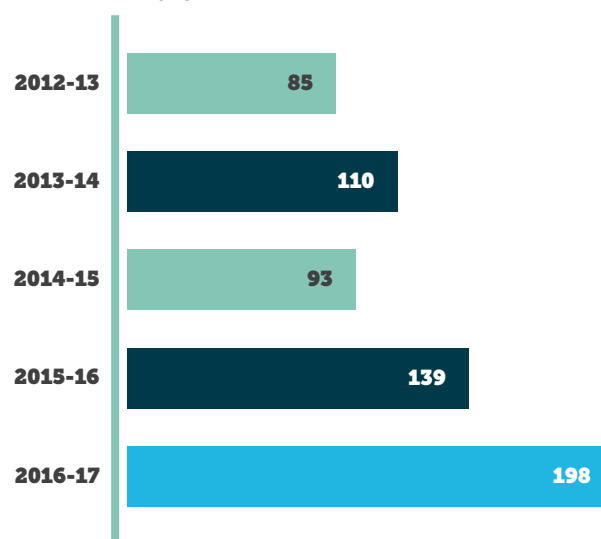
Proceedings can be brought even if the practitioner is no longer registered at the time that the prosecution is brought. Proceedings will also continue even if the practitioner chooses not to attend or to be legally represented.

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

Referrals to the Director of Proceedings

Chart 33 shows that in 2016-17, there was a 42.4% increase in the number of complaints referred following investigation to the Director of Proceedings, from 139 in 2015-16 to 198 in 2016-17.

Chart 33 | Complaints referred to Director of Proceedings 2016-17



Counted by provider

In 2016-17, 66.7% of investigations into registered health practitioners resulted in referral to the Director of Proceedings for consideration of prosecution. This is higher than the result in 2015-16 (63.8%).

During the year, the Director of Proceedings made 103 determinations on whether to prosecute a health practitioner before a disciplinary body. This compares to 140 determinations for the previous year. 89.2% of the determinations made in 2016-17 were considered within three months of the complaint being referred which is lower than 93.5% in 2015-16 primarily due to the volume and complexity of the matters referred to the Director of Proceedings.

Of the complaints referred to a disciplinary body, 76 were referred to the NSW Civil Administration Tribunal (NCAT) and 20 to a Professional Standards Committee.

In seven complaints, the Director of Proceedings decided not to prosecute the health practitioner. The reasons for this included that the practitioner was no longer registered, had previously been prosecuted and there was no reasonable prospect of a successful prosecution.

The percentage of matters referred for prosecution within 30 days of consultation with the relevant professional council rose from 78.9% to 82.5%.

Prosecution outcomes

The number of matters finalised by the Legal Division in 2016-17 was 95, consistent with the previous year (94 in 2015-16). A steady increase has been observed in the number of matters referred to NCAT.

A matter may include multiple complaints against the same health practitioner. As shown in Chart 34, the 95 matters finalised included 55 matters before NCAT, 26 matters before a Professional Standards Committee, nine appeals and other applications, and five review and re-registration matters. The outcomes of these matters are detailed in Table 1.

Pleasingly, the rate of successful prosecutions remains very high. Of all matters that were heard and finalised before NCAT or a Professional Standards Committee, 96.2% were found proved.

Both the Commission and a practitioner may appeal a decision. The number of appeals against decisions has remained consistent over the five year period between 2012-13 to 2016-17, the majority of which were ultimately dismissed or withdrawn. If an appeal is dismissed, the original decision stands.

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

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

Chart 34 | Legal matters finalised 2012-13 to 2016-17

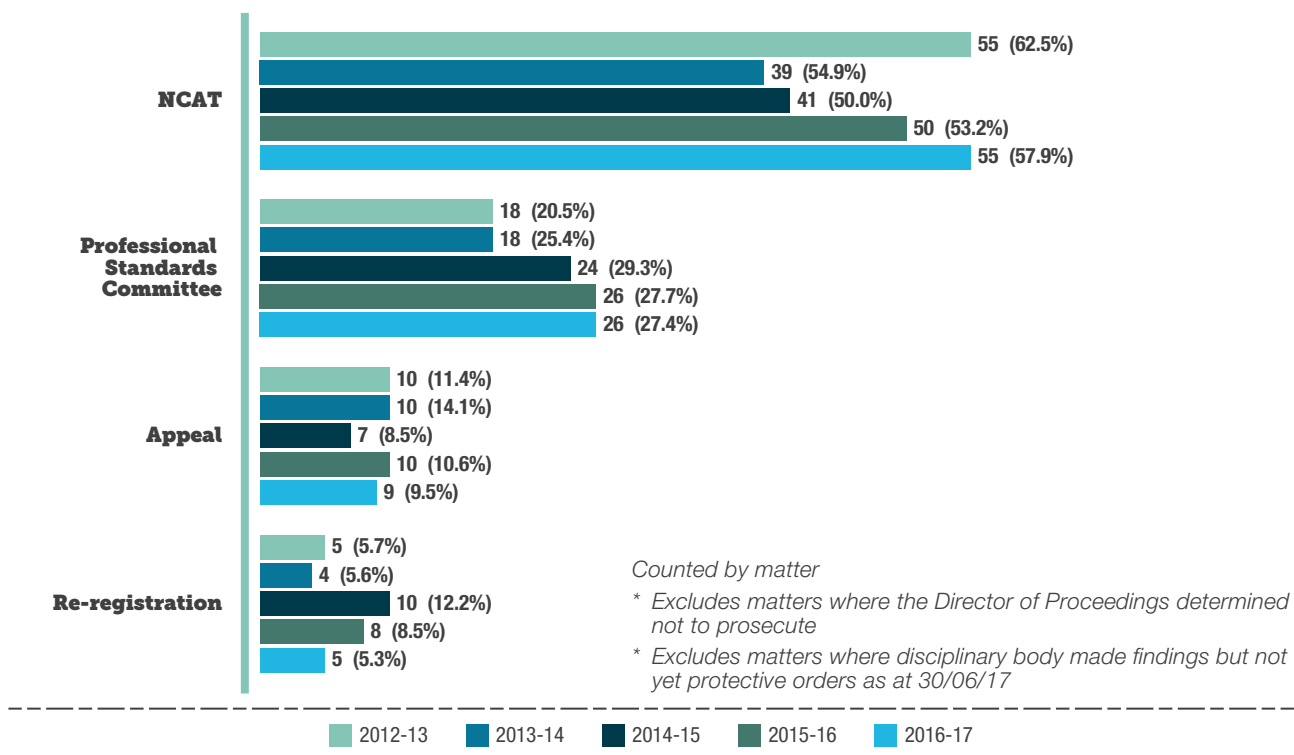


Table 1 | Outcome of disciplinary matters finalised in 2016-17

Forum Name	Orders	No.
Professional Standards Committee		
Medical Professional Standards Committee	Caution, Reprimand and Conditions	2
	Caution	1
	Caution and Conditions	2
	Reprimand and Conditions	7
	Reprimand and Fine	1
	Withdrawn	1
Nursing and Midwifery Professional Standards Committee	Not Proved	2
	Caution and Conditions	1
	Reprimand and Conditions	8
	Reprimand	1
Professional Standards Committee total		26
Tribunal		
NCAT – Chinese Medicine	Conditions	1
NCAT – Chiropractic	Cancellation	1
	Reprimand and Conditions	1
NCAT – Dental	Conditions	1
	Reprimand and Conditions	1
	Cancellation	1
NCAT – Medical	Withdrawn and dismissed	1
	Cancellation	13
	Disqualified	3
	No orders	1
	Reprimand	1
	Reprimand and Conditions	4
	Suspension and Conditions	3
NCAT – Nursing and Midwifery	Cancellation	8
	Conditions	1
	Disqualified	6
NCAT – Pharmacy	Conditions	1
	Reprimand and Conditions	1
	Cancellation	2
NCAT – Psychology	Cancellation	3
	Disqualified	1
Tribunal total		55
Appeals/Applications		
Court of Appeal	Appeal by practitioner – Withdrawn	1
	Appeal by practitioner –	
	Appeal dismissed	1

Forum Name	Orders	No.
High Court of Australia	Application by practitioner – Application struck out	1
Local Court	Application by practitioner – Actioned	1
NCAT – Dental	Application by practitioner – Application dismissed	1
NCAT – Medical	Appeal by Commission – Appeal dismissed	1
NCAT – Osteopathy	Appeal by practitioner – Withdrawn	1
Supreme Court	Appeal by practitioner – Dismissed	1
	Application by practitioner – Dismissed	1
Appeals/Applications total		9
NCAT – Chiropractic	Dismissed	1
NCAT – Nursing and Midwifery	Dismissed	2
	Withdrawn	2
Re-Registrations total		5
Total Legal matters finalised		95

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



Case study – Criminal convictions determining a person unfit to practise

The Commission prosecuted a complaint before the New South Wales Civil and Administrative Tribunal (the Tribunal) against Dr Ong Ming Tan, a psychiatrist who practised at the Northside Clinic in Sydney.

On 6 March 2014 Dr Tan was convicted of four offences of aggravated indecent assault against four of his female patients. Each of the four patients was a young woman who suffered significant psychiatric illness, namely an eating disorder requiring lengthy admissions to a specialist unit in a private psychiatric hospital. Dr Tan had pleaded guilty to the offences and was sentenced to an aggregate term of imprisonment of three years with a non-parole period of two years.

Complaints against Dr Tan were first made in November 2011 and Dr Tan was then suspended by the Medical Council of NSW. The Commission alleged that these convictions rendered Dr Tan unfit to hold registration and that he was not a suitable person to hold registration.

The Tribunal found Dr Tan's behaviour to be predatory and that he had subtly manipulated vulnerable patients, using unorthodox techniques.

The Tribunal also found that Dr Tan suffered from bipolar disorder and an enduring narcissistic personality disorder and rejected that he was suffering from a mental illness of a more transitory nature.

The Tribunal ordered that Dr Tan's registration be cancelled and subject to a non-review period of five years. The Tribunal also ordered that he not be permitted to provide any health service as a non-registered practitioner for the same period.

Access and outreach

Provision of information to the public and working closely with our key partners is critical to gaining and maintaining confidence in the ability of the Commission to carry out its core function of protecting public health and safety. It also supports the integrity of the health system. The Commission achieves this primarily through: being accessible; raising awareness; working with others; and, being responsive to consumers.

Being accessible

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

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

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

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

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

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

Inquiry Service

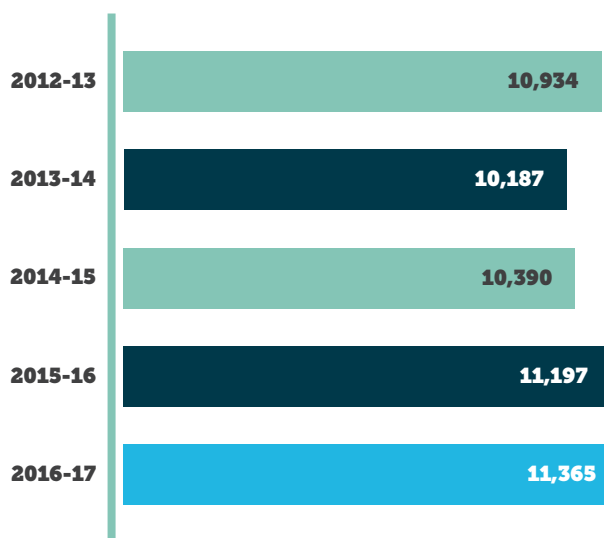
The Commission recognises that navigating the health sector can be a challenge for people, given the extensive services offered, and they may be unsure as to the next step – whether it be seeking additional information, referral to another service provider or whether to lodge a complaint itself. The Commission offers an Inquiry Service which enables health consumers to have direct one-on-one communication in real time. Inquiry Officers are able to provide a range of advice and assistance including:

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

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

As seen in Chart 35, in 2016-17 inquiries to the Commission rose 1.5%, with 11,365 inquiries received. This is a modest growth rate (compared to last year's 7.8% growth) and is in line with historical trends.

Chart 35 | Number of inquiries received from 2012-13 to 2016-17



Counted by inquiry

Method of contacting the Inquiry Service

Telephone access remains the most frequent way in which people access the service, with 90.2% of people contacting the service by phone.

In 2016-17 more people accessed the inquiry service via email, with 526 email inquiries being received (4.6% of inquiries; 2015-16: 3.7%).

Inquiry outcomes

Chart 36 shows that, as with previous years, the provision of information remains the most significant outcome, making up 42.8% (4,846) of the outcomes for callers to the Inquiry Service (2015-16: 5,237, 46.8%).

In 2016-17, there was an increase in assisted referrals with 15.3% (1,730) of inquiries treated this way compared to 11.1% (1,247) in 2015-16. This is a pleasing result as it is the Commission's objective to provide optimal support at the first point of contact, so that consumers are connected with the specific part of the system that can deliver the most appropriate and timely response as quickly as possible. It is also pleasing that the proportion of callers with whom strategies for resolution were discussed rose from 7.7% (866) in 2015-16 to 10.5% (1,189) in 2016-17. Nevertheless this is below the historical trend of around 13%. It highlights the need for continued focus and training on providing advice and support to callers to encourage them to attempt to resolve their concerns directly with the health provider or service and to make assisted referrals where appropriate.

The proportion and number of callers referred to another organisation was largely consistent in 2016-17 (9.4%; 1,062) compared to the previous year (9.7%; 1,089).



Case study – Fast, informed solutions

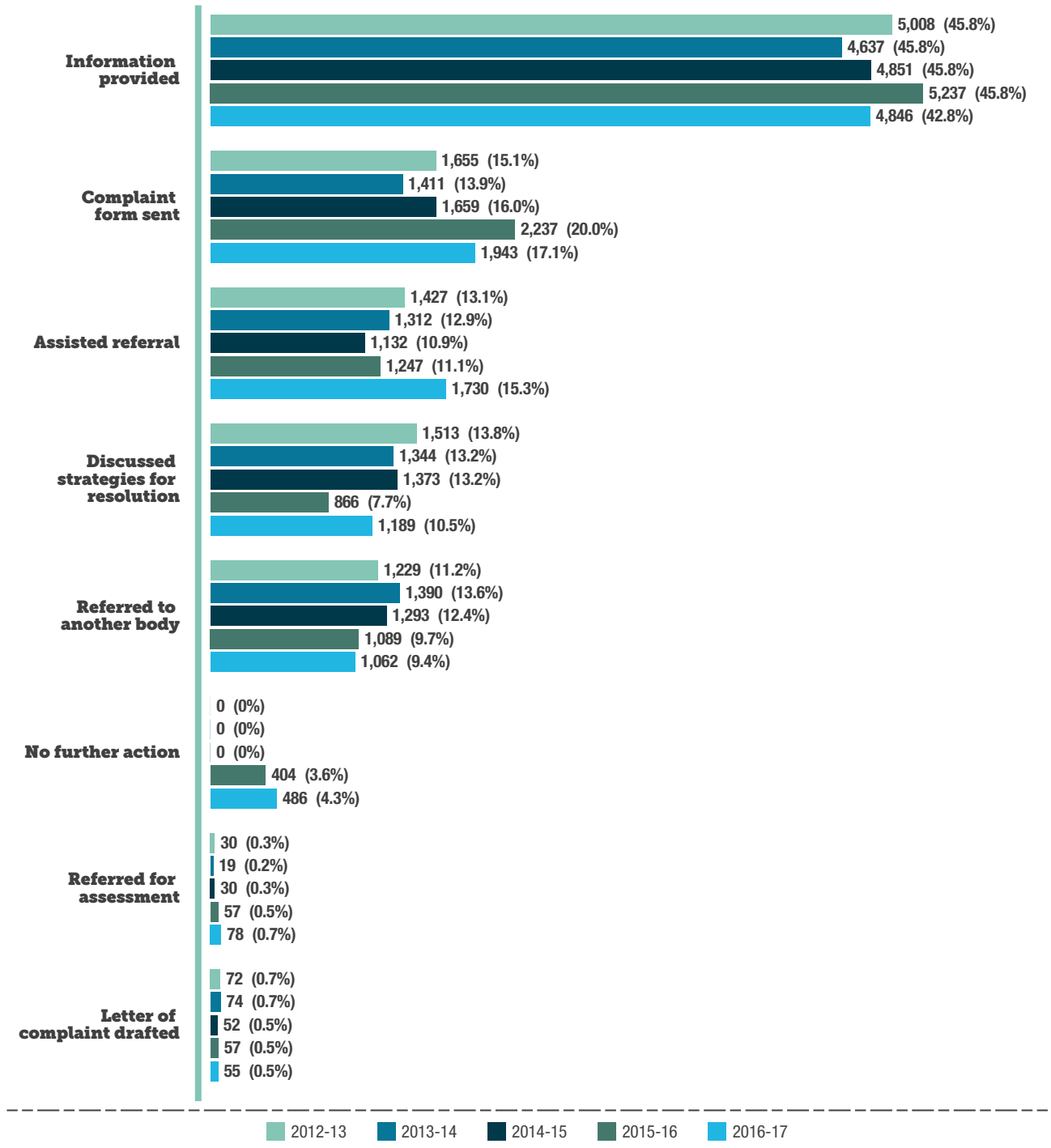
The caller advised that she attended her local GP to ask for her medical files, advising that she wanted them to hand over her records and not maintain a copy. The receptionist refused. The caller then asked for copies of her records, but was allegedly told that this would cost at least \$500. The caller advised of the need for her medical records for Centrelink purposes and would like the Commission to intervene regarding the high cost quoted.

The Commission advised the caller of the legal obligations of providers to maintain copies of records for seven years, but that they are entitled to charge a reasonable fee for providing copies of records.

The Commission phoned the clinic which advised that the cost would be \$1 per sheet plus a \$30 access fee. The receptionist also noted that the patient's records are very extensive and that it would cost \$200-\$300 for her full set of medical records to be provided.

The Commission asked whether the patient could book a billed appointment with the doctor to look at her records and determine exactly what details she needed for Centrelink so she could request only the relevant information, thus reducing her cost. The medical practice agreed.

The caller was happy with the outcome and that the Commission was able to provide a solution so promptly.

Chart 36 | Outcome of inquiries 2012-13 to 2016-17

Counted by inquiry



Case study – Addressing problems immediately

A recently widowed caller rang about her late husband's death certificate. The doctor had incorrectly written on her husband's death certificate that he had a particular medical complaint for 20 years, which was not correct. She had advised the hospital staff but had not received a response.

The Commission phoned the Nursing Unit Manager who acknowledged that the doctor made a mistake on the death certificate. She advised that they would have the certificate amended, arrange for the doctor to phone and apologise, and check up on the patient's wife periodically in her home to make sure she was doing okay.

Ultimately the corrected death certificate was sent with a written apology for the mistake. The patient's wife was understandably displeased that the matter occurred in the first place, but satisfied that the Commission was able to liaise with the hospital and have the matter resolved for her and she was very grateful to the Inquiry Officer.

Raising awareness

Presentations and workshops

Commission staff gave 32 presentations, workshops and information stalls in 2016-17 to health service providers and community groups in NSW. The presentations focused on the Commission's role, functions and the services it provides, together with discussing case studies that demonstrated best practice. The overall number of presentations was the same as last year. This is less than the Commission would generally provide as complaints management and support to individual complainants took precedence in an environment of increasing number and complexity of complaints.

This year, there was a strong focus on working closely with Local Health Districts (LHDs) on best practice in complaints management, to assist in strengthening quick front line responses where problems occur and to ensure effective responses to matters that are referred by the Commission for local resolution. There were 14 presentations and workshops delivered by Commission staff across seven LHDs, including Mid North Coast, Nepean Blue Mountains, Western NSW and Far Western LHDs. This training and development program is continuing in 2017-18.

The Commission continued its outreach program with Aboriginal health services, with a presentation to Aboriginal health workers in Northern NSW LHD.

This year, there were also several presentations to clinicians and executives, including St George Hospital Geriatricians and Multidisciplinary Team and Shoalhaven and District Hospital. There was also participation in an ethics forum for the Australian Psychological Society.

Community outreach included Community Carers in Newcastle, a Homeless Connect expo in Sydney and Probus in Sydney.

Practitioner Education

The Commission continued its commitment to presenting to health practitioner students at TAFE and universities in NSW (including across Sydney, Ballina, Lismore and Gosford). This is part of the Commission's efforts to educate practitioners at the earliest stages of their careers about their mandatory reporting obligations and how to deal with complaints appropriately.

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

The Commission also maintained structured training sessions for expert advisers who assist the Commission's investigations of health service providers and who may be called as expert witnesses in disciplinary proceedings.

Public statements and warnings

Under section 41A of the Act, the Commission may make a public statement that identifies and gives warnings or information about a health practitioner and their health services. Typically these relate to non-registered health practitioners who have had prohibition orders made against them.

In 2015 the Commission was also given a new power under section 94A(1) of the Health Care Complaints Act to issue a public warning about unsafe treatment that is detected during the course of an investigation. Previously the Commission could only issue a warning at the end of an investigation.

In 2016-17 the Commission issued one public warning and five public statements. These are translated into other languages where appropriate and made publicly available on the Commission's website.

The Commission's public warning was in relation to significant concerns it had in relation to the use of non evidence based weight loss programs.

The Commission believed it was important to raise awareness of these programs due to the risk to public health and safety, and urged those individuals seeking to engage in weight loss to be vigilant in their research prior to proceeding. Health consumers were encouraged to discuss a weight control plan with an appropriately qualified practitioner such as their general practitioner or a dietician.



Public warning under section 94A of the Health Care Complaints Act 1993 – Non-evidence Based Weight Loss Programs

In 2016-17 the NSW Health Care Complaints Commission completed its investigation into complaints about services provided by the Medical Weightloss Institute (MWI). While MWI ceased trading on 9 February 2017, the Commission is aware that there are health practitioners formerly associated with the organisation who intend to continue providing the same weight loss protocol previously promoted by MWI and who have approached former clients of MWI to offer the same services under another name.

In 2015 and 2016 MWI advertised widely in print media that it had made a “landmark discovery” of a link between hormones and weight gain, supporting the development of a treatment plan that could: “lower the production of the hormone insulin and cortisol, making it much easier to lose weight”. MWI specifically claimed that thanks to its treatments, which “reset” the hormones to burn stored fat for fuel and help to speed up metabolism, Australians could now lose weight without strenuous exercise or counting calories.

MWI then offered tailor-made weight loss programs devised by a team of “expert weight loss specialists”, based on a client’s medical history and comprehensive blood test analysis.

MWI made a number of claims about what clients would receive if they signed up with MWI. It advertised that they knew as much about medical weight loss as medical practitioners and cautioned potential clients that while there was

“nothing wrong” with talking to their GPs about the treatment protocol, “they don’t know what we know” and speaking to them first might therefore be “fraught with danger”.

The Commission considers that the claim by MWI – to have developed a “medical treatment for weight loss” based on resetting “unbalanced” hormones with supplements and prescription medication – lacks an adequate clinical basis to substantiate its efficacy and safety. Furthermore, MWI targeted a particularly vulnerable group of health care consumers with its claimed discovery of a successful formula for weight loss that is not available to other medical practitioners. MWI has actively discouraged this vulnerable cohort from seeking advice and approval of the proposed weight loss program from their GP’s, thereby putting their health and safety at risk and potentially delaying their access to more appropriate and evidence-based treatment.

The Commission’s investigation found that the services provided by MWI did not accord with their claims about what clients would receive. The investigation also found that the medication prescribed by MWI doctors was sent to clients in the mail by a compounding pharmacy without the provision of counselling and other relevant medicine information required to facilitate the safe and effective use of the compounded product.

In March 2017 the Commission issued a public warning under section 94A of its Act. MWI’s claim that it has developed a fast and easy weight loss protocol involving the correction of hormonal imbalance with tailor made prescription medication regimes is not evidence-based. The organisation is considered to have made extravagant claims not borne out by the weight of clinical research in this area. The use of initial blood testing to tailor-make the weight loss protocol is clinically spurious and designed to give an appearance of medical authenticity. In practice, the organisation’s

doctors wrote prescriptions for combinations of complementary and prescription medications without seeing or examining clients in person and a compounding pharmacy mailed the medication without the required accompanying information to ensure safety and effectiveness. A particularly vulnerable cohort of health consumers was convinced to part with large sums of money for pharmaceutical preparations that may have serious contraindications and side effects and for which there is no credible evidence of efficacy for weight loss.

The Commission urges those individuals considering programs and products for weight loss to be vigilant in their research prior to proceeding. They should discuss a weight control plan with their GP. Most can offer weight loss and healthy lifestyle advice and refer to a dietitian. Many specialise in weight loss.

The Commission recommends to consumers that they:

- be very careful about advertised claims of effortless, rapid and sustainable weight loss and offers for medicines, supplements or other products that promise to achieve this.
- find out what evidence is used to support these claims and do not rely only on testimonials from people who have used the program or products.
- always inform their doctor of any non-prescription or other prescribed products they may be considering for weight loss before signing up or taking them, so that their doctor can help assess the safety and efficacy of doing so.

Media

The Commission continued to respond to media inquiries, and provide information where possible, noting s99A of the *Health Care Complaints Act 1993* which heavily restricts the disclosure of information relating to complaints. These media inquiries predominantly related to health professionals that the Commission had prosecuted before the NSW Civil and Administrative Tribunal, or complaints under investigation.

The Commission also published 73 media releases which related to decisions of disciplinary bodies, as required under its legislation. These releases are published on the Commission's home page and subscribers to its media release mailing list are automatically notified of each new media release.

Brochure distribution

The Commission continued to have its key brochures "Concerned About Your Health Care?" and "Resolve Concerns About Your Health Care" distributed across medical practices and facilities in NSW. The content of these brochures was reviewed in 2016-17 with some minor amendments identified and made.



Public Statement (extract): Ms Nadia Abraham

The NSW Health Care Complaints Commission conducted an investigation into the conduct of Nadia Abraham, a non-registered health practitioner providing counselling services in Coffs Harbour.

The investigation found that Ms Abraham did not ensure that a suitable period of time had elapsed before commencing a close personal and then sexual relationship with a client to whom she provided counselling services in 2012. The client sought counselling to assist with issues of grief, anxiety and depression following the recent and traumatic death of his partner.

The investigation also found that Ms Abraham did not possess adequate counselling qualifications and that this contributed in large part to her ongoing failure to appreciate that the responsibility for maintaining professional boundaries with her client was hers and remained hers, even after the end of the therapeutic relationship.

The Commission considered that Ms Abraham posed a risk to the health and safety of the public.

The Commission therefore made the following prohibition order:

Nadia Abraham is prohibited from providing any counselling or psychotherapy services on a paid or voluntary basis for a period of 2 years from the date of this decision, that is, from 8 December 2016.

Before returning to the provision of counselling or psychotherapy services, Nadia Abraham must provide evidence to satisfy the Commission that:

- she has completed and been awarded level 5 qualifications in a counselling course from an institution that is accredited under the Australian Qualifications Framework (AQF); and
- the counselling course completed to attain level 5 qualifications included an ethics component.

Working together

Within NSW

When dealing with complaints, the Commission regularly consults and collaborates with the various professional councils, registration bodies, the Ministry of Health and the Local Health Districts (LHDs) on broader strategic and system wide issues.

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

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

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

The Commissioner and senior staff continued their schedule of visits to all LHDs which had commenced in 2015-16. This provided the opportunity to understand the continuing improvements to governance and patient safety that are occurring under the National Safety and Quality Framework; discuss the LHD's complaints trends and their performance comparative to other LHDs and/or regions; and, to identify areas where the Commission's processes and interactions with them could be improved.

As noted last year, the Commission has discussed with LHDs that it would be valuable for there to be an "end-to-end" picture of the complaints process where complaints are referred on, as this would assist in understanding the experience of the complainant and the eventual outcome of the complaint from the consumer perspective. During 2016-17 a feedback mechanism was established and going forward, this feedback will be used to guide continuous improvements to the complaints management process.

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

Interjurisdictional collaboration

The Commission participates in a range of national and interjurisdictional fora to ensure that it is involved in decision-making related to the health complaints management environment and development of professional standards, and also that appropriate operational partnerships and information sharing arrangements are in place.

This includes:

- The national working group on the development of a National Code of Conduct for non-registered health practitioners. NSW already has a state Code of Conduct for these practitioners and continues to play a significant advisory role on this issue.
- In May 2017 the Commissioner hosted the National Health Commissioners' conference in Sydney, which is an important forum for considering complaint trends nationally, identifying strategies for improved complaints management, and discussing matters that cross jurisdictional boundaries.
- The Commissioner is also a member of the Medical Board of Australia's Consultative Committee on revalidation for medical practitioners.
- Representing state based health complaints entities on the national Consumer Health Regulators Group which consists of regulators with an interest in consumer health across Australia. This Group is currently chaired by the Australian Competition and Consumer Commission (ACCC), other members include the Australian Health Practitioner Regulation Agency (who work in partnership with 14 National Boards in the National Registration and Accreditation Scheme), the Private Health Insurance Ombudsman and the Therapeutic Goods Administration. The Department of Health participates in the Group as an observer. Group members come together to exchange information, including about emerging issues of interest or concern, and to ensure responsibilities and functions of each regulator within

the consumer health industry are understood and consistently applied. While Group members have regularly shared information and met on a bilateral or multilateral basis in the past, the Group was formally established in April 2017 to facilitate even greater collaboration in the public interest. The Group meets quarterly, or otherwise as needed.

Consumer responsiveness

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

The Commission has now established a new position, Director Customer Engagement and Resolution, so that the experiences of those who submit complaints, those who are the subject of complaints and those against whom complaints are made are clearly understood and that their experiences shape the way we do business.

Consumer Consultative Committee

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

In 2015-16 a review of the Committee was undertaken. The members of the Committee and the Commission have identified the need to revitalise the approach to consumer engagement so that there is the opportunity for a wider range of participants in the engagement process and identification of a new and innovative techniques for hearing from consumers and adopting more responsive business practices as a result.

In October 2016 a workshop was held amongst members to discuss what this may look like in practice. It was agreed that a good model would be to move to topic based and with additional attendees based on interests in the topics. Depending on topics, a forum should be held every six months or thereabouts.

Complaints about the Commission

In 2016-17, the Commission received three formal complaints about its staff. All complaints concerned staff contact with people who had made a complaint and the management of their complaints. Following investigation, two complaints resulted in counselling about measures required to improve professional behaviour. In one complaint, the temporary contract of the staff member was terminated.

Complaints to the Ombudsman

The NSW Ombudsman has advised that in 2016-17, it received 20 complaints about the Commission. This is one less than the previous year.

Complaints to the Ombudsman generally related to alleged failures to respond to people and delays in managing their complaints, decisions made by the Commission, and disputes over expert judgment.

Of those complaints received:

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

In addition to the 20 complaints in 2016-17, the Ombudsman recorded 62 inquiries about the Commission.

Privacy

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

In 2016-17, the Commission received one request for internal review under the same Act. It concerned an allegation of disclosure of private information to third parties. The Commission conducted a review of the alleged conduct and found it to have occurred. All of the complainant's requests were met in terms of remediation, including a formal apology, an acknowledgement of the distress it had caused and confirmation that the disclosed information had been destroyed by the third parties.

Complainant and provider feedback

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

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

The rate of response from complainants was 7.8%. Of these, 81.3% stated they were satisfied with the Commission's service. The rate of response from health service providers was 11.5% – of these 66.7% stated they were satisfied with the Commission's service.

With the establishment of the new Director Customer Engagement and Resolution, there will be renewed focus on securing and utilising feedback, not just from the parties to complaints, but also from other key stakeholders.

The *Health Care Complaints Act* entitles complainants to a review of Commission decisions in relation to the assessment and investigation of complaints. The number and outcomes of reviews have been outlined in the Chapter, Assessing and Resolving Complaints.

