HEALTH CARE COMPLAINTS COMMISSION

ANNUAL REPORT 2003-2004

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The Hon. Morris Iemma, MP
Minister for Health
Parliament House
Macquarie Street

SYDNEY NSW 2000

Dear Minister

Report of activities for the year ended 30 June 2004

Forwarded is the Annual Report including financial statements for the Health Care Complaints Commission for the financial year ended 30 June 2004 for presentation to the Parliament of NSW.

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

Yours sincerely

Judge K V Taylor, AM, RFD
Acting Commissioner
Health Care Complaints Commission

About us

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Patient Support Service

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Penrith / Blue Mountains	(02) 4734 3870
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South Western Sydney	(02) 9828 5710
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Our vision

The Health Care Complaints Commission acts in the public interest by resolving, investigating and prosecuting complaints about health care with a view to maintaining, promoting and improving health standards and the quality of health care services in NSW.

Our charter

Established under the *Health Care Complaints Act 1993*, the Commission's role is:

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

The services provided by the Commission include:

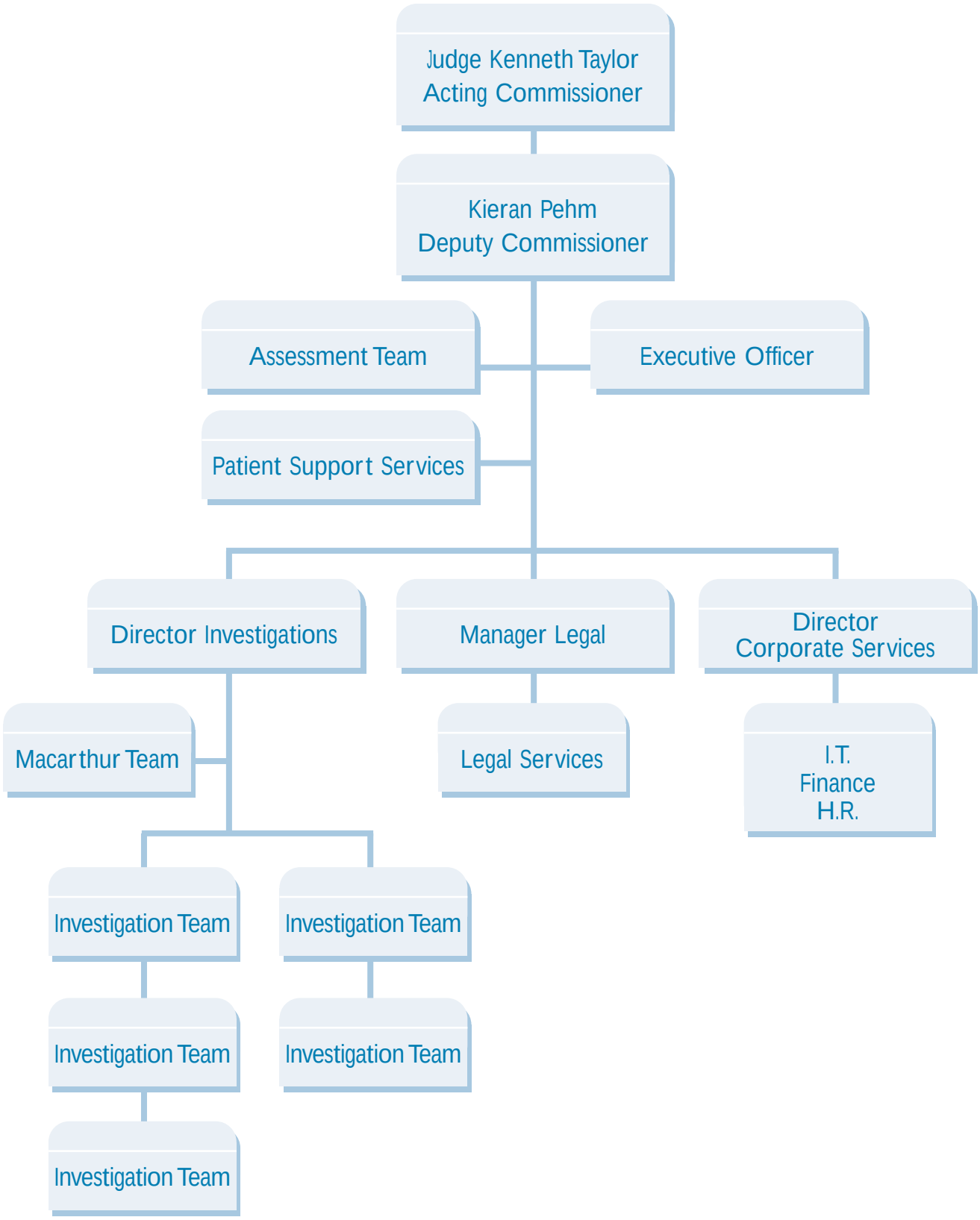
- receiving and dealing with complaints concerning the care and treatment provided by health practitioners and health services
- resolving complaints with the parties
- providing opportunities and support for people to resolve their complaints and concerns locally
- investigating complaints and taking appropriate action
- prosecuting cases before disciplinary bodies
- publishing and distributing helpful information about the Commission's work and activities
- advising the Minister and others on trends in complaints
- consulting with consumers and other key stakeholders.

Our stakeholders

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

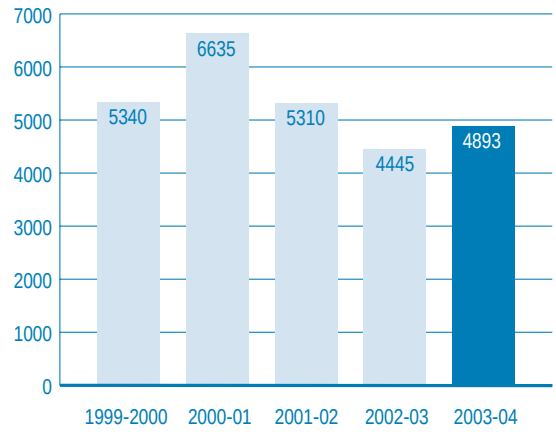
Health Care Complaints Commission

Organisation Chart

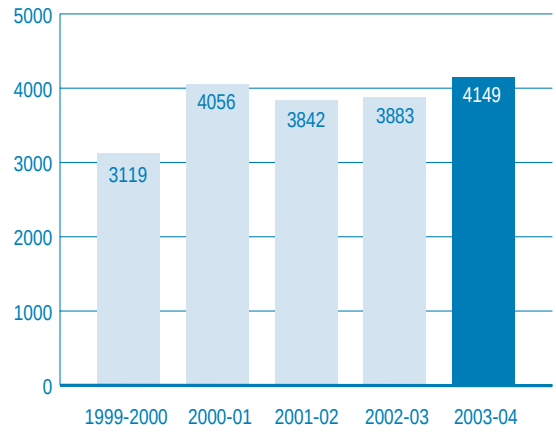


Five years at a glance

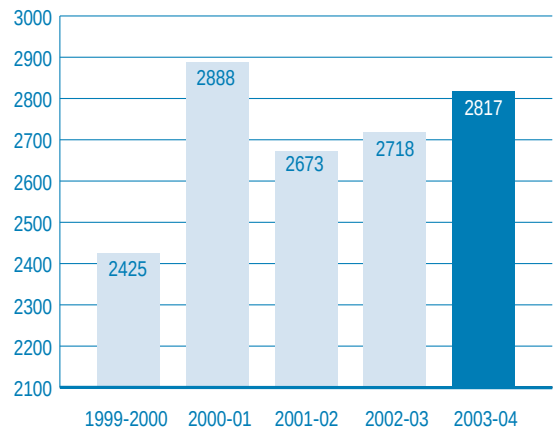
NUMBER OF TELEPHONE INQUIRIES RECEIVED



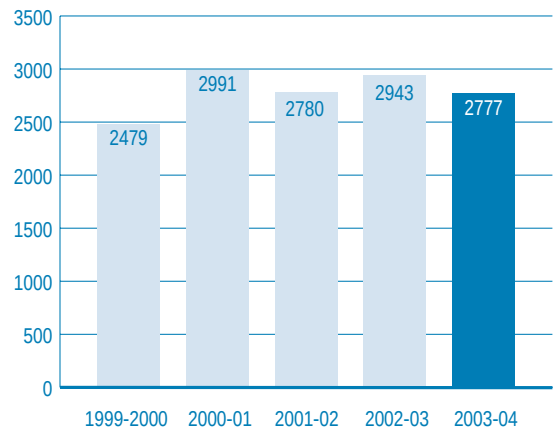
NUMBER OF PATIENT SUPPORT SERVICE CLIENTS



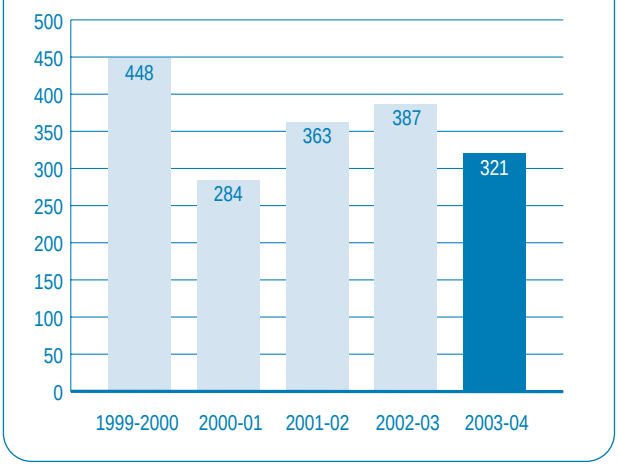
NUMBER OF COMPLAINTS RECEIVED



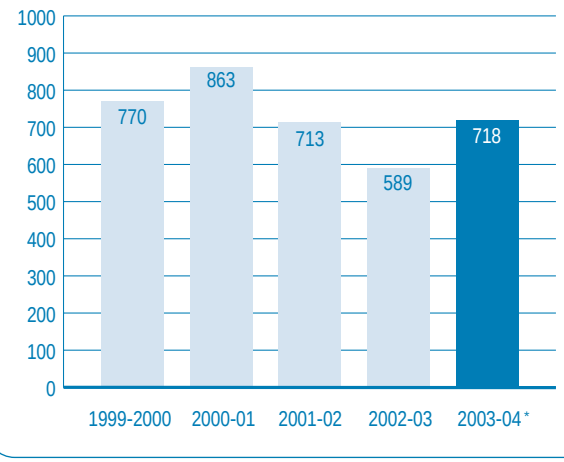
NUMBER OF COMPLAINTS FINALISED



NUMBER OF INVESTIGATIONS FINALISED

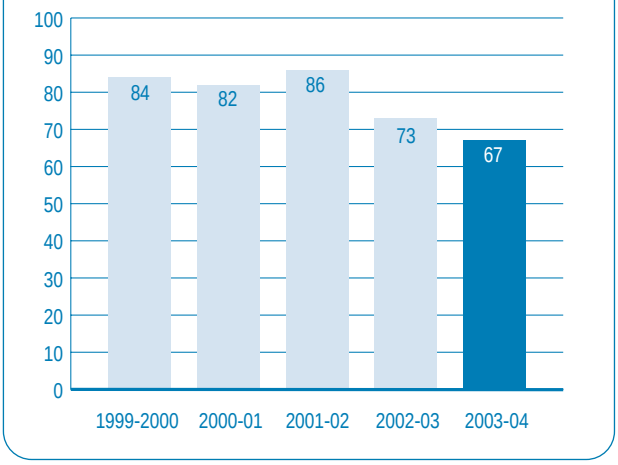


NUMBER OF INVESTIGATIONS OPEN AS AT 30 JUNE

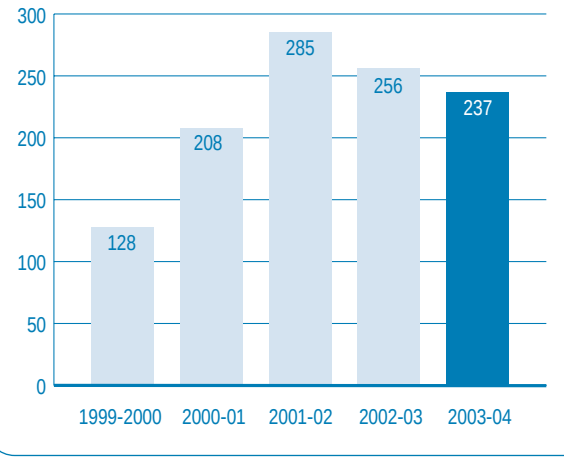


** including Campbelltown / Camden Hospitals investigations*

NUMBER OF DISCIPLINARY ACTIONS FINALISED



NUMBER OF SECTION 26 REVIEWS FINALISED



Commissioner's overview

This year is the tenth anniversary of the establishment of the Health Care Complaints Commission. It has been tumultuous. Substantial and rapid change has occurred. This was triggered by the publication of the Commission's final investigation report into a complaint made in December 2002 by the Director General of the Department of Health setting out allegations concerning clinical, management, performance, process issues and specific adverse incidents at Campbelltown and Camden Hospitals in the Macarthur Health Service.

Whilst that report was accepted as making useful recommendations for organisational improvement the Minister for Health, the Hon. Morris Iemma M.P, criticised the report as not going far enough and failed to hold any person accountable by not making specific recommendations for action. The Minister stated that he had lost confidence in the Commission and took the following four steps. First, the appointment of the Commissioner was terminated. Second, Mr Bill Grant, the Chief Executive of the Legal Aid Commission, was appointed as Interim Commissioner. Third, the Interim Commissioner was directed to refocus the Commission to ensure it concentrated on rigorously investigating individual cases of poor health care and professional misconduct. Finally, the Cabinet Office was requested to review the legislation governing the Commission.

The Minister also announced the appointment of Senior Counsel Mr Bret Walker by the New South Wales Government to conduct an inquiry to investigate allegations of unsafe treatment or inadequate care at Camden and Campbelltown Hospitals.[1]

Mr Grant took steps to set up a separate team to investigate issues of individual responsibility for the clinical incidents in the Commission's December 2003 report. Action was also taken to communicate with all of the families of deceased patients and patients who were involved in the clinical incidents which form part of the Macarthur investigation. Mr Grant continued as Interim Commissioner until my appointment on 22 March 2004. The special team created to deal with references from the Special Commission has been separated from the body of the Commission and operates under my direct supervision with the assistance of senior counsel, counsel and solicitors from the Crown Solicitors Office.

The Special Commission identified cases or incidents that warrant further investigation in its Interim Reports of 31 March and 1 June. The Special Commission continued the process of identification, and referrals to the Commission have been ongoing. The Macarthur team is mostly concerned with gathering information and assessing the individual cases. Its work is progressing well and I expect that all investigations will be completed in the first quarter of 2005.

In refocussing on individual instances of poor patient care the Commission is tackling an unacceptably large backlog of uncompleted investigations. Mr Grant identified this issue and defined the backlog as all open investigations as at 1 August 2003. At the end of March 2004 the backlog stood at 448 open investigations. This was reduced to 315 at 30 June and halved by the end of July.

The fact that only 105 investigations were completed in the first half of the reporting period indicates a concentration of effort on the Macarthur investigation. It also shows the need for attention to be given to the backlog. It is self evident that delay is an evil that must be minimised. When consumers and carers make a complaint about health care services they initially want respect, to know their complaint is being taken seriously, and timely resolution[2]. The Commission has resolved to use its best endeavours to finalise 80% of current complaints (after 1 August 2003) within twelve months.

The increased tempo of operations has been made possible by the provision by the Government of an additional $M5.7 to address both the Macarthur investigations and the backlog. Fifteen new investigators have been recruited for twelve months. Additional to the Commission's induction training further instruction on investigation techniques, interviews and taking statements was conducted in July and August 2004.

Further, the Commission has contracted for the development of an electronic case management system called CaseMate. This is scheduled to 'go live' in 2005.

The leadership team and organisation of the Commission has been changed. Mr Kieran Pehm recently Deputy Commissioner at ICAC, and with extensive experience in complaints handling over a twenty year period, has been appointed Deputy Commissioner. A Director,

1. Speech by the Hon. Morris Iemma M.P NSW Minister for Health, Investigation Into Camden and Campbelltown Hospitals Thursday December 11 2003.
2. *Annotated Literature Review: learning from consumer reported incidents*, Health Issues Centre and Health Care Complaints Commission 2003.

Investigations has been recruited. Positions previously concerned with partnership development and education have been deleted or realigned to the Commission's principal business of complaint handling. The former Complaint Resolution Teams comprising a mix of investigative, patient support and case assessment staff have been dissolved.

The Commission has moved away from the qualitative aspects of health care, including the development of partnerships with health service providers to address systemic issues identified from investigations, and the development of the Commission's role as commentator on systemic health issues by publishing reports on specific topics. This is because the Director General, in response to the Commission's draft Macarthur Investigation report of 28 August 2003, appointed a review of patient systems at Campbelltown and Camden Hospitals. Subsequently, in October, recommendations by that review were accepted and implementation commenced which is ongoing. In the result a Clinical Excellence Commission [CEC] will shortly take over the responsibility for systemic improvement within the NSW health system. It will be important for the Commission to develop a workable protocol with the CEC to ensure that individual and community needs are met from the Commission's perspective. This concurrent development has facilitated the Commission's refocus on its statutory obligations.

There is arising, the outline of a refocused Commission ready to respond to individual complaints in a timely way and realigned to its statutory responsibilities. The way ahead is clear. The backlog must go and the Macarthur investigations completed in a thorough and timely way. The process of legislative reform has commenced and the Commission needs to argue strongly for a model which moves away from the construct of only a "prosecuting and investigating arm and conciliation arm"[3], developed in the late 1980's, to a 'one stop shop' with a range of resolution techniques available to it, in the context of a robust co-regulatory relationship with the registration boards. Increased powers are required to obtain relevant documents for assessment and investigation and, during the investigation process, interview witnesses. The Commission recognises the need to ensure that its processes are fair to all concerned in the complaints process. It seeks to ensure that no person with a complaint or the subject of a complaint is left with a sense of grievance.

The Commission has undertaken a review of the means by which it gains advice on clinical standards through its Professional Advisors and Reviewers Panel. This review is part of the Commission's development of a code of practice, in consultation with its stakeholders, to provide guidance on the way in which the Commission intends to carry out its functions.

Resolution of the Macarthur and backlog issues, would well position an enhanced Commission to re-establish public confidence as the health care complaints watchdog.

The Commission's staff has responded well to the new direction and the ups and downs of the past twelve months. Their efforts, and I trust their rewards, are seen in their service.

3. Second Reading Speech *Health Care Complaints Bill* 1993.

Performance report for 2003 – 04

In December 2003, the Minister appointed Mr Bill Grant as Acting Commissioner, announcing that he "has been instructed to refocus the HCCC to ensure it concentrates on rigorously investigating individual cases of poor care."

To this end, a series of reforms were instigated. Given that no Corporate Plan had been developed for the organisation for the reporting period, a short term Action Plan was drafted. This Plan was endorsed and implemented by the current Acting Commissioner, Judge Taylor, with the support of a $5.7 million funding boost for the Commission.

Staffing

The Commission's Executive was restructured to restore focus on investigations.

Two Assistant Commissioner positions replaced by one Deputy Commissioner and a new position of Director, Investigations, was established.	Working closely with the Acting Commissioner and the Investigation Team Managers, the new Deputy Commissioner has succeeded in focussing Commission activities on meeting statutory deadlines and client expectations.

The former Complaint Resolution Teams – comprising a mix of investigative, patient support and case assessment staff – were dissolved.

Complaint Assessment Team formed	This team ensures that as much information as possible is obtained prior to assessment and that complainants are advised of the reasons for assessment decisions.
Patient Support Service role redefined	Patient Support Service focus changed from patient advocacy to impartial facilitation of complaint resolution.
A separate "Macarthur" Investigation Team established.	This Team comprises legal, investigative and clinical experts with no previous involvement in investigations into Camden and Campbelltown hospitals. The Team ensured that all practitioners, patients or next of kin who could be identified as having been subject to complaints at Camden or Campbelltown hospitals were notified. All complaints were assessed and the appropriate course of action identified.
Investigation teams expanded and restructured.	Fifteen additional investigators recruited to work through the backlog of complaints, defined as all complaints older than 1 August 2003. In March, 2004 this backlog included some 448 complaints. At 30 June 2004 the backlog had been reduced to 315 complaints.
Closer involvement of clinical and legal experts in investigation teams increased.	A Legal Officer works full-time with the Investigation Officers to improve the standard of evidence gathering and to ensure that appropriate referrals for disciplinary action are made. Greater use has been made of clinical experts, including doctors, nurses and a pharmacy advisor to assist Commission staff in the assessment and analysis of clinical issues that arise from complaints.

Policy and practice

Review of the Health Care Complaints Act 1993.	Following extensive consultation, barriers to timely resolution of complaints identified and proposed for amendment of the current Act.
Delegations under current Act reviewed.	Delegations changed to reflect new structure and to ensure that decisions are made at the appropriate level.
Compliance with statutory timeframes enforced.	At the end of this reporting period all respondents had been provided with notification of complaint within 14 days of receipt of the complaint.
Backlog policy developed.	Priority protocols established and files reviewed to determine appropriate action.
Peer review database redesigned.	Selection of appropriate reviewer facilitated.
Skills required by Investigators identified.	Responsibility for internal training and development allocated to a Commission officer. All new investigation staff attend an intensive induction program. Investigations training organised for all investigation staff.

In the coming reporting period the Commission will be continuing this process of reform and redevelopment. A corporate plan for the year 2004/05 is being developed – this plan will form the framework for sound business planning relating to all the Commission's functions. At the time of writing, the Plan is concentrating on:

ACTION	AIM
Review of the system of obtaining peer reviews will be reviewed in consultation with relevant stakeholders.	Initiatives will be developed to increase access to peer reviewers and to develop selection processes that promotes impartiality.
A performance management system will be implemented for all staff.	All staff to have performance agreements flowing from the corporate plan and divisional business plans to increase accountability and the professional development of staff.
A new case management system	Information about the progress of complaints will be more readily available; workflow planning will be facilitated; work effectiveness and performance management will be improved.
Investigation skills training.	This training will develop the capacity of Commission investigators to conduct impartial and timely investigations.
Records management policy and plan to be developed and implemented.	Compliance with State Records Act to be achieved resulting in more accountable, accessible record keeping.

Measurable targets for these and other key business improvement strategies will be developed in a comprehensive business planning process which will be embarked upon in the new reporting period.

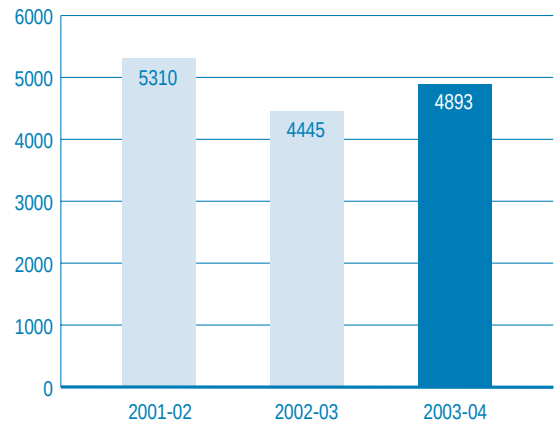
Responding to complaints

Telephone inquiries

A telephone inquiry service is available during business hours each working day. The purpose of this service is to provide health consumers with an opportunity to obtain information about the complaints process; discuss their concerns so that they are able to put them in some context; and obtain information about other avenues of redress that may be more appropriate to manage their complaint as well as to provide assistance in making complaints and advice about the support available from the Commission's Patient Support Service.

During the 2003-04 reporting period, 4,893 calls were received. In more than a third of all calls received, the person was concerned about a provision of service in relation to a doctor, and in 16.8% of all calls received, the person was seeking information.

Figure 1:
Number of telephone inquiries received



Patient Support Service

The Patient Support Service (PSS) assists consumers to resolve issues with private and public health services and providers at the local level.

