PARLIAMENT OF NEW SOUTH WALES

Committee on the Health Care Complaints Commission

Operation of the Health Care Complaints Act 1993

Discussion Paper

Report No. 5/54 – September 2009

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List of Abbreviations

AHS	Area Health Service
COTA	Council on the Ageing
DADHC	Department of Ageing, Disability and Home Care
GSAHS	Greater Southern Area Health Service
HCCC	NSW Health Care Complaints Commission
HNEAHS	New England Area Health Service
HSA	Health Services Association of NSW
NHWT	National Health Workforce Taskforce
PIAC	Public Interest Advocacy Centre
SESIAHS	South Eastern Sydney Illawarra Health Service
The Act	*Health Care Complaints Commission Act 1993*
The Board	NSW Medical Board
The Office	Queensland Office of Health Practitioner Registration Boards

Terms of Reference

That, pursuant to the functions of the Joint Parliamentary Committee on the Health Care Complaint Commission under s 65(1)(b) and s 65(1)(d) of the *Health Care Complaints Act 1993* to report to both Houses of Parliament, with such comments as the Committee thinks fit, on any matter appertaining to the Commission or connected with the exercise of the Commission's functions to which, in the opinion of the Committee, the attention of Parliament should be directed, and to report on any change that the Committee considers desirable to the functions, structures and procedures of the Commission, the Committee examine the operation of the *Health Care Complaints Act 1993*, with particular reference to:

1. the identification and removal of any unnecessary complexities in the New South Wales health care complaints system;
2. the appropriateness of the current assessment and investigative powers of the Health Care Complaints Commission; and
3. the effectiveness of information-sharing between the Health Care Complaints Commission and Area Health Services and Registration Authorities in New South Wales,

and report to Parliament on any matters connected with the Committee's statutory functions.

Chair's Foreword

One of the main functions of the Committee on the Health Care Complaints Commission, under s 65(1)(d) of the *Health Care Complaints Act 1993*, is to report to Parliament any change that the Committee considers desirable to the functions, structures and procedures of the Health Care Complaints Commission.

It was with this responsibility in mind that the Committee recommended, in the wake of its Inquiry into the conduct of the Commission's investigation into the complaints made against ex-practitioner Graeme Reeves, that the Health Care Complaints Act be the subject of a thorough review, to identify any unnecessary complexities in the health care complaints system in New South Wales.

The Committee subsequently deferred its Inquiry, due to the impetus for a National Registration and Accreditation Scheme, an important component of which was to be a national health care complaints handling system. The Committee had serious concerns that the scheme proposed would be a retrograde step towards a discredited system of self-regulation, and was pleased when the then-Minister for Health, Hon John Della Bosca MLC, announced in the Legislative Council on 23 June 2009 that New South Wales had brokered an agreement for the retention of the Health Care Complaints Commission as part of the national scheme.

I would like to take this opportunity to acknowledge the time and effort which individuals and organisations have taken in making submissions to this Inquiry. The Committee is pleased to have been able to benefit from such thoughtful consideration of the Inquiry's Terms of Reference.

In highlighting issues in this Discussion Paper, the Committee is not in any way advocating for their implementation at this time. Indeed, the Committee notes that there may be perfectly valid reasons why a seemingly reasonable course of action cannot be followed. Rather, the Committee has paid close attention to the submissions made in order to bring these issues into the public discourse on the operation of the health care complaints system in New South Wales. Accordingly, the Committee hopes that its Discussion Paper will foster debate on these important matters, and looks forward to the response of healthcare practitioners, consumers and the wider community.

Hon Helen Westwood AM MLC
Chair

Issues for Discussion

Executive Summary

In preparing this Discussion Paper, the Committee has relied on the expertise and experience of the Health Care Complaints Commission itself, healthcare practitioners and health care consumers to flag issues which ought to lead to a more effective and efficient health care complaints system in New South Wales.

The first Term of Reference is dealt with in Chapter 2. Issues raised with respect to any unnecessary complexities in the health care complaints system were the practicalities of making a complaint; additional problems facing complainants with special needs; communication generally; and the wide range of Registration Authorities to be dealt with.

The second Term of Reference is dealt with in Chapter 3. Issues raised with respect to the current assessment and investigative powers of the Commission were the conduct of the investigation process; timeliness; and final outcomes of the process.

The third Term of Reference is dealt with in Chapter 4. Issues raised with respect to information-sharing between the Commission and Area Health Services and Registration Authorities, include Area Health Services not being informed of complaints relating to practitioners, or not being updated on such complaints.

Chapter One - Background

Conduct of the Inquiry

1.1 In June 2008, the Committee tabled the report of its Inquiry into the conduct of the Commission's investigation into the complaints made against ex-practitioner Graeme Reeves. Among the Report's recommendations was that the *Health Care Complaints Act 1993* (the Act) be the subject of a thorough review, to identify any unnecessary complexities in the health care complaints system in New South Wales.

1.2 In subsequent correspondence, the Committee was advised by the then-Minister for Health, Hon Reba Meagher MP, that as the proposed national scheme for the registration of health professionals was to include a national complaints handling scheme (see below), the NSW Department of Health did not intend to undertake a review of the Act.[1] As the new scheme was not intended to be introduced until July 2010, Committee Members were concerned at this delay.

1.3 Accordingly, at its meeting of 25 September 2008, the Committee resolved to undertake its own Inquiry, pursuant to its statutory responsibilities. The Inquiry was advertised, and the Committee received 27 submissions. However, as the momentum for the national complaints handling scheme grew, the Committee deferred the conduct of its inquiry, in order to establish whether or not New South Wales would retain its co-regulatory system.

1.4 As noted in the Chair's Foreword, it was announced in June 2009 that the NSW Health Care Complaints Commission will be retained as a component of the national complaints handling scheme.

National Registration and Accreditation Scheme for the Health Professions

1.5 In 2006, the Council of Australian Governments (COAG) agreed to a national health workforce reform package aimed at better preparing the health workforce for the changing healthcare needs of the Australian community. This included the establishment of the National Health Workforce Taskforce (NHWT), to undertake projects for practical solutions to issues of workforce reform. These included a national scheme for the registration of health professionals, which was to be implemented by a scheme of State-based legislation, and would commence in July 2010.

1.6 The Committee had grave concerns that the Consultation Paper of the Practitioner Regulations Subcommittee of the NHWT proposed a return to a model of self-regulation which had been discredited and abandoned in a range of jurisdictions. Specifically, the Committee considered that the proposed model would not have been as effective as the NSW co-regulatory model in meeting the NHWT's own criteria for a health complaints system, which are to:

- ensure that public protection is paramount;
- maintain a high degree of transparency; and

[1] Meagher MP, Hon R P, Minister for Health. Correspondence to Hon Helen Westwood MLC, Chair of the Committee on the Health Care Complaints Commission, 1 September 2008.

- be appropriately accountable.[2]

1.7 The Committee also noted that the proposed model was based largely on the health care complaints system currently operating in Victoria. This was a matter of particular concern, given that this system had recently been the subject of strong criticism by the Victorian Ombudsman in his *Report of an Investigation into issues at Bayside Health*.[3]

1.8 Therefore, the Committee urged the National Health Workforce Taskforce to reconsider its advocacy of a model which had signally failed to protect the health and safety of the public, and to extend the consultation process in order for a range of complaints handling systems to be more fully explored, with an open mind towards the adoption of alternative models to that currently proposed.

1.9 Accordingly the Committee is pleased that the Health Care Complaints Commission is retained as part of the national scheme.