Research projects

A five-part research project comparing complaint handling in NSW to other Australian jurisdictions, was completed in 2016-17. This project was run by the University of Sydney in cooperation with the Commission, the Australian Health Practitioner Regulation Agency, the national boards, the NSW Health Professional Councils Authority. A summary of the project and its findings is on page 71.

The research highlights that there is a need for more concerted effort to fully understand and respond to the issues raised in complaints and to demonstrate how the work on individual complaints drives improvement in the system. Through the increased focus on data analysis and on customer engagement the Commission is taking the lessons from this research to improve our work.

In addition, the Commission continues to provide advice and statistical data to smaller research projects on request.



Your feedback

"On behalf of my sister, my wife and myself we would like to take this opportunity to put on record our sincere gratitude in the way [Assessment Officer] handled the initial investigation into my father's death. Her approach was genuine, understanding and sympathetic. We appreciate everything that has been done to date to help us understand how and why my father passed away in the manner he did." – **complainant feedback**

"A great thank you to [Resolution Officer] for her work on this case. She was excellent to deal with, very informative, caring, compassionate and understanding whilst maintaining extreme professionalism. She gave me time that no one else would and she persevered for a mutual happy and positive outcome."

– **complainant feedback**

"I wish to thank everyone involved with making sure that care of the elderly is as important as anyone in the community."

– **complainant feedback**

"I was very happy with the [Resolution Officer] that was there with us in talking to the Hospital. I did get some answers. Thank you."

– **complainant feedback**

"I was very happy with the assistance received during the complaint process, however I found it quite overwhelming receiving the complaint notice by e-mail without any other contact. I would have also liked to have received a notification that my response had been received once it was submitted." – **provider feedback**

"Thank you for the opportunity to respond to [the] complaint against my reporting practices. I am appreciative that my honest comprehensive description of events and communications were taken into account by the HCCC in its assessment of this case. I am pleased with the outcome of the HCCC's assessment."

– **provider feedback**

Australian Research Council Grant:

Comparison of complaints handling in NSW to other Australian jurisdictions

In 2016-17 the Commission continued its support of a five-part research project comparing complaints handling in NSW to other Australian jurisdictions. The project was run by the University of Sydney in cooperation with the Commission, the NSW Health Professional Councils Authority, the Australian Health Practitioner Regulation Agency (AHPRA) and the national boards. The Commission provided feedback on draft papers and participated in stakeholder meetings.

PROJECT CONTEXT:

Health practitioners in Australia are registered under the National Registration and Accreditation scheme (NRAS), under which 14 groups of health practitioners are each governed by a National Registration Board. The National Boards for each profession are administered by the Australian Health Practitioner Regulation Agency (AHPRA).

Health care complaints are managed in Australia under two distinct models. In the first, National Boards are responsible for developing and monitoring processes for registration, accreditation and professional standards. They are also accountable for the management of notifications and complaints about practitioners. Notifications that are made can be managed by the National Board or the states based complaints entity. Referral protocols apply to both.

The second model applies in NSW and Queensland and it takes a co-regulatory approach. Complaints regarding practitioner conduct, performance or health issues are handled by a state based independent regulator in conjunction with the relevant professional Council. In NSW, the Health Care Complaints Commission (HCCC) is responsible for the investigation and prosecution of complaints after consultation with the appropriate professional council.

The project aimed to:

- Analyse the different processes of health practitioner complaint handling, including investigation and disciplinary procedures in NSW and nationally through AHPRA.
- Provide advice on best practices in complaint handling in relation to the receipt, assessment, method for resolution and outcomes.

- Establish which system offers the most effective and efficient system for managing complaints involving health professionals.
- Ascertain complainants' perceptions and experiences of the processes in the two complaint notification systems.

PROJECT CONCLUSIONS

The project looked at complaints data nationally. Of the five practitioner groups most complained about (medical practitioners, nurses and midwives, dentists, psychologist and pharmacists) roughly 1.5% of practitioners had a complaint made about them each year. Approximately half of those complaints concerned a medical practitioner. Five percent of doctors and dentists received a complaint against them each year, with fewer than two percent of psychologists, pharmacists and nurses/midwives being the subject of complaints. The most common complaints concerned clinical care, medication, practitioner health impairment, communication and documentation.

Despite legislative differences, the complaints handling processes under both the NSW and national systems were found to be quite similar. The most substantial difference was that NSW was more likely to order counselling of practitioners whereas under the national system, practitioners were more likely to receive a caution. The term "investigation" also differed, where in NSW it refers to formal investigations in serious matters. Similarly, there were no significant differences noted between the schemes in the decision making processes that took place during the management or investigation of a complaint, and applied similar considerations.

Consumer experience with the complaint handling process was also explored, and again, no clear differences were identified. Members of the public consistently reported levels of dissatisfaction with complaint outcomes. Complainants stated that they wished to report practitioner behaviour that was incorrect, unfair or unsafe, often to prevent others from having similar experiences. Many felt that the issues raised in complaints were not addressed to their satisfaction, or they did not agree with the outcome of the complaint, particularly decisions that were perceived to be insufficient or fail to lead to obvious improvement. This suggests that a lack of clarity remains regarding what "protecting the public" means in practical or operational terms.

Organisation and governance

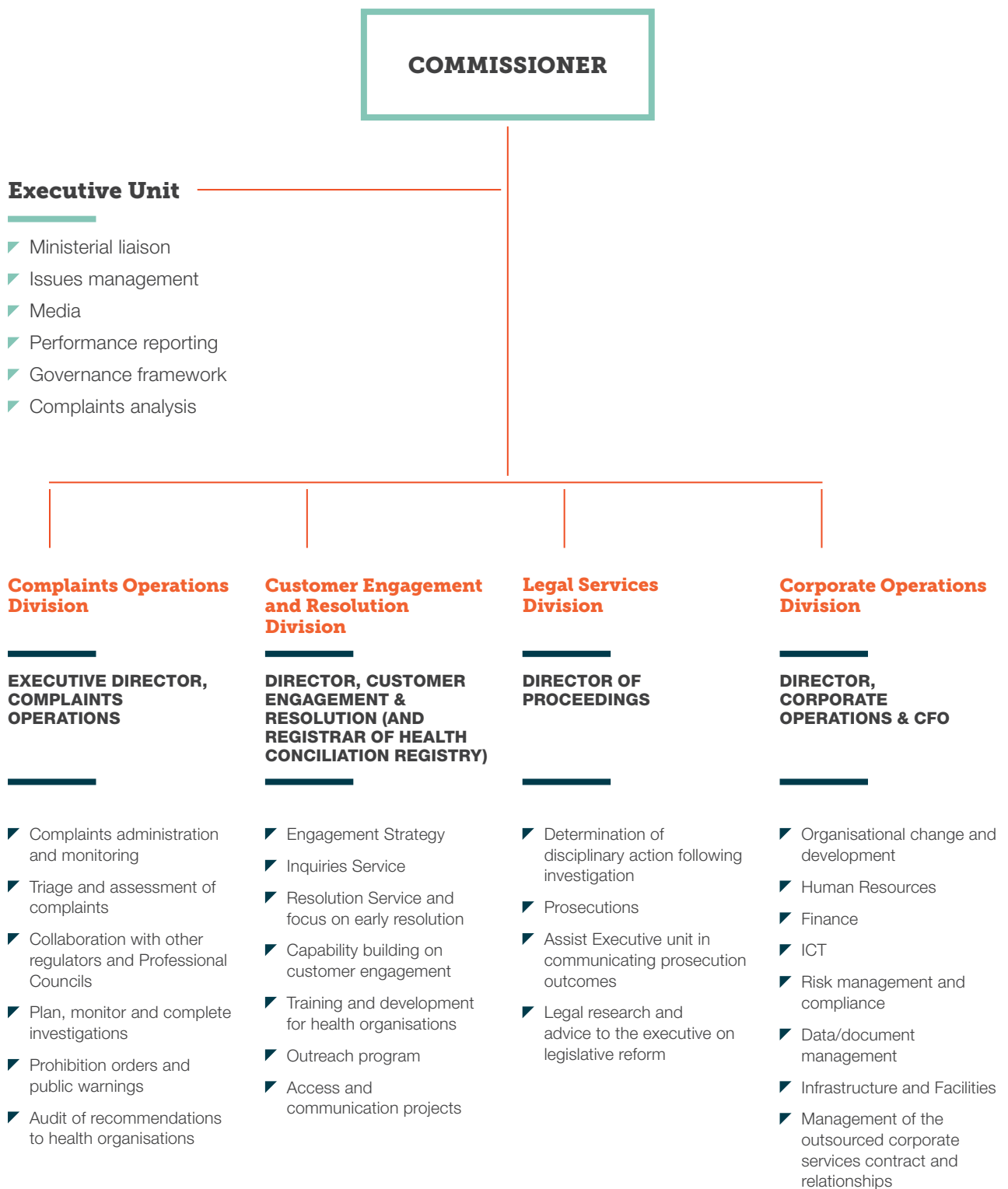
Corporate structure

During 2016-17 the Commission considered the need to adapt its structure in response to the imperatives to:

- Ensure that assessment functions are arranged in a way that responds to the need for effective triaging of complaints, stronger focus on early resolution of complaints; appropriate use of internal medical advice and, monitoring of complaints performance;
- Maintain effective investigation capability;
- Be more customer focused;
- Use data more actively and effectively.

The changes are reflected in Chart 34 and take effect from July 2017. The core elements of the functional arrangements are:

- A complaints analysis capability has been established within the Executive Unit.
- The assessment and investigation functions have been integrated into a Complaints Operations Division. The purpose of this is to foster improved sharing of capability and expertise throughout all steps in managing complaints. Where a matter is serious, it is imperative that the assessment process is focused and disciplined and the information gathered must address the key issues and be to a high standard. This would provide a strong platform to progress any subsequent investigation in a timely and effective way.
- Renewed emphasis on the needs and experiences of customers through establishment of a dedicated Customer Engagement and Resolution Division. This will strengthen the focus on building customer responsiveness and access into everything that the Commission does as well as highlighting the Commission's expertise and commitment to complaints resolution.
- Legal policy and procedural advice is provided through the Legal Services Division and prosecution decisions are undertaken by the independent Director of Proceedings. This Division ensures that the Commission is taking strong disciplinary action where this is required and also using the experiences from individual cases to inform legal policy decision making and regulatory reform.
- Corporate functions are consolidated and given a stronger business improvement emphasis through the formation of the Corporate Operations Division. This Division will be driving the delivery of systems reforms that will be fundamental to streamlining our processes and making a successful transition to automated complaints management, as well as focusing on capability building and financial strength.

Chart 34 | Organisation Structure

Commission staff

The Commission employed a total of 95 full and part time staff as at 30 June 2017.

Table 2 | Staff numbers by employment category 2013-14 to 2016-17 (as at 30 June 2017)

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

Table 3 | Average full-time equivalent staffing 2013-14 to 2016-17

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

Staff changes

In 2016-17 16 employees resigned and 16 took leave, took on other career changes or completed contracts as follows: two employees left for 12 months maternity leave, one employee retired, one employee went on leave without pay, two employees were seconded to other agencies, five employees permanently transferred to another agency, and five ended fixed term contracts.

Conditions of employment and movement in salaries and allowances

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

Employees under the Crown Employee (Public Service Conditions of Employment) Award received a 2.5% increase in salary and related allowances from the first full pay period in July 2017. The Commission employs medical advisers who are employed under the Crown Employees (Health Care Complaints Commission) Medical Advisers Award and they received a 2.5% annual increase from October 2016.

The Statutory and Other Officers Remuneration Tribunal (SOORT) determined a performance-based increase of 2.5% for the Commissioner and other Public Service Senior Executives in August 2016.

Public Service Senior Executives

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

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

In 2016-17 and during the development of the new structure, the Commission had two transitional roles, making a total of six Public Service Senior Executives:

- Commissioner, Senior Executive Band 3 – Sue Dawson, Bachelor of Laws (Hons 1) (LLB), Master of Urban Planning, Bachelor of Social Work (Hons 1), Executive Fellow, Australia New Zealand School of Government
- Director of Proceedings, Senior Executive Band 1 – Karen Mobbs, Bachelor of Arts (BA) and Bachelor of Laws (LLB)
- Director of Investigations, Senior Executive Band 1 – Tony Kofkin, Bachelor of Arts (BA), former Detective Chief Inspector at Kent Police (UK)
- Director of Assessment and Resolution, Senior Executive Band 1 – Ian Thurgood, Certificate in Orthopaedic Nursing, Certificate of General Nursing, accredited mediator – July to December 2016.
- Celia Murphy, Bachelor of Applied Science (Exercise and Sport Science), Postgraduate Diploma in Health Administration and Legal Profession Admission Board. Acting Director, Business Improvement – October 2016 – January 2017. This temporary role was established to dedicate a senior executive to conduct end-to-end review of the complaints management processes and identification of actions that could be taken to streamline and improve the processes. Ms Murphy also acted in the role of Director, Assessments and Resolution from January 2017 to July 2017.
- Acting Director, Organisational Development (temporary position) – Michael Doran, Bachelor of Science (Hons) Psychology and Master of Science (Organisation Psychology). This temporary role managed the transition to a new corporate services provider and delivered functions performed by the previous Director, Corporate Services, Independent Commission Against Corruption, Andrew Koureas (who was a sitting member on the Executive from 1 July to 1 September 2016, reflecting the shared corporate services agreement that was in place between the Commission and ICAC until 1 September).

10.7% of the Commission's employee related expenditure in 2016-17 was related to senior executives, compared with the 11.2% in 2015-16.

Table 4 | Senior Executive as at 30 June 2017

Band	2016		2017	
	Female	Male	Female	Male
Band 3 (Commissioner)	1	0	1	0
Band 1 (Directors)	1	2	2	2*
Totals	2	2	3	2

* One temporary

Table 5 | Remuneration of Senior Executives as at 30 June 2017

Band	Range \$	Average remuneration	
		2016	2017
Band 3 (Commissioner)	328,901 – 463,550	\$336,525	\$369,000
Band 1 (Directors)	183,300 – 261,450	\$214,167	\$223,149

Personnel policies and practices

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

The Commission has a number of policies and procedures regarding conditions of employment, work health and safety, equity, security and other operational requirements.

The Commission commenced a process of review and consolidation of the personnel policies in the Compliance Monitoring Register in 2016-17. This process involves consolidation of the unwieldy suite of 38 policies into a set of 18 policies which give clearer guidance on HR policies, procedures and entitlements and to ensure application of all policies. The policy review project is continuing in 2017-18.

Performance management

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

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

Staff development and training

All employees had personal development discussions and plans set as part of their Annual Performance Agreements. The key development themes across these plans have been identified and addressed.

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

This included continuation of the commitment to making resilience training available for all Commission staff, so that they are well equipped work in a sustainable and constructive way with aggrieved, distressed, angry or abusive clients and in working with a wide range of health consumers. Staff feedback is that the training was well planned and the interactive exercises gave them an opportunity to hone their skills in handling the more emotionally demanding side of complainant interactions.

Table 6 | Training offered and attendees

Course name	Number of attendees
People Management Program	16
Managing Sexual Assault Complaints	14
Child Sexual Abuse Dynamics	6
Trauma Informed Practice and Managing the "Cost of Caring" to Promote Helper Resilience training	18
Resilience Refresher	5
Casemate training	34
Casemate refresher training	65
Other training and conferences	152

An Executive Coaching Program was delivered by WhyteCo. The program was designed to support executive members and some managers to build the leadership, project management, delegation and communication skills required to ensure good performance. It was delivered over six months and included a 360 assessment of “the leadership circle”, 6x 90 minute coaching sessions, development of individual development plans with the coach and 2x 3-way meetings between the individual, their coach and their line manager.

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

In addition to formal training the Commission also offered a range of other opportunities for the development of employees. These included delivery of masterclasses on aspects of complaints handling, regular IT training, performing higher duties, leadership or participation in projects, mentoring and coaching, and cross Divisional information sharing and teaching.

Employee engagement and staff wellbeing

The 2016 People Matter Employee provided information on employee experiences and perceptions and guided identification of actions required to improve the engagement, inclusion and support of staff.

The Commission developed a culture plan in response which included a number of priority measures in four key areas:

- ensure mutual respect and integrity
- build leadership/manager capability
- reduce stress and workload
- communication and transparency.

Employee assistance program

The Commission has an established Employee Assistance Program (EAP) and during 2016-17 OPTUM provided free confidential and professional counselling in relation to any work-related or personal concerns of an employee or their immediate family members.

The Commission also reviewed its needs consistent with the commitment to effectively supporting employees who are exposed to challenging complaints situations and following some feedback received about OPTUM. Following the review and evaluation of the current and other potential EAP providers, the Commission has engaged Davidson Trahaire Corpsych as the EAP provider for 2017-18.

Flexible work arrangements

Commission offers flexible work arrangements to allow its employees to balance their work with other commitments, including caring for children or elderly parents. In 2016-17, 10 staff had flexible work agreements, including part-time work, parental leave without pay and working from home.

Grievance Officer

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

Staying healthy

Every year, the Commission offers free influenza vaccinations for staff. In 2016-17, 33 staff elected to have the vaccination. Staff can also participate in lunch hour on-site Pilates classes, at their own expense.

Industrial relations and the Workplace Consultative Committee

The divisional directors, nominated staff and the Public Service Association of NSW meet quarterly as members of the Workplace Consultative Committee to discuss issues relating to the conditions of employment and entitlements of staff, including recruitment, training, work health and safety (WHS) matters, and any new policies.

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

There was one industrial dispute involving the Commission in 2016-17, relating to unfair dismissal.

Multicultural Policies and Services Program

The Commission upholds the NSW Government's principles of multiculturalism as defined in the *Multiculturalism Act 2010* as it relates to employees and clients from culturally and linguistically diverse backgrounds. The Commission has a Multicultural Policies and Services Plan which is actively applied through governance and management practices.

The Commission's key information resources are available in 20 different languages on its website and through the NSW Multicultural Health Communication Service.

Additionally, the Commission has employees accredited to receive the Community Language Allowance Scheme (CLAS) and can provide frontline client interpreting services. When required, the Commission engages additional accredited interpreters to assist clients throughout the complaints process – through either Multicultural NSW or NSW Multicultural Health.

The Commission has focused outreach services to specific stakeholder groups which included people from culturally and linguistically diverse backgrounds. Employees gave presentations to a variety of community groups. These included Homeless Connect and Community Carers.

Other outreach activities have been held with Aboriginal health workers who are integral to ensuring appropriate services are provided to Aboriginal patients. The Commission also presented workshops with Aboriginal health employees in the public health system.

Disability Action Plan

The Commission's Disability Action Plan 2014-19 aims to ensure an accessible workplace for people living with disabilities and to eliminate discriminatory practices. The Commission has an online induction program which includes a section on disability and equal access. Other actions undertaken to meet the Disability Action Plan objectives include:

- Workplace assessments to identify potential issues for employees with disabilities
- Workplace adjustments to support employees with disabilities
- An external provider to prepare and coordinate return to work plans for employees with work related injuries and/or temporary disabilities
- Providing ergonomic equipment for workplace adjustments for employees.
- Accessible parking space at the Commission's office for visitors.

Workplace Diversity Plan

The Commission has a Workforce Diversity Plan, which with its Disability Action Plan and Multicultural Policies and Services Program, guide the Commission to meet NSW government's workplace diversity benchmarks.

All employees within the Commission have undertaken mandatory induction training to ensure they understand the Commission's Code of Conduct, its policies on workplace diversity, anti-discrimination and prevention of bullying and harassment.

The Commission regularly reviews its policies and initiatives to achieve its workplace diversity program goals, and the five year Workplace Diversity Plan (2014-19) outlines the Commission's responsibility under Section 63 of the Government Sector Employment Act 2013 and demonstrates the Commission's commitment to achieving the key outcomes of:

- A diverse and skilled workforce
- A workplace culture displaying fair practices and behaviour
- Improved employment access.

The following tables show trends in representation and distribution of diverse employee groups:

Table 7 | Trends in the Representation of Workforce Diversity Groups

Workforce Diversity Group	Benchmark/Target	2015	2016	2017
Women	50%	77.5%	79.1%	76.9%
Aboriginal People and Torres Strait Islanders	2.6%	2.5%	1.2%	1.1%
People whose First Language Spoken as a Child was not English	19.0%	12.8%	14.6%	13.3%
People with a Disability	N/A	6.4%	4.8%	6.5%
People with a Disability Requiring Work-Related Adjustment	1.5%	2.6%	2.4%	4.3%

Table 8 | Trends in the Distribution of Workforce Diversity Groups

Workforce Diversity Group	Benchmark/Target	2015	2016	2017
Women	100	N/A	N/A	N/A
Aboriginal People and Torres Strait Islanders	100	N/A	N/A	N/A
People whose First Language Spoken as a Child was not English	100	N/A	N/A	N/A
People with a Disability	100	N/A	N/A	N/A
People with a Disability Requiring Work-Related Adjustment	100	N/A	N/A	N/A

Note 1: A Distribution Index of 100 indicates that the centre of the distribution of the Workforce Diversity group across salary levels is equivalent to that of other staff. Values less than 100 mean that the Workforce Diversity 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. In some cases the index may be more than 100, indicating that the Workforce Diversity group is less concentrated at lower salary levels.

Note 2: The Distribution Index is not calculated where Workforce Diversity group or non-Workforce Diversity group numbers are less than 20.

Work Health and Safety (WHS) Plan

The Commission's Work Health and Safety (WHS) Plan provides a safe and secure environment for employees and clients. Strategies include:

- An accredited rehabilitation provider to assess individual workplaces and ensure appropriate equipment, modifications and adjustments are provided for employees specific needs and ensure their wellbeing at work
- Ergonomic assessments of workstations for new employees and providing assessments for any employee requests. Workstations for new employees are reviewed in the first two months or earlier of their commencement.
- Accredited rehabilitation provider conducts working from home assessments when required.

The Commission also:

- conducts quarterly workplace inspections to identify and assess potential and/or actual hazards
- provides online work health and safety training for new employees
- recruits Work Health and Safety Officers and first aid officers
- provides first aid recertification courses for first aid officers as required.

As previously mentioned, each year the Commission offers free influenza vaccinations to all employees, with 33 employees choosing to take up this offer in 2016-17.

The WHS Committee meets quarterly to review WHS policies and practices, and to resolve safety issues and reported hazards.

Work group negotiations commenced in June 2016 between the Commission and a Public Service Association (PSA) delegate. The agreed outcome was that there is one work group at the Commission to represent all staff and nominations would commence for two Health and Safety Representatives (HSR), to be appointed at the start of 2017-18.

There was one notification of injury in 2016-17 at the Commission, which remained as a notification only and did not result in a new claim. The injury occurred offsite in the carpark and resulted in minor injuries.

Legislative change

During 2016-17 there were no legislative changes that affected the operating environment of the Commission. This is largely due to the fact that the *Health Practitioner National Law (NSW) Amendment Review Act 2016* passed on 9 March 2016 and came into effect on 1 July 2016. These changes were outlined in the previous year's Annual Report.

It is anticipated that there will be several miscellaneous amendments to the *Health Care Complaints Act 1993* in 2017-18, and this will include implementation of arrangements for the registration of paramedics.

The Commission continued to be represented by the Director of Proceedings on the NSW Civil and Administrative Tribunal Liaison Group which is chaired by the President of NCAT and meets bi-annually. Representatives from the Legal Division also participate in periodic NCAT Occupational Division user group forums.

Table 9 | Work health and safety incidents, injuries and claims 2014-15 to 2016-17

	2014-15	2015-16	2016-17
Number of new claims	1	0	0
Number of workers compensation claims accepted	1	0	0
Fall trip slip outside workplace	0	0	1
Work practice / set up related	0	0	0
Total injuries	1	0	1

Governance

Governance structures

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

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

The Investigation Review Group (IRG) – made up of the Commissioner, Executive Director, Complaints Operations, the two Investigation Managers, the Legal Officer and the Executive Officer – closely monitors the progress of investigations. All investigations identified as carrying significant risk to public health and safety were reviewed. In addition, the progress of all investigations that involved unexpected and catastrophic health outcomes for complainants and all investigations into non registered practitioners were reviewed and resources were allocated to ensure effective outcomes.

The ICT Steering Committee has met every two months as planned to manage the Commission's ICT requirements and to decide on strategic ICT issues. It also oversaw the engagement of auditors to review the Commission's core business process case management system (Casemate).

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

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

Staff Workplace Consultative Committee is made up of the divisional directors, nominated staff and the Public Service Association of NSW. The Committee meets quarterly to discuss issues relating to the conditions of employment and entitlements of staff, including recruitment, training, WHS matters, and any new policies.

Each division has monthly or more frequent employee meetings to discuss operational pressures and priorities, identify and address team performance, and continue a focus on strengthening culture and engagement.

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

Risk management and insurance activities

The Commission reviewed its business risks as part of the corporate planning process. The Commission's Risk Register and Risk Policy were subsequently amended to reflect revised assessment, evaluation and treatment of risks.

The Commission has also reviewed its Business Continuity Plans and ICT Disaster Recovery Plan. An external review of the Commission's Risk Management Framework and policy was also undertaken.

The NSW Treasury Managed Fund provides the Commission with insurance cover for workers compensation, motor vehicles, public liability, property and other items. Workers compensation insurance is provided by QBE Ltd, with GIO General Ltd providing insurance for the remaining categories.

Workers compensation premiums decreased by \$12,138 (30.2%) from the previous year, due to a reduction in estimated claims, and the remaining insurance categories also decreased, by \$4,672 (44%) due to a reduction in the car fleet.

Internal Audit and Risk Management Statement Attestation Statement for the 2016-2017 Financial Year for the Health Care Complaints Commission

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

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

Membership

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

- Independent Chair – Ms Claudia Bels appointed from 1 February 2013 to 31 January 2016 and initially as independent member, extended to 31 August 2016. Reappointed as Independent Chair to 31 August 2020.
- Independent Member – Mr Ray Petty appointed from 1 September 2012 to 31 August 2015, extended to 31 August 2016 as independent chair. Reappointed as independent member to 31 August 2020.
- Independent Member – Mr Norman Smith appointed from 18 May 2016 to 17 May 2018.
- Non Independent Member – Mr Tony Kofkin, Executive Director, Complaint Operations



Sue Dawson
Commissioner
Health Care Complaints Commission

20 September 2017

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

Audit Committee and internal audit

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

The internal auditors conducted a major audit of the Commission's case management system, Casemate which was concluded in November 2016. A number of opportunities for improvement were identified which can broadly be categorised into system/ enhancements to Casemate and business process improvements to identify manual processes that could be automated. These recommendations now form the basis for a number of strategic projects to improve the efficiency of inquiry and complaint handling.

A comprehensive three-year Internal Audit Plan that covers the period to June 2020 has been developed and this is reviewed, amended and reported upon to the Audit and Risk Committee.

The Commission received the formal Independent Auditors report from the NSW Auditor General on 20 September 2017.

Public interest disclosures

The *Public Interest Disclosures Act 1994* requires the Commission to report public interest disclosures made to it.

The Commission has a public interest disclosure policy that encourages and guides staff to report potential wrongdoing. The Commission reports that in 2016-17:

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

Government information

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

In relation to its complaint-handling functions, the Commission is exempt from the *Government Information (Public Access) Act 2010*.

During the year, the Commission received 14 applications for the release of documents under the Act. All of these were applications for documents that related to the Commission's complaint-handling functions and were therefore invalid applications. The tables in Appendix F confirm that no valid applications were received in 2016-17 as required under the Act.

Compliance with the NSW Carers (Recognition) Act 2010

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

The Act requires public sector agencies to:

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

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

The Commission report on compliance is:

- **Education strategies:** Staff at the Commission are expected to comply with the Commission's Code of Conduct, which is covered in staff induction training. The Commission's Code reflects the core principles and values outlined in the Carers Charter around integrity, diversity and service. Specific awareness of the Carers Charter is planned in 2017-18 through placement of promotional material around the Commission office, and raising it in internal meetings.
- **Consultation and liaison with carers:** Policies that were reviewed and updated in 2016-17, such as Fraud and Corruption Prevention; Preventing Bullying and Harassment; and Resolving Unsatisfactory Performance, were internally focused and largely did not directly affect carers.
- **Staff carer support:** As outlined earlier, Commission staff have access to flexible working arrangements under its Policy of the same name. These arrangements support those staff who are carers, particularly for young children, dependents living with a disability and elderly parents. This Policy is currently under review and will consider any opportunities to improve this support.

It is also noted that the Commission's EAPs services are available to staff and their partners and family members.

Information and communications technology

The Information and Communications Technology (ICT) Strategic Plan 2014–17 outlined relevant emerging technologies that offered the potential to improve the Commission's operational efficiency.

Actions taken under this plan in 2016-17 are detailed below.

ICT infrastructure upgrade project

During this period the ICT unit:

- introduced improvements to backup procedures
- conducted a feasibility analysis of migrating its ICT data centre to the Government Data Centre (GovDC) site at Silverwater
- successfully implemented a secure link to the GovDC site at Silverwater to enable and facilitate the secure provision of HR and Finance related outsourced transactional services and GovConnect support services
- replaced the Commission's ageing security card and perimeter security system with a more modern and reliable version
- improved security in the Reception area by installing a CCTV system.

Digital Information Security Policy

Following the implementation of the Digital Information Security Policy (DISP) last year to meet the NSW Government's digital information security requirements for the public sector, ongoing monitoring was performed throughout the year to ensure the new security classifications were being used correctly and staff awareness programs were provided to new staff.

Enhancements to the case management system

In 2016-17 the Commission has focused on improving the way staff handle complaints with an emphasis on KPIs, by harnessing new technologies and implementing improvements to systems to deliver productivity benefits to the Commission's operations. Its core case management system (Casemate) has undergone ongoing development to provide staff with new or enhanced features to assist them with the handling of increased workloads.

These improvements include:

- the introduction of an electronic signature feature that significantly reduces reliance on paper records creation, by reducing the need for manual tasks normally required by staff including printing, copying, scanning etc.
- a new feature that allows the collation of numerous documents into one primary document for use in investigation and legal briefs. This can then be stored independently from other documents and securely distributed.
- an automated self-service capability. This is the first stage where ICT process automation meets business process automation. Staff can choose reports from a list and initiate process execution themselves, without having to involve someone from ICT operations.
- electronic monitoring which provides a staff task list that gives staff regular feedback of work performance, and enables them to take corrective action when necessary. It also satisfies the worker's need for self-evaluation and reduces performance uncertainty by specifying upcoming tasks and deadlines that need to be achieved.
- advanced management reporting capabilities such as:
 - the ability to receive monthly reports about complaints that are older than 60 days and drill down into individual cases
 - caseload management report which provides Assessment Officers with information about where cases are up to, in terms of the stage of the process and the number of days where they are under 60 days.
- improved system functionality reflecting divisional requirements, in particular the Commission's Business Process Review for the Assessments & Resolution division. This is an ongoing project.
- improved system stability and performance.

The Commission also arranged an internal audit by KPMG to:

- review change management over configuration and functional changes to Casemate
- identify the current and future requirements of the Commission
- perform a comparison of the functionality currently available within Casemate against functionality required by key users and stakeholders, and
- perform a market scan in order to identify possible alternative systems.

The recommendations following this audit were:

- Recruit an additional application developer to support Casemate
- Conduct an end to end process efficiency review of the Commission's complaints management process, and
- Conduct an RFP for to evaluate alternate case management systems.

These recommendations were agreed to and are continuing to be implemented.

Records management

In 2016-17, the Commission undertook a number of records-related projects, including:

- the ongoing identification and preparation of records for future transfer to the State Archives.
- digitising approximately 4,000 paper-based case files, which significantly reduced offsite storage costs of paper files.

Internet and intranet website enhancements

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

The Commission commenced a comprehensive review and update of its intranet site, in consultation with a reference group consisting of nominated staff throughout the Commission. This project will continue during 2017-18.