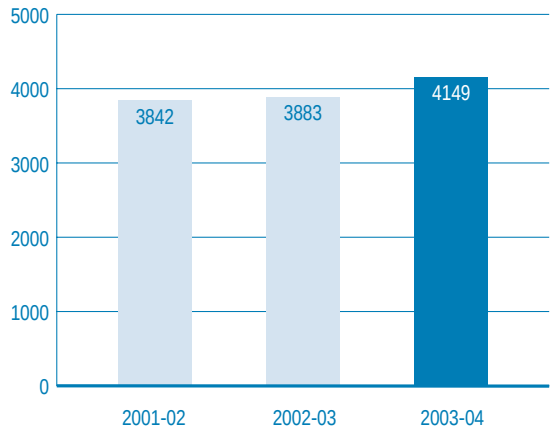
There are 11 Patient Support Officers in NSW. Ten are out-posted in Area Health Services; six within the metropolitan area, based in Central Sydney, Northern Sydney, Penrith, South Eastern Sydney, South Western Sydney and Western Sydney, and four in regional areas, based in Newcastle, Wollongong, Dubbo and Lismore. One Patient Support Officer (PSO) is based in the Commission and provides relief services. The PSS manager is also based at the Commission.

Aims of the Service

The PSS aims to:

- assist in the timely, efficient and effective resolution of health issues
- encourage people to have a positive and active role in their health care and to resolve their own issues in the future
- assist consumers and health providers to understand approaches to local resolution of health issues
- facilitate access to appropriate health care
- promote and protect the rights of health consumers.

Figure 2:
Number of PSS clients



Highlights

In 2003-04, three new PSOs became fully operational at Dubbo, Lismore and Wollongong. There was a consequent increase in accessibility for clients in those regional areas with complaint numbers rising substantially. There was also an 80% increase in service to inmates due to access to a free call number for the Commission in all NSW Correctional facilities that was implemented during the past year.

In total, the PSS provided a service to 4,149 people, a 7% increase on the previous year. During the same period the PSS closed 4,150 files, some of which had been opened in previous financial years.

The Patient Support Service is repositioning itself from what has been perceived as a consumer advocacy service to supplying an impartial complaints resolution service. Some health practitioners have perceived that the Commission was biased towards complainants. This does not facilitate complaint resolution. The change increases the ability of PSOs to work more directly with providers and make clearer that the main aim of PSO

work is complaint resolution rather than advocacy. It is important to address perceptions if they might adversely affect the sensible resolution of complaints.

Referral sources

People were referred to or obtained information about the PSS from a variety of sources in 2003-04. Table 1 details how clients found out about the PSS. The primary means of referral to the PSS is the Commission. Complainants also can be referred to the PSS from a variety of external sources.

The Commission referred the majority of clients (67%) to the PSS. Assessment officers refer people who telephone the Commission but have not lodged a formal complaint. These people may request assistance in the local resolution of their issues with a health service provider. Assessment officers may also refer people with communication difficulties who need further assistance to clarify issues or to write a letter of complaint.

Following formal assessment of a complaint under the Act, the Commission may involve the PSS. Where a written complaint is referred to another body, e.g. an Area Health Service or Registration Board, the Commission will generally allocate a PSO to assist the complainant. The Commission also refers complaints that do not warrant investigation or conciliation but are of a nature where the complainant requires assistance to resolve the matter directly with the health service provider.

Types of issues raised by PSS clients

PSS clients raise a wide range of issues about health services. Table 2 classifies them using the Commission's complaint categories.

Table 1: How clients found out about the PSS 2001-02 to 2003-04

	2001-2002		2002-2003		2003-2004	
	No.	%	No.	%	No.	%
HCCC	2,644	68.8%	2,872	74.0%	2,785	67.1%
PSS promotion	570	14.8%	466	12.0%	648	15.6%
Health provider/facility	132	3.4%	131	3.4%	246	5.9%
Other/not known	334	8.7%	241	6.2%	207	5.0%
Government body	60	1.6%	80	2.1%	92	2.2%
Directories	49	1.3%	44	1.1%	67	1.6%
Consumer organisation	42	1.1%	37	1.0%	60	1.4%
Member of Parliament	11	0.3%	12	0.3%	44	1.1%
Total	**3,842**	**100.0%**	**3,883**	**100.0%**	**4,149**	**100.0%**

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

Table 2: Type of concerns raised by PSS clients 2001-02 to 2003-04

	2001-2002		2002-2003		2003-2004	
	No.	%	No.	%	No.	%
Clinical standards/treatment	1,710	29.2%	1,300	24.3%	1503	26.5%
Quality of care	818	14.0%	834	15.6%	947	16.7%
Clinical standards/communication	919	15.7%	798	14.9%	772	13.6%
Clinical standards/other	313	5.3%	492	9.2%	487	8.6%
Business practices	504	8.6%	460	8.6%	437	7.7%
Patient rights	391	6.7%	386	7.2%	392	6.9%
Miscellaneous	436	7.4%	428	8.0%	356	6.3%
Clinical standards/diagnosis	319	5.4%	260	4.9%	340	6.0%
Prescribing drugs	149	2.5%	124	2.3%	145	2.6%
Complaints management	100	1.7%	37	0.7%	89	1.6%
Provider-patient/client relationship	92	1.6%	85	1.6%	72	1.3%
Waiting list	48	0.8%	40	0.7%	56	1.0%
Fraud	0	0.0%	14	0.3%	22	0.4%
Resources	0	0.0%	5	0.1%	22	0.4%
Other unenthical/Improper conduct	0	0.0%	31	0.6%	20	0.4%
Illness Related	0	0.0%	0	0.0%	1	0.0%
Re-Registration	0	0.0%	1	0.0%	1	0.0%
Other	59	1.0%	57	1.1%	0	0.0%
Total*	**5,858**	**100.0%**	**5,352**	**100.0%**	**5,662**	**100.0%**

** This total is based on the 4149 files opened during the financial year. It differs from the total number of clients because some clients raised more than one concern.*

Table 2 shows the types of issues raised by PSS clients. The clinical standard of treatment received was the major source of concern. It has remained the major category of concern of PSS clients for the past three years and this year accounted for 26.5% of all issues. This category of complaint includes issues such as inadequate or incorrect diagnosis, inadequate or incorrect treatment, infection control or the quality of medical records. Most people sought explanations about what went wrong and assurances that it would not happen to others.

Quality of care forms the second largest category of concern (16.7%). Inadequate nursing care in hospitals and nursing homes was the primary issue raised in this category during the year. Also, issues about admission and discharge procedures are a significant part of this category.

The third largest category was communication issues. This category includes rude/insensitive communication, the failure to provide information and incorrect/misleading communication. People regularly complain that health professionals do not provide enough information or do not explain issues clearly enough. Some providers are thought to be dismissive or rude when further information is sought.

PSS issues by location and service sector

Table 3 breaks down the issues raised with the PSS by health service location and type of service (public, private, non-government or other).

Type of service provided by the PSS

The services provided and recorded by the PSS are the provision of information, support and assisted resolution. The PSS works with both the consumer and the provider to tailor a resolution strategy that will work for both parties. The flexibility of the model is critical to its acceptance and success. Table 4 shows the type of service provided to clients for the past three years.

Eighty per cent of clients, whose issues were finalised during the year, were provided with either support or assisted resolution services. 'Support' means listening, clarifying issues and assisting people to identify the most appropriate option for resolution. PSOs aim to encourage people to take action for themselves.

'Assisted resolution' may include arranging and/or attending resolution meetings between the consumer and the health service; negotiating directly with the health service/provider to reach a solution for the

Table 3: PSS concerns by location and service sector 2001-02 to 2003-04

	2001-2002	2002-2003	2003-04			
AHS	**Total No.**	**Total No.**	**Public[1]**	**Private[2]**	**Other[3]**	**Total No.**
Central Coast AHS	121	135	61	78	4	143
Central Sydney AHS	317	329	155	138	23	316
Corrections HS	52	158	281	1	4	286
Far West AHS	20	23	17	9	2	28
Greater Murray AHS	60	85	42	46	2	90
Hunter AHS	331	331	152	149	15	316
Illawarra AHS	141	147	174	115	9	298
Interstate/Out of State	11	4	6	2	1	9
Macquarie AHS	50	44	95	42	4	141
Mid North Coast AHS	126	146	71	66	7	144
Mid Western AHS	52	57	27	22	3	52
New England AHS	57	52	18	22	1	41
Northern Rivers AHS	100	129	94	112	1	207
Northern Sydney AHS	576	458	191	233	24	448
Not known	164	100	6	34	25	65
South Eastern Sydney AHS	533	612	206	346	4	556
South Western Sydney AHS	463	416	281	220	5	506
Southern AHS	92	80	33	33	3	69
Wentworth AHS	171	131	70	50	7	127
Western Sydney AHS	447	504	229	196	36	461
Total*	**3,884**	**3,941**	**2,209**	**1,914**	**180**	**4,303**

** This total is based on the 4149 files opened in the financial year. It differs from the total number of clients because some clients raised concerns about more than one health provider*

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

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

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

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

Table 4: Type of service provided by PSS 2001-02 to 2003-04

	2001-2002		2002-2003		2003-2004	
	No.	%	No.	%	No.	%
Support & Assisted Negotiation	3,071	79.0%	3,059	79.1%	3,469	80.1%
Information only	815	21.0%	808	20.9%	861	19.9%
Total*	**3,886**	**100.0%**	**3,867**	**100.0%**	**4,330**	**100.0%**

** This total is based on the 4150 files closed during the financial year. It differs from the total number of clients because some clients raised concerns about more than one provider*

consumer; assistance with writing a letter, locating health services that address the client's needs or other means of facilitating local resolution. When resolution meetings are organised, the PSO works with both parties to clarify issues and desired outcomes. In complex cases, an issues paper is prepared and sent to the provider or health organisation prior to the meeting. More than one meeting may be required to reach resolution.

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

Outcomes achieved 2003-04

The various outcomes of the PSS for the past three years are noted in Table 5. The total for 2003-04 reflects the number of outcomes recorded on the 4,150 files that were closed in the reporting year. More than one outcome is possible for each client e.g. an apology and a change in procedure. The number of outcomes therefore does not match the total number of clients or issues.

Outcomes of complaints for consumers are known where PSOs have been involved in the resolution of the issues. These known outcomes are recorded under 'resolved', 'partially resolved', 'not resolved' and 'unable to be resolved'. Outcomes are generally not known where the client pursued the issues with another body or where the client declined PSS involvement. Where PSOs were involved in the resolution of issues, 84.3% of matters were resolved or partially resolved compared with the performance target of 80%.

Types of outcomes

Total/partial resolution

Close to sixty per cent (57.4%) of outcomes recorded indicate total or partial resolution of client issues. The provision of information or an explanation resolved client issues in over half of those cases (1,451). For example, clients were able to understand: what actually happened to them when something went wrong; why and how decisions were taken during treatment; or what the doctor or dentist meant when using medical jargon.

Approximately a quarter of the cases (662) were resolved when clients received services as a result of raising their issues. For example clients were able to access health services; they were offered another operation/alternate service or received a copy of the medical records that had previously been refused.

An apology resolved issues in approximately 5% of cases (211) and refunds or waived fees in 145 cases.

Table 5: PSS outcomes 2003-04

PSO Outcome Description	Count
No contact or patient declined involvement	324
Client pursued with another body/person	1211
HCCC	499
Health facility/provider	393
Other Government Body	117
Legal advisor	110
Other (Specify)	92
Resolved	2086
Explanation/Information	998
Received service	593
Apology provided	152
Other (Specify)	137
Refund/expenses paid	116
System/practice change	90
Incomplete Resolution	666
Explanation/Information	453
Received service	69
Apology provided	59
System/practice change	43
Refund/expenses paid	29
Other (Specify)	13
Not Resolved	362
Parties unable to agree on facts/resolution	174
Client did not proceed	163
Provider – refusal to participate	21
Other (Specify)	4
Unable to be Resolved	148
Lost contact with party/ies	61
Other (Specify)	58
Information not available	29
Total	**4797**

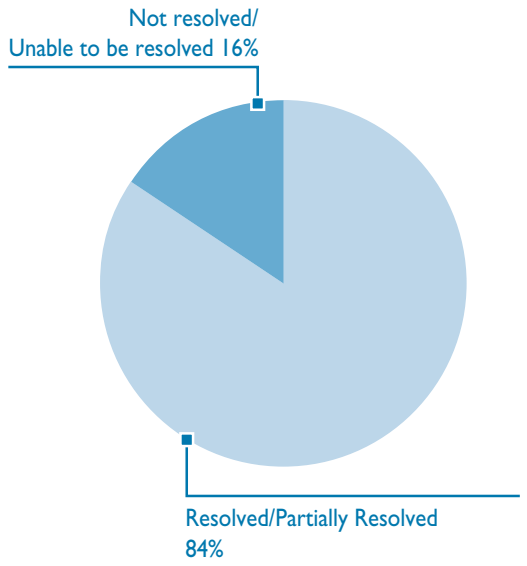
Practice/system changes were recorded in 133 cases and clients were reassured that what had gone wrong would be avoided in future.

Not resolved/unable to be resolved

A relatively small percentage (7.5%) of issues were recorded as 'not resolved' due to a range of reasons including: client expectations were unable to be met; there was disagreement on facts; the options for resolution were not acceptable to the client or provider; and grief.

A further small percentage (3.1%) of matters were unable to be resolved because of factors such as: lost medical records or reports; the age of the event presented difficulties in locating health providers; the client was unwilling to pursue the matter after the resolution process commenced; or information relating to a third party was not able to be obtained.

Figure 3:
PSS outcomes 2003-2004



Clients pursued with another body/person

In other matters, the PSO may have assisted the client to develop and carry out a resolution strategy. In these matters the PSO rarely knows the outcome. Where this occurs, the PSO involvement is categorised as 'client pursued with another body/person'. This outcome was recorded in 25.2% of cases. 499 clients pursued their matters with the Commission by lodging formal complaints, 393 directly with a health provider or facility and 110 indicated that they would pursue legal options.

No contact

Close to ninety-three per cent (93.2%) of people who were offered the PSS used the service. In a small number of cases (6.8%), the PSO could not locate the client or the client decided against using the services of the PSS when contacted.

Timeliness of PSS service

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

The graph at right indicates how long it took to complete PSS cases in 2003–04.

21% of cases were completed within a week; 47.4% within a month; 73.5% within three months and 96.4% within a year. The small number of cases (3.6%) that took more than a year were delayed because of reasons including the complexity of the issues and the multiple activities required before completion; difficulties in contacting and getting responses from providers; time taken by clients to decide when or how to proceed.

Results of the PSS satisfaction survey 2003-04

The PSS seeks client feedback after service provision through a satisfaction survey. Surveys were posted to clients together with a reply paid envelope. The survey included questions about the accessibility, timeliness and responsiveness of the service as well as overall satisfaction. The PSS received 429 completed surveys with a response rate of 37.7%. Three hundred and eighty eight were responses to 1,027 surveys sent this reporting period. 41 were responses to surveys sent in the previous reporting period.

Key results include:

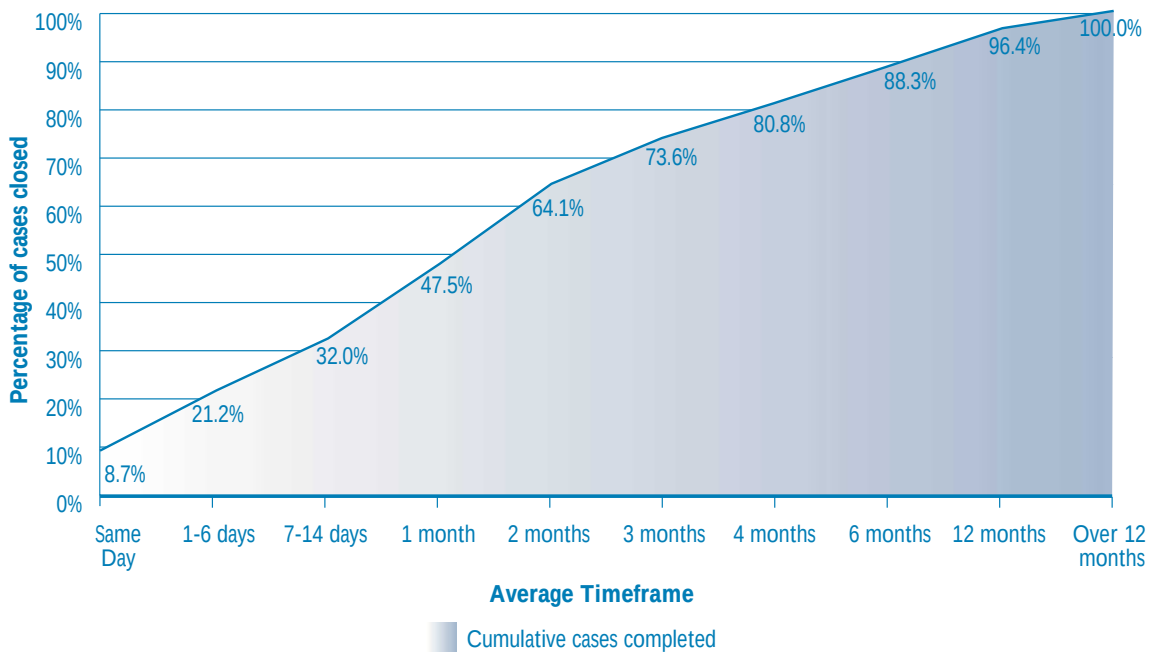
- 88.0% thought PSOs were responsive to their issues
- 82.0% found PSOs were prompt in returning their calls
- 81.4% were satisfied with the service they received
- 80.7 % would use the service again.

Clients' feedback from the satisfaction survey

Following are some quotes from the surveys:

- "We appreciated the advice about my son's rights as a mental health patient, and how to go about fixing up all the mistakes that had happened with his medications and treatment with his case manager."
- "The patient support service was quick to resolve the matter and got back to me about the complaints as quick as they could."
- "What was most useful about the Patient Support Service is the PSO listened carefully to my complaints in order to help me write a letter to the doctor."

Figure 4:
Patient Support Service Timeframe to Complete Cases



- "This is my first time using the service and I was wary about who would want to help me. The PSO showed me I was wrong."
- "Her knowledge and comprehension of the 'system'. Her empathy for my situation; her willingness to try to mediate and negotiate, taking my desires into account and trying to obtain a resolution for me that would, at least, partially meet my needs."
- "The human understanding and support she gave. She did not judge my complaint, she was very helpful and supportive as well as prompt, courteous and very friendly."
- "Sympathetic, offered alternate strategies; was very supportive of my issues."
- "Acting on advice from the PSO the problem with my doctor was resolved."

Provider feedback

To seek feedback from health providers on the performance of PSOs the PSS Manager contacted and met with staff from Area Health Services. No complaints about the Service were raised. Staff commented that:

- The independence of the position is very important for certain complainants
- Good trust has developed and there is a non-adversarial relationship with Health Service managers and Area Coordinators
- The PSS provides a separate way to manage complaints about public health services
- Barriers to complaints management at the local level, e.g. time it takes to listen, failure by staff to list all the issues, no-one available to help complainants write complaints have been overcome by the PSO. Complaints in which the PSO is involved are a "whole lot clearer." It helps the local staff refocus.

One CEO of an AHS wrote to the A/Commissioner expressing satisfaction with the PSS saying that the PSO "has been at all times professional, approachable and efficient." The CEO added "it is rewarding to note the success of the resolution meetings (organised by the PSO). The Area advocates a policy of open disclosure and communication with our consumers and will continue to invite clients to resolve their questions and concerns at these meetings."

Additional performance monitoring measures

The PSS monitors the quality of service provided by PSOs in various ways. The manager reviews all client files to ensure that service standards have been met, appropriate complaint resolution options identified and adequate support provided to consumers to resolve their health complaints. The manager also conducts monthly on-site supervision sessions and provides guidance and advice in complex matters. As well, performance and development needs are identified to ensure staff are equipped with the necessary knowledge, skills and values to meet the performance goals set for them as individuals and for the organisation as a whole.

PSS case studies

Improving quality of life

When a new regional office was set up the Commission actively promoted the PSS. A man heard a new PSO being interviewed on the radio and called about complications following heart surgery ten years ago.

The man was referred to the PSO in the area where he had the surgery. He explained that after the heart surgery he developed pneumonia and required admission to a different hospital. Further examination showed that a nerve had been cut during the heart surgery resulting in a collapsed lung and extreme breathlessness. The man had not been able to work since the heart surgery or enjoy a game of golf or fly.

The PSO approached the original surgeon who agreed to see the man immediately and carried out corrective surgery several months later. The surgeon admitted to the man that such an error should not have happened.

The man feels fortunate to have heard the radio interview and made contact with the PSS as he now has a better quality of life.

Revised procedures

An elderly man was given a brochure on the PSS by hospital staff. He called the PSO stating that the hospital had lost his medications.

After spending a month in a public hospital the man was transferred to a nursing home while waiting for a bed in a public rehabilitation hospital. At the nursing home approximately $80 worth of medication had been ordered from the local pharmacy. This was a significant cost to a pensioner. This medication was taken to the rehabilitation hospital.

It was explained that the rehabilitation hospital would order new medication. The medication the man brought with him was his property and would be returned to him on discharge. At the time of discharge, however, the medication could not be located.

The retail pharmacy provided a list of medications to the hospital pharmacy and the PSO was able to negotiate a full refund for the man. The hospital pharmacy also explained how the medication had been discarded by mistake and apologised. As a result of this complaint the hospital pharmacy revised their policy and procedures to ensure medications are returned to family members or stored safely until a patient is discharged.

Supporting family to obtain medical treatment

A woman telephoned the Commission with concerns about her sister who was living in a group home for people with intellectual disabilities. The woman was referred to the PSO.

The woman's sister had been content living in the group home for six years. After a number of recent falls, staff at the group home had suggested that the sister should be placed in a nursing home. The woman wanted her sister to have the best chance to remain in the group home for as long as possible. She believed that her sister was being "pushed out" before a medical assessment to determine the cause of the falls and other health problems. The sister had recently undergone cataract surgery and also needed time to recuperate.

The PSO helped the woman to formulate her questions, concerns and requests. The woman decided she wanted to negotiate directly with the manager of the disability service.

The woman reported back to the PSO that the staff at the group home had arranged with the GP for the sister to have all the tests requested. The sister had improved following the cataract operation and had now had X-rays, scans and a flu needle. There had been no further talk about her sister leaving the group home.

The woman still held some concerns about the way staff at the group home managed behaviour problems with the sister. The PSO consulted with the Community Services Commission to provide the woman with information about appropriate avenues to seek further help. The woman planned to pursue the outstanding issues with the service manager in the first instance. She was encouraged that with the information and support provided by the PSO she had already been able to successfully obtain appropriate health services for her sister.

Return of a back brace

An inmate of non-English speaking background from a state correctional facility was referred by the Commission to the PSO requesting help to have an approved, privately owned, back brace returned to him. He claimed that the brace had been approved by the health service for use for a back injury. The inmate also understood that the Governor of the facility had issued a written authority for the inmate to use the brace.

The inmate told the PSO that the brace had recently been taken from him by Department of Corrective Services staff at the prison. He had not been given any explanation for the removal of the brace. The inmate sought assistance from the PSO to have the brace returned or review of his treatment by a spinal specialist.

The PSO contacted the Governor explaining the inmate's concerns including that the inmate feared his back injury would worsen without the use of the brace. The Governor commented that the brace had been removed because of tightened security at the facility.

The Governor agreed to seek further clarification of the client's medical needs and arranged for him to be reviewed by the medical officer. The PSO also liaised with the Nurse Manager who actively pursued the matter directly with the Governor.

The inmate was most appreciative of the intervention by the PSO when the back brace was returned to him within seven days and he was provided with an explanation about the security issues that some medical aids present.

An apology

A woman had been discharged from hospital on antibiotics. She started vomiting overnight and her GP suggested she go to Emergency. In Emergency the woman was told to sit in the waiting area. When she went to sit down she vomited and feeling faint she lay on the floor. A friend called for a nurse. Two nurses came and told the woman to get up. When she tried to do this she did not have the strength and fell back down. The nurses walked away and the woman was left feeling humiliated. After twenty minutes a doctor called the woman. A man in the waiting area and the friend helped the woman up from the floor and in to see the doctor.

The woman approached hospital management about what happened. She met with the General Manager who apologised on behalf of the hospital but this was not what the woman was seeking. The woman wanted to meet face to face with the nurses involved and receive an apology directly from them. When this didn't eventuate she made a complaint to the Commission.

The matter was referred to the AHS and also the PSS. The PSO telephoned the woman who explained that she had been told by hospital staff that it was not usual process for the nurses involved to meet with her. The woman was still keen for this to happen. The PSO negotiated with the hospital about the woman's request.

A further meeting at the hospital took place and both the nurses attended. The woman told the PSO that the nurses could not give any explanation for their behaviour but they apologised to her and said they would not act that way again. It had been important for the client to tell the nurses she had felt totally degraded by the way they treated her. The client said she forgave the young nurses and she was now satisfied that the matter had been resolved.