Principles of a complaints handling system for the 21st century

1.10 In considering the operation of the Act, the Committee has been cognisant of other Australian jurisdictions, and in overseas jurisdictions where comparisons are appropriate.[4] It has concluded that the optimal way to ensure the protection of the health and safety of the public is a health care complaints system governed by the following principles:

- **Accountability**: Decision-making authorities must be accountable to the NSW community in carrying out their statutory functions;
- **Transparency**: Decision-making processes should be open, clear and understandable for both the consumers and the professions;
- **Fairness**: Decision-making authorities should maintain an acceptable balance between protecting the rights and interests of patients and those of the practitioners;
- **Effectiveness**: The regulatory system should be effective in protecting the public from harm and supporting and fostering equity of access and the provision of high-quality care;

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2 Practitioner Regulation Subcommittee, Health Workforce Principal Committee. 2008. Consultation Paper, *Proposed arrangements for handling complaints, and dealing with performance, health and conduct matters*, 7 October 2008, Australian Health Ministers' Advisory Council, p. 4.

3 See Ombudsman Victoria. 2008. *Whistleblowers Protection Act 2001, Report of an Investigation into issues at Bayside Health*, <www.ombudsman.vic.gov.au/resources/documents/Bayside_Health_Report.pdf>

4 See Ontario Health Professions Advisory Council. 2001. *Adjusting the balance: a review of the Regulated Health Professions Act*, p. 3.

- **Efficiency**: The resources expended and the administrative burden imposed by the regulatory system must be justified in terms of the benefits to the New South Wales community; and
- **Flexibility**: The regulatory system should be well equipped to respond to emerging challenges in a timely manner, as the health care system evolves and the roles and functions of health professionals change.[5]

[5] See, also, Victorian Department of Human Services. 2003. *Regulation of the health professions in Victoria: a discussion paper*, p. 10.

Chapter Two - A complex health care complaints system

2.1 The system of health care complaints in NSW is complex and multi-faceted. This largely reflects the fact that many complaints will themselves be complex, such as those relating to hospital care. Having regard to the Committee's findings in examining the conduct of the Commission's investigations into complaints made against Graeme Reeves, the first Term of Reference of this Inquiry was to identify any unnecessary complexities in the NSW health care complaints system.

The objects of the Health Care Complaints Act 1993

2.2 Section 3(1) of the Act defines the primary role of the Commission as follows:

- receiving and assessing complaints relating to health services and health service providers in New South Wales;
- investigating and assessing whether such complaints are serious and if so, whether they should be prosecuted;
- prosecuting serious complaints; and
- resolving or overseeing the resolution of complaints.

2.3 Pursuant to s 3(2) of the Act, when the Commission exercises any functions under the Act, the protection of the health and safety of the public must be the paramount consideration.[6] The joint submission of Positive Life NSW and HIV/AIDS Legal Centre suggested that a "more generous" reading of the Commission's responsibilities under s 3(2) - or, indeed, an amendment of s 3 - might allow for the Commission to fulfil a governance role, whereby it would engage with other parties in the wider NSW healthcare system to improve healthcare quality, policy and practices generally. In doing so, the Commission would draw on its "direct and detailed knowledge of complaints".[7]

2.4 The submission of the Public Interest Advocacy Centre (PIAC) noted that in July 2008, the Australian Health Ministers adopted the *Australian Charter of Healthcare Rights* (see Appendix 5), developed by the Australian Commission on Health Safety and Quality in Health Care.[8] PIAC considers that the current assessment and investigative powers of the HCCC would be strengthened by references to the Charter in the Act. PIAC would prefer to see the Charter enforced directly by a body such as the HCCC through the Act, along the lines of the New Zealand model. However, PIAC recognises that this would be a fundamental change to the system of health care complaints in New South Wales, and so suggested a number of more incremental alternatives.

ISSUE 1: That s 3 of the Health Care Complaints Act 1993 be amended to

6 Section 3(2) of the *Health Care Complaints Act 1993*.
7 Submission no. 27, Positive Life NSW, p. 8.
8 Submission no. 25, Public Interest Advocacy Centre, p. 9.
See Australian Commission on Safety and Quality in Healthcare. 2008. *Australian Charter of Healthcare Rights,* <www.safetyandquality.gov.au/internet/safety/publishing.nsf/content/Priorityprogram-01>.

include a fifth object "to uphold the rights set out in the *Australian Charter of Healthcare Rights*".

ISSUE 2: That the Health Care Complaints Act 1993 be amended to include a provision that the Health Care Complaints Commission should consider the *Australian Charter of Healthcare Rights* when assessing or otherwise dealing with a complaint.

ISSUE 3: That the *Australian Charter of Healthcare Rights* be added as a Schedule to the Health Care Complaints Act 1993.

Public health organisations

2.5 Section 3A(4) of the Act notes that public health organisations are responsible for achieving and maintaining adequate standards of patient care and services, which may include a role in resolving complaints at a local level. Their role involves liaising with the Commission and registration authorities.

2.6 In its submission, the Health Services Association of NSW (HSA) notes that, while s 7 of the *Health Services Act 1997* defines three types of public health organisations – namely Area Health Services, Statutory Health Corporations and Affiliated Health Organisations – it does not create a hierarchy among these organisations, all of which report directly to the Minister for Health. Having regard to this, the HSA maintains that the Act inappropriately deems the Director-General of the Department of Health to be personally responsible for the governance of public health organisations, as evidenced by the requirements under s 25(1) and s 25A for the Commission to inform the Director-General of a complaint, but not the public health organisation involved.[9]

2.7 The HSA notes that some public health organisations claim that they are not directly informed about complaints, and are therefore unable to directly manage them. Moreover, the submission suggests that responses from public health organisations to the Commission under s 43 of the Act are submitted through the Director-General, and have on occasion been changed without consultation with the public health organisation.[10]

ISSUE 4: The following amendments be made to the Health Care Complaints Act 1993:

[9] The submission notes that while it is expected that the Director-General would notify the public health organisation, that is not a requirement under the Act: Submission no. 7, Health Services Association of NSW, pp. 3-4.

[10] Submission no. 7, Health Services Association of NSW, p. 4. Section 43(1) provides that if, at the end of the investigation of a complaint against a health organisation, the Commission proposes to make recommendations or comments to the health organisation on the matter the subject of the complaint, it must first inform the health organisation of the substance of the grounds for its proposed action and give the health organisation an opportunity to make submissions.

- that s 3A(4) give full recognition to public health organisations as the primary legal entities responsible for their own management and control of clinical issues;
- that s 25 and 25A require the Commission to directly inform a public health organisation of a complaint made against it; and
- that s 43 require a public health organisation to make any submissions in response to a Commission's recommendations or comments directly to the Commission.

Communication

2.8 A number of submissions made reference to the need for better liaison between officers of the Commission and complainants.[11] It was suggested that some of the problems associated with the healthcare complaints system - as well as the perception of those problems within the wider community - stem from a lack of adequate communication about how the system and the processes work.[12]

2.9 Specifically, the Greater Southern Area Health Service (GSHAS) raised the issue of communications between the Commission and medical practitioners, noting that doctors have resigned or withdrawn services from the AHS due to distress over Commission correspondence advising them that they are under investigation. This, in turn, consumes significant resources of the AHS in supporting doctors at this difficult time.[13]

ISSUE 5: That the Commission review its procedures for advising practitioners that they are under investigation, with a view to providing detailed information of what to expect from that process, including statutory timeframes, and of any support services which might be available.

Complainants with special needs

2.10 In its submission, the Department of Ageing, Disability and Home Care (DADHC) noted that general practitioners manage up to 90 per cent of patients with mental health issues in the community.[14] It also noted that people with an intellectual disability often have communication disabilities, which can limit their ability to effectively utilise the services of the Commission, should they need to make a complaint about a practitioner.

2.11 DADHC further notes that, pursuant to s 28A of the Act, the Commission is to use its 'best endeavours' to give notification of the outcomes of complaint assessment to a

11 Submission no. 6, Greater Southern Area Health Service, p. 2; Submission no. 19, Royal Australasian College of Physicians, p. 3.

12 See, e.g., Submission no. 2, Clinical Excellence Commission, p. 1; Submission no. 8, Country Women's Association of NSW, p. 2; Submission no. 9, NSW Consumer Advisory Group - Mental Health Inc, p. 3; and Submission no. 26, NSW Department of Health, p. 4.