ISO27001 Standard for Information Security

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

The last independent annual external audit was successfully completed in November 2016. During this audit, the Commission gained a three year certification to the ISO 27001:2013 Standard and has continued maintaining its Information Security Management System (ISMS). The ISMS is a systematic approach to managing sensitive company information so that it remains secure. It includes people, processes and ICT systems by applying a specific risk management process. The next surveillance audit is due in November 2017.

Other technologies

Further to Casemate, technology enabling improvements have also included:

- establishment of a direct link to AHPRA's case management system for quick retrieval of current practitioner information. This removes the multiple days previously absorbed where staff requested and were manually provided with required information
- the ability to remotely access work systems supporting a more flexible workforce which allows staff to work smarter and be more productive
- the provision of data extracts to staff which improve the quantity and quality of statistical data available to staff for analytical and reporting purposes
- better reporting tools – enabling reports can be generated as/when required and sent to recipients electronically at designated intervals.

Digital Information Security Annual Attestation Statement for the 2016-17 Financial Year for the Health Care Complaints Commission

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

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

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

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



Sue Dawson

Commissioner

Health Care Complaints Commission

Finance

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Preamble

The Commission's Net Result before capital was a deficit of \$113,000 which was \$31,000 higher than budgeted. The result was primarily due to higher than budgeted contractor costs associated with the transition to a new corporate services provider and special projects associated with business improvement.

Payment Performance Indicators

Aged analysis at end of each quarter 2016-17

	Current (i.e.) within due date	Less than 30 days overdue	Between 30 and 60 days overdue	Between 60 and 90 days overdue	More than 90 days overdue
Quarter	\$'000	\$'000	\$'000	\$'000	\$'000
All suppliers					
September	1,155	12	–	–	–
December	832	363	17	32	5
March	589	178	41	4	16
June	1,020	109	5	6	6
Small business suppliers					
September	17	–	–	–	–
December	8	–	–	–	–
March	3	–	–	–	–
June	6	–	–	–	–

Accounts due or paid within each quarter				
Measure	September	December	March	June
All suppliers				
Number of accounts due for payment	678	448	367	462
Number of accounts paid on time	505	365	274	409
Actual percentage of accounts due for payment	74.48%	81.47%	74.66%	88.53%
Dollar amount of accounts due for payment	1,452,966	1,212,003	698,087	1,059,434
Dollar amount of accounts paid on time	1,270,426	1,000,858	546,353	1,000,720
Actual percentage of accounts paid on time (based on \$)	87.44%	82.58%	78.26%	94.46%
Number of payments for interest on overdue accounts	—	—	—	—
Interest paid on overdue accounts	—	—	—	—
Small business suppliers				
Number of accounts due for payment	22	20	18	24
Number of accounts paid on time	22	20	18	24
Actual percentage of accounts due for payment	100%	100%	100%	100%
Dollar amount of accounts due for payment	68,544	78,944	18,862	47,003
Dollar amount of accounts paid on time	68,544	78,944	18,862	47,003
Actual percentage of accounts paid on time (based on \$)	100%	100%	100%	100%
Number of payments for interest on overdue accounts	—	—	—	—
Interest paid on overdue accounts	—	—	—	—

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

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



INDEPENDENT AUDITOR'S REPORT

Health Care Complaints Commission

To Members of the New South Wales Parliament

Opinion

I have audited the accompanying financial statements of the Health Care Complaints Commission (the Commission), which comprise the statement of financial position as at 30 June 2017, the statement of comprehensive income, the statement of changes in equity and the statement of cash flows for the year then ended, notes comprising a summary of significant accounting policies and other explanatory information of the Commission and the consolidated entity. The consolidated entity comprises the Commission and the entities it controlled at the year's end or from time to time during the financial year.

In my opinion, the financial statements:

- give a true and fair view of the financial position of the Commission and the consolidated entity as at 30 June 2017, and of their financial performance and cash flows for the year then ended in accordance with Australian Accounting Standards
- are in accordance with section 41B of *Public Finance and Audit Act 1983* (PF&A Act) and the Public Finance and Audit Regulation 2015.

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

Basis for Opinion

I conducted my audit in accordance with Australian Auditing Standards. My responsibilities under the standards are described in the 'Auditor's Responsibilities for the Audit of the Financial Statements' section of my report.

I am independent of the Commission and the consolidated entity in accordance with the requirements of the:

- Australian Auditing Standards
- Accounting Professional and Ethical Standards Board's APES 110 'Code of Ethics for Professional Accountants' (APES 110).

I have also fulfilled my other ethical responsibilities in accordance with APES 110.

Parliament further promotes independence by ensuring the Auditor-General and the Audit Office of New South Wales are not compromised in their roles by:

- providing that only Parliament, and not the executive government, can remove an Auditor-General
- mandating the Auditor-General as auditor of public sector agencies
- precluding the Auditor-General from providing non-audit services.

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

The Commissioner's Responsibility for the Financial Statements

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

In preparing the financial statements, the Commissioner must assess the ability of the Commission and the consolidated entity to continue as a going concern except where operations will be dissolved by an Act of Parliament or otherwise cease. The assessment must, disclose, as applicable, matters related to going concern and the appropriateness of using the going concern basis of accounting.

Auditor's Responsibility for the Audit of the Financial Statements

My objectives are to:

- obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and
- issue an Independent Auditor's Report including my opinion.

Reasonable assurance is a high level of assurance, but does not guarantee an audit conducted in accordance with Australian Auditing Standards will always detect material misstatements. Misstatements can arise from fraud or error. Misstatements are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions users take based on the financial statements.

A description of my responsibilities for the audit of the financial statements is located at the Auditing and Assurance Standards Board website at: www.auasb.gov.au/auditors_responsibilities/ar3.pdf. The description forms part of my auditor's report.

My opinion does *not* provide assurance:

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



Chris Clayton
Director, Financial Audit Services

20 September 2017
SYDNEY

Health Care Complaints Commission

Statement by Commissioner

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

- (a) the accompanying financial statements in respect of the year ended 30 June 2017 have been prepared in accordance with applicable Australian Accounting Standards (which include Australian Accounting Interpretations), the requirements of the Act, Regulation 2015, and the Financial Reporting Directions published in the Financial Reporting Code for NSW General Government Sector Entities or issued by the Treasurer under section 9(2) of the Act
- (b) the financial statements exhibit a true and fair view of the financial position and financial performance of the Health Care Complaints Commission
- (c) there are no circumstances that would render any particulars included in the financial statements to be misleading or inaccurate.



Sue Dawson
Commissioner
20 September 2017

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Health Care Complaints Commission Consolidated Financial Statements for the year ended 30 June 2017

**Health Care Complaints Commission
Statement of Comprehensive Income
for the year ended 30 June 2017**

		Actual	Consolidated	Actual	Actual	Parent
	Notes	2017	Budget	2016	2017	Actual
			2017			2016
Expenses excluding losses						
Operating expenses						
Employee related expenses	2(a)	10,277	10,154	8,755	-	-
Personnel Services	2(a)	-	-	-	9,959	8,755
Other operating expenses	2(b)	4,580	3,627	4,407	4,580	4,407
Depreciation and amortisation	2(c)	243	145	195	243	195
Total expenses excluding losses		15,100	13,926	13,357	14,782	13,357
Revenue						
Grants and contributions	3(a)	13,902	13,191	12,317	13,902	12,317
Acceptance by the Crown Entity of employee benefits and other liabilities	3(b)	318	268	135	-	135
Other revenue	3(c)	767	385	787	767	787
Total Revenue		14,987	13,844	13,239	14,669	13,239
Net result		(113)	(82)	(118)	(113)	(118)
Other comprehensive income						
Total other comprehensive income		-	-	-	-	-
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		(113)	(82)	(118)	(113)	(118)

The accompanying notes form part of these financial statements

Health Care Complaints Commission
Statement of Financial Position
as at 30 June 2017

		Consolidated		Parent	
		Actual	Budget	Actual	Actual
Notes		2017	2017	2016	2016
		\$'000	\$'000	\$'000	\$'000
ASSETS					
Current assets					
Cash and cash equivalents	5	590	368	256	256
Receivables	6	337	215	356	356
Total current assets		927	583	612	612
Non-current assets					
Receivables	6	137	-	184	184
Property, plant and equipment					
Leasehold improvements		26	59	76	76
Plant and equipment		129	192	234	234
Total property, plant and equipment	7	155	251	310	310
Intangible assets	8	52	34	77	77
Total non-current assets		344	285	571	571
Total assets		1,271	868	1,183	1,183
LIABILITIES					
Current liabilities					
Payables	9	369	243	374	374
Provisions	10	1,360	787	820	820
Total current liabilities		1,729	1,030	1,194	1,194
Non-current liabilities					
Provisions	10	21	333	355	355
Total non-current liabilities		21	333	355	355
Total liabilities		1,750	1,363	1,549	1,549
Net assets/(liabilities)		(479)	(495)	(366)	(366)
EQUITY					
Accumulated funds/(deficit)		(479)	(495)	(366)	(366)
Total Equity		(479)	(495)	(366)	(366)

The accompanying notes form part of these financial statements

**Health Care Complaints Commission
Statement of Changes in Equity
for the year ended 30 June 2017**

	Consolidated		Parent	
	Accumulated		Accumulated	
	Funds	Total	Funds	Total
	\$'000	\$'000	\$'000	\$'000
Balance at 1 July 2016	(366)	(366)	(366)	(366)
Net result for the year	(113)	(113)	(113)	(113)
Other comprehensive income	-	-	-	-
Total other comprehensive income	-	-	-	-
Total comprehensive income for the year	(113)	(113)	(113)	(113)
Balance at 30 June 2017	(479)	(479)	(479)	(479)
Balance at 1 July 2015	(248)	(248)	(248)	(248)
Net result for the year	(118)	(118)	(118)	(118)
Other comprehensive income	-	-	-	-
Total other comprehensive income	-	-	-	-
Total comprehensive income for the year	(118)	(118)	(118)	(118)
Balance at 30 June 2016	(366)	(366)	(366)	(366)

The accompanying notes form part of these financial statements

**Health Care Complaints Commission
Statement of Cash Flows
for the year ended 30 June 2017**

		Consolidated		Parent	
		Actual	Budget	Actual	Actual
		2017	2017	2016	2017
Notes		\$'000	\$'000	\$'000	\$'000
CASH FLOWS FROM OPERATING ACTIVITIES					
Payments					
Employee related		(9,727)	(9,897)	(8,941)	-
Personnel services		-	-	-	(9,993)
Other expenses		(5,064)	(3,917)	(4,658)	(5,064)
Total Payments		(14,791)	(13,814)	(13,599)	(15,057)
Receipts					
Grants and contributions		13,902	13,191	12,317	13,902
Other		1,286	684	1,181	1,286
Total Receipts		15,188	13,875	13,498	15,188
NET CASH FLOWS FROM OPERATING ACTIVITIES					
	15	397	61	(101)	131
CASH FLOWS FROM INVESTING ACTIVITIES					
Purchases property, plant and equipment		(40)	(65)	(91)	(40)
Purchase intangible assets		(23)	-	-	(23)
NET CASH FLOWS FROM INVESTING ACTIVITIES					
		(63)	(65)	(91)	(63)
NET INCREASE (DECREASE) IN CASH					
Opening cash and cash equivalents		334	(4)	(192)	68
		256	372	448	256
CLOSING CASH AND					
CASH EQUIVALENTS					
	5	590	368	256	324
					256

The accompanying notes form part of these financial statements

Health Care Complaints Commission
Notes to the financial statements
for the year ended 30 June 2017

Notes to and forming part of the financial statements for the year ended 30 June 2017

1 Summary of significant accounting policies

(a) Reporting entity

The Health Care Complaints Commission (HCCC) is a NSW Government statutory body, responsible for protecting the health and safety of the public by dealing with complaints about health service providers which affects, or is likely to affect, the clinical management or care of an individual client.

The HCCC is a not-for-profit entity (as profit is not its principal objective) and it has no cash generating units. The reporting entity is consolidated as part of NSW Total State Sector Accounts.

The HCCC, as a reporting entity, comprises all the entities under its control, namely the Health Care Complaints Commission and the Health Care Complaints Commission Staff Agency.

In the process of preparing the consolidated financial statements for the economic entity, consisting of the controlling and controlled entities, all inter-entity transactions and balances have been eliminated and like transactions and other events are accounted for using uniform accounting policies.

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

These consolidated financial statements for the year ended 30 June 2017 have been authorised for issue by the Commissioner on 20 September 2017.

(b) Basis of preparation

The HCCC's financial statements are general purpose financial statements which have been prepared on an accruals basis and in accordance with:

- applicable Australian Accounting Standards (which include Australian Accounting Interpretations)
- the requirements of the *Public Finance and Audit Act 1983* and Regulation 2015; and
- the Financial Reporting Directions published in the Code for NSW General Government Sector Entities or issued by the Treasurer.

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

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

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

(i) Going concern

The Commission is a 'going concern' public sector entity. The Commission receives annual grant funding from the Ministry of Health to fund its operations. As presented in the NSW Governments 2016-17 Budget Paper 3, NSW Treasury through the NSW Ministry of Health, provides grant funding to the Commission to meet its legislative responsibilities each year including meeting its liabilities inclusive of its financial liquidity and balance sheet provisions. Allocated funds, combined with other revenues earned (legal cost recoveries), are applied to pay debts as and when they become due and payable. The Commission has the capacity to review timing of grant payments from the NSW Ministry of Health to ensure that debts can be paid when they become due and payable.

The closing cash balance is as a result of NSW Treasury's cash management reforms outlined in Circular 15-01 Cash Management - Expanding the Scope of the Treasury Management system which requires all non-restricted cash and cash equivalents in excess of a readily assessable short term level to be held within the Treasury Banking System.

The closing cash balance of \$590,000 at 30 June 2017 is higher than the agreed Treasury cash buffer of \$250,000, due to the timing of creditor invoices falling due for payment.

Health Care Complaints Commission
Notes to the financial statements
for the year ended 30 June 2017

1 Summary of significant accounting policies (cont'd)

(c) Statement of compliance

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

(d) Insurance

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

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

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

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

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

(f) *Income recognition*

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

(i) Parliamentary appropriations and contributions

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

(ii) Rendering of services

Revenue is recognised when the service is provided.

(iii) Interest revenue

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

(iv) Legal cost recoveries

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

(g) Property, Plant and Equipment

(i) Property, Plant and Equipment

Assets acquired are initially recognised at cost. Cost is the amount of cash or cash equivalents paid or the fair value of the other consideration given to acquire the asset at the time of its acquisition or construction or, recognised where applicable, the amount attributed to that asset when initially recognised in accordance with the requirements of other Australian Accounting Standards.

Assets acquired at no cost, or for nominal consideration, are initially recognised at their fair value at the date of acquisition. Fair value is the price that would be received to sell an asset in an orderly transaction between market participants at measurement date.

Health Care Complaints Commission
Notes to the financial statements
for the year ended 30 June 2017

1 Summary of significant accounting policies (cont'd)

(g) *Property, Plant and Equipment (cont'd)*

Where payment for an asset is deferred beyond normal credit terms, its cost is the cash price equivalent, i.e. deferred payment amount is effectively discounted over the period of credit.

(ii) Capitalisation thresholds

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

(iii) Maintenance Cost

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

(iv) Depreciation of property, plant and equipment

Depreciation is provided for on a straight-line basis for all depreciable assets so as to write off the depreciable amount of each asset as it is consumed over its useful life to the HCCC.

All material identifiable components of assets are depreciated separately over their useful lives.

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

<u>Asset category</u>	<u>Gross value measurement basis</u>	<u>Depreciation method</u>	<u>Depr'n life in years 2016-17</u>	<u>Depr'n life in years 2015-16</u>
Computer equipment	Purchase price	Straight line	4	4
Plant and equipment	Purchase price	Straight line	5	5

Leasehold improvement assets are depreciated on a straight line basis at the lesser of five years or the lease term.

(v) Revaluation of property, plant and equipment

Physical non-current assets are valued in accordance with the 'Valuation of Physical Non-Current Assets at Fair Value' Policy and Guidelines Paper (TPP 14-1). This policy adopts fair value in accordance with AASB 13 Fair Value Measurement, AASB 116 Property, Plant and Equipment and AASB 140 Investment Property.

Property, plant and equipment is measured at the highest and best use by market participants that is physically possible, legally permissible and financially feasible. The highest and best use must be available at a period that is not remote and take into account the characteristics of the asset being measured, including any socio-political restrictions imposed by government. In most cases, after taking into account these considerations, the highest and best use is the existing use. In limited circumstances, the highest and best use may be a feasible alternative use, where there are no restrictions on use or where there is a feasible higher restricted alternative use.

Non-specialised assets with short useful lives are measured at depreciated historical cost as an approximation of fair value. The entity has assessed that any difference between fair value and depreciated historical cost is unlikely to be material.

(vi) Impairment of property, plant and equipment

As a not-for-profit entity with no cash generating units, impairment under AASB 136 Impairment of Assets is unlikely to arise. As property, plant and equipment is carried at fair value, impairment can only arise in the rare circumstances where the costs of disposal are material. Specifically, impairment is unlikely for not-for-profit entities given that AASB 136 modifies the recoverable amount test for non-cash generating assets of not-for-profit entities to the higher of fair value less costs of disposal and depreciated replacement cost, where depreciated replacement cost is also fair value.

(h) Leases

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

Health Care Complaints Commission
Notes to the financial statements
for the year ended 30 June 2017

1 Summary of significant accounting policies (cont'd)

(h) Leases (cont'd)

Where a non-current asset is acquired by means of a finance lease, at the commencement of the lease term, the asset is recognised at its fair value or, if lower, the present value of the minimum lease payments, at the inception of the lease. The corresponding liability is established at the same amount. Lease payments are allocated between the principal component and the interest expense.

Property, plant and equipment acquired under finance leases are depreciated over the asset's useful life. However if there is no reasonable certainty that the lessee entity will obtain ownership at the end of the lease term, the asset is depreciated over the shorter of the estimated useful life of the asset and the lease term.

Amounts due from lessees under finance leases are recognised as receivables at the amount of the entity's net investment in the lease. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the entity's net investment outstanding in respect of the leases.

An operating lease is a lease other than a finance lease. Operating lease payments are recognised as an operating expense in the Statement of Comprehensive Income on a straight-line basis over the lease term.

Lease income from operating leases where the entity is a lessor is recognised in income on a straight-line basis over the lease term. The respective leased assets are included by the lessor entity in the Statement of Financial Position based on their nature.

(i) Intangible assets

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

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

Intangible assets are tested for impairment where an indicator of impairment exists. However, as a not for profit entity with no cash generating units, the HCCC is effectively exempted from impairment testing.

The useful life of the Commission's Intangible assets is as follows:

Asset category	Gross value measurement basis	Method	Amortisation life in years	Amortisation life in years
			2016-17	2015-16
Software	Purchase price	Straight line	4	4

Health Care Complaints Commission
Notes to the financial statements
for the year ended 30 June 2017

1 Summary of significant accounting policies (cont'd)

(j) Financial Instruments

A financial instrument is any contract that gives rise to a financial asset of one entity and a financial liability or equity instrument of another entity.

Financial assets and financial liabilities are initially measured at fair value. Transaction costs that are directly attributable to the acquisition or issue of financial assets and financial liabilities (other than financial assets and financial liabilities at fair value through profit or loss) are added to or deducted from the fair value of the financial assets or financial liabilities, as appropriate, on initial recognition.

The HCCC determines the classification of its financial assets and liabilities after initial recognition and, when allowed and appropriate, re-evaluates this at each financial year end.

(i) Financial assets

Financial assets are classified, at initial recognition, as financial assets at fair value through profit or loss, loans and receivables, held-to-maturity investments, available-for-sale financial assets, or as derivatives designated as hedging instruments in an effective hedge, as appropriate. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

- **Loans and receivables**

Trade receivables, loans, and other receivables that have fixed or determinable payments that are not quoted in an active market are classified as loans and receivables. Loans and receivables are measured at amortised cost using the effective interest method, less any impairment. Changes are recognised in the net result for the year when impaired, derecognised or through the amortisation process.

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

(ii) Financial liabilities

Financial liabilities are classified as either 'at fair value through profit or loss' or 'at amortised cost'.

- **Financial liabilities at amortised cost (including borrowings and trade payables)**

Financial liabilities at amortised cost are initially measured at fair value, net of transaction costs. These are subsequently measured at amortised cost using the effective interest method, with interest expense recognised on an effective yield basis.

Payables represent liabilities for goods and services provided to the HCCC and other amounts. Short-term payables with no stated interest rate are measured at the original invoice amount where the effect of discounting is immaterial.

Borrowings are financial liabilities at amortised cost. Gains or losses are recognised in the net result for the year on de-recognition of borrowings.

Finance lease liabilities are determined in accordance with AASB 117.

(iii) Derecognition of financial assets and financial liabilities

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

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

Health Care Complaints Commission
Notes to the financial statements
for the year ended 30 June 2017

1 Summary of significant accounting policies (cont'd)

(j) Financial Instruments (cont'd)

Where the HCCC has neither transferred nor retained substantially all the risks and rewards or transferred control, the asset continues to be recognised to the extent of the commission's continuing involvement in the asset. In that case, the HCCC also recognises an associated liability measured on a basis that reflects the rights and obligations that the HCCC has retained.

Continuing involvement that takes the form of a guarantee over the transferred asset is measured at the lower of the original carrying amount of the asset and the maximum amount of consideration that the entity could be required to repay.

A financial liability is derecognised when the obligation specified in the contract is discharged or cancelled or expires. When an existing financial liability is replaced by another from the same lender on substantially different terms, or the terms of an existing liability are substantially modified such an exchange or modification is treated as the de-recognition of the original liability and the recognition of the new liability. The difference in the respective carrying amounts is recognised in the net results.

Financial assets and financial liabilities are offset and the net amount is reported in the Statement of Financial Position if there is a currently enforceable legal right to offset the recognised amounts and there is an intention to settle on a net basis, or to realise the assets and settle the liabilities simultaneously

(k) Employee benefits and other provisions

(i) Salaries and wages, annual leave, sick leave and on-costs

Salaries and wages (including non-monetary benefits), and paid sick leave that are expected to be recognised and measured at the undiscounted amounts based on the amounts of the benefits.

Annual leave is not expected to be settled wholly before twelve months after the end of the annual reporting period in which the employees render the related service. As such, it is required to be measured at present value in accordance with AASB 119 *Employee Benefits*. (Although short-cut methods are permitted).

Actuarial advice obtained by Treasury has confirmed that using the nominal annual leave balance plus the annual leave on annual leave liability (using 7.9% of the nominal value of annual leave) can be used to approximate the present value of annual leave liability. The entity has assessed the actuarial advice based on the entity circumstances and has determined that the effect of discounting is immaterial to annual leave.

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

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

(ii) Long service leave and superannuation

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

Long service leave is measured at present value in accordance with AASB 119 *Employee Benefits*. This is based on the application of certain factors (Specified in NSWTC 15-09) to employees with five or more years of service using the current rates of pay. These factors were determined based on the actuarial review to approximate present value.

Health Care Complaints Commission
Notes to the financial statements
for the year ended 30 June 2017

1 Summary of significant accounting policies (cont'd)

(k) Employee benefits (cont'd)

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

(iii) Consequential on-costs

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

(l) Other Provisions

The HCCC has a present legal obligation which amortises costs to the expiration date of the lease term on the 30 April 2018.

As the effect of the time value of money is material, provision was discounted at 1.6% which is a pre-tax rate that reflects the current market assessments of the time value of money and the risks specific to the liability.

(m) Fair value hierarchy

A number of the entity's accounting policies and disclosures require the measurement of fair value, for both financial and non-financial assets and liabilities. When measuring fair value, the valuation technique used maximises the use of relevant observable inputs and minimises the use of unobservable inputs. Under AASB 13, the entity categorises, for disclosure purposes, the valuation techniques based on the inputs used in the valuation techniques as follows:

- Level 1 - quoted prices in active markets for identical assets / liabilities that the entity can access at the measurement date.
- Level 2 - inputs other than quoted prices included within Level 1 that are observable, either directly or indirectly.
- Level 3 - inputs that are not based on observable market data (unobservable inputs).

The HCCC recognises transfers between levels of the fair value hierarchy at the end of the reporting period during which the change has occurred.

As disclosed in Note 1(g) (v), the HCCC holds non specialised assets with short useful lives and these are measured at depreciated historical cost as a surrogate for fair value. Consequently there are no further disclosures made in relation to the AASB 13 fair value hierarchy.

(n) Equity and reserves

(i) Accumulated Funds

The category accumulated funds includes all current and prior period retained funds.

(o) Budgeted amounts

The budgeted amounts are drawn from the original budgeted financial statements presented to Parliament in respect of the reporting period, as adjusted for section 24 of the Public Finance and Audit Act 1983 where there has been a transfer of functions between departments. Other amendments made to the budget are not reflected in the budgeted amounts.

(p) Comparative information

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

Health Care Complaints Commission
Notes to the financial statements
for the year ended 30 June 2017

1 Summary of significant accounting policies (cont'd)

(q) Changes In accounting policy, including new or revised Australian Accounting Standards

(i) Effective for the first time in 2016-17

The accounting policies applied in 2016-17 are consistent with those of the previous financial year except as result of the AASB 124- Extended Related Party Disclosure to Not-for-Profit Entity that has been applied for the first time in year ending 30 June 2017.

- AASB 124 Related Party Disclosures.

AASB 2015-6 Amendments to Australian Accounting Standards – Extending Related Party Disclosures to Not-for-Profit Public Sector Entities extends the scope of AASB 124 Related Party Disclosures to include application by not-for-profit public sector entities. The application of this standard has resulted in increased disclosures in the financial statements relating to related party transactions and Key Management Personnel compensation.

(ii) Issued but not yet effective

NSW public sector entities are not permitted to early adopt new Australian Accounting Standards, unless Treasury determines otherwise.

The following new Australian Accounting Standards have not been applied and are not yet effective. (NSW TC 17- 04).

- AASB 9 Financial Instruments
- AASB 15, AASB 2014-5, AASB 2015-8, 2016-3, AASB 2016-7 and AASB 2016-8 regarding Revenue from Contracts with Customers
- AASB 16 Leases
- AASB 1058 Income of Not for profit Entities
- AASB 2016-2 Amendments to Australian Accounting Standards - Disclosure Initiative: Amendments to AASB 107
- AASB 2016-6 Amendments to Australian Accounting Standards - Applying AASB 9 with AASB 4 Insurance Contracts
- AASB 2017-2 Amendments to Australian Accounting Standards - Further Annual Improvements 2014 2016 Cycle

The Commission anticipates that adoption of these standards in the period of initial application will have no material impact on the financial statements

Health Care Complaints Commission
Notes to the financial statements
for the year ended 30 June 2017

2 EXPENSES EXCLUDING LOSSES

	Consolidated		Parent	
	2017	2016	2017	2016
	\$'000	\$'000	\$'000	\$'000
(a) Employee related expenses				
Salaries and wages (including annual leave)	8,677	7,494	-	-
Redundancy	76	-	-	-
Superannuation - defined benefit plans	46	72	-	-
Superannuation - defined contribution plans	678	589	-	-
Long service leave	272	59	-	-
Workers' compensation insurance	28	40	-	-
Payroll tax and fringe benefit tax	500	501	-	-
Personnel services	-	-	9,959	8,755
	10,277	8,755	9,959	8,755

	Consolidated		Parent	
	2017	2016	2017	2016
	\$'000	\$'000	\$'000	\$'000
(b) Other operating expenses include the following:				
Auditor's remuneration - audit of the financial statements	32	20	32	20
Contractors	1,173	755	1,173	755
Equipment and Plant	22	20	22	20
Insurance	11	20	11	20
Postage and telephone	150	150	150	150
Printing	57	38	57	38
Operating lease rental expenses - minimum lease payments	994	993	994	993
Training	43	97	43	97
Travelling	81	46	81	46
Fees - Legal Witness	46	68	46	68
Fees - Translators	15	11	15	11
Legal fees and adverse costs	998	802	998	802
Fees for services rendered	278	664	278	664
Fees - Peer review reports	257	186	257	186
Other operating expenses	297	333	297	333
Stores	126	204	126	204
	4,580	4,407	4,580	4,407

(c) Depreciation and amortisation expense

	Consolidated		Parent	
	2017	2016	2017	2016
	\$'000	\$'000	\$'000	\$'000
Depreciation				
Leasehold improvements	76	24	76	24
Plant Equipment	28	28	28	28
Computer Equipment	91	91	91	91
Total Depreciation	195	143	195	143
Amortisation				
Software	48	52	48	52
Total depreciation and amortisation	243	195	243	195

Health Care Complaints Commission
Notes to the financial statements
for the year ended 30 June 2017

3 REVENUE

	Consolidated		Parent	
	2017	2016	2017	2016
	\$'000	\$'000	\$'000	\$'000
(a) Grants and contributions				
Recurrent - (NSW Ministry of Health)	13,764	12,252	13,764	12,252
Capital - (NSW Ministry of Health)	65	65	65	65
Redundancy	73	-	73	-
	13,902	12,317	13,902	12,317

(b) Acceptance by the Crown Entity of employee benefits and other liabilities

Long service leave	270	59	-	59
Superannuation - defined benefit plans	46	72	-	72
Payroll tax	2	4	-	4
	318	135	-	135

	Consolidated		Parent	
	2017	2016	2017	2016
	\$'000	\$'000	\$'000	\$'000
(c) Other revenue				
Legal cost recoveries	762	745	762	745
Other	5	42	5	42
	767	787	767	787

4 SERVICE GROUP OF THE HEALTH CARE COMPLAINTS COMMISSION

Complaints handling

The HCCC has one service group - complaints handling. This service group covers processing, assessing and resolving of health care complaints through assisted resolution, facilitated conciliation or referral for investigation. The Commission also investigates and prosecutes any serious cases of inappropriate health care and makes recommendations to health organisations to address any systemic health care issues.

5 CURRENT ASSETS - CASH AND CASH EQUIVALENTS

	Consolidated		Parent	
	2017	2016	2017	2016
	\$'000	\$'000	\$'000	\$'000
Cash at bank and on hand	590	256	324	256
	590	256	324	256

For the purposes of the Statement of Cash Flows, cash and cash equivalents include cash at bank, cash on hand.