Prompt surgical treatment

NSW Health and a state MP referred the parents of a 14 year-old patient suffering from a bone chip knee injury to the PSO. The family had contacted the MP and Department concerned that a public hospital had planned to discharge their child when surgery was delayed for 12 days. The child would be re-admitted to another hospital for the corrective surgery.

The PSO spoke to the parents who believed that the proposed discharge was inappropriate. They wanted the hospital to review the decision to discharge and were worried that the delay in treatment might lead to complications of the knee injury.

When the PSO contacted the hospital the immediate discharge was deferred. Senior doctors reviewed the child's injury and it was agreed that her clinical condition warranted more expedient surgery. The discharge plans were cancelled and the girl was scheduled for emergency surgery.

Timely intervention and local knowledge of the hospital system resulted in prompt treatment for this young girl. The parents were pleased with the outcome.

Co-ordination of services

The PSO was telephoned by the father of a 27 year-old man who has a history of bipolar disorder and drug abuse. He had previously lodged a formal complaint with the HCCC that was referred to the PSO. The man contacted the PSO again when his son was scheduled to the psychiatric unit in his local hospital. The hospital had decided to transfer the son to a larger psychiatric unit in another hospital that had more secure facilities.

The father acknowledged his son's behaviour could be demanding and inappropriate but he was most concerned that 16 months earlier the larger psychiatric unit had discharged the son after one night in the unit. This discharge happened after 5 pm on a Friday and the family was not made aware of the discharge. The son was 130 kilometres from his home and had no money. Shortly after discharge the son committed an assault and was incarcerated. The family did not want the same thing to happen again.

The PSO agreed to make contact with the two hospitals to establish the treatment plan and appropriate contacts for the family. The PSO helped put the family in touch with the Nursing Unit Manager, the resident doctor and the social worker. The family was able to obtain regular updates regarding their son's progress and their request that the son return to the local hospital before discharge was made known. The PSO also obtained clear information about the reason for transfer from the local hospital and the role of the community case worker in liaising with the hospital out of the area.

The son returned to the local psychiatric unit some weeks later. He improved quickly and, after some day leave, was discharged. The father told the PSO that he was pleased his son was doing well out of hospital. He was taking his medication and planning to return to work. Although there were still some incidences of poor communication during the hospital admission overall the family were much happier this time with the care provided to their son in hospital. The father felt that the intervention undertaken by the PSO had been very beneficial in getting the services to work together in their son's best interests. The family had also appreciated the support provided by the PSO.

Receiving health services as an inmate

The parents of an inmate contacted Commission concerned about his medical treatment and was referred to PSO. The parents explained the inmate had a heart valve replacement and was on warfarin to prevent clotting. While in gaol his blood clotting (INR) levels had been unstable. He had one admission to hospital and was later told he had a mini stroke. Both the family and the inmate believed his condition was not being treated adequately in gaol.

The inmate was able to provide the PSO with records he had kept of his test results and medication given over the previous few months. The PSO started negotiations with the service and put forward the questions that the parents were asking regarding the inadequate control of blood clotting (INR) levels. As new issues emerged these were also taken up with the health service. These included medication being missed, a lack of continuity of care due to doctors' rosters, as well as some nurses refusing to contact the doctor to check the appropriate warfarin dose when the levels varied.

When after one month there had been only one INR reading in the therapeutic range the PSO discussed with the parents the option of writing to the head of the Health Service. The parents faxed a letter to the CEO outlining the issues. The PSO continued to negotiate with the health service and suggested to the service that a meeting with the parents may be productive.

Initially the CEO responded in writing but the parents did not feel the issues had been adequately addressed in the letter. The inmate, his parents, the PSO plus clinic staff and senior nursing and medical staff of the service met together to resolve the treatment issues. It was agreed that the medical and nursing staff in consultation with the inmate would prepare an appropriate treatment plan for the inmate. The Nurse Manager arranged training on warfarin treatment for the clinic staff. Apologies were provided for errors and for the negative staff attitudes that had been encountered. The family was given reassurance about future treatment and provided with contacts for dealing with any further issues.

The parents were pleased with these outcomes and put the new relationship between the parties to the test within days when another health concern for their son arose. The service provided a prompt high-level response to the inmate and his parents and this reassured the family that the arrangements put in place were effective.

Access to dental treatment

A client was referred to the PSO by the Commission to seek assistance after having been on a waiting list for dentures for over two years. The client was in her sixties, on a pension and had multiple sclerosis. Due to continuing deterioration of her teeth the woman recently contacted the public dental service but was advised that she would not be seen for another eight months.

The woman explained to the PSO that her teeth had deteriorated to the point that she was largely unable to eat solid foods. Her multiple sclerosis was exacerbated by the problems with her teeth and her difficulties eating. The client was keen to access dental treatment urgently.

The PSO contacted the Area Oral Health Manager to explore what options were available to the woman. The Oral Health Manager reviewed the file and advised that if the client requested a report from her treating GP confirming that her dental problems were exacerbating the multiple sclerosis and her general health, then her situation would be reviewed.

The woman obtained the GP's report and an appointment with the public dental service was arranged. Some remedial dental work was undertaken which resulted in the woman suffering less pain and being able to eat more. The woman still waited some months to receive new dentures, however, with the assistance of the PSO the woman was able to gather the information needed and provide this to the appropriate person to access treatment in the interim.

Negotiating methadone service delivery in a regional area

The manager of a drug and alcohol service contacted the PSO when the relationship between the staff on the methadone program and a client had deteriorated to the point that the service felt unable to continue. The service had advised the man that his dose was being scaled back with a view to removing him from the methadone program.

The PSO met with the man and his mother and learned that following an incident 18 months earlier the man had his takeaway doses cancelled. At this time a breach in confidentiality by the service also lead to the man losing his job. The man remained angry about the handling of this matter and felt he had been dealt with unfairly. As the man's frustration heightened he had become abusive to staff. Incident reports about the man's attitude and non-compliance with the program were completed and the man perceived the service to be punitive in their approach.

The PSO spoke with the program manager to understand the perspective of the service and to identify a way ahead. All parties were worried about how the man would cope if he was removed from the program.

The PSO assisted the man to prepare a document clearly expressing his frustrations with the service and his treatment. The man made a commitment to stop taking his anger out on staff. The PSO attended a meeting with the man, his mother, the case worker and the prescribing doctor. At this meeting the doctor agreed to reinstate the man to the program on a number of conditions.

Changing to a different program was not an option due to the remote location of the service. With the assistance of the PSO the man and the service were able to reach agreement as to the circumstances under which the man could continue on the methadone program.

Written Complaints

Assessment of complaints

Structural change

The Acting Commissioner, Mr Bill Grant, identified that the location of the complaint assessment processes in the investigation teams organised by geographical area had significant limitations. There was substantial non-compliance in meeting the legislative timeframes associated with the assessment of complaints; an unacceptable level of error in letters dealing with complaints assessment; difficulty for managers of investigation teams in providing effective supervision for staff associated with the complaints assessment processes and a lack of conformity in approach within each team. These problems resulted in the formation of the Complaint Assessment Team, dedicated to the management of the complaint assessment process in mid February, 2004.

Changing nature of assessments

Historically, the materials that were used to inform an assessment decision were the written complaint and any additional material the person lodging the complaint may have provided. Correspondence around the assessment process involved standard letters which provided a great deal of form information but said little to address the substance of complaints. There has been a deliberate shift in focus for the last four months of this reporting period.

The change in focus is to increase the opportunity to make more fully informed assessment decisions by obtaining as much information as possible prior to assessment whilst meeting the legislative timeframe requirements. There has also been considerable emphasis placed on correspondence that is tailored to the individual matter and seeks to properly explain the reasons for the assessment decision.

Table 6: Summary of complaints received by category 2001-02 to 2003-04

	2001-2002		2002-2003		2003-2004	
Category	**No.**	**%**	**No.**	**%**	**No.**	**%**
Clinical standards	1,404	52.5%	1357	49.9%	1451	51.5%
Quality of care	337	12.6%	498	18.3%	384	13.6%
Business practices	248	9.3%	289	10.6%	262	9.3%
Prescribing drugs	124	4.6%	115	4.2%	142	5.0%
Miscellaneous	85	3.2%	9	0.3%	107	3.8%
Provider-consumer relationship	95	3.6%	103	3.8%	107	3.8%
Patient rights	104	3.9%	101	3.7%	75	2.7%
Impairment	91	3.4%	82	3.0%	72	2.6%
Fraud	35	1.3%	49	1.8%	67	2.4%
Other unethical/improper conduct	89	3.3%	79	2.9%	59	2.1%
Complaints management	26	1.0%	16	0.6%	34	1.2%
Resources	11	0.4%	6	0.2%	27	1.0%
Character	10	0.4%	8	0.3%	15	0.5%
Waiting lists	10	0.4%	6	0.2%	11	0.4%
Professional Practice	0	0.0%	0	0.0%	2	0.1%
Operative complication	4	0.1%	0	0.0%	2	0.1%
Total	**2,673**	**100.0%**	**2,718**	**100.0%**	**2,817**	**100.0%**

Table 7: Assessment decision of complaints received 2001-02 to 2003-04

	2001-2002		2002-2003		2003-2004	
Assessment decision	**No.**	**%**	**No.**	**%**	**No.**	**%**
Refer to another body or person	1,213	45.4%	1,118	41.1%	964	34.2%
Decline	502	18.8%	543	20.0%	659	23.4%
Other resolution	486	18.2%	612	22.5%	551	19.6%
Investigation by the Commission	212	7.9%	232	8.5%	455	16.2%
Conciliation consented to or awaiting consent*	221	8.3%	202	7.4%	171	6.1%
Awaiting assessment as at 30 June	39	1.5%	11	0.4%	17	0.6%
Total	**2,673**	**100.0%**	**2,718**	**100.0%**	**2,817**	**100.0%**

** As at 30.6.2004, 62 complaints were awaiting consent from either the complainant or respondent*

** As at 30.6.2004, 52 complaints were awaiting an outcome report from Health Conciliation Registry*

Table 8: Breakdown of category of complaints received 2003-04

Complaint Type	Count
Clinical Standards	1451
Treatment - Inadequate	344
Adverse Treatment Outcomes	171
Communication: Insensitive/Rude	152
Diagnosis - Inadequate/Incomplete	120
Treatment - Incorrect	119
Diagnosis - Incorrect	95
Communication - Nil	63
Delay in Treatment	63
Communication: Incorrect/Misleading	59
Competence	49
Delay in Attending	39
Consent	37
Refusal to Treat	32
Diagnosis - Nil	27
Infection Control	19
Refusal to Attend	18
Failure to follow-up results	11
Prosthetic Devices	8
Medical records - nil	8
Medical records - quality	4
Medical records - incomplete	4
Treatment - Gross Mismanagement	3
Use of Interpreter	2
Experimental Treatments	2
Medical Records	1
Transmission of Infection	1
Quality Of Care	384
Institutions/Hospital Practice	126
Inappropriate Care	69
Standards of Care: Facilities	67
Inappropriate Discharge	25
Administrative Practice	23
Inappropriate admission (Mental Health)	22
Inadequate/un-qualified personnel	8
Delayed transfer	7
Refusal to Discharge	7
Standards of Care: Hygiene	7
Inappropriate Transport	5
Delay in Admission	4
Refusal to Admit	4
Premature Discharge	3
Inappropriate Admission	3
Delayed transport	2
Discrimination	1
Statutory Compliance	1
Business Practices	262
Fees	115
Medico-Legal Reports	31
Medical Certificates	26
Inappropriate Commercial Activities	17
Refusal to hand over medical records	16
Medico-legal report - rough/inadequate	16
Commercial Advertising	11
Medico-legal report-inadequate/incorrect	11
Medico-legal report - fraud	5
Medico-legal report - nil communication	4
Death/ Other Certificate	3
Clinical Advertising	3
Debt Collection	3
Statutory Breaches	1

Complaint Type	Count
Prescribing Drugs	142
Wrong/Incorrect Prescribing	54
Dispensing	47
Over Prescribing	14
Administration	12
Illegal Prescribing	8
Diversion	5
Inducement/Favour to Prescribe	1
Withdrawal of drug authority	1
Miscellaneous	107
Type to be determined	89
Provide Information	12
No Jurisdiction	4
Notification	2
Provider-Patient/Client Relationship	107
Physical Assault	30
Inappropriate Examination/Treatment	26
Sexual Assault	24
Inappropriate Relationship	19
Sexual Relationship	7
Sexual Harassment	1
Patient Rights	75
Breach of Confidentiality	31
Access to Records/Reports	19
Personal Privacy	16
Discrimination	6
Records: Accuracy	3
Impairment	72
Mental/Physical Capacity	33
Drugs	24
Age	11
Breach of Conditions	4
Fraud	67
Holding Out/Misrepresentation	32
Falsification/Fabrication/Plagiarism	15
Financial Inducement/Advantage	11
Overservicing	5
Extraordinary Claims	4
Other Ethical Improper Conduct	59
Inappropriate professional conduct	49
Acts of Dishonesty	9
Use of deleterious drugs	1
Complaints Management	34
Dissatisfaction with process/outcome	16
Delay/no response	9
No/Insufficent Information	6
Retaliation/staff attitude	3
Resources	27
Resources	27
Character	15
Breach of conditions	7
Conviction/Offence under legislation	7
Offences under Legislation	1
Waiting List	11
Waiting List	11
Operative Complication	2
Operative Complication	2
Professional Practice	2
Professional Character	2
TOTAL	**2817**

Table 9: Outcome of assessment reviews 2001-02 to 2003-04

Review result	2001-2002 No.	2001-2002 %	2002-2003 No.	2002-2003 %	2003-2004 No.	2003-2004 %
No further action required	166	86.0%	120	85.1%	54	47.8%
Conciliation	9	4.7%	5	3.5%	38	33.6%
Refer to another body	9	4.7%	8	5.7%	12	10.6%
Resolution by the Commission	8	4.1%	1	0.7%	9	8.0%
Investigation by the Commission	1	0.5%	7	5.0%	0	0.0%
Total	**193**	**100.0%**	**141**	**100.0%**	**113**	**100.0%**

Meeting the Commission's legislative requirements regarding timeframes

At the end of this reporting period, there were no written complaints overdue in relation to the requirement to provide notification to respondents within 14 days of receipt of the complaint. In mid-March 2004, there were 75 complaints overdue for notification to the respondent.

At the same time, there was also substantial non-compliance (94 complaints) with the statutory time frame of 60 days for assessment of complaints. In some cases, complaints had not been assessed for over a year.

At the end of June 2004, there were 8 written complaints where an assessment decision was overdue. In all of the eight complaints, the Commission had formed an assessment recommendation but was waiting for registration boards to consult with the Commission in order to form an assessment decision. The Commission is reviewing and improving assessment processes for consultations with the relevant registration boards and would particularly like to thank the Nurses Registration Board for increasing assessment consultation meetings from monthly to fortnightly.

Table 10: Complaint assessment performance 2003-04

	2001-2002	2002-2003	2003-2004
% of complaints assessed within 60 days	99%	99.7%	92.3%
Average number of days to finalise non-investigation complaints	49 days	39 days	39 days

Table 11: Complaints under investigation as at 30 June 2004

Year	No	%
1998	1	0.1%
1999	16	2.2%
2000	51	7.1%
2001	61	8.5%
2002	130	18.1%
2003	207	28.8%
2004	252	35.1%
Total	**718**	**100.0%**

Gaining additional information before an assessment decision is made

- Increased telephone or face-to-face communication with complainants if it is considered necessary to be able to clarify issues.
- Collection of medical records and review by one of the Commission's Internal Medical Advisers where appropriate.
- Collection of other information that may assist to inform the assessment decision.

Improved information about the assessment process and outcome

- Increased telephone contact with both complainant and respondents regarding a complaint.
- A reduced reliance on standard letters, with a developing initiative to prepare more individually responsive letters with greater detail regarding the reasons for assessment decisions reached.

Increasing emphasis on resolution

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

- a complaint that relates to the reimbursement of fees for a health service that was inadequately provided was resolved when the service provider became aware of the written complaint to the Commission;
- a health practitioner provided an apology to the complainant relating to the manner of communication that occurred when this was the issue of the complaint.

The Commission believes that opportunities for alternate dispute resolution have not been fully explored in the past and that the location of the formal conciliation function within the Commission, together with the existing alternate resolution processes employed by the Patient Support Service, will promote opportunities for the Commission's assessment staff to further develop this area.

Complaint assessment outcomes

During the reporting period, the Commission received 2,817 written complaints. This was a slight increase on the previous annual reporting period. Of all the written complaints received, 91.2% were assessed within the legislative requirement of 60 days.

In almost half of the complaints received, the complainant was the person who received the health service. The largest number of complaints identified issues associated with clinical standards, with doctors being the most frequently identified health professional. In terms of health facilities, the most frequently identified respondents were hospitals, with Accident and Emergency areas being the most complained about areas within hospitals.

The emerging trends from the assessment of those complaints were:

- a significant increase in the percentage of complaints (from the three previous reporting periods) that were identified as requiring investigation by the Commission, with the percentage identified during this reporting period being 16.2% of complaints;
- a decrease in the percentage of complaints (from the three previous reporting periods) referred to other organisations for their investigation or management, with 34.2% referred during this reporting period;
- a decrease in the percentage of complaints managed by other resolution strategies from the previous reporting period, with 19.6% identified for management in this way during this period;
- a decrease in the percentage of matters identified as suitable for conciliation from the previous two reporting periods, with 6.1% being identified during the current reporting period.

Review of assessment decisions

Section 28 of the *Health Care Complaints Act 1993* provides that the Commission must review a decision made after assessing a complaint if asked to do so by the complainant. There were 231 requests for reviews of assessment decisions received during the reporting period. This compares with 165 in 2002-03 and 183 in 2001-02. The increase this year may be partly attributed to the increased publicity the Commission attracted as a result of the Campbelltown/Camden hospitals matters and concern that other decisions of the Commission may have been flawed. Many requests received during this year related to assessment decisions that were many years old.

Further, there was a significant backlog of requests for review that had not been determined for some time. At the end of May 2004, there were some 128 matters waiting for review determinations, with the oldest request dating from August 2003. In May 2004, these matters were re-allocated from the one officer then handling them and distributed among the general investigation staff for review and recommendation for appropriate action to the Commissioner. The backlog and unacceptable delays had been largely addressed by the end of August 2004.

Investigation of complaints

In the reporting period, the Commission received 2,817 complaints. Of these, 455 were assessed as suitable for investigation. Those investigations were about individual health practitioners and health organisations. This number represented 16.2% of the complaints received at the Commission in the reporting period.

Table 12: Outcomes of health service investigations 2001-02 to 2003-04

Outcome	2001-2002 No.	2001-2002 %	2002-2003 No.	2002-2003 %	2003-2004 No.	2003-2004 %
Terminated by the Commission	21	48.8%	28	56.0%	39	73.6%
Make comment or recommendation	22	51.2%	22	44.0%	14	26.4%
Refer to DPP	0	0.0%	0	0.0%	0	0.0%
Total	**43**	**100.0%**	**50**	**100.0%**	**53**	**100.0%**

Table 13: Outcome of finalised investigations about health practitioners 2001-02 to 2003-04

Outcome	2001-2002 No.	2001-2002 %	2002-2003 No.	2002-2003 %	2003-2004 No.	2003-2004 %
Terminated by the Commission	179	55.9%	191	56.7%	156	58.2%
Prosecute a complaint before a disciplinary body	54	16.9%	74	22.0%	46	17.2%
Refer to a registration authority for disciplinary action	40	12.5%	33	9.8%	37	13.8%
Make comments to the practitioner about the complaint	47	14.7%	38	11.3%	29	10.8%
Refer to Director of Public Prosecutions	0	0.0%	1	0.3%	0	0.0%
Intervene in any proceedings before a disciplinary body	0	0.0%	0	0.0%	0	0.0%
Total	**320**	**100.0%**	**337**	**100.0%**	**268**	**100.0%**

321 investigations were finalised by the Commission during the year, a fall from 387 finalised the previous year. This reduction can be partly attributed to the concentration of the Commission during the year on its investigation into complaints arising out of Campbelltown and Camden hospitals, which last year's annual report estimated diverted some 30% of resources from the usual casework.

Tables 12 and 13 show the outcome of finalised investigations against health organisations and health practitioners respectively.

Delay

Section 95 of the *Health Care Complaints Act 1993* requires the Commission to report on the time intervals involved in complaint processes. The delays in Commission investigations are unacceptable. Last year's annual report noted that 92 investigations were more than three years old. At the end of this reporting year, there were 88 investigations more than three years old. As at 30 June 2004, there were still 2 investigations open dating from 1998, 16 from 1999 and 51 dating from 2000. Table 14 sets out the timeframes taken for the completion of investigations.

Delay is an evil that is unfair to practitioners and complainants alike. Extra investigators recruited as a result of the funding boost did not commence until May and June 2004 so their impact on this year's figures is negligible. Substantial reduction in the number of open investigations has been made at the time of writing.

Longer term, the Commission requires substantial changes and improvements to its investigations procedures and skills. The Commission's initiatives in this area are set out below.

Improving investigations

The Commission is reviewing its current processes for managing investigations. This includes re-engineering the investigations process, including the development of investigation plans responsive to the particular issues raised by complaints.

Training is ongoing and will ensure investigators have the skills required to conduct expeditious, proportionate and thorough investigations. The Commission has invested substantially in investigations skills training for all investigations staff and will continue its commitment to staff development.

Currently, the Commission is using an Access database to record the data pertaining to investigations. This cannot be used as a case management system for investigations and is primarily used to record information about each investigation.

On 30 June 2004, a contract was signed for the development of a new electronic case management system called CaseMate. CaseMate will be a comprehensive case management system that will be used to manage the information about all Commission inquiries, complaints and investigations and will allow investigators to more efficiently prioritise the investigations they are undertaking. It will also provide for the effective monitoring of progress on investigations and the more effective management and supervision of cases. CaseMate will improve the efficiency of investigations by generating management reports that will help ensure that investigators and their team leaders are accountable.

The benefits include:

- improvement of the management of investigations through task allocation
- improvement the Commission's services to stakeholders and clients
- better delivery of legislative functions
- efficient reporting and data analysis
- ability to tailor investigation plans according to complexity
- use of future capable technology.

Table 14: Average length of time taken to complete investigations 2000-01 to 2003-04

Timeframe	2001-2002				2002-2003				2003-2004			
	Health service		Health practitioner		Health service		Health practitioner		Health service		Health practitioner	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
less than 6 months	0	0.0%	11	3.6%	2	4.0%	23	6.8%	5	9.4%	45	16.8%
6-12 months	1	2.4%	33	10.9%	1	2.0%	33	9.8%	3	5.7%	15	5.6%
12-18 months	2	4.9%	42	13.9%	5	10.0%	35	10.4%	9	17.0%	31	11.6%
18-24 months	11	26.8%	54	17.8%	8	16.0%	66	19.6%	3	5.7%	26	9.7%
24-30 months	13	31.7%	59	19.5%	10	20.0%	56	16.6%	2	3.8%	32	11.9%
30-36 months	5	12.2%	50	16.5%	6	12.0%	50	14.8%	6	11.3%	31	11.6%
36 months or more	9	22.0%	54	17.8%	18	36.0%	74	22.0%	25	47.2%	88	32.8%
Total	**41**	**100.0%**	**303**	**100.0%**	**50**	**100.0%**	**337**	**100.0%**	**53**	**100.0%**	**268**	**100.0%**

The Commission's investigation section consists largely of investigation officers at the same level with limited supervisory capacity. The Commission has recently restructured the section on a temporary basis into five teams of about five officers, each with a team leader responsible to the Director of Investigations. This structure should provide the basis for greater teamwork and more effective and consistent management.

Case studies: Types of cases that went to investigation in 2003-04

Section 59 of the *Health Care Complaints Act 1993* also requires the Commission to report on the number and types of complaints investigated by the Commission during the year. While the statistical tables show the numbers of complaints investigated, the following case studies are provided as some qualitative indication of the types of complaints that are investigated. It should be emphasised that the matters set out below are complaints only and no assumption should be made that they have been substantiated.