13 Submission no. 6, Greater Southern Area Health Service, p. 3.

14 Submission no. 11, Department of Ageing, Disability and Home Care, p. 1.

client whose treatment is the subject of the complaint and who is not required to be given notice under s 28, unless that client is:

(a) deceased; or

(b) incapable of understanding the notification.

2.12 However, DADHC is concerned that the lack of any guidance within the Act itself as to how this provision is to be put into effect may mean that people with an intellectual disability are not being fully informed of the results of the investigation of any complaint they have made.

ISSUE 6: That the Health Care Complaints Commission develop guidelines or criteria by which either 'best endeavours' may be measured, or by which a client's capacity to understand might be assessed.

2.13 In its submission, the Council on the Ageing (COTA) stressed that health care consumers need to be able to have recourse to simple systems which are consumer-focused. In particular, COTA noted that the very process of initiating a complaint can be distressing when it relates to a long-term and previously trusted provider of health care services.[15] Similarly, the submission from Carers NSW highlighted the importance of a "simple, accessible and user friendly" complaints process.[16]

2.14 While the Committee acknowledges that making a complaint to the Commission can be a daunting process, it is important to also acknowledge the considerable work which the Commission has done recently to make its website, forms and the complaint process generally much more accessible than had previously been the case. In addition, the Commission is now actively promoting community awareness of its services, in ways such as involvement with the *Good Service Mob*, who host free consumer information days for Indigenous communities throughout the State.[17] It is hoped that these positive changes will serve to more effectively address the concerns of complainants with special needs raised in submissions to the Inquiry.

2.15 An additional cause of concern was the requirement, under s 9 of the Act, that a complaint to the Commission must be in writing, and contain particulars of the allegations on which it is founded. The Committee notes that the Act also requires staff of the Commission to help a person to make a complaint if the person requests assistance to do so, but a complaint cannot be acted on until it is put in writing.

Registration authorities

2.16 New South Wales has a co-regulatory model of health care complaints handling, such that the Commission shares its responsibilities with the various Registration

15 Submission no. 13, Council of the Ageing, p. 2.

16 Submission no. 12, Carers NSW, p. 9.

17 In addition to the Commission, the agencies collaborating in *Good Service Mob* are the Commonwealth Ombudsman, the Energy & Water Ombudsman NSW (EWON), the Financial Ombudsman Service, Legal Aid NSW, NSW Anti-Discrimination Board, NSW Office of Fair Trading, NSW Ombudsman, and Telecommunications Industry Ombudsman: <www.goodservicemob.com.au>

Boards, such as the NSW Medical Board, which registers medical practitioners in the State.[18] The other NSW Registration Boards are as follows:

- Chiropractors Registration Board;
- Dental Board;
- Dental Technicians Registration Board**;**
- Nurses and Midwives Board**;**
- Optical Dispensers Licensing Board**;**
- Optometrists Registration Board**;**
- Osteopaths Registration Board**;**
- Pharmacy Board**;**
- Physiotherapists Registration Board**;**
- Podiatrists Registration Board; and
- Psychologists Registration Board.[19]

2.17 Section 3A of the Act provides that these Boards are:

> responsible for the registration of health professionals and the management of complaints in conjunction with the Commission. The registration authorities are also responsible for protecting the public through promoting and maintaining professional standards.

2.18 One of the Recommendations arising from the Committee's Inquiry into the Reeves investigations was that all legislation establishing Registration Boards in New South Wales ought to be amended to provide, as much as is reasonably possible, for standardised internal complaint handling procedures in line with those of the NSW Medical Board.

2.19 As one of the largest registration authorities in the country, it is reasonably to be expected that the Medical Board would provide a template for complaints handling processes. By the same token, it might be considered unreasonable for much smaller Boards – both in terms of number of registrants and number of complaints made – to comply with the procedures of the Medical Board. Nonetheless, healthcare consumers ought to be able to expect a consistent degree of accountability, transparency, etc., regardless of which Board they are dealing with.

2.20 In its submission, the Department of Health noted that the range of complaints recognises the different needs of differing groups, and the need to design systems with sufficient flexibility to operate effectively:

> …most of the professions registered in NSW rely on an Assessment Committee/Board structure for dealing with lower level complaints. This enables an external committee to investigate these matters, with recommendations provided to the Board. The Board will then deal with these matters sitting as a formal inquiry, normally at the times allocated for the monthly Board meetings. This system works with great efficiency in the smaller professional groups, as the numbers of registrants and the number of complaints are

[18] Thus, the Commission and the Board are required to notify each other when a complaint is made to, or by, either of them; and of any matter that comes to the notice of either of them which may involve the professional misconduct of a registered medical practitioner: s 46 of the *Medical Practice Act 1992*.

[19] See Appendix 1 for an overview of regulated health professions in New South Wales

relatively low, enabling direct Board involvement at the Board's regular meetings without adversely impacting on its day-to-day business.[20]

2.21 The Committee notes that the number of complaints made to the Commission annually about healthcare practitioners other than medical practitioners and nurses is relatively small (see Appendix 3). However, the Committee also notes the potential for the operation of small, separate Registration Boards to be inefficient, with costs ultimately being borne by consumers. Moreover, these arrangements may not facilitate the sharing of important expertise across the Boards, or the establishment of consistent processes for managing common statutory functions.

2.22 In its submission, the Commission noted that it would be useful if a number of definitions used in the Medical Practice Act were replicated in the other health registration Acts.[21] The Commission also suggested further that recent amendments to the Medical Practice Act regarding public hearings and other changes for Professional Standards Committees, and procedures for suspension of practitioners, should be extended to all health registration Acts.[22] With respect to fairness of proceedings, the Commission also noted that where a Board's handling of a complaint against a practitioner becomes protracted, the Board should be required to give reasonable progress reports to the complainant.[23]

2.23 One option to bring about the requisite transparency, consistency and fairness would be would be to enact an "umbrella Act", whereby the separate registration Acts would be repealed, and replaced with a single "Health Professionals Registration Act", while retaining the separately constituted Registration Boards. The Boards would have common core powers and functions, and would maintain their own offices and administrative arrangements.

ISSUE 7: That the various NSW Registration Acts be repealed, and replaced by a single Health Professionals Registration Act.

2.24 The Committee notes that another alternative would be the establishment of an entity equivalent to the Queensland Office of Health Practitioner Registration Boards (the Office), an independent statutory body established under the *Health Practitioner Registration Boards (Administration) Act 1999* (QLD). The Office provides administrative and operational support to assist the various Queensland Registration Boards[24] to exercise and discharge their powers, authorities, duties and functions by providing:

- client services associated with application for, and renewal of, registration with the Boards;

[20] Submission no. 26, Department of Health, p. 5.

[21] This would mean that the reference to fitness to practice would be considered in relation to protective orders rather than being a pre-requisite to proving the complaint: Submission no. 16, Health Care Complaints Commission, p. 9.

[22] Submission no. 16, Health Care Complaints Commission, p. 13.

[23] Submission no. 16, Health Care Complaints Commission, p. 13.

[24] These are the Chiropractors Board, Dental Board, Dental Technicians and Dental Prosthetists Boards, Medical Radiation Technologists Board, Occupational Therapists Board, Osteopaths Board, Pharmacists Board, Physiotherapists Board, Podiatrists Board, Psychologists Board, and the Speech Pathologists Board.