	Consolidated		Parent	
	2017	2016	2017	2016
	\$'000	\$'000	\$'000	\$'000
Cash and cash equivalents (per statement of financial position)	590	256	324	256
Closing cash and cash equivalents (per statements of cash flows)	590	256	324	256

Health Care Complaints Commission
Notes to the financial statements
for the year ended 30 June 2017

6 CURRENT/NON-CURRENT ASSETS - RECEIVABLES

	Consolidated		Parent	
	2017	2016	2017	2016
	\$'000	\$'000	\$'000	\$'000
Current assets				
GST Receivables	55	109	55	109
Legal Cost Recoveries	225	143	225	143
Other	18	71	9	71
Intercompany receivable	-	-	140	-
Prepayment	39	33	39	33
	337	356	468	356
	Consolidated		Parent	
	2017	2016	2017	2016
	\$'000	\$'000	\$'000	\$'000
Non-current assets				
Debtors - Legal cost recoveries	137	184	137	184
	137	184	137	184
Total current/non-current assets - receivables	474	540	605	540

7 NON CURRENT ASSETS – PROPERTY, PLANT AND EQUIPMENT

	Leasehold Improvements \$'000	Computer equipment \$'000	Plant and equipment \$'000	Work in progress \$'000	Total \$'000
At 1 July 2016 - fair value					
Gross carrying amount	1,088	670	262	38	2,058
Accumulated depreciation and impairment	(1,012)	(532)	(204)	-	(1,748)
Net carrying amount	76	138	58	38	310
At 30 June 2017 - fair value					
Gross carrying amount	1,114	576	260	-	1,950
Accumulated depreciation and impairment	(1,088)	(493)	(214)	-	(1,795)
Net carrying amount	26	83	46	-	155

Reconciliation

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

	Leasehold Improvements \$'000	Computer equipment \$'000	Plant and equipment \$'000	Work in progress \$'000	Total \$'000
Year ended 30 June 2017					
Net carrying amount at start of year	76	138	58	38	310
Purchases	-	24	16	-	40
Transfer to/(from) other assets classes	26	12	-	(38)	-
Depreciation expense	(76)	(91)	(28)	-	(195)
Net carrying amount at end of year	26	83	46	-	155

Health Care Complaints Commission
Notes to the financial statements
for the year ended 30 June 2017

7 NON CURRENT ASSETS - PLANT AND EQUIPMENT (cont'd)

	Leasehold Improvements \$'000	Computer equipment \$'000	Plant and equipment \$'000	Work in progress \$'000	Total \$'000
At 1 July 2015 - fair value					
Gross carrying amount	1,039	654	238	35	1,966
Accumulated depreciation and impairment	(988)	(441)	(176)	-	(1,605)
Net carrying amount	<u>51</u>	<u>213</u>	<u>62</u>	<u>35</u>	<u>361</u>
At 1 July 2016 - fair value					
Gross carrying amount	1,088	670	262	38	2,058
Accumulated depreciation and impairment	(1,012)	(532)	(204)	-	(1,748)
Net carrying amount	<u>76</u>	<u>138</u>	<u>58</u>	<u>38</u>	<u>310</u>

Reconciliation

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

	Leasehold Improvements \$'000	Computer equipment \$'000	Plant and equipment \$'000	Work in progress \$'000	Total \$'000
Year ended 30 June 2016					
Net carrying amount at start of year	51	213	62	35	361
Additions	49	-	5	38	92
Transfer to/(from) other asset classes	-	16	19	(35)	-
Depreciation expense	(24)	(91)	(28)	-	(143)
Net carrying amount at end of year	<u>76</u>	<u>138</u>	<u>58</u>	<u>38</u>	<u>310</u>

8 INTANGIBLE ASSETS - COMPUTER SOFTWARE

	Software
At 1 July 2016	
Cost (gross carrying amount)	1,075
Accumulated amortisation and impairment	(998)
Net carrying amount	<u>77</u>
At 30 June 2017	
Cost (gross carrying amount)	1,098
Accumulated amortisation and impairment	(1,046)
Net carrying amount	<u>52</u>
Year ended 30 June 2017	
Net carrying amount at start of year	77
Additions	23
Amortisation (recognised in "depreciation and amortisation")	(48)
Net carrying amount at end of year	<u>52</u>
At 1 July 2015	
Cost (gross carrying amount)	1,075
Accumulated amortisation and impairment	(946)
Net carrying amount	<u>129</u>
At 30 June 2016	
Cost (gross carrying amount)	1,075
Accumulated amortisation and impairment	(998)
Net carrying amount	<u>77</u>
Year ended 30 June 2016	
Net carrying amount at start of year	129
Amortisation (recognised in "depreciation and amortisation")	(52)
Net carrying amount at end of year	<u>77</u>

Health Care Complaints Commission
Notes to the financial statements
for the year ended 30 June 2017

9 CURRENT LIABILITIES PAYABLES

	Consolidated		Parent	
	2017	2016	2017	2016
	\$'000	\$'000	\$'000	\$'000
Payables				
Accrued salaries, wages and on-costs	27	1	-	-
Payable for personnel services	-	-	27	-
Creditors	180	6	111	-
Accrued Expenses	162	367	162	374
	369	374	300	374

10 CURRENT/NON-CURRENT LIABILITIES - PROVISIONS

	Consolidated		Parent	
	2017	2016	2017	2016
	\$'000	\$'000	\$'000	\$'000
Employee benefits and related on-costs current				
Annual Leave	720	558	-	-
Payroll tax	187	115	-	-
Fringe benefits tax	5	-	-	-
Long service leave	114	147	-	-
Provision for personnel services	-	-	960	820
Total current employee provisions	1,026	820	960	820

Other provisions – current / non-current

Lease make good provision	334	334	334	334
Long service leave – non current	21	21	-	-
Provision for personnel services – non current	-	-	21	21
Total other current/non-current provisions	355	355	355	355

Aggregate employee benefits and related on costs

Provision – current	1,026	820	-	-
Provision – non-current	21	21	-	-
Provision for personnel services- current	-	-	960	820
Provision for personnel services – non-current	-	-	21	21
Accrued salaries, wages and on-costs (Note 9)	27	1	-	-
Payable for personnel services	-	-	27	1
Total aggregate employee benefits and related on costs	1,074	842	1,008	842

Health Care Complaints Commission
Notes to the financial statements
for the year ended 30 June 2017

11 COMMITMENTS FOR EXPENDITURE

	Consolidated		Parent	
	2017	2016	2017	2016
	\$'000	\$'000	\$'000	\$'000
(a) Operating Lease Commitments				
Future non-cancellable operating lease Not Provided for and payable:				
Not later than one year	1,168	1,120	1,168	1,120
Later than one year and not later than five years	3,289	957	3,289	957
Total (including GST)	4,457	2,077	4,457	2,077

Total commitments above Included input tax credits of \$405,181 (2015-16: \$188,850) that were expected to be refunded from the Australian Taxation Office. Total commitments include the HCCC's lease on its premises at Levels 12 and 13, 323 Castlereagh Street, Sydney

12 CONTINGENT ASSETS

There are legal costs awarded in favour of the HCCC arising from prosecution of serious cases of complaints of health care where the respondents have been found to be guilty of unsatisfactory professional conduct and/or professional misconduct. The amounts are subject to negotiation and determination and total \$1,273,830 (2015-16: \$1,170,620).

13 CONTINGENT LIABILITIES

Adverse costs awarded against the HCCC, were \$110,000 at 30 June 2017 (2015-16: \$25,000)
 Costs related to various matters and were awarded to Avant Insurance to be paid by the HCCC due to cases that were lost.

The HCCC has contingent liabilities estimated at \$581,050 representing potential legal expenses for which the Crown Solicitor is acting on behalf of HCCC as at 30 June 2017 (2016: \$530,950). Approximately \$482,000 will be reimbursed by the Treasury Managed Fund if the liabilities are realised.

14 BUDGET REVIEW

The actual net result of \$113,000 deficit was higher than budget by \$31,000, primarily due to:

Expenses

The Commission's total expenditure was higher than budget by \$1,174,000, comprising of employee expenses over-expenditure of \$123,000 and operating expenses of \$1,051,000, mainly in contractor expenses and other expenditure that was higher than expected.

Revenue

The Commission's total other revenue was higher than budget by \$1,143,000 mainly due to higher grants and contributions received during 2016-17. Also, there was an additional \$73,000 recouped from Crown due to redundancy costs and higher than budgeted legal cost recoveries.

Assets and liabilities

Current assets were higher than budget due to higher cash balances and debtor receivables in 2016-17.

Plant and equipment non-current assets were lower than budget by approximately \$96,000 mainly due to additional depreciation.

Total liabilities were higher than budget due to increase in employee provisions.

Cash flows

The Commission's cash balance of \$590,000 was higher than budget of \$222,000 due to additional grants received from Treasury.

Health Care Complaints Commission
Notes to the financial statements
for the year ended 30 June 2017

15 RECONCILIATION OF CASH FLOWS FROM OPERATING ACTIVITIES TO NET RESULT

	Consolidated		Parent	
	2017 \$'000	2016 \$'000	2017 \$'000	2016 \$'000
Net cash used on operating activities	397	(101)	131	(101)
Depreciation and amortisation	(243)	(195)	(243)	(195)
Decrease / (increase) in provisions	(232)	48	(167)	48
Increase / (decrease) in receivables and other assets	(66)	84	65	84
(Increase) / decrease in creditors	31	46	101	46
Net result	(113)	(118)	(113)	(118)

16 FINANCIAL INSTRUMENTS

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

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

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

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

(a) Financial instrument categories

Financial Assets	Note	Category	Consolidated	
			Carrying Amount 2017 \$'000	Carrying Amount 2016 \$'000
Financial assets class:				
Cash and cash equivalents	5	N/A	590	256
Receivables ¹	6	Loans and receivables (at amortised cost)	362	399
Financial liabilities class:				
Payables ²	9	Financial liabilities measured at amortised cost	369	367

Notes

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

Health Care Complaints Commission
Notes to the financial statements
for the year ended 30 June 2017

16 FINANCIAL INSTRUMENTS (cont'd)

(b) Credit Risk

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

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

Cash

Cash comprises cash on hand and bank balances within the NSW Treasury Banking System.

Receivables - trade debtors

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

The HCCC is not exposed to concentrations of credit risk to trade debtors as they are mainly other government departments. Based on past experience, debtors that are not past due (2017:\$nil; 2016:\$nil) and not less than 12 months past due 2017: \$nil; (2016: \$nil) are not considered impaired.

Receivable - other debtors

Debtors (legal cost recoveries) which are currently past due (2017: \$321,100; 2016: \$364,174) represent 100% of the total debtors overdue. These debtors comprise debts arising from tribunal ordered costs against health care practitioners. The majority of the debts reported in the financial statements are being settled by agreed regular instalments and are not considered to be impaired in a material way.

	Consolidated		Parent	
	Past due but not impaired \$'000	Considered impaired \$'000	Past due but not impaired \$'000	Considered impaired \$'000
2017				
< 3 months overdue	88	-	88	-
3 months – 6 months overdue	21	-	21	-
> 6 months overdue	212	-	212	-
2016				
< 3 months overdue	-	-	-	-
3 months – 6 months overdue	23	-	23	-
> 6 months overdue	341	-	341	-

Notes

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

Health Care Complaints Commission
Notes to the financial statements
for the year ended 30 June 2017

16 FINANCIAL INSTRUMENTS (cont'd)

(c) Liquidity risk

Liquidity risk is the risk that the HCCC will be unable to meet its payment obligations when they fall due. The HCCC continuously manages risk through monitoring future cash flows to ensure adequate holding of liquid assets. During the current and prior years, there were no defaults on any loans payable. No assets have been pledged as collateral. The HCCC's exposure to liquidity risk is deemed insignificant based on prior periods' data and other current assessment of risk.

The liabilities are recognised for amounts due to be paid in the future for goods or services received, whether or not invoiced. Amounts owing to suppliers (which are unsecured) are settled in accordance with the policy set out in TC11/12. For small business suppliers, where terms are not specified, payment is made no later than 30 days from date of receipt of a correctly rendered invoice. For other suppliers, if trade terms are not specified, payment is made no later than the end of the month following the month in which an invoice or a statement is received. For small business suppliers, where payment is not made within the specified time period, simple interest must be paid automatically, unless an existing contract specifies otherwise. For payments to other suppliers, the Manager Corporate Services may authorise the automatic payment of simple interest to the supplier.

(d) Market risk

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

Interest rate risk

Exposure to interest rate risk arises primarily through the HCCC's interest bearing liabilities. The HCCC does not have any interest bearing liabilities.

(e) Fair value compared to carrying amount

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

Health Care Complaints Commission
Notes to the financial statements
for the year ended 30 June 2017

17 Related Party Disclosures

The entity's key management personnel compensation was paid by the Health Care Commission Staff Agency and details for the year ending 30 June 2017 are as follows:

	2017 \$'000
Short term employee benefits:	
Salaries	1,301
Other monetary allowances	9
Non-monetary benefits	15
Other long-term employee benefits	55
Post-employment benefits	-
Termination benefits	-
Total remuneration	<u>1,380</u>

During the year, the Health Care Commission did not enter into any other transactions with key management personnel, their close family members and controlled or jointly controlled entities thereof.

In addition, the Health Care Commission entered into transactions on arm's length terms and conditions with other entities controlled by NSW Government. These transactions include:

- Payments into the icare TMF Scheme
- Long Service Leave and Defined Benefit Superannuation assumed by the Crown
- Payment for Payroll Tax
- Allocations from NSW Ministry of Health
- Payment for the audit of our financial statements
- Grants and contributions related to funding specific programs and projects
- Government Property NSW

18 EVENTS AFTER THE REPORTING PERIOD

There were no after reporting period events.

End of audited financial statements



INDEPENDENT AUDITOR'S REPORT

Health Care Complaints Commission Staff Agency

To Members of the New South Wales Parliament

Opinion

I have audited the accompanying financial statements of the Health Care Complaints Commission Staff Agency (the Staff Agency), which comprise the statement of financial position as at 30 June 2017, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes comprising a summary of significant accounting policies and other explanatory information.

In my opinion, the financial statements:

- give a true and fair view of the financial position of the Staff Agency as at 30 June 2017, and of its financial performance and its cash flows for the year then ended in accordance with Australian Accounting Standards
- are in accordance with section 41B of the *Public Finance and Audit Act 1983* (PF&A Act) and the Public Finance and Audit Regulation 2015.

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

Basis for Opinion

I conducted my audit in accordance with Australian Auditing Standards. My responsibilities under the standards are described in the 'Auditor's Responsibilities for the Audit of the Financial Statements' section of my report.

I am independent of the Staff Agency in accordance with the requirements of the:

- Australian Auditing Standards
- Accounting Professional and Ethical Standards Board's APES 110 'Code of Ethics for Professional Accountants' (APES 110).

I have fulfilled my other ethical responsibilities in accordance with APES 110.

Parliament promotes independence by ensuring the Auditor-General and the Audit Office of New South Wales are not compromised in their roles by:

- providing that only Parliament, and not the executive government, can remove an Auditor-General
- mandating the Auditor-General as auditor of public sector agencies
- precluding the Auditor-General from providing non-audit services.

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

The Commissioner's Responsibility for the Financial Statements

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

In preparing the financial statements, the Commissioner must assess the Staff Agency's ability to continue as a going concern except where the Staff Agency will be dissolved by an Act of Parliament or otherwise cease operations. The assessment must disclose, as applicable, matters related to going concern and the appropriateness of using the going concern basis of accounting.

Auditor's Responsibility for the Audit of the Financial Statements

My objectives are to:

- obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error
- issue an Independent Auditor's Report including my opinion.

Reasonable assurance is a high level of assurance, but does not guarantee an audit conducted in accordance with Australian Auditing Standards will always detect material misstatements. Misstatements can arise from fraud or error. Misstatements are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions users take based on the financial statements.

A description of my responsibilities for the audit of the financial statements is located at the Auditing and Assurance Standards Board website at: www.auasb.gov.au/auditors_responsibilities/ar4.pdf. The description forms part of my auditor's report.

My opinion does *not* provide assurance:

- that the Staff Agency carried out its activities effectively, efficiently and economically
- about the security and controls over the electronic publication of the audited financial statements on any website where they may be presented
- about any other information which may have been hyperlinked to/from the financial statements.



Chris Clayton
Director, Financial Audit Services

20 September 2017
SYDNEY

Health Care Complaints Commission Staff Agency

Statement by Commissioner

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

- (a) the accompanying financial statements in respect of the year ended 30 June 2017 have been prepared in accordance with applicable Australian Accounting Standards (which include Australian Accounting Interpretations), the requirements of the Act, Regulation 2015, and the Treasurer's Directions
- (b) the financial statements exhibit a true and fair view of the financial position and financial performance of the Health Care Complaints Commission Staff Agency
- (c) there are no circumstances that would render any particulars included in the financial statements to be misleading or inaccurate.



Sue Dawson
Commissioner
20 September 2017

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**Health Care Complaints Commission
Staff Agency
Financial Statements
For the year ended 30 June 2017**

Health Care Complaints Commission Staff Agency
Statement of Comprehensive Income
For the year ended 30 June 2017

	Notes	Actual 2017 \$'000	Actual 2016 \$'000
Expenses excluding losses			
Operating expenses			
Employee related expenses	2	10,277	8,755
Total Expenses excluding losses		10,277	8,755
Revenue			
Personnel services	3	9,959	8,755
Acceptance by the Crown Entity of employee benefits and other liabilities		318	-
Total Revenue		10,277	8,755
Net result		-	-
Other comprehensive income		-	-
Total Other comprehensive income		-	-
TOTAL COMPREHENSIVE INCOME		-	-

The accompanying notes form part of these financial statements.

Health Care Complaints Commission Staff Agency
Statement of Financial Position
As at 30 June 2017

	Notes	Actual 2017 \$'000	Actual 2016 \$'000
ASSETS			
Current Assets			
Cash & cash equivalents	4	266	-
Receivables	5	997	821
Total Current Assets		<u>1,263</u>	<u>821</u>
Non-Current Assets			
Receivables	5	21	21
Total Non-Current Assets		<u>21</u>	<u>21</u>
Total Assets		<u>1,284</u>	<u>842</u>
LIABILITIES			
Current Liabilities			
Payables	6	237	1
Provisions	7	1,026	820
Total Current Liabilities		<u>1,263</u>	<u>821</u>
Non-Current Liabilities			
Provisions	7	21	21
Total Non-Current Liabilities		<u>21</u>	<u>21</u>
Total Liabilities		<u>1,284</u>	<u>842</u>
Net Assets		<u>-</u>	<u>-</u>
EQUITY			
Total Equity		<u>-</u>	<u>-</u>

The accompanying notes form part of these financial statements.

Health Care Complaints Commission Staff Agency
Statement of Changes in Equity
For the year ended 30 June 2017

	Accumulated Funds \$'000	Total \$'000
Balance at 1 July 2016	-	-
Net result for the year	<u>-</u>	<u>-</u>
Total comprehensive income for the year	<u>-</u>	<u>-</u>
Balance at 30 June 2017	<u>-</u>	<u>-</u>
 Balance at 1 July 2015	 -	 -
Net result for the year	<u>-</u>	<u>-</u>
Total comprehensive income for the year	<u>-</u>	<u>-</u>
Balance at 30 June 2016	<u>-</u>	<u>-</u>

The accompanying notes form part of these financial statements.

Health Care Complaints Commission Staff Agency
Statement of Cash Flows
For the year ended 30 June 2017

	Actual 2017 \$'000	Actual 2016 \$'000
Notes		
CASH FLOWS FROM OPERATING ACTIVITIES		
Payments		
Employee related expenses	(10,277)	-
Increase in payables/provisions	442	
Total Payments	(9,835)	-
Receipts		
Personnel services related	9,959	-
Acceptance by the Crown Entity of employee benefits	318	
Increase in receivables	(176)	
Total Receipts	10,101	-
NET CASH FLOWS FROM OPERATING ACTIVITIES	266	-
	266	-
NET INCREASE /(DECREASE) IN CASH	266	-
Opening cash and cash equivalents	-	-
CLOSING CASH AND CASH EQUIVALENTS	266	-

The accompanying notes form part of these financial statements

Health Care Complaints Commission Staff Agency
Notes to the Financial Statements
For the year ended 30 June 2017

1 Summary of Significant Accounting Policies

(a) Reporting entity

The Health Care Complaints Commission Staff Agency (the Agency) is a division of the Government Service, established pursuant to Part 3 of Schedule 1 to the *Government Sector Employment Act 2013*. It is a not-for-profit entity as profit is not its principal objective. It is consolidated as part of the NSW Total State Sector Accounts.

The Staff Agency's objective is to provide personnel services to the Health Care Complaints Commission. The staff agency is controlled by the Health Care Complaints Commission (immediate parent) and by the State of New South Wales (ultimate parent).

The financial statements for the year ended 30 June 2017 have been authorised for issue by the Commissioner on 20 September 2017.

(b) Basis of preparation

The Staff Agency's financial statements are general purpose financial statements which have been prepared on accrual basis in accordance with:

- applicable Australian Accounting Standards (which include Australian Accounting Interpretations)
- the requirements of the *Public Finance and Audit Act 1983 and Public Finance and Audit Regulation 2015 and*
- the Financial Reporting Directions published in the Financial Reporting Code for NSW General Government Sector Entities or issued by the Treasurer.

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

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

(c) Statement of compliance

The Staff Agency's financial statements and notes comply with Australian Accounting Standards, which include Australian Accounting Interpretations.

(d) Insurance

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

(e) Income recognition

Income is measured at the fair value of the consideration or contribution received or receivable. Revenue is received for cost of providing personnel services for the year to the Health Care Complaints Commission.

(f) Assets

(i) Receivables

Receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. These financials assets are recognised initially at fair value, usually based on the transaction cost or face value. Subsequent measurement is at amortised cost using the effective interest method, less an allowance for any impairment of receivables. Any changes are accounted for in the statement of comprehensive income when impaired, derecognised or through the amortisation process.

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

(g) Liabilities

(i) Payables

These amounts represent liabilities for goods and services provided to the Staff Agency and other amounts. Payables are recognised initially at fair value, usually based on the transaction cost or face value. Short-term

**Health Care Complaints Commission Staff Agency
Notes to the Financial Statements
For the year ended 30 June 2017**

1 Summary of Significant Accounting Policies (cont'd)

payables with no stated interest rate are measured at the original invoice amount where the effect of discounting is immaterial.

(ii) Employee benefits

(a) Salaries and wages, annual leave, sick leave and on-costs

Salaries and wages (including non-monetary benefits) and paid sick leave that are expected to be settled wholly within 12 months after the end of the period in which the employees render the service are recognised and measured at the undiscounted amounts of the benefits.

Annual leave is not expected to be settled wholly before twelve months after the end of the annual reporting period in which the employees render the related service. As such, it is required to be measured at present value in accordance with AASB 119 *Employee Benefits* (although short-cut methods are permitted). Actuarial advice obtained by Treasury has confirmed that the use of a nominal approach plus the annual leave on annual leave liability (using 7.9%) of the nominal value of annual leave) can be used to approximate the present value of the annual leave liability. The Staff Agency has assessed the actuarial advice based on the entity's circumstances and has determined that the effect of discounting is immaterial to annual leave.

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

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

(b) Long service leave and superannuation:

The Staff Agency's liabilities for long service leave are assumed by the Crown Entity. The Staff Agency accounts for the liability as having been extinguished resulting in the amount assumed being shown as part of the non-monetary revenue item described as "Acceptance by the Crown Entity of employee benefits and other liabilities".

Long service leave is measured at present value of expected future payments to be made in respect of services provided up to the reporting date. Consideration is given to the certain factors based on actuarial review, included future wage and salary levels, experience of employee departures, and periods of service. The expected future payments are discounted using common wealth government bond rate at the reporting date.

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

(c) Consequential on-costs:

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

(d) Personnel Services:

The Personnel Services are provided by the Health Care Complaints Commission Staff Agency according to the Administrative Arrangements Order 2014 and is pursuant to Part 2 of Schedule 1 of the *Government Sector Employment Act 2013* (formerly the Health Care Complaints Commission Division established under the former *Public Sector Employment and Management Act 2002*).

(e) Revision of estimates:

As a result of an actuarial valuation of long service leave performed by Treasury's actuary (NSWTC 15-09),

**Health Care Complaints Commission Staff Agency
Notes to the Financial Statements
For the year ended 30 June 2017**

1 Summary of Significant Accounting Policies (cont'd)

the Staff Agency has adjusted defined benefit superannuation on-cost as well as the defined contribution superannuation on-cost for 2016-2017. The factor for defined benefit superannuation on-cost and for defined contribution superannuation on-cost is 1.2% and 3.8% respectively.

(h) Comparative information:

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

(i) Changes in accounting policy, including new or revised Australian Accounting Standards

(i) Effective for the first time in 2016-17

The accounting policies applied in 2016-17 are consistent with those of the previous financial year except as result of the AASB 124- Extended Related Party Disclosure to Not-for-Profit Entity that has been applied for the first time in year ending 30 June 2017.

- AASB 124 Related Party Disclosures.
AASB 2015-6 Amendments to Australian Accounting Standards – Extending Related Party Disclosures to Not-for-Profit Public Sector Entities extends the scope of AASB 124 Related Party Disclosures to include application by not-for-profit public sector entities. The application of this standard has resulted in increased disclosures in the financial statements relating to related party transactions and Key Management Personnel compensation.

(ii) Issued but not yet effective

NSW public sector entities are not permitted to early adopt new Australian Accounting Standards, unless Treasury determines otherwise. The following new Australian Accounting Standards have not been applied and are not yet effective (NSW TC 17/04).

- AASB 9 Financial Instruments
- AASB 15, AASB 2014-5, AASB 2015-8, 2016-3, AASB 2016-7 and AASB 2016-8 regarding Revenue from Contracts with Customers
- AASB 16 Leases
- AASB 1058 Income of Not-for-profit Entities
- AASB 2016-2 Amendments to Australian Accounting Standards – Disclosure Initiative: Amendments to AASB 107
- AASB 2016-6 Amendments to Australian Accounting Standards – Applying AASB 9 with AASB 4 Insurance Contracts
- AASB 2017-2 Amendments to Australian Accounting Standards – Further Annual Improvements 2014-2016 Cycle

The Commission anticipates that adoption of these standards in the period of initial application will have no material impact on the financial statements.

Health Care Complaints Commission Staff Agency
Notes to the Financial Statements
For the year ended 30 June 2017

2 Expenses Excluding Losses

	2017 \$'000	2016 \$'000
(a) Employee related expenses		
Salaries and wages (including recreation leave)	8,677	7,494
Redundancy	76	-
Superannuation - defined benefits plans	46	72
Superannuation - defined contribution plans	678	589
Long service leave	272	59
Workers compensation insurance	28	40
Payroll tax and fringe benefit tax	500	501
	<u>10,277</u>	<u>8,755</u>

3 Revenue

	2017 \$'000	2016 \$'000
Rendering of personnel services	9,959	8,755
Acceptance by the Crown Entity of employee benefits and other liabilities	318	-
	<u>10,277</u>	<u>8,755</u>

4 Current Assets – Cash and Cash Equivalents

	2017 \$'000	2016 \$'000
Cash at bank and on hand	<u>266</u>	-
	<u>266</u>	-

For the purposes of the statement of cash flows, cash and cash equivalents include cash at bank; cash on hand, short-term deposits and bank overdraft.

Cash and cash equivalent assets recognised in the statement of financial position are reconciled at the end of the financial year to the statement of cash flows.

Refer to Note 10 for details regarding credit risk, liquidity risk, and market risk arising from financial instruments.

5 Current / Non-Current Assets – Receivables

	2017 \$'000	2016 \$'000
Personnel services - current	988	821
Other	9	-
Personnel services – non - current	21	21
	<u>1,018</u>	<u>842</u>

Details regarding credit risk, liquidity risk and market risk, including financial assets that are either past due or impaired, are disclosed in Note 10.

Health Care Complaints Commission Staff Agency
Notes to the Financial Statements
For the year ended 30 June 2017

6 Current Liabilities – Payables

	2017 \$'000	2016 \$'000
Accrued salaries, wages and on-costs	27	1
Creditors	70	-
Intercompany payable	140	-
	<u>237</u>	<u>1</u>

Details regarding credit risk, liquidity risk and market risk, including a maturity analysis of the above payables, are disclosed in Note 10.

7 Current / Non-Current Liabilities – Provisions

	2017 \$'000	2016 \$'000
Current		
Employee benefits and related on-costs		
Annual leave	720	558
Long service leave	114	147
Payroll tax	187	115
Fringe Benefits Tax	5	-
Total current provisions	<u>1,026</u>	<u>820</u>

	2017 \$'000	2016 \$'000
Non-current		
Employee benefits and related on-costs		
Long service leave	21	21
Total provisions	<u>1,047</u>	<u>841</u>

Aggregate employee benefits and related on-costs

Provisions - current	1,026	820
Provisions - non-current	21	21
Accrued salaries, wages and on-costs (Note 6)	27	1
	<u>1,074</u>	<u>842</u>

8 Contingent Liabilities and Contingent Assets

The Staff Agency is not aware of any contingent liabilities and/or contingent assets associated with its operations.

9 Reconciliation of Cash Flows from Operating Activities to Net Result

	2017 \$'000	2016 \$'000
Net cash from operating activities	266	-
Decrease / (increase) in provisions	(206)	-
Increase / (decrease) in receivables	176	-
Decrease / (increase) in creditors	(236)	-
Net result	<u>-</u>	<u>-</u>

Health Care Complaints Commission Staff Agency
Notes to the Financial Statements
For the year ended 30 June 2017

10 Financial Instruments

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

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

The Commissioner has overall responsibility for the establishment and oversight of risk management and reviews and approves policies for managing risks. The risk policy and framework are established to identify and analyse the risks faced by the Commission, to set risk appetite, controls and monitor risks. Supporting the Commissioner with this governance responsibility and compliance with the policy is the Audit and Risk Committee, internal auditors and Executive Director on a continuous basis.

(a) Financial instrument categories

Financial Assets	Note	Category	Carrying Amount 2017 \$'000	Carrying Amount 2016 \$'000
Class:				
Cash and cash equivalents	4	Cash	266	-
Receivables ¹	5	Receivables (at amortised cost)	1,018	842
Financial Liabilities				
Class:				
			2017 \$'000	2016 \$'000
Payables ²	6	Financial liabilities measured at amortised cost	167	1

Notes:

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

(b) Credit Risk

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

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

Cash

Cash comprises cash on hand and bank balances within the NSW Treasury Banking System.

Receivables - trade debtors

All receivables are for personnel services receivable and are recognised as amounts receivable at balance date. Review of the collectability of debtors is not required as the only debtor is the HCCC.

The Staff Agency is not materially exposed to concentrations of credit risk to a single trade debtor or group of debtors. There are no debtors which are currently past due or impaired.

**Health Care Complaints Commission Staff Agency
Notes to the Financial Statements
For the year ended 30 June 2017**

10 Financial Instruments (cont'd)

(c) Liquidity risk

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

During the current and prior years, there were no defaults on or breaches of any loans payable. No assets have been pledged as collateral. The Staff Agency's exposure to liquidity risk is deemed insignificant based on prior periods' data and current assessment of risk.

The liabilities are recognised for amounts due to be paid in the future for goods or services received, whether or not invoiced. Amounts owing to suppliers (which are unsecured) are settled in accordance with the policy set out in NSW TC 11/12. For small business suppliers, where terms are not specified, payment is made no later than 30 days from date of receipt of a correctly rendered invoice. For other suppliers, if trade terms are not specified, payment is made no later than the end of the month following the month in which an invoice or a statement is received. For small business suppliers, where payment is not made within the specified period, simple interest must be paid automatically unless an existing contract specifies otherwise. For payment to other suppliers, the Head of an authority (or a person appointed by the Head of an authority) may automatically pay the supplier simple interest. No interest for the late payment was paid during the year (2016 -2017 nil).

(d) Market risk

Market risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market price.

The Staff Agency has no borrowings, no exposure to foreign currency risk and does not enter into commodity contracts.

(e) Fair value measurement

Fair value compared to carrying amount

Financial instruments are generally recognised at cost. The amortised cost of financial instruments recognised in the statement of financial position approximates the fair value, because of the short-term nature of many of the financial instruments. There are no financial instruments where the fair value differs from the carrying amount.

11 Commitments

The agency did not have any expenditure commitments as at 30 June 2017 (2016: \$nil)

12 Related Party Disclosures

All transactions and outstanding balances in these financial statements relate to the Staff Agency's function as the provider of personnel services to the immediate parent. The Staff Agency's total income is sourced from the immediate parent, and cash receipts and payments are affected by the immediate parent on the Staff Agency's behalf.

Key management personnel compensation are borne by the immediate parent. There were no other transactions with the ultimate parent during the financial year.

13 Events after the Reporting Period

There are no events subsequent to balance date which materially affect the financial statements.

End of audited financial statements.