- The Commission received a complaint from a woman whose mother had been admitted to hospital following an adverse reaction to a prescribed drug. At the hospital, her mother was given another drug which may have been contraindicated given her condition. The complainant's mother died the following day. The complainant fears that her mother's death was due to the treatment her mother received at the hospital.
- A woman complained to the Commission about eye surgery she had undergone to remove cataracts and another procedure called a victrectomy. Following this she suffered a retinal detachment. The woman said that she was not told of the risks of this occurring by the surgeon. She also said that after surgery, when she complained about problems with her vision, her surgeon did not respond appropriately. She alleged that he took too long to see her and then did not act on the seriousness of the problem. The woman subsequently had four operations and lost the sight in one eye.
- The Commission was notified by an Area Health Service that a registered nurse had been taking nitrous oxide. The nurse had abandoned duties without notice and was later found in the hospital. It was believed that the nurse had taken nitrous oxide from the breathing apparatus in the maternity labour room.
- The NSW Medical Board received a complaint from the Pharmaceutical Services Branch about a medical practitioner. It was alleged that the medical practitioner had purchased large quantities of anabolic/androgenic steroids and pituitary hormones that could not be accounted for and that he had administered anabolic/androgenic steroids for non-medical purposes, specifically bodybuilding.
- A young child presented twice at hospital and died of pneumonia and sepsis. The mother complained that there was inadequate assessment and treatment of her child. The specific allegations were that the doctor who saw the patient did not conduct the appropriate tests to correctly diagnose him and that the ambulance officers who took the child to the hospital did not carry out an adequate assessment.
- The Commission received a complaint, from the partner of a patient who had died, complaining of mistreatment and failure to attend to the patient on three admissions to emergency within two days. The patient was treated as critical on the third admission. The complaint concerned incorrect assessment and triage of the patient in the emergency department.

Table 15: Category of complaints assessed for investigation 2001-02 to 2003-04

	2001-2002		2002-2003		2003-2004	
Category	**No.**	**%**	**No.**	**%**	**No.**	**%**
Clinical standards	45	21.2%	57	24.6%	268	58.9%
Provider-consumer relationship	54	25.5%	61	26.3%	65	14.3%
Quality of care	13	6.1%	23	9.9%	33	7.3%
Prescribing drugs	34	16.0%	36	15.5%	31	6.8%
Other unethical/improper conduct	30	14.2%	16	6.9%	15	3.3%
Character	6	2.8%	7	3.0%	11	2.4%
Impairment	15	7.1%	10	4.3%	11	2.4%
Fraud	4	1.9%	7	3.0%	9	2.0%
Business practices	6	2.8%	13	5.6%	7	1.5%
Patient rights	5	2.4%	1	0.4%	4	0.9%
Complaint Management	0	0.0%	0	0.0%	1	0.2%
Waiting Lists	0	0.0%	1	0.4%	0	0.0%
Total	**212**	**100.0%**	**232**	**100.0%**	**455**	**100.0%**

- The Commission received a complaint from the Nurses Registration Board that a registered nurse had forged a medical officer's signature in order to rechart medications for a patient.
- A social worker working in a sexual assault unit made a complaint about a psychologist. It was alleged that an 18 year-old presented at the unit and disclosed that they had been in a sexual relationship with their treating psychologist.
- A complaint was received from the father of a young man who had died in hospital. It was alleged that a drug that had been administered through the spine when it should not have been. It was also alleged that the error was not detected for some time.
- The NSW Medical Board complained that an anaesthetist was suspected of diverting anaesthetic for self-administration, breaches of clinical standards and patient care during surgical procedures, and administration of watered-down anaesthetic to patients to allow diversion. The anaesthetist had allegedly taken the anaesthetic pump home to practise techniques for bypassing the security system to allow for substitution of generic anaesthetic, had taken home used syringes, and had repeatedly left a sedated patient in closed theatre to go to the toilet before a planned urine test.

The Macarthur Investigation

In December 2003, the Commission finalised the report of its investigation into Campbelltown and Camden hospitals in the Macarthur Area Health Service. This investigation commenced after the Director-General of NSW Health referred a complaint to the Commission about practices at the two hospitals raised by a number of nurses who worked there.

Following the publication of that report, the Government established a Special Commission of Inquiry to consider certain allegations of inadequate patient care or treatment at Campbelltown or Camden Hospitals and to identify any further action to be taken, including referral of any matter to any other person or body for prosecution or disciplinary or other investigative action. The Special Commission was also required to examine the role of the Health Care Complaints Commission and recommend appropriate changes to the way it operated. The Special Commission found that the Commission's investigation was deficient in its focus on systemic issues and failure to comply with legislative requirements to investigate individual practitioners involved in the incidents of patient care which were the subject of complaint.

The Health Care Complaints Commission established a separate investigation team to review the incidents of patient care described in its December 2003 report. This team included Commission investigators, as well as medical and nursing advisers not involved in the previous investigation, and was advised by Mr Peter Johnson SC, Mr Mark Lynch of counsel and solicitors from the Crown Solicitors Office.

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

Independently of the Commission, the Special Commission of Inquiry also reviewed the 47 incidents described in the investigation report. On 1 April 2004,

Table 16: Outcomes of unsatisfactory professional conduct cases completed 2003-04

			No.
MEDICAL PROFESSIONAL STANDARDS COMMITTEE	**Proved**	Reprimand	3
		Reprimand and conditions	6
		Conditions	Nil
		Caution and Conditions	1
	Not Proved/Inquiry Not Held	Withdrawn and dismissed	1
NURSES PROFESSIONAL STANDARDS COMMITTEE	**Proved**	Reprimand	1
		Reprimand and Conditions	2
		Caution and Conditions	1
		Referred to Nurses Tribunal	1
	Not Proved/Inquiry Not Held	Heard and dismissed	Nil
	TOTAL		**16**

Parliament enacted amendments to the *Health Care Complaints Act 1993* to facilitate investigations and prosecutions arising from the Special Commission of Inquiry. Through these amendments the Commission was required to investigate any matter concerning the conduct of an individual practitioner referred to it by the Special Commission of Inquiry. Similar obligations required the Commission to refer individual medical practitioners to the NSW Medical Board for Performance Assessment under Part 5A of the *Medical Practice Act 1992*.

The Special Commission of Inquiry issued two interim reports, on 31 March and 1 June. Its final report was issued on 30 July 2004.

In total, the Special Commission referred by name 14 doctors and 11 nurses, a further unidentified doctor, a group of doctors and three groups of nurses for investigation by the Commission in relation to the treatment given to 20 patients. (some doctors and nurses provided treatment to more than one patient). The Special Commission also referred for investigation a further 11 matters raised by the nurse informants, involving six doctors by name as well as groups of unidentified nurses, doctors and physiotherapists.

The Commission also decided, in consultation with the relevant registration boards, to investigate a further 37 health service providers in addition to those referred by the special commission of inquiry, including doctors, nurses and a physiotherapist.

A total of seven doctors were referred to the NSW Medical Board for performance assessment as a result of the Special Commission's referral. The Commission, in consultation with the board, referred the medical treatment provided by 18 doctors (including two of those referred by the Special Commission) for performance assessment. Again, some doctors were referred in relation to the medical treatment given to more than one patient.

The Commission, in consultation with the Nurses Registration Board, referred nurses involved in eight incidents to the Area Health Service to take appropriate action over what appeared to be widespread deficiencies in taking and recording patient observations.

The Commission anticipates that its investigation into these matters will be finalised in early 2005.

Table 17: Complaints about health practitioners referred for disciplinary proceedings at the end of an investigation 2001-02 to 2003-04

	2001-2002		2002-2003		2003-2004	
Disciplinary body referred to	**No.**	**%**	**No.**	**%**	**No.**	**%**
Medical Tribunal	13	13.8%	28	26.2%	22	27.5%
Nurses Tribunal	13	13.8%	14	13.1%	13	16.3%
Medical Board	21	22.3%	23	21.5%	11	13.8%
Medical Professional Standards Committee	16	17.0%	18	16.8%	10	12.5%
Nurses Professional Standards Committee	5	5.3%	5	4.7%	9	11.3%
Nurses Board	19	20.2%	9	8.4%	4	5.0%
Optometrist Board Inquiry	0	0.0%	0	0.0%	2	2.5%
Chiropractors Board Inquiry	0	0.0%	0	0.0%	2	2.5%
Chiropractors & Osteopaths Tribunal	1	1.1%	0	0.0%	2	2.5%
Physiotherapists Board	0	0.0%	0	0.0%	2	2.5%
Psychologists Board	0	0.0%	5	4.7%	1	1.3%
Psychologists Tribunal	0	0.0%	0	0.0%	1	1.3%
Chiropractors Board	0	0.0%	0	0.0%	1	1.3%
Dental Technicians Board	0	0.0%	2	1.9%	0	0.0%
Dental Board	3	3.2%	1	0.9%	0	0.0%
Pharmacy Board Inquiry	0	0.0%	1	0.9%	0	0.0%
Psychologists Board Inquiry	0	0.0%	1	0.9%	0	0.0%
Psychologists Professional Standards Committee	3	3.2%	0	0.0%	0	0.0%
Podiatrists Professional Standards Committee	0	0.0%	0	0.0%	0	0.0%
Total	**94**	**100.0%**	**107**	**100.0%**	**80**	**100.0%**

Disciplinary and other legal cases

At the end of 2003-04, the Commission had finalised 67 cases, including 51 disciplinary cases, 8 review or re-registration applications and 8 appeals. In 2 cases inquiries were not held because the practitioners involved were no longer registered or could not be located.

Two cases were withdrawn and in another no evidence was offered. One complaint was dismissed as the disciplinary body was not satisfied that the complaint was proved. In relation to the 8 appeals, the Commission agreed to consent orders upholding 1 appeal in the Court of Appeal and discontinued another in the same Court.

At 30 June 2004, 62 cases were awaiting hearings. A further 14 cases had been heard and were awaiting judgments or written decisions.

There was a 6% decrease in disciplinary and other cases finalised compared to last year (67 as against 73). This was due to the decreased number of cases to be heard,

Table 18: Outcomes of professional misconduct and unsatisfactory professional conduct cases completed 2003-04

			No.
MEDICAL TRIBUNAL	**Proved**	De-registered (Frocht, Ireland, Reimers, Ali, Towndrow, Anderson, Stoermer, Aslam)	8
		Reprimand and conditions (Bahrami, Sant Ram)	2
		Reprimand (Douaihy, Hobday)	2
		Reprimand, fine and conditions	Nil
		Conditions (Perera)	1
	Not Proved/ Inquiry Not Held	Heard and dismissed	Nil
		Practitioner deceased/no longer registered	1
		Withdrawn	1
		Inquiry not held	1
NURSES TRIBUNAL	**Proved**	De-registered (Griffin, Cunningham, Goulston, Taninaka, Tan, Taylor)	6
		Suspension (Waterman)	1
		Suspended and conditions (James)	1
		Reprimand (O'Rance)	1
		Reprimand and conditions (Gould, Taylor, Saggers)	1
		Conditions (Owens)	
	Not Proved/ Inquiry Not Held	Heard and dismissed	Nil
		Withdrawn and dismissed	1
PSYCHOLOGISTS	**Proved**	De-registered (Peinecke)	1
		Reprimand and conditions (Goard, Webster, Bahadourian)	3
	Not Proved/ Inquiry Not Held	Heard and dismissed	1
		TOTAL	**32**

Table 19: Outcomes of appeal cases completed 2003-04

Appeals	Outcome	No
High Court		
Special leave application by practitioner against Court of Appeal decision (Gorman)	Refused	1
Court of Appeal		
Appeal by medical practitioner against Medical Tribunal decision (Hobday)	Allowed	1
Appeal by medical practitioner against Medical Tribunal decision (Dr A)	Dismissed	1
Appeal by Commission against Medical Tribunal decision (Bahrami, Abou-Hatoum)	Dismissed/ Discountinued	2
Summons by practitioner against Medical Tribunal decision concerning withdrawn appeal by practitioner against a PSC decision (Dr A)	Dismissed	1
Supreme Court		Nil
District Court		Nil
Administrative Decisions Tribunal		
Application by practitioner for review of alleged breach of privacy (Curtis)	Dismissed	1
Application by practitioner for review (Druett)	Dismissed	1
Appeal to Medical Tribunal		Nil
Total		**8**

the number of cases awaiting decisions, and the decline in referrals for prosecution in recent years in some jurisdictions.

There was no adverse criticism of the Commission in a judgment by a disciplinary or appellant body concerning the conduct of a prosecution. However, there was comment made about delay in a small number of cases. The delay concerned the time taken to investigate the complaints. The Commission has recently implemented a number of strategies to address investigation delays which are outlined elsewhere in this report.

Table 20: Outcomes of re-registration/review application cases completed 2003-04

Re-Registration/Review Applications	No
Medical Tribunal	
Re-registered with conditions (Abou-Hatoum)	1
Heard and Dismissed (Bannister, Edelsten)	2
Nurses Tribunal	
Re-registered with conditions (Feeney, Walker)	2
Heard and Dismissed	Nil
Medical Board Inquiry	
Re-registered with conditions	1
Conditions removed	1
Physiotherapists	
Re-registered with conditions	Nil
Heard and Dismissed (Rasaiah)	1
Total	**8**

Case studies

Court of Appeal

Dr A – procedural fairness

Dr A issued a summons in the Supreme Court seeking an order pursuant to section 69 of the *Supreme Court Act 1970* in the nature of *certiorari* to quash a decision of the Medical Tribunal concerning an appeal by the practitioner against a decision of a Professional Standards Committee.

Before evidence was completed in the appeal, the Deputy Chairperson of the Tribunal indicated that there was a substantial prospect that the Tribunal would exercise its powers in the interests of protection of the public and impose a far more substantial fine, restrictions and conditions on the practitioner than were imposed by the Committee. The Tribunal indicated it may also consider lodging its own complaint.

Counsel representing the practitioner saw the Deputy Chairperson's remarks as a Parker warning. A Parker warning refers to the Court of Appeal decision in Parker -v- Director of Public Prosecutions (1992) 28 NSWLR 282. It was submitted that the Tribunal's decision was vitiated by lack of procedural fairness on the part of the Tribunal because the practitioner was not able to complete his case to finality and to put before the Tribunal the balance of his evidence.

Figure 5: Legal Cases 2003-2004

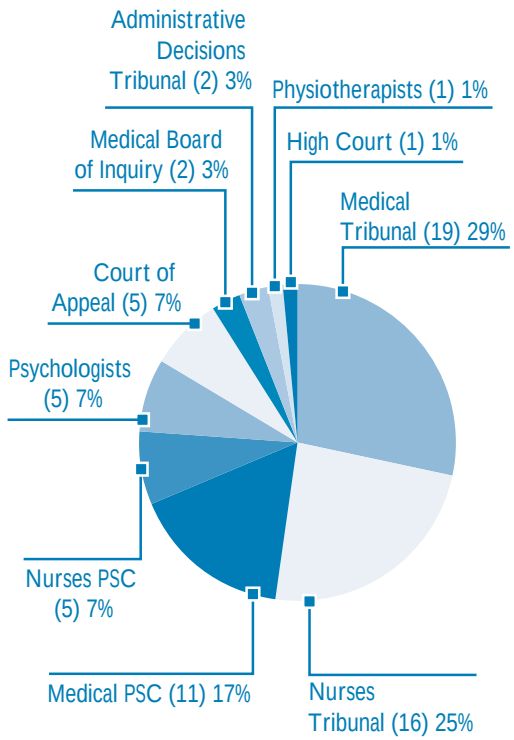
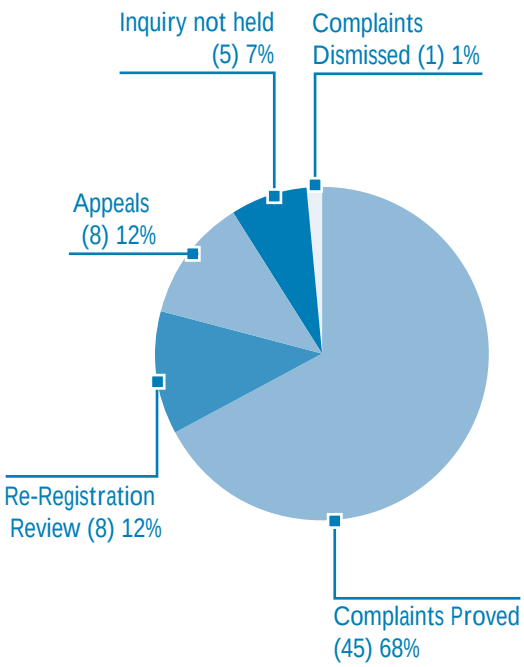


Figure 6: Overview of Cases 2003-2004



The Court of Appeal held that the remarks of the Deputy Chairperson could not be interpreted as indicating any more than the giving of a fair warning to the practitioner that his case was not proceeding well. The Court stated that *"the very principles of Parker's case referred to in another context show that the Tribunal would, under some circumstances, have been obliged to give a warning of the nature that was given. Had it not been given then there would undoubtedly have been cause for complaint. The fact that it was given can hardly be characterised as having any bearing upon a claim of denial of natural justice."* The Court also stated that *"the particular warning given, carefully qualified as it was and made in its present forensic context, was not such as to give rise to any procedural unfairness, that is procedural unfairness by way of pressure, prejudgment or otherwise."*

The summons was dismissed.

Medical Tribunal

Dr Reimers – self-administration of narcotics

Dr Gerrit Reimers was a specialist anaesthetist. The Commission prosecuted complaints of professional misconduct and impairment before the Medical Tribunal.

The complaints of professional misconduct related to four distinct areas: clinical management of a patient in February 2000; wrongful handling and misappropriation of anaesthetic drugs at various Sydney hospitals in 1996, 1997 and 2000; self-administration of drugs of addiction and benzodiazepines whilst on duty between 1996 and 2000; and deliberately misleading the Medical Board about drug use on various occasions between May 1997 and March 2000. The complaint of impairment concerned admitted addiction to narcotics between 1996 and 2000.

Dr Reimers admitted to the Medical Tribunal that he had been addicted to narcotics. He also admitted substantial aspects of the misconduct complaints.

Dr Reimers gave a history of first taking a small amount of the drug Pethidine around the end of 1995 when he was an intern. He later started taking Pethidine and Fentanyl in September 1996 when he was working as an anaesthetic registrar at Hornsby Hospital. He diverted supplies of the drugs from patient controlled anaesthesia. On less than 10 occasions he stated he tried Valium and Hypnovel. When he fell under suspicion, Dr Reimers falsely pretended to colleagues at Hornsby Hospital and other officials that he was not abusing narcotics but was using benzodiazepines.

In early 1997, Dr Reimers took up a further registrar position at Liverpool Hospital. In his first few weeks at Liverpool, he again diverted drugs that were prescribed for patients. His drug use was detected and although Dr Reimers falsely denied any narcotic use, his practice was supervised at Liverpool Hospital and his access to narcotic drugs was restricted for a period. In 1998, Dr Reimers gained his Fellowship from the College of Anaesthetists. He then commenced working at a number of different locations and later in 1998 commenced to abuse narcotic drugs again.

It was during the period that Dr Reimers admitted that he was habitually abusing narcotic drugs at the time that he cared for the patient at Hornsby Hospital. The patient was undergoing a routine operation for bowel cancer. In the recovery area after the operation the registered nurse noted that the patient was in poor condition. The nurse repeatedly drew Dr Reimers' attention to the patient's condition. Dr Reimers' efforts to resuscitate the patient were ineffective. Eventually the nurse summoned other medical officers at the hospital to assist. The patient was found to have suffered very serious brain damage due to hypoxia and died a few days later.

There was a police investigation and Dr Reimers was charged criminally. He was not found guilty of any charges. In the period following the patient's death, Dr Reimers admitted to some colleagues that he had a drug problem and sought treatment. In April 2000, Dr Reimers was suspended from medical practice by the Medical Board and he remained suspended up until the time of the Medical Tribunal hearing.

The Medical Tribunal found Dr Reimers guilty of professional misconduct. It was also satisfied that Dr Reimers continued to suffer from an impairment even though there was no evidence that he had taken any drugs since 2000.

The Tribunal found that Dr Reimers had lied about his drug use over a number of years and that he engaged in dishonest and deceptive conduct in a number of other areas. It considered that the only appropriate order was deregistration. It noted that *"Dr Reimers has exhibited extremely significant deficiencies both of character and of skill in the practice of medicine. He was shown to be willing on many occasions to put his own interest above those of patients, probably, in the case of SB, at least contributing to her tragic death"*.

The Tribunal ordered that Dr Reimers not be permitted to re-apply for registration for a period of 10 years.

Mr Edelsten – re-registration application

Mr Edelsten made another application to be re-registered as a medical practitioner. This was his third application. The Medical Tribunal dismissed the application.

The main grounds for the application were that the applicant was now a fit and proper person to be registered as a medical practitioner; he was competent

to practice medicine; he was of good character; and the Tribunal could rely upon the worthiness and reliability of the applicant as a medical practitioner for the future.

The Tribunal noted that Mr Edelsten was deregistered in 1988 when found guilty of professional misconduct and not of good character. The Tribunal stated that it bears the responsibility to protect the public interest, its health and safety when considering the question of restoring the applicant to medical practice. A further important consideration is the protection of the profession. It noted that medical practitioners are in a highly privileged position of trust. They must be seen to be honest and must possess not only medical skills, but the highest moral and ethical standards, and to be persons of probity whose integrity is unquestionable.

The Tribunal found that Mr Edelsten failed to demonstrate the honesty and frankness requisite in any applicant seeking to be regarded as a person of probity who has overcome his previous dishonesty and gross defects in character which lead to his previous criminal and dishonest conduct. The Tribunal stated that the applicant proffered so many untruths and deliberately misleading statements on so many occasions prior to coming before the Tribunal and in the proceedings before it for his application to have any prospect of success.

The Tribunal found that Mr Edelsten had not discharged the onus upon him of establishing that he had overcome the defects in his character which lead to the dishonourable conduct resulting in his removal from the register, and that he had not rehabilitated himself so that he is now a person of good character for the purpose of practising medicine.

The Tribunal ordered that no further application for review could be made for a period of four years.

Dr Aslam – sexual misconduct

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

The practitioner met the patient when she was admitted to the accident and emergency department of the hospital where he worked. The complaint alleged numerous boundary violations by the medical practitioner including inviting the patient to his motel room, giving her his mobile phone number, permitting her to shower in his room at the motel, providing her with a meal and discussing matters personal to the patient and himself. The complaint also alleged that the practitioner had sexual intercourse with the patient.

The practitioner denied some of the particulars of complaint but admitted that his conduct constituted professional misconduct.

The Medical Tribunal stated *"It is clear on the evidence that the practitioner was fully aware that the patient was a disturbed 16 year-old. Her history of previous self-mutilation which was known to him and it was patently obvious that by reason of her age and her mental condition that she was vulnerable in the extreme. Such was her mental state at the hospital that he referred her to the Mental Health Team and as stated, he had personally noted that she was a serious suicide risk. The Tribunal considers it beyond question that for him to provide her with his mobile phone number and his motel room number that he was, in effect, inviting her to contact him for reasons unrelated to any clinical purpose. It would have been obvious that the girl related to him. There can be no reasonable explanation for these actions other than that he wished her to visit him."*

The Tribunal further stated that the practitioner *"would have been fully aware of the potentially devastating effect of his sexual exploitation of such a disturbed and vulnerable teenage girl. The Tribunal holds no doubt, that at all stages from the time the practitioner gave the patient his home number and motel address, he was completely aware that what he was doing involved gravely serious misconduct."*

The Tribunal found that the practitioner exploited the patient to gain sexual gratification by an act of non-consensual sexual intercourse.

The Tribunal concluded *"that it had serious doubts that the practitioner has any real insight into the impropriety of his conduct, and as at today it holds the opinion that there is a reasonable probability of the practitioner re-offending. This situation could change and he could well gain the necessary insight and achieve rehabilitation."*

The Tribunal found the practitioner was guilty of professional misconduct and ordered that his name be removed from the Register of Medical Practitioners of NSW. The Tribunal ordered that the practitioner may not make an application for review until the expiration of four years.

Dr Anderson – sexual misconduct

The Commission made a complaint to the Medical Tribunal alleging that Dr Anderson, a general practitioner, was guilty of unsatisfactory professional conduct and professional misconduct in that he had a sexual relationship with a patient for four years. At the time the relationship began, the practitioner was treating the patient for depression. The practitioner also continued to treat the patient's husband and children.

The practitioner admitted the complaint and admitted that his conduct amounted to professional misconduct.