- administrative support for Board meetings and legal advice and support on matters related to a Board's functions under relevant legislation;
- management of all processes associated with complaints made, or information received, about the conduct or health of registrants; and
- corporate support.[25]

2.25 The Office also has a service level agreement for the provision of corporate services to the Office of the Medical Board. The Registration Boards pay for the services provided by the Office under the service level agreement, supplemented by a small income from research grant revenues and interest.[26]

2.26 Under its Professional Standards Program, the Office assesses complaints and undertakes investigations on behalf of a Board; and ensures that all investigative and disciplinary proceedings are conducted fairly and efficiently and that registrants remain compliant with conditions or undertakings. A complaint handling Memorandum of Understanding exists between the Office and a range of relevant State authorities, setting out procedures and working arrangements to assist with notifications between the parties of complaints and serious adverse health incidents, coordination of concurrent investigations, the sharing of information and the safety and wellbeing of consumers.[27]

ISSUE 8: That a NSW Office of Health Practitioner Registration Boards be established to provide administrative and operational support to assist the various NSW Registration Boards and to assess complaints and undertake investigations on their behalf.

2.27 At the core of these concerns is the potential for both practitioners and healthcare consumers to suffer from a lack of accountability, transparency and efficiency in respect of the smaller Registration Boards. The Committee considers that one means of overcoming this would be for effective oversight of those bodies by a Parliamentary Committee. This could be achieved either by the establishment of a new Committee, or by ensuring that each Annual Report of each Registration Board is examined by the Legislative Assembly's Public Bodies Review Committee.[28]

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25 Office of Health Practitioner Registration Boards, *Annual Report* 2007-08, p. 1.

26 Total income for 2007-8 was $7,802,412, whereas total operating expenses for salaries, rental and general expenditure were $8,241,988. In 2007-08, the Office processed 2,851 applications for registration approval, assessed 327 complaints about the professional conduct of registrants and conducted 190 investigations on behalf of the Boards: Office of Health Practitioner Registration Boards. 2008. *Annual Report 2007-08*, pp. 24 & 32.

27 These are the Health Quality and Complaints Commission; the Office of Health Practitioner Registration Boards; the Queensland Nursing Council; the Chief Health Officer; the State Coroner; the Crime and Misconduct Commission; Queensland Police Service; Queensland Ombudsman; and the Commission for Children and Young People and Children's Guardian: Office of Health Practitioner Registration Boards, *Annual Report 2007-08*, pp. 10-11, www.healthregboards.qld.gov.au/PlansAndPublications/OHPRB_AnnRpt08.pdf>.

28 The Public Bodies Review Committee is a current standing committee of the Legislative Assembly which examines the annual reports of all public bodies and enquires into and reports on the adequacy and accuracy of all financial and operational information, and on any matters arising from the annual report concerning the efficient and effective achievement of the agency's objectives.

ISSUE 9: That a Committee on Health Registration Authorities be established with a remit over all NSW Registration Boards similar to that of the Committee on the Health Care Complaints Commission.

ISSUE 10: That the Public Bodies Review Committee resolve to review each Annual Report of all NSW Registration Bodies and report back to the Legislative Assembly on these reviews.

Chapter Three - The assessment and investigative powers of the Health Care Complaints Commission

3.1 At the conclusion of its investigation into the complaints made against ex-practitioner Graeme Reeves, the Committee supported the recommendation of Ms Deirdre O'Connor that the following amendments be made to the *Health Care Complaints Act 1993*:

- amending s 21A to allow the Commission to exercise all of the powers under s 34A as part of its assessment phase; and
- extending s 34A to give the Commission power to compel documents and information from any person, rather than being limited to complainants and health service providers.

3.2 The Committee is pleased to note that these, along with other recommendations for change from the Commission itself, were included in the provisions of the *Health Legislation Amendment Act 2009*.[29]

3.3 In its submission, the Commission made a number of additional suggestions to enhance its current assessment investigative powers, and the functions and powers of the Director of Proceedings. The Committee notes that the Commission made two overarching recommendations, namely, that the Act ought to be amended so that the Commission will be able to:

- conduct inquiries and investigations of its own motion, without the need for a complaint (s 7 of the Act); and
- inquire into complaints about a health service provider which affect the clinical management or care of patients in general, rather than that "of an individual client" (ss 7(1)(b), 25(40)(b) & 25A(3)(b)).[30]

3.4 This was supported by the submission from the Public Interest Advocacy Centre (PIAC), which suggested that s 8 of the Act be amended to give the Commission discretion, in certain circumstances, to trigger the complaints process by its own motion. PIAC stressed that the obligation to comply with natural justice principles would remain - including the statutory notice provisions and timelines in the Act in dealing with complaints – and suggested that the Commission could initiate its own complaints in four particular situations:

- threats to public health and safety;
- adding new respondents or new issues;
- urgent matters for resolution; and
- broader investigations and inquiries.[31]

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29 For the Act's Second Reading Speech, see Sharpe MLC, Hon P G, Parliamentary Secretary. Legislative Council *Hansard*, 5 May 2009.

30 Submission no. 16, Health Care Complaints Commission, p. 2. See also Submission no. 3, Dr and Mrs Willets, which suggests the need to extend the remit of the Commission to investigate health administrators as well as practitioners; p. 1.

31 Submission no. 25, Public Interest Advocacy Centre, p. 4.

ISSUE 11: That the Health Care Complaints Act 1993 be amended so that the Health Care Complaints Commission can conduct investigations of its own motion, and so that investigations can be made more generally into the clinical management of care of patients in general.

Assessment

3.5 Pursuant to s 3A(2) of the Act, the Commission complaints handling responsibility is to have particular emphasis on the investigation and prosecution of "serious complaints". Section 20(1) provides that assessment of a complaint is for the purpose of deciding how the Commission should deal with it, e.g., investigation, conciliation or referral to another body.[32]

3.6 Greater Southern Area Health Service (GSAHS) notes that there does not appear to be any guidelines as to how the Commission decides upon a course of action under s 20(1). GSAHS also expressed concerns that the Commission's assessment process does not appear to take into account the severity of the matter, in that the Commission does not operate under the *Severity Assessment Code* (SAC 1-4) used by NSW Health agencies (See Appendix 4).[33] Whilst the Committee notes that the Commission has a statutory responsibility to investigate serious matters, transparency of the assessment process would undoubtedly increase public confidence in the Commission.

3.7 In its submission, the GSAHS suggested that there is a particular need for a set of guidelines as to what constitutes a matter which is appropriate for resolution, conciliation, or discontinuation.[34] However, the Committee notes that the types of complaints which the Commission will assess as suitable for conciliation are likely to meet at least one of the following criteria:

- there was a breakdown in communication between the parties;
- insufficient information was provided to the complainant;
- an inadequate explanation was given for a poor outcome or adverse event;
- the complainant is seeking an improvement in the quality of the particular health service; or

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[32] Section 20(2) provides that, unless the Commission declines to entertain a complaint, it is, as part of its assessment of the complaint and as soon as practicable after commencing its assessment:
(a) to identify the specific allegations comprising the complaint and the person or persons whose conduct appears to be the subject of the complaint, and
(b) to use its best endeavours to confirm with the complainant and with any other person who provided relevant information in relation to the complaint that the matters so identified accord with the information provided by them.

[33] The GSAHS also noted that there is an inconsistency in the time required for responding – whereas the Commission requires a response within 21 days, NSW Health policy provides for 35 days: Submission no. 6, Greater Southern Area Health Service, p. 2. See also Submission no. 14, Australian College of Midwives NSW Branch, p. 1.

[34] Submission no. 6, Greater Southern Area Health Services, p. 1. The submission from Positive Life NSW also suggested that there is a perception that the Commission has not used its conciliation functions as effectively as other bodies, such as the Anti-Discrimination Board or the Australian Human Rights Commission: p 1.

- the complainant is seeking a refund or financial compensation as an outcome.[35]

ISSUE 12: That the Health Care Complaints Commission make publicly-available guidelines, setting out the manner in which it determines how a complaint is to be dealt with under s 20(1) of the Health Care Complaints Act 1993.

3.8 In its submission, the Nurses Association suggested that s 20 should be amended to make clear that assessment is required to determine that the complaint is not "malicious or vexatious". [36]

ISSUE 13: That s 20(1) of the Health Care Complaints Act 1993 be amended to provide that assessment of a complaint includes determining whether that complaint is malicious or vexatious.