Appendices

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A Complaints statistics

Table A.1 | Complaints received by issue category 2012-13 to 2016-17

Issue Category	2012-13		2013-14		2014-15		2015-16		2016-17	
	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total
Treatment	3,340	40.0%	3,241	40.2%	3,519	39.4%	5,008	42.3%	4,852	41.5%
Professional Conduct	1,000	12.0%	1,150	14.3%	1,272	14.2%	1,763	14.9%	1,917	16.4%
Communication/information	1,731	20.7%	1,328	16.5%	1,471	16.5%	2,035	17.2%	1,857	15.9%
Medication	647	7.8%	520	6.5%	577	6.5%	700	5.9%	739	6.3%
Access	269	3.2%	317	3.9%	282	3.2%	453	3.8%	431	3.7%
Fees/costs	301	3.6%	282	3.5%	317	3.5%	402	3.4%	380	3.2%
Environment/Management of Facilities	250	3.0%	374	4.6%	413	4.6%	348	2.9%	354	3.0%
Consent	181	2.2%	134	1.7%	246	2.8%	237	2.0%	265	2.3%
Reports/Certificates	207	2.5%	203	2.5%	255	2.9%	258	2.2%	263	2.2%
Medical Records	178	2.1%	163	2.0%	242	2.7%	260	2.2%	232	2.0%
Discharge/transfer arrangements	120	1.4%	147	1.8%	139	1.6%	187	1.6%	212	1.8%
Grievance Processes	121	1.4%	202	2.5%	207	2.3%	191	1.6%	192	1.6%
Total	8,345	100.0%	8,061	100.0%	8,940	100.0%	11,842	100.0%	11,694	100.0%

Counted by issue raised in complaint.

Table A.2 | Breakdown of complaints received 2016-17

Issue category and name	No.	% of Total
Treatment		
Inadequate treatment	1,480	12.7%
Diagnosis	578	4.9%
Inadequate Care	517	4.4%
Unexpected treatment outcome/complications	498	4.3%
Wrong/inappropriate treatment	424	3.6%
Delay in treatment	351	3.0%
Inadequate/inappropriate consultation	322	2.8%
Coordination of treatment/Results follow-up	182	1.6%
Rough and painful treatment	179	1.5%
No/inappropriate referral	86	0.7%
Infection control	80	0.7%
Excessive treatment	70	0.6%
Attendance	23	0.2%
Inadequate prosthetic equipment	20	0.2%
Withdrawal of treatment	19	0.2%
Public/private election	13	0.1%
Experimental treatment	10	0.1%
Treatment total	4,852	41.5%
Professional Conduct		
Impairment	370	3.2%
Breach of Guideline/Law	302	2.6%
Illegal practice	288	2.5%
Competence	265	2.3%
Sexual misconduct	137	1.2%
Inappropriate disclosure of information	105	0.9%
Boundary violation	104	0.9%
Misrepresentation of qualifications	100	0.9%
Assault	69	0.6%
Breach of condition	52	0.4%
Annual declaration not lodged/incomplete/wrong or misleading	39	0.3%
Discriminatory conduct	39	0.3%
Financial fraud	30	0.3%
Advertising	6	0.1%
Emergency treatment not provided	5	0.0%
Scientific fraud	4	0.0%
Child Sexual Abuse	2	0.0%
Professional Conduct total	1,917	16.4%

Table A.2 | Continued

Issue category and name	No.	% of Total
Communication/information		
Attitude/manner	906	7.7%
Inadequate information provided	602	5.1%
Incorrect/misleading information provided	326	2.8%
Special needs not accommodated	23	0.2%
Communication/information total	1,857	15.9%
Medication		
Prescribing medication	443	3.8%
Dispensing medication	154	1.3%
Administering medication	120	1.0%
Supply/security/storage of medication	22	0.2%
Medication total	739	6.3%
Access		
Refusal to admit or treat	213	1.8%
Waiting lists	110	0.9%
Service availability	97	0.8%
Access to facility	11	0.1%
Remoteness of service	1	0.0%
Access total	432	3.7%
Fees/costs		
Billing practices	318	2.7%
Cost of treatment	35	0.3%
Financial consent	27	0.2%
Fees/costs total	380	3.2%
Environment/management of facilities		
Administrative processes	152	1.3%
Cleanliness/hygiene of facility	65	0.6%
Physical environment of facility	63	0.5%
Staffing and rostering	44	0.4%
Statutory obligations/accreditation standards not met	30	0.3%
Environment/management of facilities total	354	3.0%

Table A.2 | Continued

Issue category and name	No.	% of Total
Consent		
Consent not obtained or inadequate	121	1.0%
Involuntary admission or treatment	83	0.7%
Uninformed consent	60	0.5%
Consent Total	264	2.3%
Reports/certificates		
Accuracy of report/certificate	187	1.6%
Refusal to provide report/certificate	46	0.4%
Timeliness of report/certificate	23	0.2%
Report written with inadequate or no consultation	6	0.1%
Cost of report/certificate	1	0.0%
Reports/certificates total	263	2.2%
Medical Records		
Record keeping	130	1.1%
Access to/transfer of records	93	0.8%
Records management	9	0.1%
Medical records total	232	2.0%
Discharge/transfer arrangements		
Inadequate discharge	180	1.5%
Delay	18	0.2%
Patient not reviewed	10	0.1%
Mode of transport	4	0.0%
Discharge/transfer arrangements total	212	1.8%
Grievance processes		
Inadequate/no response to complaint	175	1.5%
Reprisal/retaliation as result of complaint lodged	12	0.1%
Information about complaints procedures not provided	5	0.0%
Grievance processes total	192	1.6%
Grand total	11,694	100.0%

Counted by issue raised in complaint.

Table A.3 | Complaints received about health practitioners 2012-13 to 2016-17

Health practitioner	2012-13		2013-14		2014-15		2015-16		2016-17	
	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total
Registered health practitioner										
Medical practitioner	1,622	55.0%	1,673	54.0%	1,939	56.3%	2,134	54.5%	2,298	56.0%
Nurse/midwife	377	12.8%	480	15.5%	506	14.7%	501	12.8%	629	15.3%
Dental practitioner	435	14.8%	363	11.7%	349	10.1%	542	13.8%	370	9.0%
Psychologist	137	4.6%	149	4.8%	149	4.3%	177	4.5%	211	5.1%
Pharmacist	149	5.1%	167	5.4%	211	6.1%	197	5.0%	200	4.9%
Chiropractor	20	0.7%	26	0.8%	36	1.0%	59	1.5%	65	1.6%
Physiotherapist	22	0.7%	26	0.8%	34	1.0%	33	0.8%	38	0.9%
Medical radiation practitioner**	4	0.1%	14	0.5%	10	0.3%	12	0.3%	26	0.6%
Optometrist	12	0.4%	24	0.8%	28	0.8%	24	0.6%	24	0.6%
Chinese medicine practitioner***	15	0.5%	5	0.2%	13	0.4%	30	0.8%	23	0.6%
Podiatrist	12	0.4%	12	0.4%	17	0.5%	15	0.4%	18	0.4%
Occupational therapist*	7	0.2%	10	0.3%	12	0.3%	22	0.6%	14	0.3%
Student Nurse****	–	0.0%	12	0.4%	16	0.5%	17	0.4%	15	0.4%
Osteopath	6	0.2%	4	0.1%	10	0.3%	12	0.3%	9	0.2%
Student medical practitioner****	2	0.1%	4	0.1%	3	0.1%	5	0.1%	6	0.1%
Student Chiropractor****	–	0.0%	–	0.0%	–	0.0%	–	0.0%	2	0.0%
Student Osteopath****	–	0.0%	1	0.0%	–	0.0%	–	0.0%	1	0.0%
Student Pharmacist****	1	0.0%	–	0.0%	2	0.1%	–	0.0%	–	0.0%
Student Physiotherapist****	–	0.0%	1	0.0%	–	0.0%	–	0.0%	–	0.0%
Registered health practitioner total	2,821	95.7%	2,971	96.0%	3,335	96.8%	3,780	96.6%	3,949	96.3%

Table A.3 | Continued

Health practitioner	2012-13		2013-14		2014-15		2015-16		2016-17	
	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total
Non-registered health practitioner										
Counsellor/therapist	9	0.3%	14	0.5%	10	0.3%	17	0.4%	19	0.5%
Social worker	9	0.3%	11	0.4%	2	0.1%	9	0.2%	16	0.4%
Assistant in nursing	21	0.7%	23	0.7%	10	0.3%	13	0.3%	13	0.3%
Alternative health provider	19	0.6%	11	0.4%	9	0.3%	12	0.3%	12	0.3%
Administration/ clerical staff	24	0.8%	10	0.3%	15	0.4%	9	0.2%	9	0.2%
Cosmetic therapist	3	0.1%	4	0.1%	1	0.0%	8	0.2%	9	0.2%
Massage therapist	6	0.2%	10	0.3%	8	0.2%	12	0.3%	8	0.2%
Dietitian/nutritionist	1	0.0%	3	0.1%	2	0.1%	7	0.2%	5	0.1%
Ambulance personnel	1	0.0%	1	0.0%	–	0.0%	3	0.1%	3	0.1%
Dental technician	4	0.1%	4	0.1%	1	0.0%	2	0.1%	3	0.1%
Homeopath	1	0.0%	–	0.0%	1	0.0%	1	0.0%	2	0.0%
Natural therapist	–	0.0%	2	0.1%	–	0.0%	–	0.0%	2	0.0%
Audiologist	–	0.0%	–	0.0%	1	0.0%	–	0.0%	1	0.0%
Hypnotherapist	2	0.1%	–	0.0%	2	0.1%	1	0.0%	1	0.0%
Naturopath	6	0.2%	4	0.1%	2	0.1%	3	0.1%	1	0.0%
Personal care assistant	–	0.0%	–	0.0%	–	0.0%	2	0.1%	1	0.0%
Psychotherapist	3	0.1%	3	0.1%	1	0.0%	1	0.0%	1	0.0%
Speech pathologist	2	0.1%	2	0.1%	1	0.0%	–	0.0%	1	0.0%
Doula	–	0.0%	1	0.0%	1	0.0%	–	0.0%	–	0.0%
Kinesiologist	–	0.0%	2	0.1%	–	0.0%	–	0.0%	–	0.0%
Optical dispenser	1	0.0%	–	0.0%	–	0.0%	–	0.0%	–	0.0%
Residential care worker	2	0.1%	2	0.1%	–	0.0%	1	0.0%	–	0.0%
Student Psychologist	–	0.0%	–	0.0%	1	0.0%	–	0.0%	–	0.0%
Venopuncturist	–	0.0%	–	0.0%	–	0.0%	1	0.0%	–	0.0%
Non-registered health practitioner	114	3.9%	107	4.0%	68	3.2%	102	3.4%	107	2.6%
Other/unknown health practitioner	12	0.4%	18	0.6%	42	1.2%	33	0.8%	46	1.1%
Health practitioner total	2,947	100.0%	3,096	100.0%	3,445	100.0%	3,915	100.0%	4,102	100.0%

* Occupational therapist registered from 1 July 2012

** Medical radiation practitioner registered from 1 July 2012

*** Chinese medical practitioner registered from 1 July 2012

*** All student practitioners are registered and are now reported under registered health practitioner except with psychology students who are not registered

Table A.4 | Complaints received about medical practitioners by service area 2012-13 to 2016-17

Service area	2012-13		2013-14		2014-15		2015-16		2016-17	
	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total
General medicine	708	43.6%	622	37.2%	702	36.2%	828	38.8%	1,047	45.6%
Surgery	214	13.2%	194	11.6%	276	14.2%	257	12.0%	233	10.1%
Psychiatry	66	4.1%	104	6.2%	101	5.2%	73	3.4%	123	5.4%
Mental health	74	4.6%	68	4.1%	71	3.7%	116	5.4%	92	4.0%
Emergency medicine	39	2.4%	71	4.2%	57	2.9%	94	4.4%	63	2.7%
Administration/ Non-health related	23	1.4%	44	2.6%	40	2.1%	22	1.0%	55	2.4%
Oncology	22	1.4%	19	1.1%	13	0.7%	51	2.4%	54	2.3%
Early childhood/ Paediatric Medicine	33	2.0%	36	2.2%	52	2.7%	55	2.6%	50	2.2%
Anaesthesia	32	2.0%	31	1.9%	35	1.8%	41	1.9%	47	2.0%
Ophthalmology	26	1.6%	32	1.9%	47	2.4%	62	2.9%	40	1.7%
Obstetrics	35	2.2%	33	2.0%	52	2.7%	66	3.1%	38	1.7%
Dermatology	23	1.4%	41	2.5%	39	2.0%	38	1.8%	37	1.6%
Gynaecology	35	2.2%	29	1.7%	42	2.2%	48	2.2%	37	1.6%
Medico-Legal	81	5.0%	71	4.2%	70	3.6%	66	3.1%	34	1.5%
Cardiology	18	1.1%	27	1.6%	41	2.1%	16	0.7%	31	1.3%
Cosmetic Services	20	1.2%	24	1.4%	23	1.2%	45	2.1%	31	1.3%
Gastroenterology	22	1.4%	21	1.3%	28	1.4%	19	0.9%	28	1.2%
Radiology	11	0.7%	23	1.4%	25	1.3%	28	1.3%	26	1.1%
Neurology	18	1.1%	27	1.6%	29	1.5%	33	1.5%	24	1.0%
Geriatrics/Gerontology	4	0.2%	16	1.0%	25	1.3%	15	0.7%	20	0.9%
Aged Care	29	1.8%	18	1.1%	24	1.2%	20	0.9%	17	0.7%
Drug and alcohol	21	1.3%	19	1.1%	17	0.9%	15	0.7%	16	0.7%
Rehabilitation medicine	8	0.5%	7	0.4%	10	0.5%	14	0.7%	13	0.6%
Pain Management	3	0.2%	8	0.5%	12	0.6%	11	0.5%	11	0.5%
Endocrinology	5	0.3%	8	0.5%	11	0.6%	10	0.5%	9	0.4%
Haematology	2	0.1%	8	0.5%	2	0.1%	2	0.1%	9	0.4%
Intensive care	–	0.0%	2	0.1%	2	0.1%	9	0.4%	9	0.4%
Respiratory/ Thoracic medicine	4	0.2%	10	0.6%	6	0.3%	7	0.3%	9	0.4%
Rheumatology	3	0.2%	4	0.2%	2	0.1%	9	0.4%	8	0.3%
Alternative health	2	0.1%	1	0.1%	–	0.0%	3	0.1%	7	0.3%
Immunology	7	0.4%	10	0.6%	7	0.4%	5	0.2%	7	0.3%
Other service areas	34	2.1%	45	2.7%	78	4.0%	55	2.6%	73	3.2%
Total	1,622	100.0%	1,673	100.0%	1,939	100.0%	2,134	100.0%	2,298	100.0%

Counted by provider identified in complaint.

Table A.5 | Complaints received about health practitioners by issue category 2016-2017

	Issue Category												Total No.	% of Total	No. of practitioners with NSW as principal place of practice as at 30.6.2017*
	Treatment	Professional conduct	Communication/ information	Medication	Fees/costs	Reports/certificates	Medical records	Consent	Access	Grievance processes	Environment/ management of facilities	Discharge/transfer arrangements			
Health practitioner	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	Total No.	% of Total	
Registered health practitioner															
Medical practitioner	1,893	678	777	319	123	156	91	90	86	40	23	31	4,307	61.2%	34,255
Nurse/midwife	242	486	118	53	1	10	38	8	5	10	18	6	995	14.1%	107,544
Dental practitioner	451	83	86	9	86	5	14	27	9	16	8		794	11.3%	6,765
Psychologist	79	144	56		3	29	6	12	3	2	1		335	4.8%	11,522
Pharmacist	3	118	32	109	5		1		4		4		276	3.9%	9,270
Chiropractor	17	56	5	1	1	2		2					84	1.2%	1,771
Physiotherapist	22	19	4	1	2	2	1	2	1		2		56	0.8%	8,900
Chinese Medicine Practitioner	9	18	2	1	1		4	1			1		37	0.5%	1,984
Optometrist	18	9	4	3			1		1				36	0.5%	1,807
Medical Radiation Practitioner	4	22	3			1			1				31	0.4%	5,217
Podiatrist	14	7	3		2			1			1		28	0.4%	1,370
Occupational Therapist	6	6	5		1	3		1	1			1	24	0.3%	5,516
Student Nurse		16											16	0.2%	–
Osteopath	2	7	1		1								11	0.2%	564
Student medical practitioner		6											6	0.1%	–
Student Chiropractor		2											2	0.0%	–
Student Osteopath		1											1	0.0%	–
Registered health practitioner total	2,760	1,678	1,096	496	226	208	156	144	111	68	58	38	7,039	100.0%	

Table A.5 | Continued

Issue Category														
	Treatment	Professional conduct	Communication/ information	Medication	Fees/costs	Reports/certificates	Medical records	Consent	Access	Grievance processes	Environment/ management of facilities	Discharge/transfer arrangements		
Health practitioner	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	Total No.	% of Total
Non-registered health practitioner														
Counsellor/therapist	14	14	7				1	1					37	18.5%
Social worker	7	14	7		2	2	1	2	1				36	18.0%
Cosmetic therapist	6	10	1	1	1						1		20	10.0%
Alternative health practitioner	4	11	2		2								19	9.5%
Assistant in nursing	3	11	2	2							1		19	9.5%
Other	4	8	4	2		1							19	9.5%
Massage therapist	6	4	1										11	5.5%
Administration/clerical staff		4	3						1		2		10	5.0%
Dental technician		4	2										6	3.0%
Dietitian/nutritionist	2	2	1			1							6	3.0%
Ambulance personnel	1	1	1										3	1.5%
Homeopath		3											3	1.5%
Natural therapist	1	1			1								3	1.5%
Hypnotherapist	1				1								2	1.0%
Naturopath		1	1										2	1.0%
Audiologist			1										1	0.5%
Personal care assistant		1											1	0.5%
Psychotherapist		1											1	0.5%
Speech pathologist		1											1	0.5%
Non-registered health practitioner total	62	113	43	7	7	4	2	6	2	0	6	0	200	100.0%
Unknown	13	22	10	2				3			2		52	100%
Health practitioner total	2,822	1,791	1,139	503	233	212	158	150	113	68	64	38	7,291	100.0%

Counted by provider identified in complaint

Table A.6 | Complaints received about health organisations 2012-2013 to 2016-2017

Health organisation	2012-13		2013-14		2014-15		2015-16		2016-17	
	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total
Public Hospital	763	47.5%	761	45.6%	868	47.7%	926	42.9%	1,016	45.9%
Correction and detention facility	187	11.6%	249	14.9%	192	10.5%	301	13.9%	257	11.6%
Medical centre	99	6.2%	96	5.7%	98	5.4%	189	8.8%	164	7.4%
Private Hospital	81	5.0%	82	4.9%	100	5.5%	113	5.2%	121	5.5%
Pharmacy	62	3.9%	28	1.7%	40	2.2%	67	3.1%	90	4.0%
Dental facility	62	3.9%	61	3.7%	33	1.8%	64	3.0%	75	3.4%
Psychiatric hospital/unit	32	2.0%	31	1.9%	41	2.3%	88	4.1%	71	3.1%
Community Health Service	53	3.3%	54	3.2%	64	3.5%	74	3.4%	64	2.9%
Aged care facility	47	2.9%	70	4.2%	75	4.1%	61	2.8%	61	2.8%
Ambulance service	28	1.7%	27	1.6%	43	2.4%	47	2.2%	61	2.7%
Alternative health facility	15	0.9%	26	1.6%	31	1.7%	13	0.6%	31	1.4%
Radiology facility	37	2.3%	31	1.9%	33	1.8%	29	1.3%	30	1.4%
Pathology centres/labs	20	1.2%	18	1.1%	28	1.5%	31	1.4%	29	1.3%
Local Health District		0.0%		0.0%		0.0%		0.0%	27	1.2%
Specialist medical practice		0.0%		0.0%		0.0%	23	1.1%	26	1.2%
Cosmetic health facility		0.0%		0.0%		0.0%	39	1.8%	21	0.9%
Day procedure centre	8	0.5%	15	0.9%	9	0.5%	11	0.5%	15	0.7%
Drug and alcohol service	6	0.4%	6	0.4%	9	0.5%	12	0.6%	14	0.6%
Optometrist facility		0.0%	4	0.2%	5	0.3%	5	0.2%	9	0.4%
Chiropractic facility	2	0.1%	1	0.1%	4	0.2%	2	0.1%	6	0.3%
Government Department	5	0.3%	5	0.3%	7	0.4%	3	0.1%	5	0.2%
Aboriginal health centre	7	0.4%	1	0.1%	9	0.5%	10	0.5%	4	0.2%
Nursing agency		0.0%		0.0%	2	0.1%		0.0%	4	0.2%
Multi purpose service	4	0.2%	4	0.2%	6	0.3%	4	0.2%	3	0.1%
Other/unknown health organisations	8	0.5%	5	0.3%	14	0.8%	7	0.3%	3	0.1%
Rehabilitation facility	2	0.1%	2	0.1%	2	0.1%	6	0.3%	3	0.1%
Health fund		0.0%		0.0%		0.0%	1	0.0%	2	0.1%
Educational facility		0.0%		0.0%		0.0%		0.0%	1	0.0%
NSW Department of Health		0.0%		0.0%		0.0%		0.0%	1	0.0%

Table A.6 | Continued

Health organisation	2012-13		2013-14		2014-15		2015-16		2016-17	
	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total
Physiotherapy facility	1	0.1%	6	0.4%	3	0.2%	5	0.2%	2	0.0%
Respite Service		0.0%		0.0%	2	0.1%	1	0.0%	1	0.0%
Sexual Assault Service	1	0.1%	1	0.1%		0.0%		0.0%	1	0.0%
Blood Bank	1	0.1%		0.0%		0.0%		0.0%		0.0%
Boarding house	1	0.1%		0.0%		0.0%		0.0%		0.0%
Local Health District/Specialty network	18	1.1%	20	1.2%	18	1.0%	19	0.9%		0.0%
Medical practice	53	3.3%	49	2.9%	83	4.6%		0.0%		0.0%
Optical Laboratory		0.0%		0.0%	1	0.1%		0.0%		0.0%
Osteopathy facility		0.0%	3	0.2%		0.0%		0.0%		0.0%
Podiatry practice	1	0.1%	2	0.1%		0.0%		0.0%		0.0%
Psychology facility	1	0.1%	6	0.4%		0.0%	5	0.2%		0.0%
Supported accommodation services (not aged care)	2	0.1%	6	0.4%	1	0.1%	4	0.2%		0.0%
Health organisation total	1,607	100.0%	1,670	100.0%	1,821	100.0%	2,160	100.0%	2,218	100.0%

Counted by provider identified in complaint

Table A.7 | Complaints received about public and private hospitals by service areas 2012-13 to 2016-17

Service area	2012-13		2013-14		2014-15		2015-16		2016-17	
	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total
Public hospital										
Emergency medicine	207	27.1%	200	26.3%	177	20.4%	190	20.5%	292	28.7%
Surgery	122	16.0%	92	12.1%	132	15.2%	93	10.0%	138	13.6%
Mental health	111	14.5%	77	10.1%	89	10.3%	101	10.9%	129	12.7%
Obstetrics	52	6.8%	52	6.8%	61	7.0%	62	6.7%	71	7.0%
General medicine	49	6.4%	71	9.3%	85	9.8%	182	19.7%	53	5.2%
Administration/ Non-health related	21	2.8%	27	3.5%	15	1.7%	27	2.9%	40	3.9%
Early childhood/ Paediatric Medicine	16	2.1%	25	3.3%	42	4.8%	47	5.1%	36	3.5%
Geriatrics/ Gerontology	4	0.5%	31	4.1%	43	5.0%	29	3.1%	35	3.4%
Oncology	19	2.5%	14	1.8%	10	1.2%	26	2.8%	26	2.6%
Palliative care	9	1.2%	16	2.1%	13	1.5%	13	1.4%	23	2.3%
Cardiology	13	1.7%	18	2.4%	33	3.8%	20	2.2%	17	1.7%
Gastroenterology	10	1.3%	10	1.3%	17	2.0%	12	1.3%	16	1.6%
Radiology	12	1.6%	2	0.3%	5	0.6%	3	0.3%	16	1.6%
Rehabilitation medicine	4	0.5%	8	1.1%	14	1.6%	10	1.1%	13	1.3%
Neurology	14	1.8%	10	1.3%	9	1.0%	13	1.4%	12	1.2%
Gynaecology	15	2.0%	8	1.1%	10	1.2%	16	1.7%	11	1.1%
Intensive care	8	1.0%	4	0.5%	7	0.8%	5	0.5%	11	1.1%
Midwifery	10	1.3%	13	1.7%	14	1.6%	5	0.5%	9	0.9%
Nephrology	1	0.1%	1	0.1%		0.0%		0.0%	7	0.7%
Drug and alcohol	5	0.7%	4	0.5%	5	0.6%	5	0.5%	5	0.5%
Endocrinology		0.0%	2	0.3%	4	0.5%	5	0.5%	5	0.5%
Haematology	4	0.5%	1	0.1%	1	0.1%	2	0.2%	5	0.5%
Pain Management	3	0.4%	2	0.3%	3	0.3%	3	0.3%	5	0.5%
Ophthalmology	7	0.9%	2	0.3%	5	0.6%	3	0.3%	4	0.4%
Physiotherapy		0.0%	1	0.1%	2	0.2%	1	0.1%	4	0.4%
Respiratory/ Thoracic medicine	9	1.2%	5	0.7%	5	0.6%	3	0.3%	4	0.4%
Other service area	38	5.0%	65	8.5%	67	7.7%	50	5.4%	29	2.9%
Public hospital total	763	100.0%	761	100.0%	868	100.0%	926	100.0%	1,016	100.0%

Table A.7 | Continued

Service area	2012-13		2013-14		2014-15		2015-16		2016-17	
	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total
Private hospital										
Surgery	32	39.5%	28	34.1%	25	25.0%	40	35.4%	38	31.4%
Mental health	8	9.9%	1	1.2%	8	8.0%	13	11.5%	15	12.4%
Rehabilitation medicine	4	4.9%	7	8.5%	8	8.0%	6	5.3%	12	9.9%
Administration/ Non-health related	4	4.9%	5	6.1%	4	4.0%	3	2.7%	10	8.3%
Emergency medicine	7	8.6%	5	6.1%	4	4.0%	5	4.4%	8	6.6%
General medicine	3	3.7%	9	11.0%	16	16.0%	21	18.6%	8	6.6%
Cardiology		0.0%	1	1.2%	3	3.0%	2	1.8%	4	3.3%
Geriatrics/ Gerontology	2	2.5%	1	1.2%	3	3.0%	2	1.8%	4	3.3%
Obstetrics	2	2.5%	5	6.1%	6	6.0%	7	6.2%	3	2.5%
Ambulance Service		0.0%		0.0%		0.0%		0.0%	2	1.7%
Dentistry		0.0%	1	1.2%	1	1.0%		0.0%	2	1.7%
Drug and alcohol	1	1.2%	1	1.2%		0.0%		0.0%	2	1.7%
Early childhood/ Paediatric Medicine	3	3.7%	1	1.2%		0.0%		0.0%	2	1.7%
Intensive care	1	1.2%	1	1.2%		0.0%	1	0.9%	2	1.7%
Nephrology		0.0%		0.0%		0.0%		0.0%	2	1.7%
Anaesthesia	1	1.2%		0.0%		0.0%		0.0%	1	0.8%
Gastroenterology	2	2.5%	2	2.4%	4	4.0%		0.0%	1	0.8%
Oncology	1	1.2%	1	1.2%	1	1.0%	3	2.7%	1	0.8%
Palliative care	1	1.2%	1	1.2%	2	2.0%	1	0.9%	1	0.8%
Psychiatry	1	1.2%	3	3.7%	3	3.0%	1	0.9%	1	0.8%
Respiratory/ Thoracic medicine		0.0%		0.0%	1	1.0%		0.0%	1	0.8%
Sleep medicine		0.0%		0.0%	1	1.0%		0.0%	1	0.8%
Other service area	8	9.9%	9	11.0%	10	10.0%	8	7.1%		0.0%
Private hospital total	81	100.0%	82	100.0%	100	100.0%	113	100.0%	121	100.0%
Grand Total	844	100.0%	843	100.0%	968	100.0%	1,039	100.0%	363	100.0%

Counted by provider identified in complaint

Table A.8 | Complaints received about public hospitals by Local Health District in 2012-13 to 2016-17

Local Health District*	2012-13		2013-14		2014-15		2015-16	
	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total
Hunter New England	110	14.4%	105	13.8%	111	12.8%	161	17.4%
South Western Sydney	84	11.0%	76	10.0%	97	11.2%	83	9.0%
South Eastern Sydney	64	8.4%	57	7.5%	80	9.2%	77	8.3%
Western Sydney	77	10.1%	85	11.2%	84	9.7%	81	8.7%
Sydney	48	6.3%	58	7.6%	78	9.0%	67	7.2%
Illawarra Shoalhaven	41	5.4%	51	6.7%	58	6.7%	49	5.3%
Western NSW	38	5.0%	33	4.3%	46	5.3%	47	5.1%
Northern Sydney	55	7.2%	63	8.3%	68	7.8%	57	6.2%
Northern NSW	36	4.7%	34	4.5%	46	5.3%	52	5.6%
Nepean Blue Mountains	38	5.0%	37	4.9%	39	4.5%	54	5.8%
Central Coast	41	5.4%	49	6.4%	50	5.8%	53	5.7%
Mid North Coast	34	4.5%	18	2.4%	24	2.8%	39	4.2%
Southern NSW	34	4.5%	18	2.4%	20	2.3%	25	2.7%
St Vincent's Health Network	19	2.5%	23	3.0%	16	1.8%	23	2.5%
Murrumbidgee **	27	3.5%	29	3.8%	17	2.0%	20	2.2%
Sydney Children's Hospital Network	11	1.4%	14	1.8%	14	1.6%	20	2.2%
Albury Wodonga Health (network with Victoria)***		0.0%		0.0%	6	0.7%	15	1.6%
Far West	3	0.4%	6	0.8%	12	1.4%	3	0.3%
Other/Unknown public hospital	3	0.4%	5	0.7%	2	0.2%		0.0%
Total	763	100.0%	761	100.0%	868	100.0%	926	100.0%

Counted by provider identified in complaint.

* Excludes psychiatric hospitals/units

** Previously complaints about facilities in Albury were processed in the Murrumbidgee LHD. These complaints are now processed by Albury Wodonga Health

*** Albury/Wodonga LHD is unique in that it spans NSW and Victoria. The statistics represent complaints for facilities in NSW only.