The Tribunal found the complaint proved and stated *"the transgressions of Dr Anderson established in this case were very serious. [Patient] A was vulnerable and Dr Anderson, exhibiting grievous deficiencies of character took advantage (perhaps unwittingly) of that vulnerability. He compounded this by continuing the improper relationship established for some four years and further compounded it by continuing to treat A and her family, especially her husband during that period."*

The practitioner submitted that he should not be deregistered because he had reformed his character and he would not re-offend. The Tribunal was not persuaded that Dr Anderson had proved that his character was fully re-established and, to mark the Tribunal's grave disapproval of his conduct, and to demonstrate for the benefit of other practitioners the consequences that normally will flow from such conduct, it deregistered the practitioner.

The Tribunal ordered that Dr Anderson could not make an application for review of its order for at least 12 months.

Mr Griffin – convictions for sexual offences

Mr Griffin, a nurse, was convicted and sentenced to imprisonment in 1999 for sexual offences. The charges for which Mr Griffin was convicted and to which he pleaded guilty can be grouped and summarised as follows: sexual intercourse with males between 10-18 years; inducing a child to participate in an act of child prostitution; aggravated acts of indecency; employing a child for pornographic purposes; indecent assault on a minor by a person in authority over that minor; and indecent assault.

The Commission made a complaint to the Nurses Tribunal that Mr Griffin had been convicted of criminal offences that render him unfit in the public interest to practice nursing and that he was not of good character. Mr Griffin was represented at the inquiry by counsel and an instructing solicitor but did not attend the inquiry himself.

The Tribunal found that *"overall, the circumstances in which he committed the offences are marked by a desire to have sexual gratification without regard to the vulnerability of and with little regard to the damage he was causing the victim. This attitude of the respondent displayed qualities which are fundamentally inconsistent with the qualities required of a nurse who is in a position of trust with his or her patient who is in a vulnerable and dependent position to the nurse. In addition it must be noted that these offences took place over a period of some 11 years and involved 12 different victims. The circumstances are such that the respondent could be described as a sexual predator and a serial offender."*

The Tribunal further stated that *"these matters are of sufficient seriousness and gravity, taking into account all of the matters referred to above, any order other than removal from the register would not be sufficient to protect the public interest. In addition the Tribunal found that the respondent is not of good character."*

The Tribunal ordered that the appropriate period before Mr Griffin could be permitted to re-apply for registration was five years.

Mr Peinecke – false and misleading evidence to court

The complaint against the psychologist related to events connected to a murder trial. The psychologist provided counselling to Patient A. Patient A informed the police that his then partner, Ms B, confessed to him that she had murdered her husband. Ms B was subsequently charged with murder. Ms B's solicitor subpoenaed Patient A's counselling records from the psychologist's employer. The psychologist informed his employer and the police that the records were missing. The psychologist also told the Local and the Supreme Courts on oath that the records were missing.

Some time later, a former colleague of the psychologist came forward and said that the psychologist had admitted to her that he had destroyed the patient's counselling records. The Supreme Court issued a certificate to the psychologist pursuant to s.128 of the *Evidence Act 1995*. The certificate afforded the psychologist protection from any criminal or civil proceedings which may be brought against him in NSW in relation to the evidence he gave in the court, that is, that he destroyed the patient's counselling records and perjured himself in the Local Court and the Supreme Court on numerous occasions.

The Commission made a complaint under the *Psychologists Act 2001* that Mr Peinecke was guilty of unsatisfactory professional conduct and professional misconduct in that he failed to produce a patient's counselling records to the Local Court when served with a subpoena to do so, and that he deliberately destroyed those counselling records. The complaint further alleged that the psychologist gave false and misleading information to his employer and the police and on oath in the Local Court and the Supreme Court about the whereabouts of the missing counselling records.

The Commission also alleged that the psychologist was guilty of unsatisfactory professional misconduct in that he failed to warn the patient about the legal limits of confidentiality prior to or during the counselling sessions.

The psychologist decided not to give evidence in the Psychologists Tribunal as he might incriminate himself. As the Tribunal is not a court, it does not have the power to issue a s.128 certificate.

The Tribunal found that the psychologist selectively and deliberately destroyed the patient's counselling records and that he embarked upon a deliberate course of dishonesty by the fabrication of explanations as to how the notes may have gone missing between April 1998 and July 2000, when he made the admission to the Supreme Court. The Tribunal said *"This dishonesty occurred in the context of a murder investigation and prosecution – an extremely serious matter with the potential for extremely serious consequences for Ms B. The Tribunal finds that the context in which this dishonesty occurred contributes to the severity of the breach. It is the Tribunal's view that the breach would attract severe criticism even without the aggravating factor."*

The Tribunal found the complaint proven and stated that the only appropriate order was removal of the name of the psychologist from the register and cancellation of his registration in accordance with the legislation. The Tribunal concluded *"that it would take the psychologist at least three years to address the defects of behaviour and character that have been demonstrated by the behaviour he has been found guilty of in this matter. Even having regard to the fact that the Tribunal has no evidence of any other behaviour or conduct that is unsatisfactory. The seriousness of the professional misconduct found in this matter and the lack of appropriate steps being taken toward reform, given that there has not been closer to four years for the Psychologist to have taken such steps, support the Tribunal's view that it will take a significant period of time for appropriate reforms to take place."*

Professional Standards Committee

Drs A & B –
Surgical damage to bypass graft

At the age of 69, Ms C was referred to Dr A, consultant gynaecologist, because of excessive uterine bleeding. A hysterectomy was recommended and it was arranged that the operation would be performed by specialist gynaecologist and obstetrician, Dr B, with Dr A assisting. Dr A was unable to perform the operation himself as his registration was subject to conditions imposed by a Professional Standards Committee two years earlier which prohibited his performance of such procedures.

Neither Dr A nor Dr B took an adequate medical and surgical history, nor did they conduct a pre-operative examination of Ms C, and thus neither was aware of Ms C's right-to-left ilio-femoral bypass graft, in place for over a decade. Both practitioners were aware that the patient had a vascular graft, but not its type or position.

Neither Dr A nor Dr B was aware that Ms C's graft lay in the surgical plane and during the operation it was inadvertently cut, causing severe bleeding. Neither practitioner recognised at the time that it was damage to Ms C's bypass graft that had caused the unexpected bleeding. To stop the bleeding, Dr B ligated the graft and the hysterectomy procedure continued.

Due to post-operative bowel obstruction caused by adhesions, Ms C was not discharged until a month after the operation. At no stage during her admission was she informed about what had occurred during her hysterectomy. Shortly after the procedure, Ms C complained of coldness and lack of feeling in the left foot and it was noted that she had absent pulses in her left leg. Neither Dr A nor Dr B contacted Ms C's treating vascular surgeon to inform him of the damage done to the graft during surgery.

By the time Ms C was seen by her treating vascular surgeon, her bypass graft was occluded, circulation to her left leg was seriously compromised, and too much time had elapsed for there to be a successful replacement of the damaged graft. Ms C required a mid-thigh amputation of her left leg, which later had to be repeated at a higher level.

In two separate inquiries, Professional Standards Committees found both Dr A and Dr B guilty of unsatisfactory professional conduct. Both practitioners were severely reprimanded. Dr B was required to complete the university course "Exploring Clinical Ethics" at his own expense and the existing conditions on Dr A's practice were ordered to remain, with the addition of the condition that he not assist at major surgical operations when patients are referred to him by another medical practitioner. A de-identified copy of each decision was sent to the Royal Australian College of Obstetricians and Gynaecologists for educative purposes.

It was found by the Professional Standards Committee that Dr A's failure to adequately obtain and record a detailed history of the patient's vascular surgical history was the primary cause of the sequence of events that followed. Dr A was found to demonstrate a lack of insight into his responsibilities as the initial consultant and his responsibility for the care of the patient post-operatively. In a practitioner of over 40 years' experience, this demonstrated a lack of the expected level of skill and knowledge and his overall conduct demonstrated a serious lack of care for his patient.

It was found by the Professional Standards Committee that, as the treating surgeon, Dr B had a duty to take a history, do a physical examination and discuss any issues with Ms C and that he was in no way absolved of these responsibilities by the fact that the patient was referred to him by a gynaecological colleague, Dr A. As the patient was admitted to hospital under his care, it was also Dr B's responsibility to ensure that her treating doctor received accurate information about the events that occurred during her time in hospital. Dr B was found to have demonstrated a serious lack of judgment and care.

Nurses A & B –
Aged care

Mrs Y was admitted to an aged care facility following a fall at home in which she sustained a fractured humorous and finger. She also suffered from severe dementia. Whilst a resident of the aged care facility, Mrs Y developed pressure areas to her sacrum, hips, ears and heels. Her condition deteriorated to the extent that she was transferred to a palliative care unit and died two months after her initial admission to the aged care facility.

The Commission received a complaint regarding two registered nurses employed by the facility who provided care to Mrs Y.

The complaint made by the Commission to the Professional Standards Committee alleged that the two nurses involved in Mrs Y's care failed to initiate a nursing care plan, failed to inform the visiting medical officer of observations of the sacral pressure area anytime during their care of her, and failed to notify Mrs Y's next of kin of the deterioration in her medical condition.

Both nurses were very experienced in aged care, with one having 36 years experience in the area, and the other eight years.

The Committee found the complaint proven; both nurses were found guilty of unsatisfactory professional conduct. The Committee expressed the view that the nurses' treatment of Mrs Y showed a lack of adequate knowledge, skill, judgment and care in the practice of nursing in that, given their years of experience, it would be expected the nurses would complete accurate documentation with regard to the treatment required by the resident; they would be able to communicate a resident's condition to both colleagues and family members; and that they would thoroughly document these interactions.

An issue to arise during the hearing was that of differing techniques for recording temperatures taken per axilla. The Committee found the inability of one nurse to accurately record Mrs Y's temperature compromised her safety and may have in fact contributed to the decline in her health. The Committee emphasised the need to take accurate patient observations and to record them accordingly as part of appropriate patient care.

Both nurses were reprimanded. One of the nurses was ordered to participate in a post-graduate course and counselling in the correct methodology for taking and recording temperatures.

Service initiatives

The CaseMate project

The CaseMate project plans to deliver a flexible and effective software application for the management of complaints.

The objective of the project is to provide the Commission with a case management tool to improve the efficiency of complaint handling and ultimately eliminate any unnecessary delays. The application will be used to track the progress of complaints and to provide reports on performance.

Following a comprehensive tender process, a preferred supplier, Eclipse Computing (Australia) Pty Ltd, was selected.

The solution chosen is based on a proven and well-tested software development platform with customer sites around the world and in Australia, including other NSW agencies, some of which served as referees. The software provides maximum flexibility, value for money and forward-looking technology. The selected solution minimises the risks inherent in any large-scale development application.

A fixed-price contract was negotiated with the selected supplier, Eclipse Computing (Australia) Pty Ltd, and was signed on 30 June 2004. The project is planned for completion in February 2005. CaseMate will become a crucial tool in improving the Commission's performance.

Professional advisers and reviewers panel

The Health Care Complaints Commission relies heavily on the support and advice provided by the professions and associations. To enable this to occur as part of its routine service, the Commission maintains a Professional Advisers and Reviewers Panel, or register of peer reviewers, the members of which are called upon to assist where a matter falls into their area of expertise and knowledge.

At present there are 229 active reviewers identified on the Commission Panel. In the reporting period, 10 new panellists were recruited and 17 reviewers retired from the Panel.

In the last reporting year, the Commission developed a database to assist in the management and use of its expert panel. Problems were identified with out-dated or corrupted data regarding reviewer's details. A major data audit was conducted in early 2004 where the

Commission contacted each panellist and verified their contact details, availability, and specialties and obtained a current CV.

The database program was also remodelled to ensure an easier and more intuitive display, search functionality and case management capacity. The Commission's policy on use was reviewed and training sessions for staff on the use of the database have been organised and will continue through 2004.

In response to concerns about the use of peer reviewers, a major recruitment drive has commenced to address identified shortages on the Panel by actively seeking nominations from relevant professional colleges and associations. The Commission is also reviewing the fees it pays for peer and expert review reports, as well as developing a fee schedule for telephone consultations telephone advice from our panellists.

The Commission has found that a large percentage of people it has approached to assist as a reviewer and adviser have agreed to do so as the role is perceived as contributing to community confidence in the professions and improving health care in NSW. With the support of the NSW Medical Board, the Commission is actively negotiating with the relevant colleges and associations for continuing professional education recognition for medical practitioners who provide advice on standards. Where the practitioner's profession has a form of accreditation and/or continuing education requirements, the Commission feels that some recognition could be given for the role the practitioner plays in maintaining professional and clinical standards. These negotiations will also be taken up with the other professional bodies.

The objective of the review and recruitment is to establish a sufficiently extensive list of peers to provide for their selection on a rotational basis.

A comprehensive coordinated program is being developed to offer education and support to panellists in 2004.

The Commission is also reviewing its Professional Advisers and Peer Review Guidelines (last edition may 2002). A number of suggestions were made by the Joint Parliamentary Committee Report of the Inquiry into Procedures Followed during Investigations and Prosecutions Undertaken by the Health Care Complaints Commission which are currently being incorporated into the review for comment. The review of the guidelines is to be completed before this year's training for new reviewers.

Training Health Service staff

During 2003-04 the Commission continued to provide a training and advisory service for Area Health Service staff in on the management of complaints. This initiative resulted from an agreement the Commission reached with the Senior Executive Forum of the NSW Health Department and the Area Health Services.

As a result of the positive feedback and outcomes of the 2000 and 2001-02 training programs, the Senior Executive Forum funded the training program for another year.

The brief for the Commission was to continue to offer investigations and resolution training courses and to develop other training products that would provide opportunities for participants to build on skills acquired in previous training offered by the Commission.

In response to this request three new training products were developed. The training initiative for 2003-04 allowed for each Area Health Service (AHS), Ambulance Service of NSW, Corrections Health Service and Westmead Children's Hospital to receive 5 days of training from the suite of courses on offer.

- Complaint Management: Investigation and Resolution – 3 days
- Resolution in Health Care – 1 day
- Resolution in Health Care for Aboriginal Health Workers – 2 days
- Resolution in Health Care for Aboriginal Health Workers. Building on Resolution Skills – 1 day
- Investigation Skills and Methodology – 2 days
- Investigation: Interviewing skills – 1 day.

During the reporting period, 47 training courses were conducted in eighteen health services, with a total of 731 participants. The occupations of participants varied from area directors, unit managers, clinicians, cleaning staff, administration staff and receptionists.

The Director-General of Health requested that the courses be evaluated on completion of the series. The Commission evaluated the training for 2003 using three evaluation tools:

- participant evaluations at the conclusion of each training course;
- structured telephone interviews with key officers within four Areas, which were conducted three to eight months after training had been completed; and
- participant questionnaire provided to 191 people in three Areas, three to eight months after training had been completed (the fourth Area did not distribute the 67 questionnaires to participants).

From the evaluation feedback there is a consistent view that the training was of real value to the development of competencies of staff in relation to complaint management.

- It is apparent that this view has been sustained over time.
- At the conclusion of training, 95.0% of respondents perceived the course content to be relevant or very relevant. Some months after training, 92.1% of course participants who responded agreed or strongly agreed that the training had been relevant to their handling of complaints and 91.5% agreed or strongly agreed that they had been able to use the information they gained through the course to manage complaints more effectively.
- This view was reinforced by senior officers within Areas where 100% of those interviewed believe that their staff are managing complaints more effectively, and that staff are feeling more confident when asked to become involved in managing a complaint.

In response to the success of the training initiatives, the Commission was approached by the New Zealand Health and Disability Commission (HDC) to provide training to their staff on 8-9 September on investigation planning and interviewing. It was also an opportunity for the partner organisations to share ideas. Discussions involving the Commission's Professional Advisors and Reviewers Panel as well as other complaint management and quality improvement strategies proved mutually beneficial. This request reflects the growing reputation of the Commission as a leader of effective training products for the health sector at home and abroad.

Turning wrongs into rights: learning from consumer reported incidents

The Australian Council for Safety and Quality in Heath Care (the Council) sponsored the *Turning wrongs into rights: learning from consumer reported incidents* project to improve the way health care services managed complaints, with emphasis on the link to quality improvement.

The Council engaged the Commission to deliver the Project (on behalf of the Australasian Council of Health Care Complaints Commissioners) with the Royal Australasian College of Physicians (on behalf of the Committee of Presidents of the Medical Colleges) and the Health Issues Centre. The project was carried out between April 2003 and June 2004.

The project conducted research during 2003 to provide the basis for developing the *Better Practice Guidelines on Complaints Management for Health Care Services.* The research included a literature review, a survey of examples of better practice in complaints management at 53 health care services in Australia, and a review of relevant standards, policies and programs. A Complaints Management Handbook for health care services was developed in 2004, along with recommendations for project work to improve complaints management practices with links to quality improvement.

The project consulted widely and regularly with stakeholders with an initial promotional letter and invitation to comment, a monthly project email bulletin, a national consultative workshop in October 2003, and invitations for written submissions at various stages of the project.

The guidelines and handbook have been very well received by stakeholders, with particular support from health care complaints commissioners, accreditation and standards bodies, consumer groups, and medical defence organisations.

Better practice guidelines on complaints management for health care services

The guidelines provide a framework for health care services to develop or improve their own consumer feedback, complaints management and quality improvement systems.

The guidelines contain eight statements of principle, and each guideline is complemented by a series of indicators which describe practices that are consistent with each guideline.

1. Commitment to consumers and improvement – organisational leaders promote a consumer-focused complaints management policy and procedures as part of a continuous quality improvement program.
2. Accessible – consumers are encouraged to provide feedback about the service, including concerns and complaints, and it is easy to do.
3. Responsive – all complaints and concerns are acknowledged and responded to promptly and sensitively.
4. Assessment and accountability – complaints are assessed to determine appropriate responses by considering risk factors, the wishes of the complainant and accountability.
5. Effective resolution – complaints are dealt with in a manner that is complete, fair to all parties and provides just outcomes.
6. Privacy and open disclosure – information is managed in a fair manner so that relevant facts and decisions are openly communicated while confidentiality and personal privacy is protected.

7. Gathering and using information – complaints are recorded to enable review of individual cases, to identify trends and risks, and complaints are reported to provide information on how they have led to improvements.
8. Making improvements – complaints are used to improve the service, and the complaints management policy and practices are regularly evaluated.

In response to feedback on the guidelines, the project prepared a detailed Complaints Management Handbook with sample documents, cases studies and explanatory material.

The Australian Council for Safety and Quality in Health Care provided in principle support for the guidelines at its meeting on 4 March 2004, and the guidelines will be considered for endorsement by the Australian Health Ministers Conference when it meets on 29 July 2004.

The Complaints Management Handbook

The Complaints Management Handbook provides practical guidance on how to implement and use the guidelines. It is in four parts: research and theoretical basis, use of the guidelines, sample forms, and 10 case studies.

A number of issues arose during the consultation with stakeholders about the Handbook. The first is the definition of risk in risk management policies and standards used in the health care sector. All the major policies and standards define risk in terms of level of injury to patients or level of financial or corporate risk, and no reference to the 'customer service' relationship. The approach used in these policies is not consistent with the practice in other customer service industries, which highly value customer loyalty and satisfaction with all aspects of service delivery. The Handbook provides a definition of risk that includes damage to the customer relationship and failure of administrative systems to support patient care. The Council and health care complaints commissioners need to review risk assessment tools used in the health care sector and provide active guidance on the way risk is defined.

Secondly, the Handbook was required to apply to all types of health care settings. This was not practical given the differences in organisational systems, work practices and even the language used by health care professionals to describe their positions. The Handbook includes a four-page supplement for general practices and specialists, with general guidance and a short sample complaints policy.

The project found a great deal of support for the Guidelines and Handbook from stakeholders at the national consultative workshop and in written submissions on the draft guidelines, and through subsequent targeted consultation on the final guidelines. The project provided a summary report and communications plan to the Council in February 2004 with recommendations on guideline implementation and for future projects to build on the project's success.

The health care complaints commissioners have agreed to publish the guidelines and handbook on their websites. Both documents are to be published as joint publications of the Council and the Australasian Council of Health Care Complaints Commissioners.

Significant progress has been made with accreditation and standards bodies. The Commission will provide presentations on how to review complaints systems for the Australian Council of Health Care Standards surveyor education and development program in September and October 2004. The Royal Australian College of General Practitioners has recently reviewed Standards for General Practice 2nd edition and, in response to a submission from the project, the revised standards are expected incorporate new requirements on complaints management.

A project proposal for monitoring and evaluation of the guidelines was also provided. A key aspect of the proposal is an offer from the Australian Council on Health Care Standards to have their surveyors complete a basic questionnaire about complaints management practices for 18 months.

Recommendations for future action – improving practice

Recommendation 1:
Competencies of complaints managers

The project found that the competencies and authority of people responsible for managing and coordinating complaints is an important indicator of better practice complaints management. The role, qualifications and competencies of complaints managers in health care services varies enormously. Stakeholders identified as a priority the need to develop a national consensus on this issue and to discuss the benefits and options for credentialing complaints managers.

The project recommended that the Council commission a project to develop national agreement on the competencies and role of people with responsibilities for complaints management in health care services.

Recommendation 2:
National data on complaints

There is no national system for collecting information on the causes and outcomes of complaints about health care services. The information collected by health complaints commissions and state and territory governments is not

analysed or used for quality improvement purposes. Incident monitoring programs are starting to include complaints as a category of incidents, creating yet another source of complaints data.

The national consultative workshop supported health care complaints commissioners and state and territory governments sharing the complaints information they already collect and discussing the need, costs and benefits of a national health complaints information program. It supported funding to ensure national data on complaints is collected and reported across the health sector and the community.

Possible activities to achieve the outcome sought by stakeholders include:

- state and territory health departments establish a complaints officers' group to facilitate sharing of information about complaints information, developments in complaints policies, and training resources;
- the State Quality Officials Forum collaborating with the Australasian Council of Health Care Complaints Commissioners to review complaints reporting and incident reporting schemes to ensure complaints will be reported effectively, in a way that will facilitate system wide learning and improvement;
- state and territory health departments and health complaints commissions prepare reports on complaints information analysing the type of information collected on complaints by each jurisdiction; how the information is used and models for future reporting; and use of complaints information so that it is used effectively to improve health care services;
- state and territory health departments that have not already done so need to consider moving the administration of complaints management policies and programs into quality improvement units.

The project recommended that the Australasian Council of Health Care Complaints Commissioners and the state and territory departments of health establish a forum to facilitate sharing of information on the causes and outcomes of complaints at the national, state and territory level, to inform improvements to health care services.

Recommendation 3:
Local level complaints records

The survey of better practice found health care services use a range of customised computer products and systems to support management of complaints – recording information and tracking progress at each stage, providing prompts and generating reports. The products provide important practical support for best practice approaches to complaints management, whether in a large, complex organisation or a small health care service. There appears to be enormous duplication of effort and expense.

The project recommended that the Council collaborate with the Australasian Council of Health Care Complaints Commissioners on a project to benchmark effective complaints management products and share that information among health care services.

Recommendation 4:
Evaluation and reporting

A major challenge for health care services is to collect information of sufficient quality about the causes and outcomes of complaints, and to use it effectively for learning and to make improvements. The survey of better practice found that while many health care services prepare routine reports on complaints for quality and executive committees, a large proportion do not use them well. It found some examples of effective measures used to report on complaints to clinicians and staff, such as discussing complaints at staff meetings and displaying case studies on notice boards, or in newsletters. Almost none of the services included in the survey provided effective reports about complaints to the community as part of reporting on quality improvement.

The project recommended that the Council sponsor a collaborative research project to develop and demonstrate models for effective reporting about complaints to staff and the community, involving health care complaints commissions, consumer groups and health care services from a range of settings.

Recommendation 5:
Training and education

The project identified a range of education programs on complaints resolution and investigation that address the various training needs in the health care sector. Stakeholders expressed the view that complaints management should be included in undergraduate and postgraduate education for all health professionals as a matter of priority. A leading project in this area is the National Patient Safety Education Project, which is developing competencies in patient safety for all staff in hospitals, including competencies in handling complaints. The project worked with the National Patient Safety Education Project, providing expert advice as part of the project's validation group on core competences in complaints management.

The project recommended that the medical and nursing colleges and universities consider as a priority the inclusion of complaints management in undergraduate and postgraduate education for all health professionals as part of learning about patient safety.

Recommendation 6:
Public education

The briefing paper discussed the need to overcome negative attitudes to complaints about health care services by health care professionals, managers and the community. Participants in the national consultative workshop supported research and public education aimed at changing attitudes so that complaints are seen as opportunities for the whole community, rather than just health care professionals. Participants sought an ongoing leadership role from the Council to change public attitudes.