The investigation process

3.9 A number of submissions raised specific issues with respect to the manner in which the Commission currently conducts its investigations. Thus, the Royal Australasian College of Physicians gave the Committee some insight into the Commission's investigation process from the clinician's point of view. Specifically, the Australasian Faculty of Rehabilitation Medicine noted that when their members are asked to prepare reports, either as witness or clinician under investigation, they are not provided with information regarding the role and processes of the Commission, or the rights of those being investigated.[37]

ISSUE 14: That, when a report is requested from a health practitioner, an information package is provided which outlines the roles, powers and processes of the Health Care Complaints Commission, and contains clear plain English information regarding the possible use of any written report, and the rights of the author of the report.

3.10 The NSW Nurses Association raised an important issue about the fundamental impartiality of the Commission's investigation process. The submission points out that the Note to Division 5 of the Act (Investigation of complaints) provides as follows:

> The bulk of Commission investigations under this Division will deal with matters arising under health registration Acts relating to health practitioners. The Commission will

35 Health Care Complaints Commission. *About Us > Health Conciliation Registry*, <www.hccc.nsw.gov.au/html/hcr.htm>. The Commission also notes that a complaint will not be referred for conciliation if the complainant has clearly indicated that they do not wish to meet or interact with the provider again, and do not see conciliation as an appropriate way of resolving their complaint.

36 Submission no. 15, NSW Nurses' Association, p. 6

37 Submission no. 19, Royal Australasian College of Physicians, pp. 1 &2.

> investigate with a view to moving to prosecution of the complaint before the appropriate professional board, committee or tribunal…

3.11 The Association suggests that the second sentence of the Note raises two major concerns, namely that:

- the investigation commences from the point of assuming merit in the complaint and the guilt of the health practitioner; and
- it removes a fair and impartial system of investigation.[38]

3.12 The Association notes further:

> …the rule of law demands the principles of justice, fairness and due process. Innocent until proven guilty is fundamental to that demand. Accordingly, the purpose of the investigation should be akin to the purpose of an investigation for a coroner's inquiry - impartially collecting the evidence from all possible sources to be assessed by a separate body as to whether a complaint should be prosecuted.[39]

ISSUE 15: That the Note to Division 5 of the Health Care Complaints Act 1993 be amended by the deletion of the second sentence.

Timeliness

3.13 Whilst the Commission's 2007-2008 Annual Report evidences that there has been a significant improvement in the Commission's assessment and investigation of complaints, a considerable number of submissions expressed dissatisfaction with the timeliness of the Commission's processes. A significant number of submissions suggested generally that the current system is slow to act on complaints and respond to complainants.[40] Indeed, the joint submission from Positive Life NSW and HIV/AIDS Legal Centre suggested that a combination of the Commission's limited coercive powers and the lengthy assessment/investigation process:

> makes any complaint an unattractive option for all but the most stoic of complainants and most severe complaints.[41]

3.14 Pursuant to s 22 of the Act, the Commission must carry out its assessment of a complaint:

(a) within 60 days after receiving the complaint; or

(b) if, under s 21, the Commission has required the complainant to provide further particulars of the complaint, within 60 days after the date by which the Commission specified that those particulars were to be provided.[42]

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38 Submission no. 15, NSW Nurses Association, p. 7.

39 Submission no. 15, NSW Nurses Association, p. 7.

40 Submission no. 9, NSW Consumer Advisory Group - Mental Health Inc, p. 4; Submission no. 15, NSW Nurses' Association, p. 3; Submission no. 19, Royal Australasian College of Physicians, p. 2, Submission no. 27, Positive Life NSW, p. 4; Submission no. 25, Public Advocacy Centre, p. 11; Submission no. 8, Country Women's Association of NSW, p. 2; Submission no. 20, NSW Physiotherapists Registration Board, p. 1.

41 Submission no. 24, Positive Life NSW, p. 4.

42 However, s 92A of the *Health Care Complaints Act 1993* requires the Commission to assess, investigate and, where appropriate, prosecute as quickly as practicable a range of complaints which relate to the protection of public health, e.g., a complaint under s 54 of the *Chiropractors Act 2001*.

3.15 In its submission, the Department of Health noted concerns raised by South Eastern Sydney Illawarra Area Health Service (SESIAHS) with respect to the 28-day time frame under the Act for a health service provider to respond to serious complaints. The submission noted that, allowing for internal processes, complying with this time frame can be difficult in complex cases which may involve multiple services and providers. Accordingly, SESIAHS suggested that, in exceptional cases, the Commission may "review the progress of the assessment at 60 days and defer the decision if it is considered more expedient to do so".

ISSUE 16: That s 22 of the Health Care Complaints Commission Act be amended to provide that, in "exceptional cases", at the expiry of the 60 day period the Commission may review the progress of an assessment, defer the decision if it is considered appropriate in the circumstances, and advise the complainant of reasons for doing so.

3.16 The Committee notes that the Victorian *Health Professions Registration Act 2005* establish a legal requirement for investigations to be conducted as quickly as practicable.[43] The Committee also notes that the reasoning behind this amendment echoes the issues raised in submissions to this Inquiry:

> Some consumers lacked confidence in the transparency and fairness of complaints handling under the previous Acts, with commissioned research identifying problems such as long timeframes to settle complaints, perceived lack of procedural fairness and no formal appeal rights for complainants.[44]

ISSUE 17: That the Health Care Complaints Commission Act 1993 be amended to require that an investigation under Division 5 must be conducted as quickly as practicable having regard to the nature of the matter being investigated.

Procedural fairness

3.17 The Commission refers complaints about individual practitioners for formal investigation where, if substantiated, the complaint would provide grounds for disciplinary action, or involves gross negligence on the part of a practitioner. The purpose of an investigation is to obtain information so that the Commission can determine the most appropriate action (if any) to take, and its focus is on the protection of public health and safety.[45]

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43 Section 50 of the *Health Professions Registration Act 2005* (Vic).

44 See Victoria Department of Human Services. *Health Professions Registration Act 2005: Why were the reforms needed?* <www.health.vic.gov.au/__data/assets/pdf_file/0004/319504/info_sheet3_why_reform.pdf>

45 Health Care Complaints Commission. *Complaints > Complaints Process*, <www.hccc.nsw.gov.au/html/complaints_Process_detail.htm>

3.18 In its submission, PIAC argues that the Act should be amended to include legislative provisions that:

- mandate the provision of written reasons for assessment and post-investigation decisions; and
- provide for both internal and external review of assessment and post-investigation decisions.[46]

3.19 PIAC notes that not only can Commission decisions have serious consequences for practitioners, but that changes to torts law in New South Wales have resulted in a situation whereby:

> [a] complaint to the HCCC may be the only redress that a health consumer or a surviving relative has to resolve concerns and complaints about the treatment by or conduct of health providers and health professionals.[47]

ISSUE 18: That the Health Care Complaints Act 1993 be amended to provide for the mandatory provision of written reasons by the Commission for assessment and post-investigation decisions.

3.20 The PIAC submission notes that the Act currently provides for internal reviews under s 28 (review of assessment decision by complainant) and s 41 (review of decisions made under s 39 – post-investigation decisions by complainant), although neither section provides any guidance as to how a review is to be conducted and who is to conduct the review.[48] PIAC recommends a statutory internal review process for the Commission, based on complaint handling best practice, with the following provisions:

- complainants and respondents having a right to request a merits review after any critical decision in the complaints process;
- reviews conducted and decided by delegated officers in circumstances where there is clear separation from the Commissioner who effectively makes the initial assessment and investigation decisions under the Act;
- mandatory provision of written review decisions with reasons;
- procedural fairness principles that apply and both complainant and respondent should have an opportunity to respond and provide additional submissions and evidence if a HCCC decision is subject to review; and
- time limits should be placed on a party's opportunity to respond and the Commission's response after that.[49]

ISSUE 19: That the Health Care Complaints Act 1993 be amended to provide for a statutory internal review process for the Health Care Complaints Commission, based on complaint handling best practice.