2016-17		Number of emergency department attendances	Number of discharges from hospital	Number of outpatient services
No.	% of Total			
126	12.4%	410,418	226,086	2,166,977
122	12.0%	271,025	244,249	1,050,977
93	9.2%	219,686	182,859	1,271,644
91	9.0%	181,868	185,670	1,225,085
83	8.2%	160,073	172,769	1,260,084
64	6.3%	152,800	98,366	723,308
63	6.2%	184,528	84,667	659,968
61	6.0%	209,122	156,729	1,049,421
57	5.6%	198,644	108,301	514,582
55	5.4%	121,772	87,832	680,541
51	5.0%	131,001	92,353	656,565
34	3.3%	122,386	78,099	568,817
33	3.2%	105,684	58,109	311,654
29	2.9%	47,635	46,062	359,155
26	2.6%	145,913	76,697	587,195
13	1.3%	94,426	52,527	425,142
9	0.9%	n/a	n/a	n/a
4	0.4%	27,750	9,003	99,056
2	0.2%	n/a	n/a	n/a
1,016	100.0%	2,784,731	1,960,378	13,610,191

Table A.9 | Issues raised in all complaints received about health organisations by organisation type 2016-17

	Issue Category												Total	% of Total
	Treatment	Communication/information	Access	Environment/management of facilities	Medication	Discharge/transfer arrangements	Fees/costs	Professional conduct	Grievance processes	Consent	Medical records	Reports/certificates		
Organisation type	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	% of Total
Public Hospital	1,245	414	91	133	67	142	19	27	53	70	32	19	2,312	52.5%
Correction and detention facility	193	21	115	6	62		2	1	1	1	1	3	406	9.2%
Medical centre	68	59	42	20	1		24	4	11	1	25	4	259	5.9%
Private Hospital	118	36	6	35	15	13	15	3	21	1	1	2	266	6.0%
Dental Facility	59	20	14	10			14	11	4	1		1	134	3.0%
Community health service	50	26	12	9	3	5	3	3	3	12	4	3	133	3.0%
Psychiatric hospital/unit	53	22	10	10	8	7	1	1	9	9	3		133	3.0%
Aged care facility	61	23	1	23	8		2	1	3	1	2		125	2.8%
Pharmacy	4	19	2	5	58		16	17		3	1		125	2.8%
Ambulance service	48	10	8	3	2	4	8	2	2	2		1	90	2.0%
Alternative health facility	19	6	1	3	3		5	14	4	2		1	58	1.3%
Radiology facility	19	10		2			8	1		1		11	52	1.2%
Specialist medical practice	12	17	1	4	3		6	3	2	3		1	52	1.2%
Local Health District	22	8	8	2	2			3	2	1	1		49	1.1%
Pathology centres/labs	11	6	2	5			11	1	4		1	5	46	1.0%
Cosmetic health facility	12	1		3	2		1	14		2	1		36	0.8%
Drug and alcohol service	12	2	1	6	2	2	1	1	1				28	0.6%
Day procedure centre	5	4		2			6	3	1	2			23	0.5%
Nursing agency	7	2	1	3				1					14	0.3%
Optometrist facility	3	4	1	1			2		1	1	1		14	0.3%
Chiropractic facility							1	6					7	0.2%

Table A.9 | Continued

	Issue Category												Total	% of Total
	Treatment	Communication/information	Access	Environment/management of facilities	Medication	Discharge/transfer arrangements	Fees/costs	Professional conduct	Grievance processes	Consent	Medical records	Reports/certificates		
Organisation type	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	% of Total
Aboriginal health centre		2		2			1	2					7	0.2%
Government Department	1		2	1				2			1		7	0.2%
Multi purpose service	3					1		1		1			6	0.1%
Rehabilitation facility	3	2							1				6	0.1%
NSW Department of Health	1	1							1				3	0.1%
Other		1						2					3	0.1%
Health fund		1					1						2	0.0%
Respite Service	1			1									2	0.0%
Educational facility				1									1	0.0%
Physiotherapy facility								1					1	0.0%
Sexual Assault Service								1					1	0.0%
Total	2,030	717	318	290	236	174	147	126	124	114	74	51	4,401	100.0%

Counted by issues raised in complaint

Table A.10 | Issues raised in all complaints by service area

Service area	Issue Category												Total	% of Total
	Treatment	Professional Conduct	Communication/information	Medication	Access	Fees/costs	Environment/Management of Facilities	Consent	Reports/Certificates	Medical Records	Discharge/transfer arrangements	Grievance Processes		
	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	% of Total
General medicine	1,044	487	453	234	159	65	58	26	85	97	16	25	2,749	23.5%
Dentistry	529	99	110	9	31	100	22	28	6	14		20	968	8.3%
Surgery	524	64	158	14	27	43	30	20	13	3	28	25	949	8.1%
Mental health	373	95	152	69	33	5	40	81	11	20	31	18	928	7.9%
Emergency medicine	545	20	142	14	32	4	33	7	4	16	63	15	895	7.7%
Pharmacy/Pharmacology	7	139	51	171	7	20	9	3		1		1	409	3.5%
Aged Care	114	66	50	32	3	4	30	5	2	17		5	328	2.8%
Psychology	71	140	51		6	3	2	10	25	7		2	317	2.7%
Obstetrics	162	10	63	8	4	9	6	7	1	6	7	6	289	2.5%
Psychiatry	96	38	61	29	8	6	1	16	21	6	3	3	288	2.5%
Administration/Non-health related	15	125	24	2	9	16	33	1		6	3	4	238	2.0%
Early childhood/Paediatric Medicine	127	23	36	9	5	3	2	5	8	4	6	7	235	2.0%
Oncology	107	15	35	35			2	4	1	2	2	4	207	1.8%
Cosmetic Services	65	62	21	6		8	7	7		2		7	185	1.6%
Geriatrics/Gerontology	70	3	38	13	3		6	2	2	1	11	5	154	1.3%
Radiology	43	31	24		4	10	8	1	26		1		148	1.3%
Drug and alcohol	37	26	10	18	37		9	2		1	2	2	144	1.2%
Palliative care	58	7	28	12	1		4	2	1	4	4	2	123	1.1%
Cardiology	62	13	23	2	5	4	2	3	1	1	4	2	122	1.0%
Gastroenterology	58	1	23	3	5	5	4	5	1		2	3	110	0.9%
Rehabilitation medicine	51	11	20	8	1	2	7	1	1	1	3	2	108	0.9%
Dermatology	55	13	17	1	1	3	3	1		1		2	97	0.8%
Unknown	6	79	6	1			2					2	96	0.8%
Ophthalmology	55	7	12		5	1	1	4	2	4		4	95	0.8%
Ambulance Service	45	3	13	1	9	10	3	2	1		4	2	93	0.8%
Chiropractice	18	62	5	1	1	2		2	2				93	0.8%
Midwifery	48	16	13	2			5		1	5	1	2	93	0.8%
Gynaecology	48	10	19	1	6	1		2			3		90	0.8%
Other service areas	10	61	11	4	1			1				1	89	0.8%
Anaesthesia	30	20	6	3		15		3				1	78	0.7%
Neurology	37	8	16	3	1	3	2		1	2	4	1	78	0.7%
Medico-Legal	16	6	20					3	20				65	0.6%
Pathology	21	4	12		3	9	5		6	1		4	65	0.6%
Physiotherapy	24	19	6	1	4	2	2	2	2	1	1	1	65	0.6%
Intensive care	34	4	10	3			1	1			1	3	57	0.5%
Alternative health	10	18	8	6	1	4						4	51	0.4%

Table A.10 | Continued

Issue Category														
Service area	Treatment	Professional Conduct	Communication/information	Medication	Access	Fees/costs	Environment/Management of Facilities	Consent	Reports/Certificates	Medical Records	Discharge/transfer arrangements	Grievance Processes	Total	
													No.	% of Total
Optometry	21	9	9	3	1	3	1			1		1	49	0.4%
Pain Management	25	1	4	10	5		1		2			1	49	0.4%
Counselling	17	21	7			1			1				47	0.4%
Haematology	15	9	11	1					2		3	1	42	0.4%
Endocrinology	15	2	7	3		1	1		2	1	2		34	0.3%
Podiatry	14	4	3	1		3	1	1					27	0.2%
Respiratory/Thoracic medicine	14	1	7		2	1			1		1		27	0.2%
Traditional Chinese medicine	6	12	1	1		1	1	1		3			26	0.2%
Nephrology	7		9		1		4		1		2		24	0.2%
Immunology	12	2	4	2	1	1				1			23	0.2%
Massage therapy	9	7	1			1	1						19	0.2%
Occupational health	3	5	5		4				1		1		19	0.2%
Reproductive medicine	8	1	7					1			1	1	19	0.2%
Occupational therapy	4	4	3					1	3		1		16	0.1%
Sleep medicine	5	1	4		2	4							16	0.1%
Developmental disability	9	2	1				1	1	1				15	0.1%
Infectious diseases	4	2	2	1	2		2				1	1	15	0.1%
Family planning	8		3	1								2	14	0.1%
Rheumatology	6	2	4					1	1				14	0.1%
Osteopathy	2	9	1			1							13	0.1%
Medical Radiation Practice	4	5	1						2				12	0.1%
Renal medicine	7		2		1		1			1			12	0.1%
Acupuncture	4	2	1				1			1			9	0.1%
Natural therapy	2	5	1			1							9	0.1%
Nutrition and dietetics	4	1	1	1					1				8	0.1%
Speech therapy	2		2			2							6	0.1%
Sport medicine	2		2			1		1					6	0.1%
Health education/information	2		3										5	0.0%
Community Care	1	1	1		1								4	0.0%
Personal care	1	2	1										4	0.0%
Psychotherapy	2	1	1										4	0.0%
Sexual assault service	1	1	1							1			4	0.0%
Hypnotherapy	1					2							3	0.0%
Forensic pathology									1				1	0.0%
Total Counted by issues raised in complaint	4,852	1,917	1,857	739	432	380	354	264	263	232	212	192	11,694	100.0%

Table A.11 | Complaints received by service area 2012-13 to 2016-17

Service area	2012-13		2013-14		2014-15		2015-16		2016-17	
	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total
General medicine	1,178	25.9%	1,010	21.2%	1,143	21.7%	1,533	25.2%	1,600	25.3%
Dentistry	521	11.4%	430	9.0%	393	7.5%	648	10.7%	469	7.4%
Mental health	344	7.6%	312	6.5%	343	6.5%	492	8.1%	467	7.4%
Surgery	390	8.6%	347	7.3%	490	9.3%	432	7.1%	446	7.1%
Emergency medicine	274	6.0%	315	6.6%	267	5.1%	314	5.2%	405	6.4%
Pharmacy/Pharmacology	230	5.1%	199	4.2%	253	4.8%	260	4.3%	294	4.7%
Other service areas	90	0.2%	117	0.3%	211	1.9%	145	0.8%	252	4.0%
Psychology	118	2.6%	136	2.9%	133	2.5%	166	2.7%	204	3.2%
Administration/ Non-health related	87	1.9%	191	4.0%	126	2.4%	151	2.5%	186	2.9%
Aged Care	169	3.7%	195	4.1%	213	4.0%	179	2.9%	182	2.9%
Psychiatry	83	1.8%	167	3.5%	149	2.8%	85	1.4%	139	2.2%
Obstetrics	103	2.3%	103	2.2%	123	2.3%	145	2.4%	125	2.0%
Early childhood/ Paediatric Medicine	59	1.3%	79	1.7%	124	2.4%	125	2.1%	103	1.6%
Drug and alcohol	63	1.4%	92	1.9%	92	1.7%	101	1.7%	100	1.6%
Cosmetic Services	30	0.7%	88	1.8%	43	0.8%	94	1.5%	94	1.5%
Radiology	57	1.3%	65	1.4%	79	1.5%	71	1.2%	92	1.5%
Oncology	47	1.0%	40	0.8%	29	0.6%	100	1.6%	89	1.4%
Chiropractice	22	0.5%	24	0.5%	39	0.7%	61	1.0%	73	1.2%
Geriatrics/Gerontology	12	0.3%	51	1.1%	79	1.5%	55	0.9%	62	1.0%
Ambulance Service	27	0.6%	23	0.5%	47	0.9%	49	0.8%	61	1.0%
Cardiology	32	0.7%	60	1.3%	87	1.7%	38	0.6%	56	0.9%
Gastroenterology	37	0.8%	39	0.8%	54	1.0%	38	0.6%	53	0.8%
Gynaecology	55	1.2%	41	0.9%	52	1.0%	68	1.1%	53	0.8%
Anaesthesia	35	0.8%	36	0.8%	39	0.7%	49	0.8%	51	0.8%
Rehabilitation medicine	21	0.5%	31	0.7%	43	0.8%	40	0.7%	50	0.8%
Ophthalmology	36	0.8%	42	0.9%	55	1.0%	68	1.1%	49	0.8%
Palliative care	21	0.5%	28	0.6%	27	0.5%	32	0.5%	44	0.7%
Physiotherapy	24	0.5%	39	0.8%	42	0.8%	40	0.7%	43	0.7%
Dermatology	32	0.7%	48	1.0%	45	0.9%	43	0.7%	42	0.7%
Medico-Legal	92	2.0%	78	1.6%	78	1.5%	73	1.2%	39	0.6%
Pathology	29	0.6%	26	0.5%	31	0.6%	34	0.6%	39	0.6%
Midwifery	36	0.8%	39	0.8%	56	1.1%	32	0.5%	37	0.6%
Neurology	32	0.7%	40	0.8%	41	0.8%	51	0.8%	36	0.6%
Optometry	18	0.4%	30	0.6%	39	0.7%	35	0.6%	33	0.5%
Pain Management	8	0.2%	38	0.8%	31	0.6%	35	0.6%	30	0.5%
Intensive care	12	0.3%	10	0.2%	15	0.3%	18	0.3%	27	0.4%
Alternative health	32	0.7%	30	0.6%	47	0.9%	40	0.7%	26	0.4%

Table A.11 | Continued

Service area	2012-13		2013-14		2014-15		2015-16		2016-17	
	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total
Counselling	18	0.4%	25	0.5%	14	0.3%	16	0.3%	25	0.4%
Haematology	8	0.2%	9	0.2%	3	0.1%	6	0.1%	17	0.3%
Podiatry	13	0.3%	16	0.3%	17	0.3%	18	0.3%	17	0.3%
Endocrinology	5	0.1%	10	0.2%	18	0.3%	17	0.3%	16	0.3%
Respiratory/ Thoracic medicine	14	0.3%	17	0.4%	12	0.2%	10	0.2%	16	0.3%
Traditional Chinese medicine	5	0.1%		0.0%	1	0.0%	20	0.3%	15	0.2%
Massage therapy	9	0.2%	13	0.3%	9	0.2%	12	0.2%	14	0.2%
Nephrology	2	0.0%	4	0.1%	2	0.0%	3	0.0%	14	0.2%
Immunology	15	0.3%	20	0.4%	18	0.3%	17	0.3%	13	0.2%
Osteopathy	4	0.1%	8	0.2%	9	0.2%	13	0.2%	11	0.2%
Occupational health	5	0.1%	5	0.1%	5	0.1%	3	0.0%	10	0.2%
Grand Total	4,554	100.0%	4,766	100.0%	5,266	100.0%	6,075	100.0%	6,319	100.0%

Counted by provider identified in complaint

Table A.12 | Source of complaints 2012-13 to 2016-17

Source	2012-13		2013-14		2014-15		2015-16		2016-17	
	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total
Consumer	2,403	63.4%	2,289	57.1%	2,374	49.9%	3,182	51.4%	3,310	51.8%
Family or friend	800	21.1%	969	24.2%	1,049	22.0%	1,561	25.2%	1,599	25.0%
Unknown/other source (including members of the public)	22	0.6%	143	3.6%	451	9.5%	600	9.7%	538	8.4%
Health care provider	194	5.1%	301	7.5%	400	8.4%	357	5.8%	349	5.5%
Professional council/ association and regulatory authority	118	3.1%	127	3.2%	189	4.0%	201	3.2%	288	4.5%
Consumer organisation/ advocate/carer/employer	18	0.5%	32	0.8%	48	1.0%	169	2.7%	184	2.9%
Department of Health (State and Commonwealth)	135	3.6%	56	1.4%	82	1.7%	37	0.6%	58	0.9%
Government department	49	1.3%	66	1.6%	139	2.9%	49	0.8%	45	0.7%
Legal representative	27	0.7%	8	0.2%	7	0.1%	13	0.2%	17	0.3%
College	4	0.1%	9	0.2%	3	0.1%	2	0.0%	4	0.1%
Court	12	0.3%	6	0.1%	7	0.1%	15	0.2%	2	0.0%
Member of Parliament/ Minister	6	0.2%	2	0.0%	11	0.2%	–	0.0%	–	0.0%
Total	3,788	100.0%	4,008	100.0%	4,760	100.0%	6,186	100.0%	6,394	100.0%

Counted by Complainant and this takes into consideration multiple complainants

Table A.13 | Location of complainants 2012-13 to 2016-17

METRO	2012-13		2013-14		2014-15		2015-16		2016-17	
	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total
Metropolitan	2,725	58.8%	2,807	57.8%	3,089	57.7%	3,243	52.4%	3,346	52.3%
Non-Metro	1,203	25.9%	1,214	25.0%	1,361	25.4%	1,823	29.5%	1,535	24.0%
Interstate	166	3.6%	190	3.9%	252	4.7%	296	4.8%	245	3.8%
International	19	0.4%	20	0.4%	17	0.3%	13	0.2%	12	0.2%
Address Not Coded	523	11.3%	623	12.8%	639	11.9%	811	13.1%	1,256	19.6%
Total	4,636	100.0%	4,854	100.0%	5,358	100.0%	6,186	100.0%	6,394	100.0%

*Counted by Complainant***Table A.14** | Location of health service provider 2012-13 to 2016-17

METRO	2012-13		2013-14		2014-15		2015-16		2016-17	
	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total
Metropolitan	2,860	62.8%	3,124	65.5%	3,607	68.5%	4,147	68.3%	4,358	69.0%
Non-Metro	926	20.3%	1,178	24.7%	1,296	24.6%	1,569	25.8%	1,614	25.5%
Interstate	121	2.7%	134	2.8%	140	2.7%	184	3.0%	176	2.8%
International	7	0.2%	5	0.1%	5	0.1%	4	0.1%	7	0.1%
Address Not Coded	640	14.1%	326	6.8%	218	4.1%	171	2.8%	164	2.6%
Total	4,554	100.0%	4,767	100.0%	5,266	100.0%	6,075	100.0%	6,319	100.0%

Counted by Provider

Table A.15 | Issues raised in all complaints received by complainant location 2016-17

Issue category	Metropolitan NSW		Regional NSW		Address Not Coded		Interstate		International		Total	
	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total
Treatment	2,542	40.8%	1,480	48.9%	755	34.7%	177	40.8%	10	41.7%	4,964	41.8%
Professional conduct	1,034	16.6%	309	10.2%	498	22.9%	79	18.2%	6	25.0%	1,926	16.2%
Communication/information	950	15.3%	478	15.8%	383	17.6%	66	15.2%	4	16.7%	1,881	15.8%
Medication	421	6.8%	180	5.9%	123	5.7%	31	7.1%	1	4.2%	756	6.4%
Access	225	3.6%	140	4.6%	64	2.9%	4	0.9%		0.0%	433	3.6%
Fees/costs	249	4.0%	53	1.8%	67	3.1%	11	2.5%	1	4.2%	381	3.2%
Environment/management of facilities	159	2.6%	84	2.8%	107	4.9%	6	1.4%		0.0%	356	3.0%
Consent	160	2.6%	63	2.1%	43	2.0%	7	1.6%		0.0%	273	2.3%
Reports/certificates	143	2.3%	62	2.0%	35	1.6%	25	5.8%	1	4.2%	266	2.2%
Medical records	140	2.2%	54	1.8%	29	1.3%	12	2.8%	1	4.2%	236	2.0%
Discharge/transfer arrangements	97	1.6%	75	2.5%	38	1.7%	7	1.6%		0.0%	217	1.8%
Grievance processes	106	1.7%	50	1.7%	31	1.4%	9	2.1%		0.0%	196	1.6%
Grand Total	6,226	52.4%	3,028	25.5%	2,173	18.3%	434	3.7%	24	0.2%	11,885	100.0%

Counted by issue raised in complaint

Table A.16 | Outcome of assessment of complaints 2012-13 to 2016-17

Assessment decision	2012-13		2013-14		2014-15		2015-16		2016-17	
	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total
Discontinued*	2,148	47.3%	2,483	52.4%	2,334	46.7%	2,338	40.3%	2,008	36.8%
Referred to professional council	887	19.5%	842	17.8%	942	18.8%	1,211	20.9%	1,157	21.2%
Discontinued with comments	0	0.0%	0	0.0%	0	0.0%	288	5.0%	613	11.2%
Referred for local resolution	252	5.5%	384	8.1%	262	5.2%	411	7.1%	507	9.3%
Resolved during assessment	240	5.3%	260	5.5%	662	13.2%	692	11.9%	425	7.8%
Investigation by Commission	209	4.6%	206	4.3%	250	5.0%	344	5.9%	319	5.8%
Referred to the Commission's Resolution Service	714	15.7%	442	9.3%	409	8.2%	329	5.7%	217	4.0%
Referred to another body or person	94	2.1%	125	2.6%	143	2.9%	192	3.3%	211	3.9%
Total	4,544	100.0%	4,742	100.0%	5,002	100.0%	5,805	100.0%	5,457	100.0%

Counted by issue raised in complaint

* Includes withdrawn complaints

Table A.17 | Outcome of assessment of complaints by issues identified in complaint 2016-17

Issue category and name	Outcome								Total	% of Total
	Discontinued	Referred to Professional Council	Discontinue with comments	Referred for local resolution	Resolved during Assessment Process	Referred to the Commission's Resolution Service	Investigation by Commission	Refer to Another body		
	No.	No.	No.	No.	No.	No.	No.	No.	No.	
Treatment										
Inadequate treatment	551	262	157	91	82	99	49	21	1,312	12.5%
Diagnosis	235	89	69	37	29	47	9	2	517	4.9%
Inadequate care	189	58	61	78	32	62	3	21	504	4.8%
Unexpected treatment outcome/complications	188	105	48	14	20	40	25	10	450	4.3%
Inadequate/inappropriate consultation	158	35	79	14	39	5	5	2	337	3.2%
Delay in treatment	96	20	29	98	47	26		1	317	3.0%
Wrong/inappropriate treatment	129	48	33	22	12	15	15	3	277	2.6%
Rough and painful treatment	88	21	29	10	22	4	2	1	177	1.7%
Coordination of treatment/results follow-up	59	23	24	10	20	22	3	4	165	1.6%
No/inappropriate referral	35	18	18	4	7	5	2		89	0.8%
Excessive treatment	20	15	7	2	5	5	3	1	58	0.6%
Infection control	18	11	8	2	2	4	2	10	57	0.5%
Inadequate prosthetic equipment	5	9	3	2	3				22	0.2%
Attendance	10	1	3	5	1				20	0.2%
Withdrawal of treatment	7	1	1	5		1			15	0.1%
Public/private election	4		1	3	2		1		11	0.1%
Experimental treatment	3	1		1	1	1	1		8	0.1%
Treatment total	1,795	717	570	398	324	336	120	76	4,336	41.2%
Communication/information										
Attitude/manner	416	106	183	70	92	30	4	10	911	8.7%
Inadequate information provided	252	49	76	50	59	56	9	18	569	5.4%
Incorrect/misleading information provided	117	37	29	20	16	23	7	15	264	2.5%
Special needs not accommodated	12		3	4	3	5		2	29	0.3%
Communication/information total	797	192	291	144	170	114	20	45	1,773	16.9%

Table A.17 | Continued

Issue category and name	Outcome									% of Total
	Discontinued	Referred to Professional Council	Discontinue with comments	Referred for local resolution	Resolved during Assessment Process	Referred to the Commission's Resolution Service	Investigation by Commission	Refer to Another body	Total	
	No.	No.	No.	No.	No.	No.	No.	No.	No.	
Professional conduct										
Impairment	41	231	5		2		42	7	328	3.1%
Breach of guideline/law	65	114	15		3	1	50	37	285	2.7%
Competence	59	135	14		4		27	5	244	2.3%
Illegal practice	47	70	11		4		47	32	211	2.0%
Sexual misconduct	22	16	16	1			49	5	109	1.0%
Inappropriate disclosure of information	46	23	10	4	2		1	7	93	0.9%
Misrepresentation of qualifications	14	28	14		4		6	22	88	0.8%
Boundary violation	17	21	9				36	3	86	0.8%
Assault	17	16	9				16	3	61	0.6%
Breach of condition	5	9	2				24	6	46	0.4%
Annual declaration not lodged/incomplete/wrong or misleading	–	36	4					2	42	0.4%
Discriminatory conduct	11	8	5	3	2	1	1		31	0.3%
Financial fraud	8	7	1				1	3	20	0.2%
Emergency treatment not provided	–	3	2						5	0.0%
Scientific fraud	1						1	1	3	0.0%
Advertising	–							1	1	0.0%
Professional conduct total	353	717	117	8	21	2	301	134	1,653	15.7%
Medication										
Prescribing medication	176	66	39	40	18	14	50	8	411	3.9%
Dispensing medication	20	61	8	1	7		12	5	114	1.1%
Administering medication	21	35	16	18	4	7	6	6	113	1.1%
Supply/security/storage of medication	3	11	1	1				1	17	0.2%
Medication total	220	173	64	60	29	21	68	20	655	6.2%

Table A.17 | Continued

Issue category and name	Outcome								Total	% of Total
	Discontinued	Referred to Professional Council	Discontinue with comments	Referred for local resolution	Resolved during Assessment Process	Referred to the Commission's Resolution Service	Investigation by Commission	Refer to Another body		
	No.	No.	No.	No.	No.	No.	No.	No.	No.	
Access										
Refusal to admit or treat	94	8	36	28	24	8			198	1.9%
Waiting lists	20	1	2	60	13	3			99	0.9%
Service availability	20	2	3	53	12	2		4	96	0.9%
Access to facility	3	1		1	2			1	8	0.1%
Remoteness of service	1								1	0.0%
Access total	138	12	41	142	51	13	–	5	402	3.8%
Fees/costs										
Billing practices	103	33	44	16	63	1	2	10	272	2.6%
Cost of treatment	12	7	1	2	4	1			27	0.3%
Financial consent	11	2	3	1	7				24	0.2%
Fees/costs total	126	42	48	19	74	2	2	10	323	3.1%
Environment/management of facilities										
Administrative processes	33	5	10	24	12	6	1	14	105	1.0%
Physical environment of facility	25	2	5	21	10	11		4	78	0.7%
Staffing and rostering	9	2	7	14	9	6		5	52	0.5%
Cleanliness/hygiene of facility	13	2	6	10	1	3		9	44	0.4%
Statutory obligations/ accreditation standards not met	5	4	4	4	1	3		9	30	0.3%
Environment/management of facilities total	85	15	32	73	33	29	1	41	309	2.9%
Reports/certificates										
Accuracy of report/ certificate	92	23	32	1	12	3	1	3	167	1.6%
Refusal to provide report/ certificate	32	3	6	2	4				47	0.4%
Timeliness of report/ certificate	11	2	4	1	7	1			26	0.2%
Report written with inadequate or no consultation	2	2	1						5	0.0%
Reports/certificates total	137	30	43	4	23	4	1	3	245	2.3%

Table A.17 | Continued

Issue category and name	Outcome									% of Total
	Discontinued	Referred to Professional Council	Discontinue with comments	Referred for local resolution	Resolved during Assessment Process	Referred to the Commission's Resolution Service	Investigation by Commission	Refer to Another body	Total	
	No.	No.	No.	No.	No.	No.	No.	No.	No.	
Consent										
Consent not obtained or inadequate	66	17	18	4	6	9	1	2	123	1.2%
Involuntary admission or treatment	49	2	3	18	1	3			76	0.7%
Uninformed consent	19	11	7	1	2	3	1	1	45	0.4%
Consent total	134	30	28	23	9	15	2	3	244	2.3%
Medical records										
Record keeping	40	50	13	5	3	3	4		118	1.1%
Access to/transfer of records	28	12	8	6	23	5	1	6	89	0.8%
Records management	1	2	1	2			2	1	9	0.1%
Medical records total	69	64	22	13	26	8	7	7	216	2.1%
Discharge/transfer arrangements										
Inadequate discharge	61	12	16	23	20	25		1	158	1.5%
Delay	5		3	3	2	2			15	0.1%
Patient not reviewed	3		2	2		1			8	0.1%
Mode of transport	1			2		2			5	0.0%
Discharge/transfer arrangements total	70	12	21	30	22	30	–	1	186	1.8%
Grievance processes										
Inadequate/no response to complaint	69	14	14	16	14	24		5	156	1.5%
Reprisal/retaliation as result of complaint lodged	5	2	3	1					11	0.1%
Information about complaints procedures not provided	1		1	1	1				4	0.0%
Grievance processes total	75	16	18	18	15	24	–	5	171	1.6%
Grand Total	3,999	2,020	1,295	932	797	598	522	350	10,513	100.0%

Counted by issues raised in complaint

Table A.18 | Outcome of assessment of complaints by most common service area 2016-17

Service area	Outcome								Total	
	Discontinued	Referred to Professional Council	Discontinue with comments	Referred for local resolution	Resolved during Assessment Process	Investigation by Commission	Referred to the Commission's Resolution Service	Referred to another body		
	No.	No.	No.	No.	No.	No.	No.	No.	No.	% of Total
General medicine	569	268	208	139	104	90	23	29	1,430	26.2%
Dentistry	139	148	45	19	51	17	1	18	438	8.0%
Mental health	227	45	25	70	22	14	21	6	430	7.9%
Surgery	169	35	38	28	23	19	33	3	348	6.4%
Emergency medicine	121	33	37	70	35	3	39	2	340	6.2%
Pharmacy/Pharmacology	35	112	14	1	17	28		10	217	4.0%
Psychology	66	72	11	1	4	14		10	178	3.3%
Aged Care	37	53	9	1	3	8	5	35	151	2.8%
Obstetrics	31	21	19	17	10	2	9		109	2.0%
Psychiatry	63	13	11	2	6	5		1	101	1.9%
Administration/Non-health related	38	31	6	21	17	13		15	141	2.6%
Oncology	17	9	13	4	8	23	15	1	90	1.6%
Paediatric Medicine	25	17	13	9	10	3	11	1	89	1.6%
Drug and alcohol	23	13	4	32	6	2	2		82	1.5%
Cosmetic Services	23	12	9		5	8		23	80	1.5%
Radiology	12	22	16	6	9	1	2	1	69	1.3%
Unknown	12	46		1		6		1	66	1.2%
Chiropractice	7	40	2	1		7		6	63	1.2%
Medico-Legal	26	4	21		4	1		1	57	1.0%
Other service area	16	19		1	2	9		7	54	1.0%
Geriatrics/Gerontology	23	3	6	9	5		7	1	54	1.0%
Gynaecology	19	7	11	5	7	3	1		53	1.0%
Ophthalmology	31	7	4	2	2	7			53	1.0%
Rehabilitation medicine	18	7	4	4	10		7	2	52	1.0%
Administration	12	3	2	12	12			7	48	0.9%
Ambulance Service	12		3	21	7		2	2	47	0.9%
Anaesthesia	15	18	1		2	7			43	0.8%
Palliative care	16	6	4	2		2	11		41	0.8%
Gastroenterology	18	3	7	3	6		4		41	0.8%
Cardiology	18	1	2	7	6	4	2		40	0.7%
Dermatology	19	8	7	1	2	1		1	39	0.7%
Pathology	20	1	4	2	7		1	1	36	0.7%
Physiotherapy	16	10	2		2	1		3	34	0.6%
Neurology	10	3	6	2	5	2	5		33	0.6%
Midwifery	6	15	2	5	2		2		32	0.6%

Table A.18 | Continued

Service area	Outcome									Total	
	Discontinued	Referred to Professional Council	Discontinue with comments	Referred for local resolution	Resolved during Assessment Process	Investigation by Commission	Referred to the Commission's Resolution Service	Referred to another body			
	No.	No.	No.	No.	No.	No.	No.	No.	No.	% of Total	
Pain Management	12		3	9	4		2	1	31	0.6%	
Optometry	6	6	7	1	6			2	28	0.5%	
Alternative health	3	2	4		1	5		7	22	0.4%	
Traditional Chinese medicine	2	12	3			2		1	20	0.4%	
Counselling	8	2	5	1	1	1		1	19	0.3%	
Intensive care	3	7	1	1	1		5		18	0.3%	
Podiatry	3	6	1	2	1			4	17	0.3%	
Renal medicine	7	3		1	2		1		14	0.3%	
Immunology	6	3	1	2	1	1			14	0.3%	
Haematology	6	2		1	2		1	1	13	0.2%	
Massage therapy	2		3		3	3			11	0.2%	
Endocrinology	7			1			1	1	10	0.2%	
Osteopathy		3		1		4		2	10	0.2%	
Rheumatology	4		4		1				9	0.2%	
Reproductive medicine	6		1			1		1	9	0.2%	
Occupational therapy	6	1						1	8	0.1%	
Developmental disability	2		3					2	7	0.1%	
Infectious diseases	1	1	1	1			2	1	7	0.1%	
Respiratory/Thoracic medicine	6								6	0.1%	
Occupational health	3	1	1		1				6	0.1%	
Nutrition and dietetics	2					2		1	5	0.1%	
Sleep medicine	4		1						5	0.1%	
Acupuncture	1	1	1					2	5	0.1%	
Nephrology	3				2				5	0.1%	
Medical Radiation Practice		1	2					1	4	0.1%	
Family planning	1	1	2						4	0.1%	
Sexual assault service	2		2						4	0.1%	
Health education/information							1	2	3	0.1%	
Natural therapy	1		2						3	0.1%	
Sport medicine	1	1							2	0.0%	
Psychotherapy	1		1						2	0.0%	
Early childhood		1							1	0.0%	
Community Care							1		1	0.0%	
Forensic pathology	1								1	0.0%	
Personal care	1								1	0.0%	
Speech therapy		1							1	0.0%	
Grand Total	2,008	1,157	613	507	425	319	217	211	5,457	100.0%	