The project recommended that the Council commission a public information campaign to explain what people complain about, how complaints systems work and how complaints can help to improve health care services.

Recommendation 7:
Quality improvement awards

The briefing paper discussed strategies to promote awareness of excellence in complaints management, recommending that innovation in complaints management be included as a category in quality improvement in health care awards. The workshop supported the recommendation.

The project recommended that the Council encourage organisations that sponsor quality improvement in health care awards that they include complaints.

Access to services

Disability action plan

The induction module for staff which covers disability access issues was reviewed and expanded. This module highlights the many features of the building, in which the Commission is located, which assist people with disabilities including: level access from the street, textured guide tiles, lifts with floor announcements, Braille signs and hand rails. During the reporting period, lighting in the common areas of the building was enhanced and more signage was provided in the foyer, including Braille translations.

It was not feasible to review and update the existing action plan in the current reporting period given the level of organisational change. The Commission will ensure that resources are provided to produce and implement a new plan in the coming reporting period.

Electronic Service Delivery

The Commission continued its commitment to providing electronic services aligned to NSW Government guidelines.

The Commission continued to expand services available to the public through the Internet. Ongoing updates and additions to electronic brochures on the Internet provide consumers with accessible information.

The Commission provided a number of publications on its web site. The public had access to our annual reports, complaint forms, case studies, Patient Support Office brochures and Rights & Responsibilities brochures in multi-lingual formats.

Health care consumers can take advantage of electronic complaint and authority forms available on the Commission's web site for submitting new complaints to the Commission. Freedom of Information applications can also be accessed on the site. The Commission's web site also provides links to the NSW Government online job directory through <www.jobs.nsw.gov.au> and applications can be lodged through that site. This site allows job-seekers to view all vacancies or sort by a number of criteria including location, job category, salary range, agency name, division name, job title or pattern of work: full-time, part-time or casual.

The Commission is also registered with <www.changemyaddress.com.au>. This is a free service that allows people to advise multiple agencies of changes to their address details by simply filling in a form on-line.

The Commission commenced work on a security plan aligned with its IT strategic plan. A needs analysis was conducted and a series of improvements were identified and have since been progressively implemented. It is anticipated that this work will continue during the next year, supported by advice received from external auditors. These efforts should contribute to the development of a solid information security policy. The Commission will continue to review vulnerabilities and security risk management processes to comply with Australian standards.

Ethnic Affairs Priorities statement

Translation of the Commission's "How to get the best from your health service" brochure into 23 languages was finalised. Currently, only six of these are available on the Commission's website and work is in progress to ensure that all are widely available.

In addition to these translations, the Commission spent $10,000 on translation and interpreting services in the reporting period. These services ensure that consumers are able to express their complaints and concerns in the languages in which they are most confident.

Review of the Commission's Ethnic Affairs Priority Statement forward plan commenced but did not proceed due to the high level of organisational change in the Commission over the reporting period. The Commission will ensure that resources are provided to produce and implement a new plan in the coming reporting period.

Freedom of Information

During the reporting period 58 applications under the *Freedom of Information Act 1989* were received by the Commission. This represented an increase of 93% when compared to the previous reporting period.

Table 21:
Section A – Number of FOI requests

	FOI requests	Personal*		Other#		Total	
		2002-2003	2003-2004	2002-2003	2003-2004	2002-2003	2003-2004
A1	New	30	53	–	5	30	58
A2	Brought forward	1	–	–	–	1	–
A3	Total to be processed	31	53	–	5	31	58
A4	Completed	30	53	–	5	30	58
A5	Transferred out	–	–	–	–	–	–
A6	Withdrawn	–	1	–	–	–	1
A7	Total processed	30	52	–	5	30	57
A8	Unfinished (carried forward)	1	0	–	–	1	0

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

Section B –
What happened to completed requests?

	Results of FOI	Personal		Other	
		2002-2003	2003-2004	2002-2003	2003-2004
B1	Granted in Full	11	15	–	2
B2	Granted in Part	13	29	–	0
B3	Refused (Declined)	5	8	–	3
B4	Deferred	1	–	–	–
B5	Completed	30	52	–	5

Section C – Ministerial Certificates

None issued during this, or the previous period.

Section D – Formal consultations

		Issued		Total	
		2002-2003	2003-2004	2002-2003	2003-2004
D1	Number of requests requiring formal consultations	–	6	–	6

Section E – Amendment of personal records

No such requests were made during this or the previous period

Section F – Notation of personal records

No requests for notation were made during this or the previous period

Section G – FOI requests granted in part or refused

	Basis of disallowing or restricting access	Personal 2002-2003	Personal 2003-2004	Other 2002-2003	Other 2003-2004
G1	Section 19 (application incomplete, wrongly directed)	–	–	–	–
G2	Section 22 (deposit not paid)	1	–	–	–
G3	Section 25 (1)(a1) (diversion of resources)	–	–	–	–
G4	Section 25 (1)(a) (exempt)	12	28	–	–
G5	Section 25 (1)(b), (c), (d) (otherwise available)	–	–	–	3
G6	Section 28 (1)(b) (documents not held)	1	4	–	–
G7	Section 24 (2) (deemed refused, over 21 days)	–	–	–	–
G8	Section 31 (4) (released to Medical Practitioner)	–	–	–	–
	Schedule 2 (complaint being processed by HCCC)	4	5	–	–
G9	Totals	18	37	1	3

Section H – Costs and fees of requests processed during period

		Assessed costs 2002-2003	Assessed costs 2003-2004	FOI fees received 2002-2003	FOI fees received 2003-2004
H1	All completed requests	$20,000	$1,235	$700	$1,235

Section I – Discounts allowed

	Type of Discount Allowed	Personal 2002-2003	Personal 2003-2004	Other 2002-2003	Other 2003-2004
I1	Public Interest	–	–	–	–
I2	Financial hardship – Pensioner/Child	9	12	–	–
I3	Financial hardship – non-profit organisation	–	–	–	–
I4	Totals	9	12	–	–
I5	Significant correction of personal records	–	–	–	–

Section J – Days to process

	Elapsed Time	Personal 2002-2003	Personal 2003-2004	Other 2002-2003	Other 2003-2004
J1	0 – 21 days	24	44	–	4
J2	22 – 35 days	1	3	–	1
J3	Over 35 days	5	5	–	–
J4	Total applications	30	52	–	5

Section K – Processing time

	Processing Hours	Personal 2002-2003	Personal 2003-2004	Other 2002-2003	Other 2003-2004
K1	0 – 10 hours	26	48	–	5
K2	11 – 20 hours	4	3	–	–
K3	21 – 40 hours	–	1	–	–
K4	Over 40 hours	–	–	–	–
K5	Total applications	30	52	–	5

Section L – Reviews and Appeals

		2002-2003	2003-2004
L1	Number of internal reviews finalised	3	1
L2	Number of Ombudsman reviews finalised	–	–
L3	Number of District Court appeals finalised	–	–
	Number of ADT appeals finalised	–	–

	Bases of Internal Review Grounds on which internal review requested	Personal Upheld 2002-2003	Personal Upheld 2003-2004	Personal Varied 2002-2003	Personal Varied 2003-2004	Other Upheld 2002-2003	Other Upheld 2003-2004	Other Varied 2002-2003	Other Varied 2003-2004
L4	Access refused	1	–	–	–	–	–	–	–
L5	Deferred	–	–	–	–	–	–	–	–
L6	Exempt matter	1	–	1	1	–	–	–	–
L7	Unreasonable charges	–	–	–	–	–	–	–	–
L8	Charge unreasonably incurred	–	–	–	–	–	–	–	–
L9	Amendment refused	–	–	–	–	–	–	–	–
L10	Totals	2	–	1	1	–	–	–	–

Privacy management plan

The Commission completed a review of its Privacy Management Plan for the purpose of ensuring that its policies and practices were in compliance with the requirements of the *Privacy and Personal Information Protection Act 1998.*

No new applications under the Privacy and Personal Information Protection Act 1998 for internal reviews were received during the reporting period. One application carried forward from the previous year was not pursued by the applicant.

There was one matter before the Administrative Decisions Tribunal concerning a breach of privacy in obtaining patient records. The appeal was withdrawn and dismissed.

Promotion

Publications

Commission publications current as at 30 June 2004:

Annual Report 2002-2003

Case study booklet Vol 1

The Complaint Guide

Conciliation of health complaints

Health Care Complaints Commission introductory brochure for Aboriginal people

How to get the best from your health service available in Arabic, Chinese, English, Greek, Italian, Korean, Macedonian, Spanish and Vietnamese

How to get your health records

Patient Support Service

Sexual misconduct – leaflet for complainants

Sexual misconduct – leaflet for providers

All the above publications are available on the Commission's website: <www.hccc.nsw.gov.au>.

The Patient Support Service information sheet can be ordered from the Commission's office in Arabic, Chinese, Croatian, Farsi (Persian), Greek, Hindi, Indonesian, Italian, Khmer, Korean, Laotian, Macedonian, Polish, Portuguese, Russian, Serbian, Spanish, Tagalog, Thai, Turkish and Vietnamese.

The Investigation report: Campbelltown and Camden hospitals - Macarthur Health Service - December 2003 can be purchased from the Commission's office.

Commission policy documents

Commission policy and practice documents current as at 30 June 2004:

Code of conduct and ethics for staff

Complaint referral agreement

Consultative Resolution – partnerships and quality improvement

Consumer Consultative Committee – Terms of reference and code of conduct

Guidelines for Commission representatives consulting with registration authorities

Guidelines for professional reviewers and advisers

Independent complaint review committee – terms of reference

Information sharing agreement

Investigation policy

Memorandum of understanding with the NSW Department of Health

Patient Support Office – Resolution Meetings

Privacy Management Plan

Prosecution policy and guidelines

Practice manuals

Investigations, Prosecutions and Assessment practice manuals and the Patient Support Office Procedures manual are available for inspection only.

Inquiries concerning ordering, inspecting or purchasing these documents should be made to the Executive Officer. Inspections can be arranged at the Commission's office at L13, 323 Castlereagh Street Sydney between 9am and 5 pm Monday to Friday.

Overseas travel

The former Commissioner visited the New Zealand Health and Disability Commission (HDC) in September 2003 to discuss its possible inclusion in the CaseMate project as a partner. Whilst on that visit she presented a keynote speech with the HDC Commissioner, at the 3rd Asia Pacific forum on quality improvement in health care, entitled "A window of opportunity: consumer complaints driving improvement in health care".

The former Director, Partnerships, Quality & Development Services and an Education & Development Officer also visited New Zealand at this time. They were engaged by the HDC Commissioner to train HDC staff in investigation planning and interviewing. They also attended the Forum.

Human Resources

Management and structure

Commission members

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

Amanda Adrian, BA, LLB, RN, FRCNA, FNSWCN appointed 26 June 2000 contract terminated on 11 December 2003.

Bill Grant, LLB appointed by the Minister as Acting Commissioner on 12 December 2003 until 21 March 2004.

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

Senior Executive Service

Table 22: Senior Executive Service

	Current	Previous
Number of female executive officers for current and previous reporting years	none	one
Number of executive positions at each level for current and prior year	Level 5 – one Level 2 – one	Level 5 - one

In the 2002 – 2003 reporting period, the Commission had only one SES position, that of Commissioner at SES 5 which was occupied by a female executive officer, Amanda Adrian.

In the current reporting period, that position has been filled by the Judge, who is a Judicial Officer, not an SES Officer.

A position of Deputy Commissioner has been created at SES 5 to which Mr Kieran Pehm, BA, LLB, LLM, has been appointed. He has a remuneration package of $219,850. Mr Pehm commenced duty on 27 April 2004. In the two months of the reporting period that he has been at the Commission, Mr Pehm's performance has been quite outstanding. He has initiated recruitment of a new senior management team, commenced a corporate and business planning process and provided substantial leadership and direction to Commission staff in their casework.

A female executive officer, Ms Leena Pradhan, commenced at SES level 2 in the newly created position of Director Investigations early in the 2004/05 reporting period.

Commission staff

Table 23: The number of employees, by category – 2001-04

Number of staff at 30 June (effective full time)					
Category		**2001**	**2002**	**2003**	**2004**
Executive	Senior Executive Officer	1	1	1	1
	Senior Officer	1	1	2	1
Clerk	Grade 11/12	1	3	5	4
	Grade 9/10	4	3	5	5
	Grade 7/8	32.53	32.9	35.07	50.89
	Grade 5/6	4	2.6	1.8	0.6
	Grade 3/4	7	10	9	8
	Grade 1	1	1	1	1
Clerical Officer	Grade 3/4	8	7	8	8
	Grade 1	2	1	1	1
	Trainee		1	–	–
Legal Officer	Grade VI	1	1	1	1
	Grade III-IV	4	4	5	5
	Grade II	2	1	–	–
Medical Advisers		0.2	0.8	0.8	1.8
Total		**69.73**	**69.27**	**75.67**	**91.29**

Consultants

A number of consultants were engaged during the reporting period to advise the Commission during a period of rapid change. Several consultants were also engaged on the National Complaints Project which was funded by the Commonwealth Government.

For the purposes of this report, a consultant is defined as a person or organisation engaged under contract on a temporary basis to provide recommendations or high level specialist or professional advice to assist management decision-making.

Table 24: Consultants

Consultant	Project title	Actual costs	Purpose
Health Issues Centre	National Complaints Project	$44,040	Review past research and current practice

Category of consultancy	Total number of engagements	Total cost
Clinical advice to investigators	66	$91,335
National Complaints Project	3	$45,000
Tendering advice for software development	11	$56,857
Job evaluation	5	$16,586
Financial management	2	$11,255
Media relations	5	$3,930
Disciplinary inquiry	1	$265

Equal Employment Opportunity (EEO)

Table 25: Trends in the representation of EEO groups 2001-04

	Benchmark or Target %	% of total staff at 30 June 2004			
		2001	2002	2003	2004
Women	50	71	71	67	69
Aboriginal people and Torres Strait Islanders	2	1.4	1.4	1	2.7
People whose first language was not English	20	13	14	14	15
People with a disability	12	8	8	9	3
People with a disability who require a work-related adjustment	7	--	--	--	--

Trends in the distribution of EEO groups

The distribution index for women employed by the Commission is 96. A distribution index of 100 indicates that the distribution of the EEO group across salary levels is equivalent to that of other staff. Values less than 100 mean that the EEO group tends to be more concentrated at lower salary levels than is the case for other staff. The more pronounced this tendency is, the lower the index will be.

The distribution index is automatically calculated by the software provided by the Office of Equal Opportunity in Public Employment. The distribution index is not calculated where EEO group or non-EEO group numbers are less than 20. Women are the only EEO group employed at the Commission with more than 20 members. Last year the index was 98.

EEO achievements and planned outcomes for the coming year

The large intake of staff over the reporting period has resulted in the Commission meeting the benchmark for employment of Aboriginal and Torres Strait Islanders and improving its performance against the benchmark for employment of people whose first language was not English. Identification of people with a disability remains low given the number of work-related adjustments which the Commission has made for its staff eg. varying working hours, provision of parking, special lighting and other furniture, voice recognition software and computer peripherals. Reasons for this low rate of reporting will be examined in the coming reporting period.

Industrial relations

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

Commission representatives:

- the Commissioner or his nominee
- the Deputy Commissioner
- a senior manager.

Public Service Association representatives:

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

Personnel policies and practices

Commission staff are either members of the Senior Executive Service or officers appointed under the *Public Sector Employment and Management Act 2002* (PSE&M Act). Officers' salaries are set by awards and agreements. A 5% pay rise, being the final instalment of a 12% pay increase provided for by the Crown Employees (Public Sector – Salaries January 2002) Award, was implemented for staff in July 2003.

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

Staff education and development

Part of the Commission's corporate plan for 2002-03 related to the development requirements for complaint resolution staff in relation to investigation and resolution strategies. The Commission has been proactive in providing development opportunities for staff during this reporting period.

Quality and safety in action forums

The Commission conducted a series of one-hour forums about quality and safety in action for staff in which internal and external speakers discussed quality improvement initiatives that are the product of collaborative work.

The purpose of the forums was to:

- raise awareness of initiatives impacting on health service provision
- highlight the relevance of these initiatives to the various models of investigation and resolution used by the Commission
- provide an opportunity for Commission staff to learn about quality tools and consider their impact on the work of the Commission.

Six forums were held. An average of 20 staff attended each forum.

ErrorMed

To further develop Commission staff's investigation skills, the Commission purchased the services of Errormed's Human Error in Medicine Workshop. The workshop was developed to introduce health care workers and managers to human factors concepts and the practical management of human error in their workplace. In the workshop, human factors theory and skills have been customised and adapted to health care services.

This program provided an opportunity for Commission staff to develop their system analysis and design skills.

Twenty-seven staff attended the one-and-a-half day workshop. The course was considered by staff to be excellent.

Staff forum

The Commission was fortunate to have Professor Linda Mulcahy, a world-leading author on complaints management and quality improvement in health care services, address Commission staff at a half-day forum in October.

Professor Mulcahy discussed recent developments in the UK, including the Bristol and Shipman inquiries and three current inquiries, and findings from her own research about complaints, quality and medical negligence claims.

Joint Initiative Group occasional lunchtime seminars

The Commission is also a member of the Joint Initiatives Group. This is a network of complaint-handling and alternative dispute resolution (ADR) schemes covering a range of jurisdictions, which meets to share information, resources and opportunities for joint activities.

The ADR Occasional Seminar Series has been organised by the Joint Initiatives Group to encourage discussion and understanding of issues and developments in complaint handling and alternative dispute resolution. The seminars are presented by leading professionals and academics in the field. The Commission hosted one of the series in 2003 and staff have been regular attendees of the series.

Environmental impact

Waste reduction and purchasing policy

The Commission has continued its commitment to implementing the Government's Waste Reduction and Purchasing Policy during the reporting period through:

- reducing the generation of waste

  The Commission took a temporary lease on extra office space during the reporting period to accommodate the Macarthur Taskforce. To reduce the generation of waste, minimal modifications were made to the existing fitout. One wall was built, mostly of glass which is recyclable. Office furniture and fittings were also purchased from the previous tenant, again reducing the generation of waste. The only new items purchased were ergonomic chairs.

  Approximately 25 metres of gyprock and steel would have been sent to landfill if the premises had been completely refitted.

- resource recovery

  The Commission returns all used toner cartridges to the suppliers for recycling. The toner cartridges it purchases are constructed of recycled components.

- using recycled material

  The Commission continued to expand its use of recycled paper. Not only was the 2002-03 Annual Report printed on recycled paper, but the Commission is now using recycled content paper for photocopying and printing.

  Over the reporting period, the Commission purchased 3,600 reams of paper. Two thousand of those reams included 35% recycled content. The recycled material is paper recovered from offices and homes which would have been sent to landfill if not reused in this way.

Energy management

This is the first complete reporting year for the Commission's energy use at its new premises on L12 & 13 of Central Square. Clearly, these premises are consuming more energy than the Commission's former premises. In March, the Commission transferred to the NSW Government Energy Contract including 6% Greenpower. In the coming period, this Greenpower component, combined with initiatives such as powersave functions on computers and increased use of timers on lights and air conditioning units, should reduce the greenhouse gas impact of the Commission's operations.

In line with Government policy, Central Square will be obtaining an accredited Australian Building Greenhouse Rating by 31 December 2004. The Commission will also be participating with the Department of Energy, Utilities and Sustainability in rating its tenancy. It is anticipated that this exercise will also improve the Commission's energy efficiency.

Table 26: Energy Use

Energy use	2001-2002			2002-2003			2003-2004		
	Office	Cars	CO2 (tonnes)	Office	Cars	CO2 (tonnes)	Office	Cars	CO2 (tonnes)
Electricity (kWh)	152,811		129	242,352		235	284,887		272
Greenpower (kWh)	0			1,599			5,842		
Petrol (L)		4,682	11		5,200	12		3,665	8

Normalisation factors	2001-2002	2002-2003	2003-2004
Occupancy (No. of people)	71	85	86
Area (m2)	1,516	1,790	1,790
Distance travelled (km)	40,452	50,207	35,405

Energy utilisation index	2001-2002		2002-2003		2003-2004	
	Office	Cars	Office	Cars	Office	Cars
MJ/person/annum	7,748		10,300		12,170	
MJ/M2/annum	363		488		585	
MJ/km		4		3.5		3.5

Finance

Outline budget

The government has committed an extra $5.7M to the Commission over the 2003-04 and 2004-05 financial years to be used to refocus it on its core business of investigating complaints by health staff and members of the public. This additional funding has been used to:

- Employ 15 new investigators to work through a backlog of complaints;
- Set up a separate Macarthur Investigation Team to look at matters arising from the Special Commission of Inquiry into Camden and Campbelltown hospitals, and;
- Appoint District Court Justice Kenneth Taylor as Acting Commissioner for 12 months.

Table 27: Outline budget for 2004-05 financial year

Operating statement	2004-05 $000
Expenses	
Operating expenses	
Employee related	8,390
Other operating expenses	3,486
Maintenance	4
Depreciation and amortisation	158
Total expenses	**12,038**
Less	
Retained revenue	
Sales of goods and services	15
Investment income	20
Other revenue	303
Total retained revenue	**338**
NET COST OF SERVICES	**11,700**

Table 28: Comparison of finances 2000-04

Actual	1999-2000 $000	2000-2001 $000	2001-2002 $000	2002-2003 $000	2003-2004 $000
Total expenses	5,571	6,674	6,872	9,183	10,416
Total retained revenue	393	223	1,538	1,114	865
Gain/(loss) on sale of non-current assets	8	11	0	(23)	0
NET COST OF SERVICES	**5,170**	**6,440**	**5,334**	**8,092**	**9,551**

The Commission marked 10 years of independent administration this year and, in public service terms, is still a relatively young organisation. As part of the reform of the Commission, a systematic analysis of the resources required for the Commission to perform its role effectively has been commenced. On the basis of this review, a submission will be made to Treasury to establish the Commission's ongoing recurrent funding needs.

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

Account payment performance

The Commission's Accounts Complaints Officer is the Manager, Corporate Services. In accordance with the provisions of the *Public Finance and Audit Regulation 2000* (cl18) the Commission's purchase orders include

Table 29: Account payment performance 2003-04

Aged analysis at the end of each quarter **Quarter**	Current (ie. within due date) $	<30 days overdue $	30 – 60 days overdue $	60-90 days overdue $	>90 days overdue $
September	861,581	107,232	36,615	3,365	27,691
December	933,664	40,955	33,536	5,532	37,697
March	579,377	114,180	12,235	2,781	3,867
June	1,105,243	198,970	86,030	14,225	4,885

Accounts paid on time within each quarter		Total accounts paid on time		
Quarter	**Target %**	**Actual %**	**$**	**Total amount paid $**
September	85	83.13	861,581	1,036,483
December	85	88.80	933,664	1,051,384
March	85	81.32	579,377	712,440
June	85	78.42	1,105,243	1,409,353

the contact details for this officer and the following advice: "Except where otherwise provided by a contract or supplier's terms, invoices are payable 30 days from receipt of goods or service and receipt of a complying invoice." There were no instances where interest was paid by the Commission for late payment of accounts.

Incorporation of the Commission's financial data into the SUN finance system, as part of the Shared Corporate Services arrangement, has allowed an accurate aged analysis of the Commission's accounts for the first time. Having said this, the analysis of accounts paid in the June quarter does not include a late payment of $400,000 as it skewed the figures for the quarter and did not give a realistic reflection of the Commission's payment performance.

Clearly the Commission's payment performance requires improvement. Account payment by EFT is allowing suppliers to access their payment quicker but hasn't ensured that the account is processed more quickly. In the coming reporting period the Commission will be entering into direct debit arrangements with some suppliers to increase timeliness of payments. One factor contributing to delays in payment is provision of a "complying invoice" by suppliers. To increase compliance with the New Tax System, the Commission will be issuing recipient created tax invoices to its Peer Reviewers.

Risk management, insurance and occupational health and safety

The number of insurance claims has remained relatively static despite the increased number of staff. The average cost of claims has increased however, with several staff experiencing aggravation of existing conditions with the change of office furniture when the Commission relocated in early 2003. The current reporting period also included two staff experiencing mental stress which has kept the average cost of claims high. With the active involvement of rehabilitation providers the Commission has ensured that its office environment is ergonomically suitable for staff and the majority of claimants have experienced sustainable recovery from their conditions.

There were no prosecutions lodged against the Commission under the *Occupational Health and Safety Act 2000* in this reporting period. The Commission received a $408 rebate on its motor vehicle insurance premium due to its good performance in this area during 2002-2003.