46 Submission no. 25, Public Interest Advocacy Centre p. 7.
47 Submission no. 25, Public Interest Advocacy Centre p. 7.
48 Currently s 28 reviews are drafted by Resolution Officers and signed off by the Commissioner.
49 Submission no. 25, Public Interest Advocacy Centre, pp. 8-9.

3.21 The NSW Medical Board raised the issue of peer review as part of the investigation process, and in particular:

> the way in which the Commission feels bound to follow the opinions expressed by the expert or peer in an investigation notwithstanding the sometimes unanimous divergence from those views expressed by the medical members of the Board at the time of consultation.[50]

3.22 Whilst the Board acknowledges the difficulty of selecting peers to review a practitioner's work, it suggests that where its own Conduct Committee - which includes seven medical and two lay members - considers that the wrong expert/peer has been chosen, or that that person has applied the wrong standard, the Commission ought to be obliged "to at the very least seek a further view."[51]

ISSUE 20: That in the event of disagreement between the Commission and a Conduct Committee, or its equivalent, as to:

- the peer reviewer chosen by the Commission; or
- the standard applied by a peer reviewer in investigating a complaint,
- the Commission is to seek a further opinion prior to completing the investigation of the complaint.

3.23 The NSW Nurses Association also expressed serious concerns with the process of peer review. According to the Association, problems include the following:

- the peer reviewer is required to assume that the complaint is factually valid, thereby detracting from the objectivity of the ensuing report;
- the request occurs before the completion of the investigation;
- the broad definition of expert in s 30 of the Act results in the relevant expertise being questionable; and
- the same experts are used by the Commission regardless of the area of practice.[52]

ISSUE 21: That s 30(1) of the Health Care Complaints Act 1993 be amended to provide that "At the end of the Commission's investigation process, the Commission may obtain a report from a person (including a person registered under a health registration Act) who, in the opinion of the relevant registration authority, is sufficiently qualified or experienced to give expert advice on the matter the subject of the complaint."

50 Submission no. 21, NSW Medical Board, p. 3.
51 Submission no. 21, NSW Medical Board, p. 3.
52 Submission no. 15, NSW Nurses Association, pp. 11-12.

ISSUE 22: That a new section 30(1A) be inserted into the Health Care Complaints Act 1993 to provide that "At the time of seeking the opinion of the expert, the Commission shall provide the expert with all of the evidence relating to the complaint in respect of which the expert's opinion is sought."

3.24 With respect to the procedural fairness, the Nurses Association noted that s 16(6) and s 28(6) of the Act currently provide as follows:

> If the Commission decides that subsection (4) applies to a complaint but that some form of notice could be given of the complaint without affecting the health or safety of a client or putting any person at risk of intimidation or harassment, the Commission may give such a form of notice.

3.25 The Association submitted that the notification requirements should be mandatory.[53]

ISSUE 23: That s 16(6) and s 28(6) of the Health Care Complaints Act 1993 provide that if subsection (4) applies to a complaint, some form of notice must be given to the person or person subject of the complaints in a manner that will not affect the health or safety of a client or putting any person at risk of intimidation or harassment.

Outcomes

3.26 Section 39 of the Act provides that, at the end of the investigation of a complaint against a health practitioner - and after consulting with the appropriate registration authority - the Commission must do one or more of the following:

- refer the complaint to the Commission's Director of Proceedings;
- refer the complaint to the appropriate registration authority (if any) for consideration of the taking of action under the relevant health registration Act;
- make comments to the health practitioner on the matter the subject of the complaint;
- terminate the matter;
- refer the matter the subject of the complaint to the NSW Director of Public Prosecutions; or
- take action under s 41A, which is to make a prohibition order, or a public statement giving warnings or information about a health practitioner and health services provided by that practitioner.

3.27 The NSW Medical Board raised concerns that the principle of co-regulation underlying the Act is not applicable at the conclusion of an investigation. Although s 39(2) requires the Commission to consult with the appropriate registration authority before deciding what action to take, there is no requirement for it to give equal weight to that Body's opinion. The Board suggests that there should be either consensus, or

[53] Submission no. 15, NSW Nurses Association, p 4.

a replication of the requirement under s 13 of the Act that the more serious course of action should be followed.

ISSUE 24: That s 39 of the Health Care Complaints Commission Act 1993 be amended to provide that, at the conclusion of an investigation, in the event of disagreement between the Commission and the relevant Registration Authority, the most serious course of action proposed by a party should be followed.

3.28 The Health Services Association (HSA) noted that the Act currently does not require the Commission to review the investigation process following the conclusion of an investigation. The HSA considered that such a review would allow for an ongoing assessment of the Commission's investigation processes.

ISSUE 25: That a new s 29AB be inserted into the Health Care Complaints Act 1993 requiring the Health Care Complaints Commission, at the completion of an investigation to conduct a review of the process, to be made public to the extent that is appropriate.

3.29 GSAHS noted that all NSW Health Agencies are required to comply with the Department's *Open Disclosure Policy Directive* (PD2007_040). According to this Directive, open disclosure is the process of:

> …communicating with a patient and their support person about a patient related incident [which] provides an ethical framework for staff and Health Services to fulfill their duty of care to patients and their support person.[54]

3.30 However, GSAHS considers that the Commission does not comply with the Policy Directive. While the Committee notes that the Commission is not an agency of the Department of Health – and so not bound by the Policy Directive - it agrees with GSAHS that the provision by the Commission of a report at the end of the complaint process may not meet the needs of a complainant, especially in instances where there has been serious injury, or the loss of a loved one.

ISSUE 26: That, in dealing with complainants throughout, and at the conclusion of, the complaint process, the Commission adopt the principles outlined in NSW Health's Open Disclosure Policy Directive (PD2007_040).

[54] NSW Department of Health. 2007. *Policy Directive: Open Disclosure*, <www.health.nsw.gov.au/policies/pd/2007/pdf/PD2007_040.pdf>

Chapter Four - Information-sharing between the Commission and Area Health Services and Registration Authorities

4.1 In the course of its Inquiry into the conduct of the Commission's investigations into the complaints against Graeme Reeves, the Committee noted that a basic factor contributing to Mr Reeves' ability to practice illicitly was the limited communications between the Commission, the relevant Area Health Services, and the Medical Board. Accordingly, the Committee resolved to examine the extent and efficacy of these lines of communication.

4.2 At the outset, the Committee notes that Northern Sydney Central Cost Area Health Service suggests that information sharing "has improved significantly, with systems in place so that questions raised by the HCCC can be answered quickly".[55] However, the submission from GSAHS noted that the Commission does not have a mechanism in place to keep an AHS informed about the progress of an investigation. Whilst GSAHS noted that the Commission might be bound by privacy obligations, it suggested that a monthly update of an investigation's progress would be useful, particularly where the matter has been referred by the AHS itself.

ISSUE 27: That, where an Area Health Service has referred a complaint to the Health Care Complaints Commission, the Commission keep the Area Health Service informed of the progress of that complaint on a monthly basis.

4.3 Under s 16 of the Act, when a complaint is made, the Commission is required to notify the person against whom the complaint is made. However, the submission from the Department of Health noted that occasionally the Commission receives complaints which relate to practitioners who are currently working at a particular AHS, but which do not raise issues which relate to that AHS. Accordingly, under the current provisions of the Act, the AHS is not notified until the complaint has been assessed. The submission noted that:

> [w]hile this may occur for only a limited period of time, it may still pose a risk to the Health Service or patients being treated there. In addition, the AHS may also hold relevant information and or be investigating a concurrent complaint against the clinician which may be relevant when taken together with the HCCC complaint.[56]

4.4 The submissions from GSAHS and Hunter New England AHS (HNEAHS) also raised the issue of notification being given to an AHS.[57]

ISSUE 28: That the Health Care Complaints Act 1993 be amended to provide that where a person is named as an individual respondent to a complaint, and

[55] Submission no. 17, Northern Sydney Central Cost Area Health Service, p. 1.
[56] Submission no. 26, NSW Department of Health, p. 7.
[57] Submission no. 6, Greater Southern Area Health Service, p. 2; and Submission no. 18, Hunter New England Area Health Service, p. 2 .

that person is employed by, or contracted to work for, an Area Health Service, that Area Health Service be notified by the Commission that the complaint has been made.