Counted by issue raised in complaint

Table A.19 | Outcome of assessment of complaints by type of health service provider 2016-17

Service area	Outcome								
	Discontinued	Referred to Professional Council	Discontinue with comments	Referred for local resolution	Resolved during Assessment Process	Investigation by Commission	Referred to the Commission's Resolution Service	Referred to another body	Total
	No.	No.	No.	No.	No.	No.	No.	No.	No. % of Total
Health practitioner									
Medical practitioner	937	389	327	180	111	38	20		2,002 56.4%
Nurse/midwife	126	324	20	46	7	12			535 15.1%
Dental practitioner	110	149	37	17	31	9			353 9.9%
Psychologist	70	77	12	14	4	7			184 5.2%
Pharmacist	22	87	8	25	6	4			152 4.3%
Chiropractor	6	39	2	5		3			55 1.5%
Physiotherapist	14	10	2	1	1	2			30 0.8%
Chinese Medicine Practitioner	3	14	4	3		2			26 0.7%
Optometrist	3	7	7		4				21 0.6%
Medical Radiation Practitioner	2	12	4			2			20 0.6%
Podiatrist	3	7	1		1	6			18 0.5%
Other service area	9		3	1	2	2			17 0.5%
Social worker	10		7						17 0.5%
Unknown	9					6			15 0.4%
Occupational therapist	8	3	1			1			13 0.4%
Student Nurse	1	11							12 0.3%
Administration/clerical staff	5		1		1	3			10 0.3%
Counsellor/therapist	6		2	1		1			10 0.3%
Cosmetic therapist	2		1			6			9 0.3%
Alternative health provider	2		2	1		3			8 0.2%
Assistant in nursing	1		4	2		1			8 0.2%
Massage therapist			2	4	2				8 0.2%
Osteopath		2		4		1			7 0.2%
Dietitian/nutritionist	2			2					4 0.1%
Student Medical practitioner		1		2					3 0.1%
Ambulance personnel	1					1			2 0.1%
Dental technician					1	1			2 0.1%
Homeopath					1	1			2 0.1%
Student Chiropractor				2					2 0.1%
Audiologist	1								1 0.0%
Natural therapist			1						1 0.0%
Naturopath			1						1 0.0%
Psychotherapist			1						1 0.0%
Speech pathologist			1						1 0.0%
Student Osteopath		1							1 0.0%
Venopuncturist					1				1 0.0%
Health practitioner total	1,353	1,133	451	310	173	112	20	0	3,552 100.0%

Table A.19 | Continued

Outcome										
Service area	Discontinued	Referred to Pro- fessional Council	Discontinue with comments	Referred for local resolution	Resolved during Assessment Process	Investigation by Commission	Referred to the Commission's Resolution Service	Referred to another body	Total	
	No.	No.	No.	No.	No.	No.	No.	No.	No.	% of Total
	Health organisation									
Public Hospital	289		61	5	96	5	159	238	853	44.8%
Correction and detention facility	55		4		24		1	172	256	13.4%
Medical centre	81		26		42	6	1	2	158	8.3%
Private Hospital	47		22		15	6	16		106	5.6%
Community health service	29		2		5	3	3	25	67	3.5%
Psychiatric hospital/unit	22		3		6	2	6	27	66	3.5%
Dental Facility	21		6		15	6	1	11	60	3.1%
Pharmacy	14	24	6		11	5			60	3.1%
Aged care facility	13		4		2	33	4		56	2.9%
Ambulance service	14		3		6	1	2	22	48	2.5%
Pathology centres/labs	14		6		7		1		28	1.5%
Alternative health facility	11		3	1	1	6			22	1.2%
Cosmetic health facility	6		2	2	3	8			21	1.1%
Local Health District	7			1	1		1	8	18	0.9%
Radiology facility	3		6		6				15	0.8%
Specialist medical practice	7		3		2	1			13	0.7%
Drug and alcohol service	5		2		3		2		12	0.6%
Day procedure centre	4		1		3	2			10	0.5%
Aboriginal health centre	5					1			6	0.3%
Rehabilitation facility	3				2				5	0.3%
Chiropractic facility	0					3			3	0.2%
Government Department	1		1			1			3	0.2%
Multi purpose service	0		1		1			1	3	0.2%
Optometrist facility	2					1			3	0.2%
Other service area	1					2			3	0.2%
Nursing agency	0					1		1	2	0.1%
Respite Service	0					2			2	0.1%
Educational facility	0				1				1	0.1%
Health fund	0					1			1	0.1%
Physiotherapy facility	0					1			1	0.1%
Psychology facility	1								1	0.1%
Sexual Assault Service	0					1			1	0.1%
Supported accommodation services (not aged care)	0					1			1	0.1%
Health organisation total	655	24	162	9	252	99	197	507	1,905	100.0%
Health service provider total	2,008	1,157	613	319	425	211	217	507	5,457	100.0%

Table A.20 | Time taken to assess complaints 2012-13 to 2016-17

	2012-13	2013-14	2014-15	2015-16	2016-17
Percentage of complaints assessed within 60 days	94.5%	94.2%	92.7%	85.8%	64.5%
Average days to assess complaints	40	38	40	47	60

Counted by provider identified in complaint

Table A.21 | Requests for review of assessment decision 2012-13 to 2016-17

	2012-13	2013-14	2014-15	2015-16	2016-17
	No.	No.	No.	No.	No.
Requests for review of assessment decision	389	320	274	307	238
Percentage of all Assessments finalised	8.6%	6.7%	5.5%	5.3%	4.4%

Counted by provider identified in complaint

Table A.22 | Outcome of reviews of assessment decision 2012-13 to 2016-17

	2012-13		2013-14		2014-15		2015-16		2016-17	
	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total
Original assessment decision confirmed	344	93.2%	279	91.5%	255	92.4%	270	91.2%	167	89.3%
Assessment decision varied	25	6.8%	26	8.5%	21	7.6%	26	8.8%	20	10.7%
Total	369	100.0%	305	100.0%	276	100.0%	296	100.0%	187	100.0%

Counted by provider identified in complaint

Table A.23 | Outcome of complaints referred to the Commission's Resolution Service 2012-13 to 2016-17

	2012-13		2013-14		2014-15		2015-16		2016-17	
Outcome	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total
Resolution did proceed										
Resolved	283	44.5%	223	36.7%	127	31.3%	111	31.7%	101	39.5%
Partially resolved	123	19.3%	127	20.9%	90	22.2%	70	20.0%	52	20.3%
Not resolved	59	9.3%	94	15.5%	56	13.8%	58	16.6%	27	10.5%
Resolution did proceed total	465	73.1%	444	73.0%	273	67.2%	239	68.3%	180	70.3%
Resolution did not proceed total	171	26.9%	164	27.0%	133	32.8%	111	31.7%	76	29.7%
Grand total	636	100.0%	608	100.0%	406	100.0%	350	100.0%	256	100.0%

Counted by provider identified in complaint

Table A.24 | Outcome of conciliations initiated by the Commission's Resolution Service 2012-13 to 2016-17

Outcome	2012-13		2013-14		2014-15		2015-16		2016-17	
	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total
Conciliation process did proceed										
Resolved										
Agreement reached	14	77.8%	7	63.6%	13	100.0%	19	90.5%	2	100.0%
Not resolved	–	0.0%	–	0.0%	–	0.0%	–	0.0%	–	0.0%
Consent withdrawn	4	22.2%	–	0.0%	–	0.0%	–	0.0%	–	0.0%
The conciliation was helpful in clarifying concerns	–	0.0%	1	9.1%	–	0.0%	–	0.0%	–	0.0%
No agreement reached	–	0.0%	2	18.2%	–	0.0%	2	9.5%	–	0.0%
Conciliation process did proceed total	18	100.0%	10	90.9%	13	100.0%	21	100.0%	2	100.0%
Conciliation process did not proceed total	–	0.0%	1	9.1%	–	0.0%	–	0.0%	–	0.0%
Grand total	18	100.0%	11	100.0%	13	100.0%	21	100.0%	2	100.0%

Counted by provider identified in complaint

Table A.25 | Time taken to complete complaints referred to the Commission's Resolution Service 2012-13 to 2016-17

Time taken to complete	2012-13		2013-14		2014-15		2015-16		2016-17	
	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total
0-1 month	116	17.7%	83	13.4%	69	16.5%	49	13.2%	36	14.0%
1-2 months	133	20.3%	87	14.1%	85	20.3%	75	20.2%	53	20.5%
2-3 months	96	14.7%	74	12.0%	72	17.2%	63	17.0%	41	15.9%
3-4 months	77	11.8%	78	12.6%	82	19.6%	90	24.3%	53	20.5%
4-5 months	62	9.5%	45	7.3%	38	9.1%	32	8.6%	33	12.8%
5-6 months	48	7.3%	52	8.4%	20	4.8%	18	4.9%	13	5.0%
6-7 months	34	5.2%	41	6.6%	15	3.6%	17	4.6%	8	3.1%
7-8 months	25	3.8%	34	5.5%	16	3.8%	8	2.2%	2	0.8%
8-9 months	18	2.8%	31	5.0%	6	1.4%	3	0.8%	7	2.7%
9-10 months	12	1.8%	27	4.4%	6	1.4%	4	1.1%	4	1.6%
10-11 months	10	1.5%	21	3.4%	4	1.0%	3	0.8%	2	0.8%
11-12 months	6	0.9%	18	2.9%	0	0.0%	0	0.0%	6	2.3%
>12 months	17	2.6%	28	4.5%	6	1.4%	9	2.4%	0	0.0%
Total	654	100.0%	619	100.0%	419	100.0%	371	100.0%	258	100.0%

Counted by provider identified in complaint

Table A.26 | Outcome of investigations 2012-13 to 2016-17

Time taken to complete	2012-13		2013-14		2014-15		2015-16		2016-17	
	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total
Registered health practitioner										
Referred to Director Proceedings	85	51.2%	110	57.9%	93	53.4%	139	63.8%	198	66.7%
Referred to Council under s20A	13	7.8%	20	10.5%	19	10.9%	37	17.0%	28	9.4%
No further action	22	13.3%	27	14.2%	16	9.2%	21	9.6%	26	8.8%
Referred to Council	45	27.1%	32	16.8%	38	21.8%	13	6.0%	24	8.1%
No further action – National Board informed		0.0%		0.0%	7	4.0%	8	3.7%	19	6.4%
Make comments to the practitioner	1	0.6%	1	0.5%	1	0.6%	0	0.0%	1	0.3%
Referred to other organisation for investigation (s26)		0.0%		0.0%		0.0%		0.0%	1	0.3%
Registered health practitioner total	166	100.0%	190	100.0%	174	100.0%	218	100.0%	297	100.0%
Non-registered health practitioner										
Public Statement / Prohibition Order	8	50.0%	10	45.5%	6	54.5%	11	64.7%	15	68.2%
No further action	5	31.3%	4	18.2%	3	27.3%	4	23.5%	5	22.7%
Make comments to the practitioner	2	12.5%	6	27.3%	2	18.2%	2	11.8%	1	4.5%
Breach of Prohibition order, refer to Commissioner		0.0%	1	4.5%		0.0%		0.0%	1	4.5%
Referred to Council		0.0%	1	4.5%		0.0%		0.0%		0.0%
Referred to Council under s20A	1	6.3%		0.0%		0.0%		0.0%		0.0%
Referred to Director of Proceedings		0.0%		0.0%		0.0%		0.0%		0.0%
Non-registered health practitioner total	16	100.0%	22	100.0%	11	100.0%	17	100.0%	22	100.0%
Health practitioner total	182	100.0%	212	100.0%	185	100.0%	235	100.0%	319	100.0%
Health organisation										
Make comment or recommendation	16	84.2%	14	100.0%	9	100.0%	9	100.0%	9	81.8%
Public Warning under s94		0.0%		0.0%		0.0%		0.0%	1	9.1%
No further action	3	15.8%		0.0%		0.0%		0.0%	1	9.1%
Health organisation total	19	100.0%	14	100.0%	9	100.0%	9	100.0%	11	100.0%
Grand Total	201	100.0%	226	100.0%	194	100.0%	244	100.0%	330	100.0%

Counted by provider identified in complaint

Table A.27 | Investigations into health organisations and health practitioners finalised 2012-13 to 2016-17

Health service provider	2012-13		2013-14		2014-15		2015-16		2016-17	
	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total
Registered health practitioner										
Medical practitioner	91	50.0%	112	52.8%	71	38.6%	121	51.5%	174	54.5%
Nurse/midwife	31	17.0%	55	25.9%	53	28.8%	42	17.9%	44	13.8%
Pharmacist	8	4.4%	4	1.9%	21	11.4%	13	5.5%	23	7.2%
Psychologist	3	1.6%	6	2.8%	9	4.9%	5	2.1%	19	6.0%
Chiropractor	2	1.1%	3	1.4%	4	2.2%	5	2.1%	12	3.8%
Dental practitioner	21	11.5%	8	3.8%	15	8.2%	25	10.6%	12	3.8%
Physiotherapist	–	0.0%	1	0.5%	–	0.0%	2	0.9%	4	1.3%
Chinese Medicine Practitioner	1	0.5%	1	0.5%	–	0.0%	2	0.9%	3	0.9%
Podiatrist	3	1.6%	–	0.0%	–	0.0%	–	0.0%	2	0.6%
Student Medical Practitioner	–	0.0%	–	0.0%	–	0.0%	–	0.0%	2	0.6%
Medical Radiation Practitioner	–	0.0%	–	0.0%	–	0.0%	–	0.0%	1	0.3%
Osteopath	7	3.8%	5	2.4%	3	1.6%	2	0.9%	1	0.3%
Student Nurse	–	0.0%	–	0.0%	–	0.0%	1	0.4%	–	0.0%
Registered health practitioner total	167	91.8%	195	92.0%	176	95.7%	218	92.8%	297	93.1%
Non-registered health practitioner										
Dietitian/nutritionist	–	0.0%	–	0.0%	–	0.0%	–	0.0%	8	2.5%
Alternative health provider	2	1.1%	–	0.0%	1	0.5%	8	3.4%	4	1.3%
Cosmetic therapist	–	0.0%	–	0.0%	–	0.0%	–	0.0%	3	0.9%
Assistant in nursing	6	3.3%	6	2.8%	3	1.6%	1	0.4%	2	0.6%
Counsellor/therapist	–	0.0%	–	0.0%	1	0.5%	–	0.0%	2	0.6%
Massage therapist	4	2.2%	5	2.4%	1	0.5%	4	1.7%	2	0.6%
Other	–	0.0%	2	0.9%	–	0.0%	1	0.4%	1	0.3%
Dental technician	1	0.5%	–	0.0%	–	0.0%	–	0.0%	–	0.0%
Doula	–	0.0%	–	0.0%	–	0.0%	1	0.4%	–	0.0%
Natural therapist	–	0.0%	–	0.0%	1	0.5%	–	0.0%	–	0.0%
Naturopath	–	0.0%	2	0.9%	1	0.5%	–	0.0%	–	0.0%
Personal care assistant	–	0.0%	–	0.0%	–	0.0%	2	0.9%	–	0.0%
Psychotherapist	–	0.0%	2	0.9%	–	0.0%	–	0.0%	–	0.0%
Residential care worker	2	1.1%	–	0.0%	–	0.0%	–	0.0%	–	0.0%
Social worker	–	0.0%	–	0.0%	1	0.5%	–	0.0%	–	0.0%
Non-registered health practitioner total	15	8.2%	17	8.0%	8	4.9%	17	7.2%	22	6.9%
Health practitioner total	182	100.0%	212	100.0%	184	100.5%	235	100.0%	319	100.0%

Table A.27 | Continued

Health service provider	2012-13		2013-14		2014-15		2015-16		2016-17	
	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total
Health organisations										
Public hospital	11	57.9%	4	28.6%	6	66.7%	3	33.3%	5	45.5%
Cosmetic health facility	–	0.0%	–	0.0%	–	0.0%	4	44.4%	3	27.3%
Alternative health facility	–	0.0%	3	21.4%	–	0.0%	–	0.0%	1	9.1%
Psychiatric hospital/unit	–	0.0%	–	0.0%	–	0.0%	–	0.0%	1	9.1%
Radiology facility	–	0.0%	–	0.0%	–	0.0%	–	0.0%	1	9.1%
Aged care facility	–	0.0%	6	42.9%	1	11.1%	–	0.0%	–	0.0%
Ambulance Service	–	0.0%	–	0.0%	1	11.1%	–	0.0%	–	0.0%
Day procedure centre	–	0.0%	–	0.0%	–	0.0%	1	11.1%	–	0.0%
Dental facility	4	21.1%	–	0.0%	–	0.0%	–	0.0%	–	0.0%
Drug and alcohol service	2	10.5%	–	0.0%	–	0.0%	–	0.0%	–	0.0%
Local Health District	–	0.0%	–	0.0%	–	0.0%	1	11.1%	–	0.0%
Multi purpose service	–	0.0%	–	0.0%	1	11.1%	–	0.0%	–	0.0%
Other health organisation	–	0.0%	1	7.1%	–	0.0%	–	0.0%	–	0.0%
Private hospital	2	10.5%	–	0.0%	–	0.0%	–	0.0%	–	0.0%
Health organisations total	19	100.0%	14	100.0%	9	100.0%	9	100.0%	11	100.0%
Grand total	201	100.0%	226	100.0%	193	100.0%	244	100.0%	330	100.0%

Counted by provider identified in complaint

Table A.28 | Investigations finalised by issue category 2012-13 to 2016-17

Issue category	2012-13		2013-14		2014-15		2015-16		2016-17	
	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total
Professional conduct	138	39.3%	193	50.1%	154	48.1%	198	44.9%	322	49.2%
Treatment	136	38.7%	91	23.6%	88	27.5%	139	31.5%	197	30.1%
Medication	24	6.8%	50	13.0%	41	12.8%	36	8.2%	63	9.6%
Communication/information	13	3.7%	22	5.7%	7	2.2%	16	3.6%	36	5.5%
Medical records	10	2.8%	15	3.9%	17	5.3%	22	5.0%	14	2.1%
Consent	19	5.4%	8	2.1%	2	0.6%	5	1.1%	9	1.4%
Fees/costs	1	0.3%	1	0.3%	4	1.3%	7	1.6%	9	1.4%
Environment/management of facilities	5	1.4%	3	0.8%	3	0.9%	13	2.9%	4	0.6%
Reports/certificates	–	0.0%	–	0.0%	–	0.0%	1	0.2%	1	0.2%
Access	1	0.3%	–	0.0%	–	0.0%	–	0.0%	–	0.0%
Discharge/transfer arrangements	2	0.6%	1	0.3%	1	0.3%	3	0.7%	–	0.0%
Grievance processes	2	0.6%	1	0.3%	3	0.9%	1	0.2%	–	0.0%
Total	351	100.0%	385	100.0%	320	100.0%	441	100.0%	655	100.0%

Counted by provider identified in complaint

Table A.29 | Outcome of investigations finalised by profession and organisation type 2016-17

	Outcome											Total	
	Referred to Director Proceedings	No further action	Referred to Council under s20A	Referred to Council	No further action – National Board informed	Prohibition Order	Comments	Referred to other organisation for investigation (s26)	Breach of Prohibition order, refer to Commissioner	Recommendations	Public Warning under s94		
Health service provider	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	% of Total
Health practitioner													
Registered health practitioner													
Medical practitioner	126	10	14	14	9		1					174	58.6%
Nurse/midwife	28	7	4	1	3			1				44	14.8%
Pharmacist	9	3	4	5	2							23	7.7%
Psychologist	14	2	2		1							19	6.4%
Dental practitioner	5		2	3	2							12	4.0%
Chiropractor	10	2										12	4.0%
Physiotherapist	4											4	1.3%
Chinese Medicine Practitioner			2	1								3	1.0%
Podiatrist	1				1							2	0.7%
Student Medical practitioner		2										2	0.7%
Medical Radiation Practitioner	1											1	0.3%
Osteopath					1							1	0.3%
Registered health practitioner total	198	26	28	24	19	0	1	1	0	0	0	297	100.0%
Non-registered health practitioner													
Dietitian/nutritionist						8						8	36.4%
Alternative health provider		1				3						4	18.2%
Cosmetic therapist						2			1	1	1	3	13.6%
Massage therapist		1					1					2	9.1%
Assistant in nursing		2										2	9.1%
Counsellor/therapist						2						2	9.1%
Other health practitioner		1										1	4.5%
Non-registered health practitioner total	0	5	0	0	0	15	1	0	1	1	1	22	100.0%

Table A.29 | Continued

	Outcome											Total	
	Referred to Director Proceedings	No further action	Referred to Council under s20A	Referred to Council	No further action – National Board informed	Prohibition Order	Comments	Referred to other organisation for investigation (s26)	Breach of Prohibition order, refer to Commissioner	Recommendations	Public Warning under s94		
Health service provider	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	% of Total
Health organisation													
Public Hospital		1								4		5	45.5%
Cosmetic health facility										3		3	27.3%
Alternative health facility											1	1	9.1%
Psychiatric hospital/unit										1		1	9.1%
Radiology facility										1		1	9.1%
Health organisation total	0	1	0	0	0	0	0	0	0	9	1	11	100.0%
Health service provider total	198	32	28	24	19	15	2	1	1	10	2	330	100.0%

Counted by provider identified in complaint

Table A.30 | Request for review of investigation decision 2012-13 to 2016-17

	2012-13	2013-14	2014-15	2015-16	2016-17
Request for review of investigation decision	5	5	2	1	1
Percentage of all investigations finalised	2.5%	2.2%	1.0%	0.4%	0.3%

Counted by provider identified in complaint

Table A.31 | Outcome of reviews of investigation decision 2012-13 to 2016-17

Outcome	2012-13		2013-14		2014-15		2015-16		2016-17	
	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total
Original investigation decision confirmed	6	100.0%	5	100.0%	1	100.0%	–	0.0%	2	100.0%
Re-opened for investigation	–	0.0%	–	0.0%	–	0.0%	1	100.0%	–	0.0%
Total	6	100.0%	5	100.0%	1	100.0%	1	100.0%	2	100.0%

Counted by provider identified in complaint

Table A.32 | Time taken to complete investigations 2012-13 to 2016-17

Time taken*	2012-13		2013-14		2014-15		2015-16		2016-17	
	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total
0-1 months	2	1.0%	6	2.7%	1	0.5%	–	0.0%	10	3.0%
1-2 months	11	5.5%	5	2.2%	7	3.6%	6	2.5%	11	3.3%
2-3 months	8	4.0%	16	7.1%	6	3.1%	14	5.7%	27	8.2%
3-4 months	10	5.0%	27	11.9%	12	6.2%	4	1.6%	18	5.5%
4-5 months	19	9.5%	22	9.7%	17	8.8%	16	6.6%	19	5.8%
5-6 months	13	6.5%	26	11.5%	18	9.3%	17	7.0%	22	6.7%
6-7 months	16	8.0%	18	8.0%	20	10.3%	23	9.4%	23	7.0%
7-8 months	24	11.9%	22	9.7%	22	11.3%	19	7.8%	17	5.2%
8-9 months	21	10.4%	24	10.6%	34	17.5%	16	6.6%	12	3.6%
9-10 months	22	10.9%	14	6.2%	20	10.3%	27	11.1%	31	9.4%
10-11 months	19	9.5%	17	7.5%	11	5.7%	25	10.2%	29	8.8%
11-12 months	15	7.5%	18	8.0%	19	9.8%	35	14.3%	20	6.1%
12-18 months	14	7.0%	10	4.4%	0	0.0%	36	14.8%	76	23.0%
18-24 months	7	3.5%	1	0.4%	7	3.6%	6	2.5%	15	4.5%
24-30 months	–	0.0%	–	0.0%	–	0.0%	–	0.0%	–	0.0%
30-36 months	–	0.0%	–	0.0%	–	0.0%	–	0.0%	–	0.0%
>36 months	–	0.0%	–	0.0%	–	0.0%	–	0.0%	–	0.0%
Total	201	100.0%	226	100.0%	194	100.0%	244	100.0%	330	100.0%
Average days	244		209		230		275		273	

Counted by provider identified in complaint

* Excludes time when investigation was paused

Table A.33 | Legal matters finalised 2012-13 to 2016-17

	2012-13		2013-14		2014-15		2015-16		2016-17	
	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total
NSW Civil Administrative Tribunal										
Proved	53	60.2%	34	47.9%	34	41.5%	46	48.9%	54	56.8%
Withdrawn	2	2.3%	4	5.6%	6	7.3%	3	3.2%	1	1.1%
Not proved	–	0.0%	1	1.4%	–	0.0%	1	1.1%	–	0.0%
Dismissed	–	0.0%	–	0.0%	1	1.2%	–	0.0%	–	0.0%
NSW Civil Administrative Tribunal total	55	62.5%	39	54.9%	41	50.0%	50	53.2%	55	57.9%
Professional Standards Committee										
Proved	13	14.8%	16	22.5%	20	24.4%	24	25.5%	22	23.2%
Not proved	3	3.4%	2	2.8%	1	1.2%	1	1.1%	3	3.2%
Withdrawn	2	2.3%	–	0.0%	2	2.4%	1	1.1%	1	1.1%
Terminated and referred to Tribunal		0.0%	–	0.0%	1	1.2%	–	0.0%	–	0.0%
Professional Standards Committee total	18	20.5%	18	25.4%	24	29.3%	26	27.7%	26	27.4%
Appeal total	10	11.4%	10	14.1%	7	8.5%	10	10.6%	9	9.5%
Re-registration total	5	5.7%	4	5.6%	10	12.2%	8	8.5%	5	5.3%
Grand total	88	100.0%	71	100.0%	82	100.0%	94	100.0%	95	100.0%

Counted by matter

Table A.34 | Open complaints as at 30 June

Open Process	2012-13		2013-14		2014-15		2015-16		2016-17	
	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total
Assessment	667	51.4%	685	58.7%	895	65.3%	1,326	65.8%	2,005	73.0%
Legal processes	160	12.3%	169	14.5%	105	7.7%	215	10.7%	256	9.3%
Investigation process	161	12.4%	149	12.8%	217	15.8%	323	16.0%	322	11.7%
Resolution process	250	19.3%	96	8.2%	92	6.7%	88	4.4%	62	2.3%
Review of assessment	37	2.9%	50	4.3%	45	3.3%	51	2.5%	59	2.1%
Brief preparation	17	1.3%	13	1.1%	5	0.4%	9	0.4%	42	1.5%
Conciliation	5	0.4%	5	0.4%	11	0.8%	3	0.1%	–	0.0%
Review of investigation	–	0.0%	–	0.0%	1	0.1%	1	0.0%	–	0.0%
Total	1,297	100.0%	1,167	100.0%	1,371	100.0%	2,016	100.0%	2,746	100.0%

Counted by provider identified in complaint

Table A.35 | Number of complaints finalised by process from 2012-13 to 2016-17

Complaints finalised	2012-13		2013-14		2014-15		2015-16		2016-17	
	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total
Assessment Process	3,621	78.3%	4,094	81.3%	4,343	85.8%	5,132	87.6%	4,921	87.6%
Resolution Process	632	13.7%	598	11.9%	402	7.9%	342	5.8%	247	4.4%
Conciliation Process	18	0.4%	11	0.2%	13	0.3%	21	0.4%	2	0.0%
Investigation Process	201	4.3%	226	4.5%	194	3.8%	244	4.2%	330	5.9%
Legal Process	155	3.3%	104	2.1%	109	2.2%	122	2.1%	119	2.1%
Total	4,627	100.0%	5,033	100.0%	5,061	100.0%	5,861	100.0%	5,619	100.0%

Counted by provider identified in complaint

Complaints Finalised tracks a complaint until the end of the sequence of processes

Table A.36 | Complaints assessed, 2012-13 to 2016-17

Assessment decision	2012-13		2013-14		2014-15		2015-16		2016-17	
	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total
Discontinue	2,149	47.3%	2,488	52.7%	2,381	46.4%	2,267	39.3%	2,264	37.6%
Refer to Council	881	19.4%	828	17.6%	969	18.9%	1,207	20.9%	1,251	20.8%
Resolved during assessment process	241	5.3%	253	5.4%	672	13.1%	692	12.0%	460	7.6%
Local Resolution	257	5.7%	383	8.1%	258	5.0%	415	7.2%	549	9.1%
Discontinue with comments	–	0.0%	–	0.0%	2	0.0%	320	5.5%	658	10.9%
Resolution	714	15.7%	434	9.2%	413	8.1%	321	5.6%	224	3.7%
Investigation	207	4.6%	206	4.4%	256	5.0%	342	5.9%	323	5.4%
Refer to Another Body	92	2.0%	125	2.6%	147	2.9%	195	3.4%	258	4.3%
No outcome identified	–	0.0%	–	0.0%	28	0.5%	11	0.2%	36	0.6%
Total	4,541	100.0%	4,717	100.0%	5,126	100.0%	5,770	100.0%	6,023	100.0%

Counted by provider identified in complaint

B Performance in 2016-17 against key indicators

GOAL 1. COMPREHENSIVE AND RESPONSIVE COMPLAINT HANDLING

OBJECTIVE	Efficient and timely processing, assessment and resolution of complaints and review processes
STRATEGY	Employ best practice complaint handling processes by: <ul style="list-style-type: none"> — improving assessment and review processes and guidelines — maximising opportunity for less serious complaints to be mutually resolved — timely communication of assessment processes and outcomes
3.8% MORE COMPLAINTS ASSESSED	The Commission assessed 6,023 complaints in 2016-17 which was an increase of 3.8% on the 5,805 complaints assessed in 2015-16.
64.5% OF COMPLAINTS ASSESSED WITHIN 60 DAYS (STATUTORY TIMEFRAME – TARGET 100%)	During the year the Commission assessed 64.5% of complaints within the statutory 60 day timeframe which compares to 85.8% in 2015-16. The reduced timeliness is attributable to an increase in both the volume and complexity of complaints received. On average complaints were assessed within 60 days (2015-16: 47 days).
7.8% OF COMPLAINTS SUCCESSFULLY RESOLVED DURING ASSESSMENT OF THE COMPLAINT	7.8% of complaints were successfully resolved during the assessment process which is a decrease from 11.9% in 2015-16. The Commission has introduced early resolution procedures to identify and address straightforward or minor complaints that are amenable to swift or informal resolution during the assessment process, but resourcing and capability building is required to sustain the focus on quick and effective solutions.
4.4% OF COMPLAINTS ASSESSED WERE SUBJECT TO A REQUEST FOR A REVIEW (TARGET <10%)	In 2016-17, the Commission received 238 requests for a review of an assessment decision. This represents 4.4% of all complaints assessed which compares favourably with 5.3% in 2015-16. Of the complaints reviewed, in 89.3% of cases the decision remained unchanged, highlighting the high quality work produced by the Commission's assessment service.
16.6% OF REVIEWS COMPLETED WITHIN 4 WEEKS (TARGET 90%)	The timeliness in the completion of reviews continues to be below expectation with 16.6% being completed within four weeks, although this is an improvement from 2015-16 where 9.8% of reviews were completed within four weeks. Implementation of new business processes has contributed to this, and continued
62.7% OF DECISION LETTERS SENT WITHIN 14 DAYS (STATUTORY TIMEFRAME – TARGET 100%)	When assessment of a complaint has been finalised the Commission is required to inform all parties of the assessment decision. During the year 62.7% of decision letters were sent within 14 days of the decision being made (2015-16: 88.7%). This fall in timeliness is due the increase in complaint numbers and staff workloads.
81.3% OF COMPLAINT ASSESSMENT CLIENTS WHO COMPLETED A SURVEY WERE SATISFIED WITH SERVICE (TARGET 80%)	At the completion of each assessment process, both the health service provider and the complainant are invited to provide feedback to the Commission via a questionnaire. The rate of response from complainants was 7.8%. Of these, 81.3% stated they were satisfied with the Commission's service. The rate of response from health service providers was 11.5% – of these, 66.7% stated they were satisfied with the Commission's service

STRATEGY	
Quality file management	
48.3% OF COMPLAINTS WERE ACKNOWLEDGED WITHIN SEVEN DAYS OF RECEIPT (TARGET 90%)	When the Commission receives a complaint, an acknowledgment letter is sent to the complainant confirming receipt. In this letter they are advised of the Assessment Officer's name and the file number to quote when contacting the Commission. In 2016-17 the Commission acknowledged 48.3% of complaints within seven days, a slight decline from the 2015-16 result, where 50.0% of complaints were acknowledged in seven days. This poor timeliness is due to administrative processes not keeping pace with the rate of increase in complaint numbers, and will be a focus area of improvement in 2017-18.
92.5% OF 21 DAY FILE AUDITS RETURNED A SATISFACTORY RESULT (TARGET 90%)	Each assessment file is subject to an audit process to ensure the effective management of the file which occurs on day 21. This audit is to ensure that all activities for the collection of information have been actioned. In 2016-17, 92.5% of 21 day audits were satisfactory, an improvement from 88.4% in 2015-16.
STRATEGY	
Improve resolution/conciliation management processes & systems	
92.6% OF COMPLAINTS WHERE RESOLUTION OFFICER CONTACTS THE PARTIES WITHIN 14 DAYS (TARGET 90%)	In 92.6% of complaints referred to the Resolution Service, a Resolution Officer contacted the parties within 14 days to introduce themselves, explain the resolution process, and answer any questions regarding the assessment of the complaint. This exceeds the performance target.
71.3% OF RESOLUTIONS COMPLETED WITHIN FOUR MONTHS (TARGET 70%)	The Resolution Service closed 71.3% of matters within four months, which exceeded the target of 70%.
85.2% OF COMPLAINTS THAT PROCEEDED TO RESOLUTION WERE RESOLVED OR PARTIALLY RESOLVED (TARGET 80%)	The resolution processes delivered full or partial resolution for the complainant in 85.2% of cases which exceeded the target of 80%. This is a pleasing improvement on 2015-16 where full or partial resolution was obtained in 76.9% of cases.
76.8% OF COMPLAINT RESOLUTION/CONCILIATION CLIENTS SATISFIED WITH SERVICE (TARGET 80%)	At the completion of each resolution process both the complainant and the provider receive a satisfaction survey. During this year the response rate to the survey was 21.5% from complainants and 35.2% from providers. Both expressed a high level of satisfaction with the service with 76.8% of complainants stating they were satisfied with the service and 85.4% of providers expressing their satisfaction.