Table 30: Workers' Compensation claims 2001-04

	Accident year			
	2000-2001 as at 12/9/2002	2001-2002 as at 31/3/2003	2002-2003 as at 31/3/2004	2003-2004 as at 31/3/04
Total number of claims	6	8	7	6
Total number of employees	65	65	66	92
Number of claims per employee	0.138	0.123	0.106	0.065
Average claim cost per claim	$409	$4,055	$20,053	$13,610
Average claim cost per employee	$38	$499	$2,120	$890
Top types of claim	Body stressing (2)	Body stressing (2)	Body stressing (3)	Mental stress (2)
	Hit by objects (1)	Other/unspecified (2)	Hitting objects (3)	Fall/trip/slip (2)

Table 31: Motor vehicle claims 2001-04

	Accident year			
	2000-2001 as at 31/3/02	2001-2002 as at 31/3/03	2002-2003 as at 31/3/04	2003-2004 as at 31/3/04
Total number of claims	4	2	1	0
Fleet size	3	3	3	3
Number of claims per vehicle	1.33	0.667	0.333	0
Average claim cost per claim	$2,166	$1,794	$371	0
Average cost per vehicle	$2,888	$1,196	$124	0
Top types of claim	Accumulated damage (1)	Collision with property (1)		None
	Damage whilst parked (1)	Collision with vehicle (1)	Accumulated damage (1)	
	Collision with property (1)			

GPO BOX 12
SYDNEY NSW 2001

INDEPENDENT AUDIT REPORT
Health Care Complaints Commission

To Members of the New South Wales Parliament

Audit Opinion

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

(a) presents fairly the Health Care Complaints Commission's financial position as at 30 June 2004 and its financial performance and cash flows for the year ended on that date, in accordance with applicable Accounting Standards and other mandatory professional reporting requirements in Australia, and

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

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

The Commissioner's Role

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

The Auditor's Role and the Audit Scope

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

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

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

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

My opinion does *not* provide assurance:

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

Audit Independence

The Audit Office complies with all applicable independence requirements of Australian professional ethical pronouncements. The Act further promotes independence by:

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

P. K. Brown

P K Brown FCPA
Engagement Controller

SYDNEY
14 September 2004

HEALTH CARE COMPLAINTS COMMISSION

FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2004

CERTIFICATE OF ACCOUNTS

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

(i) the financial statements of the Health Care Complaints Commission for the year ended 30 June 2004 have been prepared in accordance with the requirements of applicable Australian Accounting Standards and the Urgent Issues Group Consensus Views, the requirements of the *Public Finance and Audit Act 1983* and Regulations, the Financial Reporting Directions published in the Financial Reporting Code for Budget Dependent Agencies or issued by the Treasurer under section 9(2)(n) of the Act.

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

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

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

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

Judge K V Taylor, AM, RFD
Acting Commissioner

Date: 10 September 2004

Statement of Financial Performance
for the Year Ended 30 June 2004

	Notes	Actual 2004 $'000	Budget 2004 $'000	Actual 2003 $'000
Expenses				
Operating Expenses				
Employee Related	*2(a)*	7,039	6,199	6,583
Other Operating Expenses	*2(b)*	3,271	2,433	2,566
Maintenance		5	10	–
Depreciation	*2(c)*	101	67	34
Total Expenses		**10,416**	**8,709**	**9,183**
Less:				
Retained Revenue				
Sale of Goods and Services	*3*	60	15	273
Investment Income	*3*	25	10	57
Grants and Contributions	*3*	491	474	474
Other Revenue	*3*	289	349	310
Total Retained Revenue		**865**	**848**	**1,114**
Gain/(loss) on Disposal of Non-Current Assets	*14*	**–**	**–**	**(23)**
Net Cost of Services	*16*	**9,551**	**7,861**	**8,092**
Government Contributions				
Recurrent Appropriations	*4*	9,669	7,213	7,277
Acceptance by the Crown Entity of employee benefits and other liabilities	*5*	655	556	784
Total Government Contributions		**10,324**	**7,769**	**8,061**
SURPLUS/(DEFICIT) FOR THE YEAR FROM ORDINARY ACTIVITIES		**773**	**(92)**	**(31)**
TOTAL CHANGES IN EQUITY OTHER THAN THOSE RESULTING FROM TRANSACTIONS WITH OWNERS AS OWNERS		**773**	**(92)**	**(31)**

The accompanying notes form part of these statements.

Statement of Financial Position
for the Year Ended 30 June 2004

	Notes	Actual 2004 $'000	Budget 2004 $'000	Actual 2003 $'000
ASSETS				
Current Assets				
Cash	*7*	1,370	771	921
Receivables	*8*	364	139	377
Other		27	32	5
Total Current Assets		**1,761**	**942**	**1,303**
Non-Current Assets				
Plant and Equipment	*9*	368	355	470
Total Non-Current Assets		**368**	**355**	**470**
Total Assets		**2,129**	**1,297**	**1,773**
LIABILITIES				
Current Liabilities				
Payables	*10*	365	444	687
Provisions	*11*	542	394	609
Total Current Liabilities		**907**	**838**	**1,296**
Non-Current Liabilities				
Provisions		69	–	97
Total Non-Current Liabilities		**69**	**–**	**97**
Total Liabilities		**976**	**838**	**1,393**
Net Assets		**1,153**	**459**	**380**
EQUITY				
Accumulated Funds	*12*	1,153	459	380
Total Equity		**1,153**	**459**	**380**

The accompanying notes form part of these statements.

Statement of Cash Flows
for the Year Ended 30 June 2004

	Notes	Actual 2004 $'000	Budget 2004 $'000	Actual 2003 $'000
CASH FLOWS FROM OPERATING ACTIVITIES				
Payments				
Employee Related		(6,869)	(5,893)	(5,652)
Other		(3,625)	(2,605)	(2,323)
Total Payments		**(10,494)**	**(8,498)**	**(7,975)**
Receipts				
Sale of Goods and Services		551	15	746
Interest Received		47	10	25
Other		351	985	105
Total Receipts		**949**	**1,010**	**876**
Cash Flows from Government				
Recurrent Appropriation		9,669	7,213	7,277
Cash Reimbursements from Crown Entity		325	250	250
Net Cash Flows from Government		**9,994**	**7,463**	**7,527**
NET CASH FROM OPERATING ACTIVITIES	*16*	**449**	**(25)**	**428**
CASH FLOWS FROM INVESTING ACTIVITIES				
Purchase of Plant and Equipment		–	–	(430)
NET CASH FLOWS FROM INVESTING ACTIVITIES		**–**	**–**	**(430)**
NET INCREASE IN CASH		**449**	**(25)**	**(2)**
Opening Cash and Cash Equivalents		921	796	923
CLOSING CASH AND CASH EQUIVALENTS	*7*	**1,370**	**771**	**921**

The accompanying notes form part of these statements.

Summary of Compliance with Financial Directives

for the Year Ended 30 June 2004

	2004				2003			
	Recurrent		Capital		Recurrent		Capital	
	Recurrent Appropriation	Expenditure/ Net Claim on Consolidated Fund	Capital Appropriation	Expenditure/ Net Claim on Consolidated Fund	Recurrent Appropriation	Expenditure/ Net Claim on Consolidated Fund	Capital Appropriation	Expenditure/ Net Claim on Consolidated Fund
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
ORIGINAL BUDGET APPROPRIATION/ EXPENDITURE								
Appropriation Act	7,213	7,118	–	–	7,040	6,867	–	–
Additional Appropriations	–	–	–	–	–	–	–	–
s21A PF&AA – special appropriations	–	–	–	–	–	–	–	–
s24 PF&AA – transfer of functions between departments	–	–	–	–	–	–	–	–
s26 PF&AA – Commonwealth specificpurpose payments	–	–	–	–	–	–	–	–
	7,213	7,118	–	–	7,040	6,867	–	–
OTHER APPROPRIATIONS/ EXPENDITURES								
Treasurer's Advance	2,551	2,551	–	–	410	410	–	–
Section 22 – expenditure for certain works and services	–	–	–	–	–	–	–	–
Transfers from another agency (s25 of the Appropriation Act)	–	–	–	–	–	–	–	–
	2,551	2,551	–	–	410	410	–	–
Total Appropriations/ Expenditure (includes transfer payments)	9,764	9,669	–	–	7,450	7,277	–	–
Drawdowns from Treasury		9,669		–		7,277		–
Total Liability to Consolidated Fund		–		–		–		–

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

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

(a) Reporting Entity

The Health Care Complaints Commission (HCCC) is an inner budget entity, responsible for protecting the public from substandard health services and incompetent and unethical health practitioners.

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

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

(b) Basis of Accounting

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

- applicable Australian Accounting Standards
- other authoritative pronouncements of the Australian Accounting Standards Board (AASB)
- Urgent Issues Group (UIG) Consensus Views
- the requirements of the *Public Finance and Audit Act* and Regulations, and
- the Financial Reporting Directions published in the Financial Reporting Code for Budget Dependent General Government Sector Agencies or issued by the Treasurer under section 9(2)(n) of the Act.

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

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

Except for plant and equipment, which are recorded at valuation, the financial statements are prepared in accordance with the historical cost convention. All amounts are rounded to the nearest one thousand dollars and are expressed in Australian currency. The accounting policies adopted are consistent with those of the previous year.

(c) Revenue Recognition

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

(i) Parliamentary appropriation and contributions from other bodies

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

(ii) Sale of Goods and Services

Revenue from the sale of goods and services comprises revenue from the provision of products or services ie. user charges. User charges are recognised as revenue when HCCC obtains control of the assets that result from them.

(iii) Investment Income

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

(d) Employee Benefits and Other Provisions

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

Liabilities for salaries and wages (including non-monetary benefits), annual leave and vesting sick leave are recognised and measured in respect of employees' services up to the reporting date at nominal amounts based on the amounts expected to be paid when the liabilities are settled.

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

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

(ii) Accrued salaries and wages – reclassification

As a result of the adoption of Accounting Standard AASB 1044 "Provisions, Contingent Liabilities and Contingent Assets", accrued salaries and wages and on-costs have been reclassified to "payables" instead of "provisions" in the Statement of Financial Position and the related note disclosures, for the current and comparative period. On the face of the Statement of Financial Position and in the notes, reference is now made to "provisions" in place of "employee entitlements and other provisions". Total employee benefits (including accrued salaries and wages) are reconciled in Note 11 "Provisions".

(iii) Long Service Leave and Superannuation

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

Long service leave is measured on a short-hand basis. The short-hand method is based on the remuneration rates at year end for all employees with five or more years of service. It is considered that this measurement technique produces results not materially different from the estimate determined by using the present value basis of measurement.

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

(e) Insurance

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

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

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

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

(g) Acquisition of Assets

The cost method of accounting is used for the initial recording of all acquisition of assets by the Commission. Cost is determined as the fair value of assets given as consideration plus the costs incidental to the acquisition.

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

Fair value means the amount for which an asset could be exchanged between a knowledgeable, willing buyer and a knowledgeable, willing seller in an arm's length transaction.

(h) Plant and Equipment

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

Cost is determined as the fair value of the assets given up at the date of acquisition plus costs incidental to the acquisition.

(i) Revaluation of Physical Non-Current Assets

Physical non-current assets are valued in accordance with the "Guidelines for the Valuation of Physical Non-Current Assets at Fair Value " (TPP 03-02). This policy adopts fair value in accordance with AASB 1041 from financial years beginning on or after 1 July 2002.

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

(j) Depreciation of Non-Current Physical Assets

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

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

Asset Description	Depreciation Life in years
Computer Hardware	5
Software	5

(k) Maintenance and repairs

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

(l) Receivables

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

(m) Payables

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

(n) Budgeted amounts

The budgeted amounts are drawn from the budgets as formulated at the beginning of the financial year with any adjustments for the effect of additional appropriations under s 21A, s 24 and/or s 26 of the *Public Finance and Audit Act 1983.*

The budgeted amounts in the Statement of Financial Performance and the Statement of Cash Flows are generally based on the amounts disclosed in the NSW Budget Papers (as adjusted above). However, in the Statement of Financial Position, the amounts vary from the Budget Papers, as the opening balances of the budgeted amounts are based on carried forward actual amounts ie. per the audited financial statements (rather than carried forward estimates).

	2004 $'000	2003 $'000
2. EXPENSES		
(a) Employee related expenses comprise the following specific items:		
Salaries and Wages (including Recreation Leave)	6,051	5,379
Superannuation	476	385
Workers compensation Insurance	32	29
Long Service Leave	138	396
Payroll tax and fringe benefit tax	342	394
	7,039	6,583

	2004 $'000	2003 $'000
2. EXPENSES (continued)		
(b) Other operating expenses		
Advertising	38	39
Auditor's remuneration - audit of the financial reports	21	11
Cleaning and Utilities	58	18
Consultancy	217	9
Electricity	29	22
Equipment and Plant	78	252
Equipment Leasing	145	–
Fees for services rendered	669	335
General administrative expenditure	52	97
Insurance	14	11
Legal fees and Adverse Costs	699	694
Motor vehicle expenditure	22	27
Printing	115	87
Rental expenses relating to operating leases	701	518
Stores	99	168
Telephone, postal and internet	157	185
Training	26	38
Travelling	131	55
	3,271	2,566
(c) Depreciation		
Computer hardware/Software	7	8
Office Furniture and equipment	8	10
Leasehold Improvements	86	16
	101	34

3. REVENUES

Rendering of services	60	273
Investment income – interest	25	57
Grants and contributions	491	474
Other Revenue – Legal cost recoveries	289	310
	865	1,114

4. APPROPRIATIONS

Recurrent appropriation

Total recurrent drawdown from Treasury (per Summary of Compliance)	7,118	6,867
Treasurers advance	2,551	410
Recurrent appropriation (per statement of Financial Performance)	9,669	7,277

	2004 $'000	2003 $'000

5. ACCEPTANCE BY THE CROWN ENTITY OF EMPLOYEE BENEFITS AND OTHER LIABILITIES

The following liabilities and/or expenses have been assumed by the Crown Entity or other government agencies		
Payroll Tax	29	24
Superannuation	476	403
Long Service Leave	150	357
	655	784

6. PROGRAM INFORMATION

Program 43.1.1- Health Care Complaints

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

7. CURRENT ASSETS – CASH

Cash on hand – Petty cash float	1	1
Cash at bank	1,369	920
	1,370	921

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

Cash (per Statement of Financial Position)	1,370	921
Closing Cash and Cash Equivalents (per Statement of Cash Flows)	1,370	921

8. CURRENT ASSETS-RECEIVABLES

Debtors	676	649
Less		
Provision for Doubtful Debts	(312)	(272)
	364	377

	2004 $'000	2003 $'000
9. NON CURRENT ASSETS – PLANT AND EQUIPMENT		
Plant and Equipment		
At Fair Value	86	86
Less Accumulated Depreciation	67	59
	19	27
Computer Equipment		
At Fair Value	72	72
Less Accumulated Depreciation	66	59
	6	13
Lease Improvements		
At Fair Value	429	430
Less Accumulated Depreciation	86	–
	343	430
Total Plant and Equipment At Net Book Value	**368**	**470**

Reconciliations

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

2004	Plant and Equipment $'000	Computer Equipment $'000	Leased Improvements $'000	Total $'000
Carrying amount at start of year	27	13	430	470
Additions	–	–	–	–
Disposals	–	–	–	–
Write off	–	–	–	–
Depreciation expense	(9)	(7)	(86)	(102)
Carrying amount at end of year	18	6	344	368

Reconciliations

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

2003	Plant and Equipment $'000	Computer Equipment $'000	Leased Improvements $'000	Total $'000
Carrying amount at start of year	103	78	531	712
Additions	–	–	430	430
Disposals	–	–	(531)	(531)
Write off	(17)	(6)	–	(23)
Depreciation expense	(59)	(59)	–	(118)
Carrying amount at end of year	27	13	430	470

	2004 $'000	2003 $'000
10. CURRENT LIABILITIES – PAYABLES		
Accrued salaries, wages and on-costs	114	152
Creditors	29	10
Other	222	525
	365	687
11. CURRENT/NON-CURRENT LIABILITIES – PROVISIONS		
Employee benefit and related on-costs		
Recreation leave	535	599
Payroll tax on long service leave	49	68
Long service leave on-costs	27	39
Total provisions	611	706
Aggregate employee benefits and related on-costs		
Provisions – current	542	609
Provisions – non-current	69	97
Accrued salaries, wages and on-costs (Note 10)	114	152
	725	858
12. CHANGES IN EQUITY		
ACCUMULATED FUNDS		
At 1 July 2003	380	411
Total Changes in Equity other than those resulting from Transactions with owners as owners		
Surplus/(Deficit) for the year from ordinary activities	773	(31)
At 30 June 2004	1,153	380
13. COMMITMENTS FOR EXPENDITURE		
Operating Lease Commitments		
Future non cancellable operating lease rentals not provided for and payable		
Not later than 1 year	1,170	926
Later than 1 year not later than 5 years	2,870	3,754
Later than 5 years	966	3,012
Total	5,006	7,692

Total Commitments above included input tax credits of $455,113 that are expected to be recovered from the Australian Taxation Office.

14. CONTINGENT LIABILITIES

Adverse costs awarded against the Commission, across a range of cases, are estimated to be as high as $585,970.00 at 30 June 2004 (2002-03-Nil) Estimates have been provided by the Commission's Chief Legal Officer.

An accrual has been recognised in these accounts of $200,000 for adverse costs likely to arise in 2004-05.

15. BUDGET REVIEW

Net Cost of Services

The Net Cost of Services was higher than Budget by $1,690,000.00. This follows the increase in average staffing of 19 persons, mainly Investigation Officers after the NSW Government's decision to overhaul the Health Care Complaints Commission.

Assets and Liabilities

Current Assets were higher than Budget following an increase in the balance of cash on hand as at 30 June 2004.

Current Liabilities were higher than Budget due to the higher accrued expenses resulting from the recent increases in staff numbers.

Cash Flows

Cash Flows were higher than Budget following the provision of additional funds by the NSW Treasurer to support increases in staff numbers during the year.

16. RECONCILIATION OF NET CASH FLOWS FROM OPERATING ACTIVITIES TO NET COST OF SERVICES

	2004 $'000	2003 $'000
Net cash from operating activities	**449**	**428**
Depreciation	(101)	(34)
Net loss on disposal of plant and equipment	–	(23)
(Increase)/Decrease in provisions	96	(311)
Acceptance by the Crown Entity of Employee benefits and other liabilities	(330)	(534)
Recurrent appropriation	(9,669)	(7,277)
Cash reimbursement from the Crown Entity	(325)	(250)
Increase/(Decrease) in Receivables and Other	7	195
(Increase)/Decrease in Payables	322	(286)
Net Cost of services	**(9551)**	**(8,092)**

17. FINANCIAL INSTRUMENTS

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

Cash

Cash comprises cash on hand and bank balances within the Treasury Banking System. Interest is earned on daily bank balances at the monthly average NSW Treasury Corporation (Tcorp) 11am unofficial cash rate adjusted for a management fee to Treasury.

Terms and Conditions - Monies on deposit attract an average interest rate of approximately 4.06%.

Receivables

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

Trade Creditors and Accruals

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

Interest Rate Risk

Interest rate risk affects cash at bank and investments where the value of these instruments is subject to fluctuations due to changes in market interest rates.

The Commission's consolidated exposure to interest rate risk and the effective interest rates of financial instruments at year end are:

	2004 $000	2003 $000	
Cash	1,370	921	all at floating interest rates
Receivables	364	377	all non-interest bearing
Creditors	251	535	all non-interest bearing

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

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

There are no unrecognised financial instruments.

18. (a) THE IMPACT OF ADOPTING AUSTRALIAN EQUIVALENTS TO INTERNATIONAL FINANCIAL REPORTING STANDARDS

The Commission will apply the Australian Equivalents to International Financial Reporting Standards (AIFRS) from the reporting period beginning 1 July 2005.

The Commission is managing the transition to the new standards by allocating resources to analyse the pending standards and Urgent Issues Group Abstracts to identify key areas regarding policies, procedures, systems and financial impacts affected by the transition.

As a result of this exercise, the agency has taken the following steps to manage the transition to the new standards:

- The Commission's service provider (The Department of Gaming and Racing-DGR) is oversighting the transition. The DGR is responsible for the project and reports regularly to the Committee on progress against plan.
- The following phases that need to be undertaken have been identified:
  - Nominate an officer to have responsibility for the implementation of AIFRS
  - Scope and impact assessment
  - Design
  - Implementation and Review
- The first phase is in progress and is due for completion in July 2004.

NSW Treasury is assisting the Commission to manage the transition by developing policies, including mandates of options; presenting training seminars to all agencies; providing a website with up-to-date information to keep agencies informed of any new developments; and establishing an IAS Agency Reference Panel to facilitate a collaborative approach to manage the change.

(b) KEY CHANGES TO ACCOUNTING POLICIES THAT ARE APPLICABLE TO THE HEALTH CARE COMPLAINTS COMMISSION

The Commission has identified a number of significant differences in accounting policies that will arise from adopting AIFRS. Some differences arise because AIFRS requirements are different from the existing AASB requirements. Other differences could arise from options in AIFRS. To ensure consistency at the whole of government level, NSW Treasury has advised the Commission of options it is likely to mandate, and will confirm during 2004-05. This disclosure reflects these likely mandates.

The Commission's accounting policies may also be affected by a proposed standard designed to harmonise accounting standards with Government Finance Statistics (GFS). This standard is likely to change the impact of AIFRS and significantly affect the presentation of the income statement. However the impact is uncertain because it depends on when this standard is finalised and whether it can be adopted in 2005-06.

Based on current information, the following key differences in accounting policies are expected to arise from adopting AIFRS:

- **AASB 1 First time Adoption of Australian Equivalents to International Financial Reporting Standards** requires retrospective application of the new AIFRS from July 2004, with limited exemptions. Similarly, AASB 108 Accounting Policies, Changes in Accounting Estimates and Errors requires voluntary changes in accounting policy and correction of errors to be accounted for retrospectively by restating comparatives and adjusting the opening balance of accumulated funds, This differs from current Australian requirements, because such changes must be recognised in the current period through profit or loss, unless a new standard mandates otherwise.
- **AASB 116 Property, Plant and Equipment** requires the cost and fair value of property, plant and equipment to be increased to include restoration costs, where restoration provisions are recognised under AASB 137 Provisions, Contingency Liabilities and Contingent Assets.

  Major inspection costs must be capitalised and this will require the fair value and depreciation of the related asset to be re-allocated.
- **AASB 117 Leases** requires operating lease contingent rentals to be recognised as an expense on a straight-line basis over the lease term rather than expensing in the financial year.

- **AASB 119 Employee Benefits** requires the defined benefit obligation to be discounted using the government bond rate as at each reporting date rather than the long-term expected rate of return on plan assets. Where the unfunded superannuation liability is not assumed by the Crown, this will increase the amount and the future volatility of the unfunded superannuation liability and the volatility of the employee benefit expense.
- **AASB 120 Accounting for Government Grants and Disclosure of Government Assistance** applies to **for-profit entities** only. Entities will either apply the current AASB 120 or early adopt a revised AASB 120, based on the grant requirements in AASB 141 Agriculture. The current AASB 120 spreads income recognition over the period necessary to match related costs. A revised AASB 120 based on AASB 141 is likely to require revenue recognition when conditions are satisfied. Both of these alternatives may have the effect of delaying revenue recognition.
- **AASB 1004 Contributions** applies to **not-for-profit entities** only. Entities will either continue to apply the current requirements in AASB 1004 where grants are normally recognised on receipt, or alternatively apply the proposals on grants included in ED 125 Financial Reporting by Local Governments. If the ED 125 approach is applied, revenue and/or expense recognition will be delayed until the Commission supplies the related goods and services (where grants are in-substance agreements for the provision of goods and services) or until conditions are satisfied.
- **AASB 132 Financial Instrument Disclosure and Presentation** prohibits in-substance defeasance. Agencies can no longer offset financial assets and financial liabilities when financial assets are set aside in trust by a debtor for the purposes of discharging an obligation, without assets having been accepted by the creditor in settlement of the obligation. This will have the effect of increasing both assets and liabilities but will have no impact on equity.
- **AASB 136 Impairment of Assets** requires an entity to assess at each reporting date whether there is any indication that an asset (or cash generating unit) is impaired and if such indication exists, the entity must estimate the recoverable amount. However, the effect of this Standard should be minimal because all the substantive principles in AASB 136 are already incorporated in Treasury's policy *Valuation of Physical Non-Current Assets at Fair Value.*
- **AASB 139 Financial Instruments Recognition and Measurement** results in the recognition of financial instruments that were previously off balance sheet, including derivatives. The standard adopts a mixed measurement model and requires financial instruments held for trading and available for sale to be measured at fair value and valuation charges to be recognised in profit or loss or equity, respectively. Previously they were recognised at cost. This may increase the volatility of the operating result and balance sheet.