4.5 HNEAHS also raised the point that, when an AHS is asked for a response to a specific complaint, the AHS may be in possession of additional information which it considers may be relevant.[58] However, there is currently uncertainty as to whether an AHS ought to provide any such additional information.

ISSUE 29: That, on requesting a response from an Area Health Service to an individual complaint against a practitioner employed by, or contracted to work for, that Area Health Service, the Health Care Complaints Commission specifically request from the Area Health Service information on any other complaints or practice-based concerns in respect of that practitioner.

4.6 The Committee notes that there may be privacy concerns relating to both the practitioner and his or her clients which would need to be further considered in the Commission adopting such a practice.

[58] Submission no. 18, Hunter New England Area Health Service, p. 1.

Appendix 1 – Submissions

No	Organisation
1	Dr Brendan Thomas O'Sullivan
2	Clinical Excellence Commission
3	Dr Neil and Mrs Ruth Willetts
4	[Confidential Submission]
5	Chinese Medicine Registration Board of Victoria
6	Greater Southern Area Health Service
7	Health Services Association of NSW
8	Country Women's Association of NSW
9	NSW Consumer Advisory Group - Mental Health Inc
10	Office of the Aged Care Commissioner
11	Department of Ageing, Disability & Home Care
12	Carers NSW
13	Council on the Ageing (NSW)
14	Australian College of Midwives NSW Branch
15	NSW Nurses' Association
16	Health Care Complaints Commission
17	Northern Sydney Central Coast Area Health Service
18	Hunter New England Area Health Service
19	Royal Australasian College of Physicians
20	NSW Physiotherapists Registration Board
21	NSW Medical Board
22	Pharmacy Guild of Australia, NSW Branch
23	NSW Institute of Medical Education and Training
24	Australian Dental Association (NSW Branch) Ltd
25	Public Interest Advocacy Centre
26	NSW Department of Health
27	Positive Life NSW

Appendix 2 – Overview of regulated health professions in New South Wales

Act	**Board**	**Size of Board**	**Operating Budget** (1/07/08 to 30/06/09)	**No. of registrants**
Chiropractors Act 2001	NSW Chiropractors Registration Board	7 members	Income $435,802 Expenditure $149, 443	At 30 June 2008: Chiropractors - 1,414 [59]
Dental Practice Act 2001	Dental Board	12 members	1/10/07 to 30/09/08 Income $1,161,855 Expenditure $1,471,464	At 30 September 2008: Dentists - 4,550 Dental Hygienists - 258 Dental Therapists - 314 Oral Health Therapists - 25 Students - 658 [60]
Dental Technicians Registration Act 1975	NSW Dental Technicians Registration Board	9 members	Income $189,894 Expenditure $215,812	At 30 June 2008 Dental Technicians - 817 Dental Prosthetists – 452 [61]
Medical Practice Act 1992	NSW Medical Board	20 part-time members	(1/07/07 to 30/06/08) Income $9,264,000 Expenditure $9,091,000	At 30 June 2008 Doctors - 30,036 Medical students – 3,195 [62]
Nurses and Midwives Act 1991	NSW Nurses and Midwives Board	16 members	Income $7,386,551 Expenditure $8,259,387	At 30 June 2007 Registered nurses - 83,425 Registered midwives - 18,058 Nurse practitioners - 99 Midwife practitioners - 2 Enrolled nurses - 17,084 [63]
Optical Dispensers Act 1963	NSW Optical Dispensers Licensing Board	7 members	Income $156,107 Expenditure $137,449	At 30 June 2008 Optical dispensers - 1,509 [64]
Optometrists Act 2002	NSW Optometrists Registration Board	9 members	Income $248,713 Expenditure $342,855	At 30 June 2008 Optometrists - 1,715 [65]
Osteopaths Act 2001	NSW Osteopaths Registration Board	7 members	Income $199,136 Expenditure $152,667	At 30 June 2008 Osteopaths – 562 [66]

[59] NSW Chiropractors Registration Board. *Annual Report for the year ended 30 June 2008,* pp. 2, 4 & 19.
[60] Dental Board of NSW. *Dental Board Annual Report for the year ended 30 September 2008*, pp. 2, 5-6, 7 & 13.
[61] NSW Dental Technicians Registration Board. *Annual Report for the year ended 30 June 2008,* pp. 2, 6 & 14.
[62] NSW Medical Board. 2008. *NSW Medical Board 2008 Annual Report,* pp. 4, 5, & 26; NSW Medical Board website, Registration categories and fees, p . 1.
[63] NSW Nurses and Midwives Board, *Nurses and Midwives Board Annual Report 2008*, pp. 6-7, 27, 52; NSW Nurses and Midwives Board website, *Fees,* p. 1.
[64] NSW Optical Dispensers Licensing Board, *Annual Report for the year ended 30 June 2008,* pp. 2, 4 & 16.
[65] NSW Optometrists Registration Board, *Annual Report for the year ended 30 June 2008,* pp. 2, 3, 7 & 18.
[66] NSW Osteopaths Registration Board, *Annual Report for the year ended 30 June 2008,* pp. 2, 6 & 22.

Act	**Board**	**Size of Board**	**Operating Budget** (1/07/08 to 30/06/09)	**No. of registrants**
Pharmacy Practice Act 2006	Pharmacy Board	10 members	(1/10/08 to 30/09/09) Income $1,884,000 Expenditure $1,960,200	At 30 September 2008 Pharmacists - 8,192 Pharmacies - 1,782 [67]
Physiotherapists Act 2001	NSW Physiotherapists Registration Board	11 members	Income $730,951 Expenditure $674,764	At 30 June 2008, Physiotherapists - 6,799 [68]
Podiatrists Act 2003	NSW Podiatrists Registration Board	7 members	Income $161,965 Expenditure $191,988	At 30 June 2008 Podiatrists - 954 [69]
Psychologists Act 2001	NSW Psychologists Registration Board	9 members	Income $887,941 Expenditure $1,542,282	At 30 June 2008 Psychologists - 9,863 [70]

The Health Administration Corporation provides administrative support to the Health Professionals Registration Boards (HPRB) created by the following legislation:

Chiropractors Act 2001;
Dental Technicians Registration Act 1975;
Nurses and Midwives Act 1991;
Optical Dispensers Act 1963;
Optometrists Act 2002;
Osteopaths Act 2001;
Physiotherapists Act 2001;
Podiatrists Act 2003;
Psychologists Act 2001.

The total administrative expenditure for all the above Boards in 2007/2008 was $10,089,043.
In the previous reporting year of 2006/2007 the total cost was $ 8,263,911.

67 Pharmacy Board of New South Wales, *Annual Report for the twelve months ended 30 September 2008*, pp. 4, 11 & 25; Pharmacy Board of New South Wales website, *Application for registration as a pharmacist under mutual recognition*, p. 1.
68 NSW Physiotherapists Registration Board, *Annual Report for the year ended 30 June 2008,* pp. 2, 5 & 18; NSW Physiotherapists Registration Board website, *Annual Authority to Practise,* p. 1.
69 NSW Podiatrists Registration Board, *Annual Report for the year ended 30 June 2008,* pp. 2, 4, 5 & 17.
70 NSW Psychologists Registration Board, *Annual Report for the year ended 30 June 2008*, pp. 2, 5 & 26.