GOAL 2. INVESTIGATE SERIOUS COMPLAINTS

OBJECTIVE	Ensure a best practice approach for the conduct of all investigations
STRATEGY	Ensure the expeditious and comprehensive investigation of complaints
72.4% OF INVESTIGATIONS FINALISED WITHIN 12 MONTHS (TARGET 90%)	The Commission finalised 72.4% of investigations within 12 months in 2016-17, a decrease from 82.8% in 2015-16. Investigations took an average of 274 days to complete (2015-16: 275 days). The increase in time taken to conduct investigations reflects both the diversity and complexity in complaints. Matters are carefully prioritised within investigations which includes ensuring that investigations where the subject of the complaint is seriously ill are expedited.
77.0% OF INVESTIGATION PLANS COMPLETED WITHIN 14 DAYS (TARGET 100%)	The Investigation Division completed 77.0% of investigation plans within 14 days of receiving the complaint from the Assessment Division in 2016-17, compared with 96.9% the previous year. The reduction in timeliness is attributable to the volume of matters under investigation. Planning is an essential aspect of the investigation process as it provides the scaffold for the entire investigation, including the identification of critical sources of information and significant witnesses to ensure that effective and timely progress is made.
STRATEGY	Monitor investigations to ensure statutory compliance, timeliness, and the reassessment of issues, including status reports to Investigation Reporting Group
75.3% OF INVESTIGATIONS REVIEWED ON TIME (TARGET 90%).	The Commission keeps all investigations and associated risks under active review to ensure that any additional parties, allegations or issues are identified in a timely manner. In addition, the information gathered during investigations often leads to the identification of new sources of evidence. Throughout the investigation review process, the Commission ensures that new information and evidence is also provided to the relevant Professional Council to aid in their own risk assessments. The 75.3% on time review rate is a decrease from 85.7% in 2015-16, and as resources permit, this will be addressed.
99.7% OF INVESTIGATION REVIEWS SHOWED SATISFACTORY PROGRESS (TARGET 90%)	Investigation practice continues to be very strong with 99.7% of all investigation reviews assessed as satisfactory. To receive this outcome, the investigation plan must be followed, evidence obtained within identified timeframes and the investigation process deemed to be on track. 2016-17 showed improvement on the previous year where 97.6% of investigation reviews showed satisfactory progress.
0.3% OF REQUESTS FOR REVIEW OF INVESTIGATION OUTCOME (TARGET <5%).	Only one review of an investigation outcome was requested during the reporting period, comparable with performance in 2015-16 (0.4%). This is testimony to the quality of the Commission's investigations and the commitment to ensuring careful and sensitive communication about the findings and outcomes. The relevant Investigation Officer will contact a complainant directly to explain investigation outcomes where required, particularly if a complaint has been identified as being distressing to the complainant or involves poor patient outcomes.

STRATEGY	Sound brief of evidence handling processes and systems in place
99.2% OF MATTERS REFERRED TO DIRECTOR OF PROCEEDINGS THAT WERE NOT REFERRED BACK FOR FURTHER INFORMATION (TARGET 90%)	Well-structured investigation plans, strong investigative review processes and effective supervision at all stages of the investigation process, ensured that comprehensive briefs of evidence are provided to the Director of Proceedings and in only a very small number of cases is additional work required before a determination about legal action can be taken.
71.2 % OF BRIEFS OF EVIDENCE PREPARED WITHIN 28 DAYS (TARGET 80%)	During 2016-17, 197 briefs of evidence were prepared for the Director of Proceedings, 50.3% of which were prepared within 28 days. This is a drop in timeliness from 2015-16 where 71.1% briefs of evidence were completed in 28 days. The reduction in timeliness is directly related to the increased number of investigations referred to the Director of Proceedings, with 198 referred in 2015-16. Changes in process, closer monitoring and efficiency gains from the electronic compilation of briefs of evidence are expected to improve performance in this area.
OBJECTIVE	Support improvements to patient care in health care delivery through recommendations arising from investigations
STRATEGY	Sound processes for the creation of recommendations
34.8% OF RECOMMENDATIONS IMPLEMENTED (TARGET 90%)	The Commission monitors the implementation of recommendations made to health organisations and reports on the outcomes in the year after they were made. In 2015-16 the Commission made 30 recommendations arising out of investigations. As of 30 June 2017, eight recommendations had been fully implemented by the relevant health organisations. The Commission has an active audit program through which it will continue to monitor the implementation of recommendations.
TWO AUDITS HELD	Two audits of health facilities were conducted in 2016-17 relating to Shellharbour Hospital and Brewarrina District Hospital. Audit reports were prepared for both relevant Local Health Districts.

GOAL 3. PROSECUTE SERIOUS COMPLAINTS

OBJECTIVE	Independent and timely prosecutions
STRATEGY	Timely determinations made to prosecute
89.4% OF COMPLAINTS CONSIDERED BY THE DIRECTOR OF PROCEEDINGS ON TIME (TARGET 80%)	The Director of Proceedings considered 89.4% of complaints within three months of referral to determine whether or not to prosecute the complaint before a disciplinary body, compared to 93.5% in 2015-16.
82.4% OF MATTERS REFERRED WITHIN 30 DAYS (TARGET 80%)	The Director of Proceedings referred 82.4% (2015-16: 78.9%) of matters to be prosecuted within 30 days of consulting with the relevant professional council.
OBJECTIVE	Professional and competent prosecutions of serious complaints in the public interest
STRATEGY	Conduct professional and competent prosecutions
96.2% success rate in prosecutions (Target 90%)	96.2% of matters prosecuted by the Commission, that were heard and finalised before the NSW Civil and Administrative Tribunal (NCAT) or a Professional Standards Committee during the reporting period were found proven. This compares to 97.2% in the previous year.
STRATEGY	Ensure compliance with timeframes imposed by Professional Standard Committees, Tribunals, and courts
93.2% compliance with deadlines (Target 80%)	The Commission complied with timeframes imposed by Professional Standards Committees, NCAT and courts in 93.2% of cases. This compares to 93.4% in the previous year.
STRATEGY	Recover legal costs
84.4% of bills of costs prepared on time (Target 75%)	84.4% of bills of legal costs were prepared internally or sent to a costs consultant within 120 days of a costs order in favour of the Commission having been made. This is a slight decrease from 90.5% in the previous year, but nevertheless exceeds the target.
Quarterly reporting on recovery of legal costs to Executive (Target: quarterly reporting)	Monthly reports on the recovery of legal costs are now provided to the Executive.

GOAL 4. ACCOUNTABILITY

OBJECTIVE	Provide timely, accurate and relevant reporting to the Minister and the Joint Parliamentary Committee
STRATEGY	Quarterly reporting on performance to Minister and Joint Parliamentary Committee (JPC) on the Health Care Complaints Commission
RESPONSIVE QUARTERLY REPORTING ON PERFORMANCE	The Commission provided quarterly reports on its complaint-handling performance to the Minister for Health, the then Assistant Minister for Health and the Joint Parliamentary Committee on the Health Care Complaints Commission in July 2016, October 2016, January 2017 and April 2017.
STRATEGY	Develop and maintain open and meaningful communication with the Minister and JPC on issues as they arise
RESPONSES TO MINISTER WITHIN 15.5 DAYS ON AVERAGE	The Commission provided 64 responses to correspondence received by the Minister during the year. On average, the requested information was provided within 14.1 days and those matters that were classified as urgent (due within 1 week) or priority (due within two weeks) were produced within those tighter timeframes in the vast majority of cases.
TIMELY RESPONSES TO JOINT PARLIAMENTARY COMMITTEE	The Joint Parliamentary Committee's annual review occurred on 8 May 2017. The Commissioner and Directors appeared at the public hearing before the Committee and provided responses to questions asked by the Committee as well as responses to questions taken on notice within the specified timeframe. The Committee's report was handed down on 11 October 2017. Five formal recommendations were made.
OBJECTIVE	Promote and publicly report about the work of the Commission
STRATEGY	The Commission's Annual Report reflects the key business and operational results for the year and fully complies with legislative requirements
ANNUAL REPORT ON TIME AND FULLY COMPLIANT	The Commission's Annual Report for 2015-16 was tabled in the Legislative Council of NSW Parliament on 15 November 2016. It was fully compliant with the Treasury's annual report checklist.
AUDITED FINANCIAL STATEMENTS	Unqualified audit certificates for the financial statements of both the Health Care Complaints Commission and the Office of the Health Care Complaints Commission were received on 23 September 2016.
INCREASED ACCESSIBILITY VIA THE WEBSITE	The Commission continues to experience a very high visitation rate to its website – in 2016-17 there were 475,148 visitors, over 1.2 million page views and over 12.4 million hits. This exceeded the target of 250,000 visitors and 7,000,000 hits.
EDUCATION ON EFFECTIVE COMPLAINTS MANAGEMENT AND THE ROLE OF THE COMMISSION	The Commission's staff gave 32 presentations and workshops to community and health professional groups across NSW which was below the target of 60. The focus this year was on Local Health District staff, mental health workers and TAFE and university students studying to become health practitioners
100% COMPLIANT WITH REQUIREMENT TO PUBLISH DISCIPLINARY DECISIONS	The Commission was fully compliant in relation to publication of decisions about the outcomes of disciplinary proceedings – 73 media releases relating to decisions of disciplinary bodies were posted. In addition, the Commission issued five public statements and one public warning about risks posed by particular health services.

GOAL 5. OUR ORGANISATION

OBJECTIVE	Continue to develop as a learning organisation that embraces a culture of continuous improvement, sharing of knowledge and promotes a productive, safe and satisfying workplace
STRATEGY	Develop the organisation's skills capability to meet expected performance requirements
PROVIDE STAFF TRAINING (TARGET: MORE THAN 2 DAYS PER STAFF MEMBER)	In 2016-17, on average, each full time equivalent staff member attended more than 2 days of training.
STRATEGY	Develop and maintain an organisational culture which promotes equity, diversity and safety
DEVELOPMENT AND REPORTING OF WHS, DIVERSITY PLAN, MULTICULTURAL PLAN, AND DISABILITY ACTION PLANS COMPLY WITH RELEVANT AGENCY TIMEFRAMES (TARGET 100%)	WH&S, Diversity, Multicultural and Disability plans were developed as five year plans in June 2014 and have been tracked and monitored to ensure compliance with actions and goals. These have been reported on in the Organisation and Governance Chapter, as part of the triennial reporting requirements.
STRATEGY	Promote internal communication throughout the organisation.
MONTHLY GENERAL STAFF BRIEFINGS ON EVENTS, OUTCOMES, ACTIVITIES, CHANGES, SIGNIFICANT ORGANISATIONAL CHANGES	The Commission hold staff meetings on a monthly basis where the Commissioner and Divisional directors inform employees about corporate strategy and planning, upcoming events and review changes which have occurred. These all staff meetings are in addition to Divisional, Team and project based collaboration.
PERCENTAGE OF KEY CORPORATE DOCUMENTS DISTRIBUTED TO ALL STAFF AND/OR INCLUDED ON THE INTRANET	All relevant corporate documents were distributed to staff and or were uploaded to the Commission's intranet site for all employees and managers to access.
OBJECTIVE	Monitor performance to ensure work quality, organisational development, good governance and effective resource management
STRATEGY	Internal management groups plan, review and monitor performance
GOVERNANCE AND ACCOUNTABILITY STRUCTURES AND PROCESSES IN OPERATION	<p>The Commission's governance and accountability structures and processes are:</p> <ul style="list-style-type: none"> — Executive Management Group – monthly monitoring of financial position, HR and operational performance and oversight of major projects — Monthly Assessment Reporting Group – monthly review of complaint assessment data and performance — Investigations Review Group – monthly monitoring and strategy for investigation cases — ICT Steering Committee — Audit and Risk Committee — Workplace Health and Safety Committee — Staff Workplace Consultative Committee — Divisional meetings — Team and project level meetings

STRATEGY	Conduct strategic planning process that integrates all planning activities, budget preparation and regular performance reporting
COMPLETE PLANNING PROCESSES FOR CORPORATE AND DIVISIONAL LEVELS ACCORDING TO THE COMMISSION'S CORPORATE GOVERNANCE FRAMEWORK DOCUMENT	The Commission holds regular strategic planning meetings and workshops with the Executive Management Group. The strategies and goals set are then implemented into Divisional plans. Key priorities are considered when setting and managing the Commission's budget and corporate functions.
STRATEGY	Monitor and report on key performance measures
MONTHLY FINANCIAL MANAGEMENT AND STAFFING REPORTS SHOWING PERFORMANCE AGAINST BUDGET.	Monthly Financial and Human Resources performance reports are tabled and reviewed at the monthly Executive Management Group meetings and any necessary corrective actions are agreed, actioned and monitored.
QUARTERLY REPORTS TO EXECUTIVE ON COMPLAINT HANDLING PERFORMANCE AGAINST KPIS	A monthly dashboard tracking and reporting on the KPIs set by the Commission is a standing item at the Executive Management Group monthly meetings.
STRATEGY	Monitor staff performance management system, including staff learning and development plans that address technical and management skills
100% OF PERFORMANCE AGREEMENTS DEVELOPED AND REVIEWED FOR STAFF (TARGET 100%)	All employees that are employed for greater than three months have performance agreements and performance reviews.
83.8% OF STAFF RATED COMPETENT OR BETTER AT PERFORMANCE REVIEW (TARGET 95%)	The nature of the work of the Commission is changing as the volume and complexity of complaints increases and as we continue to strengthen customer focus. The Commission continues to develop its staff's capabilities with appropriate training and professional development opportunities that support staff in developing new skills that are required to adapt to this changing environment.

Revised Corporate Planning and Reporting Framework

During 2016-17, the Commission revised its corporate planning and reporting framework, including its strategic plan and key performance indicators. Appendix B in the 2017-18 Annual Report will reflect the new framework.

C List of experts

The Commission uses a panel of experts from which to draw expert opinion. It should be noted that all reviewers listed may not have been used in 2016–17.

Dr. Ion Alexander	Mr. Paul Butterworth	Dr. Gregory Crosland
Dr. Roger Allan	Dr. Andrew Byrne	Dr. John Crozier
Dr. Bruce Allen	Mrs. Janice Caldwell	Ms. Allison Cummins
Dr. Stephen Allnutt	Dr. William Campbell	Dr. John Curotta
Mr. Mark Apolinario	Dr. Eric Carter	Dr. Paul Curtis
Ms. Deborah Armitage	Prof. John Carter	Mr. Mark Dalton
Dr. Mark Arnold	Prof. Jonathan Carter	Mr. Eric Daniels
Dr. Bruce Ashford	Dr. Betty Chaar	Prof. David Davies
Mr. John Baker	Dr. Daniel Challis	A/Prof. Llewelyn Davies
Dr. Michael Baldwin	A/Prof. Richard Chard	Dr. Robert Day
Dr. Jonathan Ball	Miss Kate Chellew	Dr. Gary Deed
Mrs. Susan Banks	Dr. Andrew Child	Mr. Christopher Derkenne
Dr. Simon Banting	Prof. Peter Choong	Prof. Helen Dewey
Prof. David Barnes	Dr. Louis Christie	Prof. Hugh Dickson
Mrs. Jeanne Barr	Dr. Jeremy Christley	Dr. Glenys Dore
Ms. Robyn Barrett-Roydhouse	Mr. Edward Clark	Mrs. Helen Dowling
A/Prof. James Bell	Mr. Peter Cleasby	Prof. Olaf Drummer
Mrs. Helen Benson	Prof. Geoffrey Cleghorn	Dr. Geraldine Duncan
Dr. Warwick Benson	Ms. Vanessa Clements	Dr. Iain Dunlop
Dr. Hani Bittar	Dr. Suzanne Cochrane	Dr. Paul D'Urso
Mr. Michael Blair	Prof. Paul Colditz	Ms. Maureen Edgton-Winn
Dr. Elie Bokey	Mr. Albert Coleiro	Dr. Frederick Ehrlich
Mr. Sam Borenstein	Dr. Peter Coles	Dr. David Eisinger
Dr. David Bowers	Mrs. Christine Coombs	Dr. Jeannie Ellis
Dr. David Brazier	Dr. Timothy Coombs	Dr. John England
Prof. Bruce Brew	A/Prof. Michael Cooper	Dr. Gregory Falk
Dr. Geoffrey Brodie	Dr. Rosalba Courtney	Dr. David Farlow
Dr. Andrew Brooks	Ms. Nerida Croker	Dr. Diana Farlow

Prof. Glen Farrow	Prof. James Greenwood	Dr. Peter Johnson
Mr. Mark Feldschuh	Mrs. Sue Greig	Ms. Andrea Jordan
Prof. Jennifer Fenwick	Ms. Kathrine Grover	Mrs. Tracey Jubb
Mr. John Ferguson	Dr. Graham Gumley	Dr. Stephen Jurd
Dr. Dean Fisher	Dr. Mina Gurgius	Mrs. Blanche Kairies
Prof. John Fletcher	Dr. Seyed Hamidi	Dr. Jeffrey Keir
Dr. Andrew Foote	Dr. John Harkness	Dr. Adrian Keller
Ms Elaine Ford	Dr. Stephen Harlamb	Mrs. Jacqueline Kelly
Dr. Robert Ford	Ms. Rachel Harris	Dr. Bernard Kelly, AM
Dr. Alan Forrester	Ms. Bethne Hart	Dr. Dan Kennedy
Prof. Richard Fox	Dr. Keith Hartman	Prof. Dianna Kenny
Dr. Abra Fransch	Dr. Lawrence Hayden	Dr. Timothy Keogh
Dr. Anthony Freeman	Dr. Raymond Hayek	Dr. Emery Kertesz
Ms. Julianne Friendship	Mr. Antony Heath	Dr. Suresh Khatri
Prof. Gordian Fulde	Dr. Paul Hendel	Mr. Raymond Khoury
Dr. Richard Gallagher	Dr. Illana Hepner	Mr. David Kitching
Dr. Jonathan Gani	Dr. Ralph Higgins	Prof. Leon Kleinman
Prof. Paul Gatenby	Dr. Gary Hoffman	Dr. Peter Klug
Dr. Paul Gaudry	A/Prof. Anna Holdgate	Ms. Diana Knagge
Dr. Anthony Geraghty	Dr. Herbert Hooi	Mr. Alex Knopman
Dr. Michael Giblin	Dr. George Hopkins	Prof. Paul Komesaroff
Prof. Lyn Gilbert	Dr. Craig Hore	Dr. Edward Korbel
Dr. Jonathan Gillis	Dr. Stephen Howle	Dr. Andrew Korda
Mrs. Greta Goldberg	A/Prof. Francis Hoyal	Dr. Beth Kotze
Dr. Michael Golding	Mr. Allan Hudson	Dr. Geraldine Lake
A/Prof. Peter Gonski	Dr. Melissa Hughes	Dr. Mary Langcake
Mrs. Alison Goodfellow	Dr. Carole Hungerford	Dr. Pauline Langeluddecke
Ms. Maxine Goodman	Mrs. Sarah Hunstead	Dr. Bruce Latham
Ms. Amanda Gordon	Dr. Alexander Hunyor	Ms. Janine Learmont
Dr. Sandra Grace	Ms. Lee-Ann Jackson	Mr. Jack Leigh
Ms Kathryn Grant	Prof. Michael Jelinek	Dr. Vinoo Lele

Dr. Michael Levitt	Ms. Helen Miller	Dr. Kinga Price
Dr. Danforn Lim	Dr. Janelle Miller	Prof. Joseph Proietto
Dr. Peter Liu	Dr. Peter Morse	Dr. Jennifer Prowse
Dr. Jane Lonie	Dr. Ahman Moubayed	Prof. Carolyn Quadrio
Dr. Edward Loughman	Dr. Muniswami Mudaliar	Dr. John Quinn
Mr. Ashton Lucas	Ms. Christine Muller	Dr. Geoffrey Ramin
Dr. Sara Lucas	Dr. Delma Mullins	A/Prof. Rohan Rasiah
Dr. Peter Lye	Dr. Raymond Mullins	Dr. Dennis Raymond
Mr. Stiofan Mac Suibhne	Ms Donna Muscardin	Mr. Scott Read
Dr. Kenneth Mackey	Mr. Vaneshkumar Nayak	Dr. Ian Relf
Dr. Andrew MacQueen	Dr. Gregory Nelson	Ms. Patricia Reynolds
Prof. Guy Maddern	Dr. Harry Nespolon	Dr. Adam Rish
Dr. Linda Mann	Ms. Robin Norton	Dr. Wendy Roberts
Dr. Peter Mansour	Prof. Lynne Oliver	Dr. Patricia (Patsy) Robertson
Ms Maria Marabong	Mr. Brendan O'Loughlin	Dr. Tuly Rosenfeld
Dr. Elizabeth Marles	Dr. Matthew O'Meara	Mrs. Kim Rosevear
Ms. Carol Martin	Dr. Jannifer Orman	Ms. Nadime Roumieh
Dr. Hugh Martin	Dr. Hamish Osborne	Dr. Michael Rowland
Ms. Kerri Masters	Ms. Michelle Parker	Ms. Robyn Rudner
Ms. Toni McCallum Pardey	Dr. Julian Parmegiani	Prof. Richard Ruffin
Dr. Sallyann McCarthy	Dr. Martyn Patfield	Dr. Anthony Samuels
Prof. William McCarthy	Dr. Gordon Patrick	Prof. John Saunders
Dr. Martin McGee-Collett	Dr. Andrew Paul	Ms. Dana Scott
Ms. Marrienne McGhee	Ms. Jennifer Paull	Mrs. Julie Scott
Dr. Michael McGlynn	Dr. Christopher Pearson	Dr. Diana Semmonds
Mr. John McGuire	Dr. Neil Peppitt	Mr. Stephen Seymour
Prof. Peter McMinn	Dr. John Percy	Dr. Nadine Sharples
Mr. Bernard McNair	Dr. Lian Pfitzner	Mrs. Jennifer Shaw
Ms. Rebekkah Middleton	Dr. Sharron Phillipson	Ms. Nerralie Shaw
Dr. Geoffrey Mifsud	Dr. Jeffrey Post	Mr. Warren Shaw
Dr. Antony Milch	Ms. Tracey Powell	Dr. John Sippe

Dr. George Skowronski	Dr. David Townend	Dr. Melanie Woollam
Dr. John Slaughter	Dr. Tom Tseng	Dr. John Wright
Dr. Grahame Smith	Ms Bernadette Twomey	Dr. Deborah Yates
Dr. Graydon Smith	Dr. Adrian van der Rijt	Dr. Simon Young
Ms. Marion Solomon	Mr. Andrew Van Essen	Dr. Rasiah Yuvarajan
Dr. Robert Spark	Dr. Hein Vandenberg	Prof. Chris Zaslowski
Ms. Lisa Spencer	Dr. Vincent Varjavandi	Mr. Shijing Zhang
Dr. Gautam Sridhar	Dr. Christopher Vickers	Dr. Zhen Zheng
Dr. Oscar Stanley	Ms Katrina Vukovic	
Dr. Brian Stein	Dr. Shane Waddell	
Dr. Michael Steiner	Dr. Andrew Walker	
Mr. David Stelfox	Dr. Martine Walker	
Ms. Helen Stevens	Dr. Norman Walsh	
Dr. Janine Stevenson	Dr. James Walter	
Dr. Ruth Stewart	Mr. Jonathan Wardle	
Ms. Caroline Stone	Prof. Bruce Waxman	
Dr. Neil Street	Mr. Athol Webb	
Dr. Michael Suranyi	Ms. Elvina Weissel	
Dr. Joanna Sutherland	Mr. Adam Whitby	
Ms. Sally Sutherland-Fraser	Mr. Lawrence Whitman	
Dr. Martin Suthers	Prof. Ian Wilcox	
Dr. Michael Talbot	Prof. James Wilkinson	
Dr. Deniz Tek	Dr. Cholmondeley Williams	
Mr. Jack Tillotson	Mr. Michael Williamson	
Dr. Derrick Tin	Dr. Alexander Wodak	
Dr. Kenneth Tiver	Dr. James Wong	

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F Access applications received under the Government Information (Public Access) Act

Table A36 | Number of applications by type of applicant and outcome

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

Table A37 | Number of applications by type of application and outcome

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

Table A38 | Invalid applications

Reason for invalidity	No of applications
Application does not comply with formal requirements (section 41 of the Act)	–
Application is for excluded information of the agency (section 43 of the Act)	14
Application contravenes restraint order (section 110 of the Act)	–
Total number of invalid applications received	14
Invalid applications that subsequently became valid applications	–

Table A39 | Conclusive presumption of overriding public interest against disclosure: matters listed in Schedule 1 to Act

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

Table A40 | Other public interest considerations against disclosure: matters listed in table to section 14 of Act

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

Table A41 | Timeliness

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

Table A42 | Number of applications reviewed under Part 5 of the Act (by type of review and outcome)

	Decision varied	Decision upheld	Total
Internal review	–	–	–
Review by Information Commissioner*	–	1	1
Internal review following recommendation under section 93 of Act	–	–	–
Review by Administrative Decision Tribunal	–	–	–
Total	–	1	1

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

Table A43 | Applications for review under Part 5 of the Act (by type of applicant)

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

G Index of legislative compliance

	Page number
<i>Annual Reports (Statutory Bodies) Act 1984 and Annual Reports (Statutory Bodies) Regulation 2010</i>	
Letter of submission	02
Charter	03
Aims and objectives	03
Access	Inside front cover
Management and structure	72-87
Summary review of operations	10-13
Funds granted to non-government community organisations	The Commission does not allocate funds.
Legal change	80
Factors affecting achievement of operational objectives	10-13
Management and activities	06-07, 85, 179-186
Research and development	69-71
Human resources	72-80
Consultants	In 2016–17 the Commission engaged consultants on 283 occasions to provide specialist clinical advice to support assessment and investigations functions (Category – Legal). The total cost for all engagements was \$256,912 with all engagements less than \$50,000
Workforce Diversity	78-79
Disability Inclusion Action Plan	78
Land Disposal	The Commission does not own any land.
Promotion	No overseas visits by employees in 2015-16
Consumer response	68-71
Payment of accounts	89-90
Time for payment of accounts	89-90
Risk management and insurance activities	81-83
Internal audit and risk management policy attestation	82
Disclosure of controlled entities	119-131
Multicultural Policies and Services Program	78
Agreements with Multicultural NSW	The Commission does not have any agreement with the Multicultural NSW.
Work Health and Safety (WHS)	80
Budgets	95-97, 121-124
Financial Statements	91-131
After balance date events having a significant effect in succeeding year	113-114, 130
Annual report external production costs	\$10,000

	Page number
Annual report availability	Electronic copies of this report are available on the Commission's website www.hccc.nsw.gov.au .
Investment performance	The Commission does not have surplus funds to invest.
Liability management performance	The Commission does not have debts greater than \$20m.
Exemptions from Reporting Provisions	The Commission reports on a triannual basis about Workforce Diversity, Work Health and Safety, Multicultural Policies and Services Program, and Disability Plans, with reports included in this 2016-17 Annual Report
Numbers and remuneration of senior executives	75
Carers (Recognition) Act 2010	
Carers' support	83-84
Disability Inclusion Act 2014	
Disability Inclusion Action Plans	78
Government Information (Public Access) Act (GIPA)	
Annual report of GIPA operations	83, Appendix F
Health Care Complaints Act 1993	
The number and types of complaints made during the year	10, 14-24, 133-176
The sources of those complaints	23-24, 154
The number and types of complaints assessed by the Commission during the year	10, 30-41
The number and type of complaints referred for conciliation during the year	167
The results of conciliations	167
The number and type of complaints investigated by the Commission during the year	46-48
The results of investigations	48-50
Summary of the results of prosecutions completed during the year arising from complaints	55-59
The number and details of complaints not finally dealt with at the end of the year	175-176
The time intervals involved in the complaints process	41, 43, 53, 55, 166-167, 174
The number and type of complaints referred to the Director-General during the year	There were no complaints referred under section 25
Any report made to the Minister under section 44 (2)	No report was made to the Minister under section 44(2)

	Page number
Any notification and request made to the Director-General under section 60.	There were no notifications or requests made to the Director-General under section 60.
<i>Privacy and Personal Information Protection Act 1998</i>	
Privacy	69
<i>Public Interest Disclosure Act 1994 and Public Interest Disclosure Regulation 2011</i>	
Public Interest disclosures	83
<i>Other requirements</i>	
Digital Information Security Annual Attestation Statement	87
Credit card certification	In accordance with Treasurer's Direction 205.01, it is certified that the credit card usage by officers of the Commission has complied with Government requirements.
Health Care Complaints Commission Annual Report 2016-17	
Published by the Health Care Complaints Commission 2017	
978-0-9808155-6-6	





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