The standard also includes stricter rules for the adoption of hedge accounting and where these are not satisfied, movements in fair value will impact the income statement.

To achieve full harmonisation with GFS, entities would need to designate all financial instruments at fair value through profit or loss. However at this stage it is unclear whether this option will be available under the standard and, if available, whether Treasury will mandate this option for all agencies.

END OF AUDITED FINANCIAL STATEMENTS

Appendix 1: Statistics

Table 32: Complaints received about health services 2001-02 to 2003-04

Facility	2001-2002 No.	2001-2002 %	2002-2003 No.	2002-2003 %	2003-2004 No.	2003-2004 %
Public hospital	458	49.9%	396	43.9%	484	51.4%
Private hospital	61	6.6%	71	7.9%	59	6.3%
Medical centre	42	4.6%	35	3.9%	41	4.4%
Nursing home	46	5.0%	47	5.2%	40	4.2%
Other*	90	9.8%	75	8.3%	37	3.9%
Pharmacy	15	1.6%	14	1.6%	36	3.8%
Psychiatric hospital	49	5.3%	62	6.9%	34	3.6%
Community Health Service	33	3.6%	32	3.5%	32	3.4%
Corrections Health Service	18	2.0%	32	3.5%	29	3.1%
Department of Health	4	0.4%	8	0.9%	29	3.1%
Area Health Service	20	2.2%	25	2.8%	20	2.1%
Ambulance Service	20	2.2%	17	1.9%	15	1.6%
Radiology practice	8	0.9%	17	1.9%	14	1.5%
Pathology centres/labs	11	1.2%	19	2.1%	13	1.4%
Health Fund - Public	0	0.0%	1	0.1%	11	1.2%
Day procedure centre	4	0.4%	13	1.4%	9	1.0%
Dental unit - public	16	1.7%	8	0.9%	7	0.7%
Private medical practice	11	1.2%	10	1.1%	7	0.7%
Hostel - aged	2	0.2%	8	0.9%	6	0.6%
Men's Health Clinic	6	0.7%	3	0.3%	5	0.5%
Private Psychiatric Hospital	0	0.0%	2	0.2%	4	0.4%
Dental surgery - private	1	0.1%	1	0.1%	4	0.4%
Health Fund - Private	1	0.1%	1	0.1%	3	0.3%
Optometrist Practice	2	0.2%	5	0.6%	3	0.3%
Total	**918**	**100.0%**	**902**	**100.0%**	**942**	**100.0%**

** Other: 2003-2004: Alternative health service 2; Drug & alcohol service 2; Boarding house 1; Family planning clinic 1; Group home - mental health 1; Hostel - other 2; Methadone Clinic 2; Physiotherapy clinic - private 1; Women's health centre 1; Other, no code available 24.*

Table 33: Complaints received about public hospitals by Area Health Service 2001-02 to 2003-04

Region	2001-2002 No.	2001-2002 %	2002-2003 No.	2002-2003 %	2003-2004 No.	2003-2004 %	Admissions	2003-2004 Non-Admitted Patient Services	Emergency Dept Attendance
Central Coast AHS	17	3.4%	23	5.0%	18	3.5%	71,689	936,302	51,264
Central Sydney AHS	45	9.0%	36	7.9%	32	6.3%	123,318	1,887,259	93,356
Far West AHS	7	1.4%	3	0.7%	5	1.0%	11,663	257,010	51,764
Greater Murray AHS	11	2.2%	18	3.9%	9	1.8%	55,384	839,098	161,405
Hunter AHS	35	7.0%	19	4.1%	40	7.8%	109,352	1,808,054	176,188
Illawarra AHS	32	6.4%	30	6.6%	18	3.5%	81,311	1,249,352	108,917
Interstate/Other**	27	5.4%	3	0.7%	3	0.6%	N/A	N/A	N/A
Macquarie AHS	9	1.8%	10	2.2%	17	3.3%	29,095	400,438	65,174
Mid North Coast AHS	6	1.2%	25	5.5%	21	4.1%	56,441	851,126	29,183
Mid Western AHS	20	4.0%	10	2.2%	9	1.8%	44,348	636,637	119,868
New England AHS	8	1.6%	9	2.0%	8	1.6%	46,623	506,676	86,280
Northern Rivers AHS	20	4.0%	19	4.1%	20	3.9%	69,856	846,118	184,786
Northern Sydney AHS	43	8.6%	38	8.3%	59	11.5%	101,061	1,946,071	124,454
South Eastern Sydney AHS	81	16.1%	74	16.2%	61	11.9%	175,528	3,646,909	210,450
South Western Sydney AHS	43	8.6%	42	9.2%	99	19.3%	141,913	2,267,873	163,191
Southern AHS	18	3.6%	15	3.3%	10	2.0%	32,892	713,340	96,988
Wentworth AHS	22	4.4%	24	5.2%	24	4.7%	50,584	744,780	55,497
Western Sydney AHS	58	11.6%	60	13.1%	59	11.5%	130,671	2,403,358	110,360
Total	**502***	**100.0%**	**458***	**100.0%**	**512***	**100.0%**	**1,331,729**	**21,940,401**	**1,889,125**

** Includes Psychiatric hospitals.*

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

Table 34: Complaints received about public and private hospitals analysed by service area 2003-04

	Public		Private	
Service Area	**No**	**%**	**No**	**%**
Accident and Emergency	119	23.2%	4	5.8%
Other*	42	8.2%	14	20.3%
Surgery – General	39	7.6%	11	15.9%
Obstetrics	32	6.3%	5	7.2%
Psychiatry	26	5.1%	5	7.2%
Mental Health	25	4.9%	0	0.0%
Intensive Care	25	4.9%	2	2.9%
Administration – General	22	4.3%	3	4.3%
General Medicine	20	3.9%	2	2.9%
Public Health	15	2.9%	0	0.0%
Gerontology	14	2.7%	1	1.4%
Oncology – Medical	14	2.7%	1	1.4%
Cardiology	13	2.5%	0	0.0%
Surgery – Orthopaedic	13	2.5%	7	10.1%
Rehabilitation Medicine	9	1.8%	3	4.3%
Gynaecology	8	1.6%	1	1.4%
Gastroenterology	8	1.6%	3	4.3%
Paediatric Medicine	8	1.6%	0	0.0%
Palliative Care	8	1.6%	2	2.9%
Neurology	7	1.4%	0	0.0%
Haematology (Clinical)	5	1.0%	0	0.0%
Midwifery	5	1.0%	0	0.0%
Surgery – Ear, Nose & Throat	4	0.8%	1	1.4%
Neonatology	4	0.8%	0	0.0%
Surgery – Cardiothoracic	4	0.8%	1	1.4%
Waiting Lists	4	0.8%	0	0.0%
Physiotherapy	4	0.8%	1	1.4%
Anaesthesia – Other	3	0.6%	2	2.9%
Respiratory	3	0.6%	0	0.0%
Nuclear Medicine	3	0.6%	0	0.0%
Surgery – Vascular	3	0.6%	0	0.0%
Urology	3	0.6%	0	0.0%
Total	512	100.0%	69	100.0%

** Other:*

Public hospital: Administration - Medical Records 2; Anaesthesia - Intensive Care 2; Community Health 2; Dentistry 2; Nutrition & Dietetics 2; Psychogeriatrics 2; Radiology 2; Sexual Assault Service 2; Surgery - Hand and Upper Limb 2; Surgery - Urology 2; Drugs - Administration 1; Endocrinology 1; Home Births 1; Infectious Diseases 1; Neurophysiology 1; Non Health Related 1; Oncology - Radiation 1; Osteopathy 1; Pathology 1; Personal Care 1; Renal Medicine 1; Surgery - Melanoma 1; Surgery - Oncology 1; Surgery - Paediatric 1; Therapy 1; Code not available 35.

Private hospital: General Practice (Medical Centre) 4; General Practice 2; Administration - Medical Records 1; Early Childhood, eg, Baby Health 1; Justice Health (formerly Corrections HS) 1; Occupational Therapy 1; Surgery - Hand and Upper Limb 1; Surgery - Plastic and Reconstructive 1; Code not available 2.

Table 35: Complaints received about registered and non-registered health care providers 2001-02 to 2003-04

	2001-2002		2002-2003		2003-2004	
Health practitioner	**No.**	**%**	**No.**	**%**	**No.**	**%**
Medical practitioner	1,181	67.3%	1,222	67.4%	1,227	65.5%
Nurse	192	10.9%	213	11.7%	286	15.3%
Dentist	143	8.1%	156	8.6%	157	8.4%
Other*	47	2.7%	38	2.1%	43	2.3%
Psychologist	41	2.3%	53	2.9%	43	2.3%
Physiotherapist	21	1.2%	16	0.9%	21	1.1%
Chiropractor	22	1.3%	14	0.8%	21	1.1%
Dental technician and prosthetist	14	0.8%	16	0.9%	16	0.9%
Pharmacist	51	2.9%	28	1.5%	13	0.7%
Administrative or Clerical Staff	3	0.2%	9	0.5%	11	0.6%
Podiatrist	10	0.6%	7	0.4%	10	0.5%
Social worker	5	0.3%	10	0.6%	8	0.4%
Optometrist	11	0.6%	18	1.0%	7	0.4%
Counsellor/therapist	11	0.6%	11	0.6%	5	0.3%
Traditional Medicine	3	0.0%	3	0.2%	5	0.3%
Total	**1,755**	**100.0%**	**1,814**	**100.0%**	**1,873**	**100.0%**

** Other, 2003-2004: Acupuncturist 4; Radiographer 4; Naturopath 3; Assistant in nursing 2; Natural therapist 2; Ambulance personnel 1; Deregistered health practitioner 1; Osteopath 1; Speech pathologist 1; Occupational therapist 1; Residential care worker 1, No code available 22.*

Table 36: Complaints received about registered professions by category 2003-04

Cateory	**Medical practitioner**	**Nurse**	**Dentist**	**Psychologist**	**Physiotherapist**	**Chiropractor**	**Dental Technician and prosthetist***	**Pharmacist**	**Podiatrist**	**Optometrist**	**Osteopath**	**Optical dispenser**
Clinical standards	749	123	118	9	14	11	11	1	3	5	0	0
Business practices	156	1	28	12	5	2	2	1	2	1	0	0
Miscellaneous	51	13	5	1	0	0	2	0	0	0	0	0
Prescribing drugs	58	17	0	0	0	0	0	8	0	0	0	0
Provider-patient/client relationship	44	35	1	6	2	1	0	0	0	0	0	0
Quality of care	39	16	1	0	0	0	1	0	0	0	1	0
Patient rights	39	6	2	2	0	1	0	0	0	0	0	0
Other unethical/improper conduct	27	19	0	3	0	0	0	0	0	0	0	0
Impairment	25	42	0	0	0	0	0	2	0	0	0	0
Fraud	19	5	1	9	0	6	0	0	5	1	0	0
Complaints management	12	3	0	0	0	0	0	0	0	0	0	0
Character	7	6	0	0	0	0	0	1	0	0	0	0
Operative complications	1	0	0	0	0	0	0	0	0	0	0	0
Professional Practice	0	0	1	1	0	0	0	0	0	0	0	0
Total	**1,227**	**286**	**157**	**43**	**21**	**21**	**16**	**13**	**10**	**7**	**1**	**0**
Total practitioners registered in NSW as at 30.6.2004	**26,011**	**96,953**	**4,245**	**8,093**	**6,250**	**1,244**	**711 412***	**7,414**	**751**	**1,580**	**488**	**1,402**

Table 37: Source of complaints 2001-02 to 2003-04

	2001-2002		2002-2003		2003-2004	
Source	**No.**	**%**	**No.**	**%**	**No.**	**%**
Consumer	1,752	65.5%	1,520	55.9%	1,366	48.5%
Registration Board	409	15.3%	492	18.1%	500	17.7%
Family or friend	164	6.1%	359	13.2%	475	16.9%
Department of Health (State & Cwth)	78	2.9%	91	3.3%	243	8.6%
Parliament/Minister	88	3.3%	56	2.1%	66	2.3%
Government department	50	1.9%	70	2.6%	51	1.8%
Health professional	25	0.9%	29	1.1%	40	1.4%
Other	11	0.4%	13	0.5%	27	1.0%
Legal representative	41	1.5%	37	1.4%	25	0.9%
Consumer organisation	39	1.5%	31	1.1%	9	0.3%
Non-government organisation	3	0.1%	12	0.4%	7	0.2%
Courts	11	0.4%	6	0.2%	7	0.2%
Professional association	2	0.1%	2	0.1%	1	0.0%
Total	**2,673**	**100.0%**	**2,718**	**100.0%**	**2,817**	**100.0%**

Table 38: Category of complaints referred to another body or person for action 2001-02 to 2003-04

	2001-2002		2002-2003		2003-2004	
Category	**No.**	**%**	**No.**	**%**	**No.**	**%**
Clinical standards	622	51.3%	539	48.2%	491	50.9%
Quality of care	237	19.5%	279	25.0%	154	16.0%
Business practices	67	5.5%	65	5.8%	66	6.8%
Prescribing drugs	73	6.0%	53	4.7%	66	6.8%
Impairment	74	6.1%	64	5.7%	56	5.8%
Fraud	18	1.5%	26	2.3%	34	3.5%
Miscellaneous	26	2.1%	5	0.4%	30	3.1%
Patient rights	31	2.6%	33	3.0%	22	2.3%
Other unethical/improper conduct	16	1.3%	27	2.4%	11	1.1%
Provider-consumer relationship	23	1.9%	17	1.5%	11	1.1%
Resources	8	0.7%	4	0.4%	8	0.8%
Complaints management	9	0.7%	1	0.1%	6	0.6%
Waiting list	6	0.5%	4	0.4%	4	0.4%
Character	3	0.2%	1	0.1%	3	0.3%
Professional Practice	0	0.0%	0	0.0%	1	0.1%
Operative Complication	0	0.0%	0	0.0%	1	0.1%
Total	**1,213**	**100.0%**	**1,118**	**100.0%**	**964**	**100.0%**

Table 39: Complaints referred to another body 2001-02 to 2003-04 by the type of body referred to

	2001-2002		2002-2003		2003-2004	
Body referred to	**No.**	**%**	**No.**	**%**	**No.**	**%**
Registration Board	402	33.1%	453	40.5%	483	50.1%
AHS	486	40.1%	470	42.0%	348	36.1%
Other body	89	7.3%	64	5.7%	62	6.4%
Other government department	45	3.7%	94	8.4%	40	4.1%
Other Commonwealth government body	16	1.3%	8	0.7%	14	1.5%
Director-General	80	6.6%	6	0.5%	7	0.7%
Health Insurance Commission	8	0.7%	6	0.5%	5	0.5%
Private Health Insurance Commission	0	0.0%	8	0.7%	4	0.4%
Private health provider	14	1.2%	2	0.2%	1	0.1%
Awaiting processing as at 30 June 2003	73	6.0%	7	0.6%	0	0.0%
Total	**1,213**	**100.0%**	**1,118**	**100.0%**	**964**	**100.0%**

Table 40: Category of complaints received and originally assessed for conciliation 2001-02 to 2003-04

	2001-2002		2002-2003		2003-2004	
Category	**No.**	**%**	**No.**	**%**	**No.**	**%**
Clinical standards	308	81.3%	291	66.7%	246	66.1%
Quality of care	23	6.1%	89	20.4%	72	19.4%
Miscellaneous	11	2.9%	0	0.0%	17	4.6%
Business practices	16	4.2%	31	7.1%	14	3.8%
Complaints management	5	1.3%	2	0.5%	6	1.6%
Prescribing drugs	6	1.6%	5	1.1%	5	1.3%
Other unethical/improper conduct	6	1.6%	2	0.5%	3	0.8%
Fraud	4	1.1%	0	0.0%	2	0.5%
Patient rights	0	0.0%	14	3.2%	2	0.5%
Operative complications	0	0.0%	0	0.0%	1	0.3%
Professional Practice	0	0.0%	0	0.0%	1	0.3%
Provider-consumer relationship	2	0.5%	2	0.5%	1	0.3%
Resources	0	0.0%	0	0.0%	1	0.3%
Waiting List	0	0.0%	0	0.0%	1	0.3%
Total	**379**	**100.0%**	**436**	**100.0%**	**372**	**100.0%**

Table 41: Category of complaints referred for conciliation 2003-04

	2002-2003		2003-2004	
Category	**No.**	**%**	**No.**	**%**
Clinical standards	126	67.0%	124	64.4%
Quality of care	48	25.5%	52	27.2%
Patient rights	3	1.6%	5	2.6%
Business practices	8	4.3%	3	1.6%
Miscellaneous	0	0.0%	3	1.6%
Complaints Management	0	0.0%	2	1.0%
Operative Complication	0	0.0%	1	0.5%
Other unethical/improper conduct	1	0.5%	1	0.5%
Waiting List	0	0.0%	1	0.5%
Fraud	1	0.5%	0	0.0%
Prescribing drugs	1	0.5%	0	0.0%
Total	**188**	**100.0%**	**192**	**100.0%**

66 complaints received in 2002-03 were referred for conciliation in 2003-04.

Table 42: Results of conciliation held during the year 2001-02 to 2003-04

	2001-2002		2002-2003		2003-2004	
Outcome	**No.**	**%**	**No.**	**%**	**No.**	**%**
Agreement reached/Partial agreement reached	53	80.3%	133	78.7%	113	83.7%
No agreement reached	13	19.7%	36	21.3%	22	16.3%
Total	**66**	**100.0%**	**169**	**100.0%**	**135**	**100.0%**

37 complaints did not proceed with HCR and were referred back to HCCC
52 complaints awaiting an outcome (s.53) report as at 30.6.04

Table 43: Reassessment of complaints not leading to conciliation where the parties decide not to participate 2001-02 to 2003-04

	2001-2002		2002-2003		2003-2004	
Assessment decision	**No.**	**%**	**No.**	**%**	**No.**	**%**
Resolution between the parties	130	76.9%	158	67.5%	108	53.7%
Discontinue dealing with	23	13.6%	38	16.2%	41	20.4%
Refer to another body	16	9.5%	36	15.4%	46	22.9%
Re-offer conciliation	0	0.0%	2	0.9%	0	0.0%
Investigation	0	0.0%	0	0.0%	4	2.0%
Resubmit	0	0.0%	0	0.0%	2	1.0%
Total	**169**	**100.0%**	**234**	**100.0%**	**201**	**100.0%**

Table 44: Category of complaints assessed and declined 2001-02 to 2003-04

	2001-2002		2002-2003		2003-2004	
Category	**No.**	**%**	**No.**	**%**	**No.**	**%**
Clinical standards	226	45.0%	238	43.8%	246	37.3%
Business practices	118	23.5%	122	22.5%	111	16.8%
Quality of care	33	6.6%	69	12.7%	86	13.1%
Miscellaneous	24	4.8%	3	0.6%	45	6.8%
Other unethical/improper conduct	38	7.6%	23	4.2%	32	4.9%
Provider-consumer relationship	12	2.4%	15	2.8%	31	4.7%
Prescribing drugs	4	0.8%	11	2.0%	27	4.1%
Patient rights	28	5.6%	30	5.5%	23	3.5%
Fraud	6	1.2%	15	2.8%	19	2.9%
Resources	2	0.4%	2	0.4%	16	2.4%
Complaints management	5	1.0%	8	1.5%	16	2.4%
Impairment	4	0.8%	7	1.3%	5	0.8%
Character	0	0.0%	0	0.0%	1	0.2%
Waiting List	0	0.0%	0	0.0%	1	0.2%
Other	2	0.4%	0	0.0%	0	0.0%
Total	**502**	**100.0%**	**543**	**100.0%**	**659**	**100.0%**

Table 45: Complaints open as at 30 June by assessment decision 2001-02 to 2003-04

	2001-2002		2002-2003		2003-2004	
Assessment decision	**No.**	**%**	**No.**	**%**	**No.**	**%**
Commission investigation underway	713	74.9%	589	59.4%	718	74.8%
Awaiting assessment	37	3.9%	171	17.3%	87	9.1%
Conciliation	73	7.7%	91	9.2%	57	5.9%
Resubmit	0	0.0%	0	0.0%	53	5.5%
Decline to deal with	33	3.5%	42	4.2%	17	1.8%
Referred to another body for investigation	69	7.2%	66	6.7%	16	1.7%
Assisted Resolution	0	0.0%	0	0.0%	9	0.9%
Direct resolution	22	2.3%	30	3.0%	3	0.3%
Referred to Director-General	2	0.2%	0	0.0%	0	0.0%
Consultative resolution	3	0.3%	2	0.2%	0	0.0%
Total	**952**	**100.0%**	**991**	**100.0%**	**960**	**100.0%**

Table 46: Outcome of investigation reviews 2001-02 to 2003-04

	2001-2002		2002-2003		2003-2004	
Outcome	**No.**	**%**	**No.**	**%**	**No.**	**%**
No further action	18	78.3%	5	100.0%	13	100.0%
Reopen for investigation	4	17.4%	0	0.0%	0	0.0%
Refer to another body	1	4.3%	0	0.0%	0	0.0%
Total	**23**	**100.0%**	**5**	**100.0%**	**13**	**100.0%**

Table 47: Investigations finalised about health practitioners 2001-02 to 2003-04

	2001-2002		2002-2003		2003-2004	
Description	**No.**	**%**	**No.**	**%**	**No.**	**%**
Medical practitioner	181	56.6%	216	64.1%	148	55.2%
Nurse	95	29.7%	80	23.7%	73	27.2%
Psychologist	13	4.1%	15	4.5%	7	2.6%
Optometrist	1	0.3%	1	0.3%	7	2.6%
Chiropractor	4	1.3%	4	1.2%	6	2.2%
Chiropodist/podiatrist	0	0.0%	1	0.3%	6	2.2%
Physiotherapist	5	1.6%	8	2.4%	5	1.9%
Pharmacist	3	0.9%	2	0.6%	4	1.5%
Dentist	13	4.1%	1	0.3%	4	1.5%
Naturopath	0	0.0%	0	0.0%	2	0.7%
Natural Therapist	0	0.0%	0	0.0%	2	0.7%
Unregistered (Counsellor/Therapist)	0	0.0%	0	0.0%	1	0.4%
Traditional Medicine	0	0.0%	0	0.0%	1	0.4%
Assistant in Nursing	0	0.0%	0	0.0%	1	0.4%
Administrative or Clerical Staff	0	0.0%	0	0.0%	1	0.4%
Social worker	1	0.3%	1	0.3%	0	0.0%
Other	2	0.6%	1	0.3%	0	0.0%
Osteopath	0	0.0%	1	0.3%	0	0.0%
Health practitioner de-registered	0	0.0%	2	0.6%	0	0.0%
Dental technician and prosthetist	2	0.6%	4	1.2%	0	0.0%
Total	**320**	**100.0%**	**337**	**100.0%**	**268**	**100.0%**

Table 48: Category of open investigations as at 30 June 2001-02 to 2003-04

	2001-2002		2002-2003		2003-2004	
Category	**No.**	**%**	**No.**	**%**	**No.**	**%**
Clinical standards	280	39.3%	194	32.9%	330	46.0%
Provider-patient/client relationship	132	18.5%	116	19.7%	118	16.4%
Prescribing drugs	96	13.5%	100	17.0%	88	12.3%
Quality of care	63	8.8%	49	8.3%	52	7.2%
Other unethical/improper conduct	50	7.0%	46	7.8%	47	6.5%
Impairment	24	3.4%	17	2.9%	21	2.9%
Character	14	2.0%	12	2.0%	18	2.5%
Business practices	15	2.1%	23	3.9%	16	2.2%
Miscellaneous	9	1.3%	9	1.5%	11	1.5%
Fraud	18	2.5%	12	2.0%	7	1.0%
Patient rights	9	1.3%	8	1.4%	4	0.6%
Complaints management	1	0.1%	0	0.0%	3	0.4%
Operative complications	2	0.3%	2	0.3%	2	0.3%
Waiting list	0	0.0%	1	0.2%	1	0.1%
Total	**713**	**100.0%**	**589**	**100.0%**	**718**	**100.0%**

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