Appendix 3 – Complaints received about registered and unregistered health care practitioners 2005-06 to 2007-08

	2005-06		2006-07		2007-08	
Health practitioner	**No.**	**%**	**No.**	**%**	**No.**	**%**
Registered health practitioner						
Medical practitioner	1,227	68.60%	1,104	66.60%	1,145	64.70%
Nurse	154	8.60%	177	10.70%	224	12.60%
Dentist	165	9.20%	173	10.40%	177	10.00%
Psychologist	70	3.90%	81	4.90%	77	4.30%
Dental technician and prosthetist	24	1.30%	8	0.50%	21	1.20%
Chiropractor	17	1.00%	18	1.10%	15	0.80%
Physiotherapist	19	1.10%	15	0.90%	15	0.80%
Pharmacist	17	1.00%	21	1.30%	9	0.50%
Podiatrist	10	0.60%	13	0.80%	8	0.50%
Optometrist	6	0.30%	10	0.60%	5	0.30%
Osteopath	1	0.00%	4	0.20%	2	0.10%
Optometrical dispenser	–	0.00%	1	0.00%	–	0.00%
Total registered health practitioner	**1,710**	**95.60%**	**1,625**	**98.00%**	**1,698**	**95.90%**
Unregistered health practitioner						
Previously registered health practitioner	1	0.10%	3	0.20%	44	2.50%
Alternative health provider	17	0.90%	5	0.30%	10	0.60%
Psychotherapist	2	0.10%	1	0.10%	3	0.20%
Radiographer	–	0.00%	1	0.10%	3	0.20%
Acupuncturist	1	0.10%	–	0.00%	2	0.10%
Naturopath	2	0.10%	1	0.10%	2	0.10%
Residential care worker	–	0.00%	–	0.00%	2	0.10%
Counsellor/therapist	7	0.40%	2	0.10%	1	0.10%
Dietitian/nutritionist	–	0.00%	1	0.10%	1	0.10%
Health education officer	–	0.00%	–	0.00%	1	0.10%
Home/respite care worker	–	0.00%	–	0.00%	1	0.10%
Other	30	1.70%	7	0.40%	1	0.10%
Social worker	1	0.10%	–	0.00%	1	0.10%
Welfare officer	–	0.00%	–	0.00%	1	0.10%
Administration/clerical staff	2	0.10%	2	0.10%	–	0.00%
Ambulance personnel	–	0.00%	2	0.10%	–	0.00%
Assistant in nursing	2	0.10%	2	0.10%	–	0.00%
Natural therapist	4	0.20%	2	0.10%	–	0.00%
Occupational therapist	1	0.10%	1	0.10%	–	0.00%
Traditional Chinese medicine practitioner	8	0.40%	2	0.10%	–	0.00%
Total unregistered health practitioner	**78**	**4.40%**	**32**	**2.00%**	**73**	**4.10%**
Grand total	**1,788**	**100.00%**	**1,657**	**100.00%**	**1,771**	**100.00%**

Appendix 4 – Severity Assessment Code

See table on following page

Severity Assessment Code (SAC) November 2005

This matrix should be used in conjunction with the NSW Health Incident Management Policy Directive

STEP 1 Consequences Table (For notification, consider the actual consequence or outcome using this table as a guide. The examples listed here are not exhaustive.)

		Serious	Major	Moderate	Minor	Minimum
CLINICAL CONSEQUENCE	Patient	Patients with **Death** unrelated to the natural course of the illness and differing from the immediate expected outcome of the patient management or: ■ **Suspected suicide**[1] ■ **Suspected homicide**[2] or any of the following: **The National Sentinel Events** ■ Procedures involving the wrong patient or body part ■ Suspected suicide in hospital ■ Retained instruments ■ Unintended material requiring surgical removal ■ Medication error involving the death of a patient ■ Intravascular gas embolism ■ Haemolytic blood transfusion ■ Maternal death associated with labour and delivery ■ Infant discharged to the wrong family	Patients suffering a **Major permanent loss of function (sensory, motor, physiologic or psychologic)** unrelated to the natural course of the illness and differing from the expected outcome of patient management or any of the following: ■ Suffering significant disfigurement as a result of the incident ■ Patient at significant risk due to being absent against medical advice ■ Threatened or actual physical or verbal assault of patient requiring external or police intervention	Patients with **Permanent reduction in bodily functioning (sensory, motor, physiologic, or psychologic)** unrelated to the natural course of the illness and differing from the expected outcome of patient management or any of the following: ■ Increased length of stay as a result of the incident ■ Surgical intervention required as a result of the incident	Patients requiring **Increased level of care including:** ■ **Review and evaluation** ■ **Additional investigations** ■ **Referral to another clinician**	Patients with **No injury or increased level of care or length of stay**
CORPORATE CONSEQUENCE	Staff	Death of staff member related to work incident or suicide, or hospitalisation of **3** or more staff	Permanent injury to staff member, hospitalisation of **2** staff, or lost time or restricted duty or illness for **2** or more staff or pending or actual WorkCover prosecution, or threatened or actual physical or verbal assault of staff requiring external or police intervention	Medical expenses, lost time or restricted duties or injury / illness for **1** or more staff	First aid treatment only with no lost time or restricted duties	No injury or review required
	Visitors	Death of visitor or hospitalisation of **3** or more visitors	Hospitalisation of up to **2** visitors related to the incident / injury or pending or actual WorkCover prosecution	Medical expenses incurred or treatment of up to **2** visitors not requiring hospitalisation	Evaluation and treatment with no expenses	No treatment required or refused treatment
	Services	Complete loss of service or output	Major loss of agency / service to users	Disruption to users due to agency problems	Reduced efficiency or disruption to agency working	Services: No loss of service
	Financial	**Loss of assets** replacement value due to damage, fire etc > $1M, **loss of cash/investments/assets** due to fraud, overpayment or theft >$100K or **WorkCover claims** > $100K	**Loss of assets** replacement value due to damage, fire etc $100K-$1M, **loss of cash/investments/assets** due to fraud, overpayment or theft $10K-$100K or **WorkCover claims** $50K-$100K	**Loss of assets** replacement value due to damage, fire etc $50K to $100K **or loss of cash/investments/assets** due to fraud, overpayment or theft to $10K	**Loss of assets** replacement value due to damage, fire etc to $50K	No financial loss
	Environmental	Toxic release off-site with detrimental effect. Fire requiring evacuation	Off-site release with no detrimental effects or fire that grows larger than an incipient stage	Off-site release contained with outside assistance or fire incipient stage or less	Off-site release contained without outside assistance	Nuisance releases

[1] **Suspected suicide** of a person (including a patient or community patient) who has received care or treatment for a mental illness from an Area Health Service or other PHO where the death occurs within 7 days of the person's last contact with the organisation or where there are reasonable clinical grounds to suspect a connection between the death and the care or treatment provided by the organisation;

[2] **Suspected homicide** committed by a person who has received care or treatment for mental illness from an Area Health Service or other PHO within 6 months of the person's last contact with the organisation or where there are reasonable clinical grounds to suspect a connection between the death and the care or treatment provided by the organisation.

STEP 2 Likelihood Table

Probability Categories	Definition
Frequent	Is expected to occur again either immediately or within a short period of time (likely to occur most weeks or months)
Likely	Will probably occur in most circumstances (several times a year)
Possible	Possibly will recur – might occur at some time (may happen every 1 to 2 years)
Unlikely	Possibly will recur – could occur at some time in 2 to 5 years
Rare	Unlikely to recur – may occur only in exceptional circumstances (may happen every 5 to 30 years)

STEP 4 Action Required Table

	Action Required
1	**Extreme** risk – immediate action required – Reportable Incident Brief (RIB) for all SAC 1 incidents must be forwarded to the DoH within 24 hours. A Privileged Root Cause Analysis (RCA) investigation must be undertaken for all Clinical SAC 1 incidents with a report being submitted to the DoH.
2	**High** risk – need to notify senior management. Detailed investigation required. Ongoing monitoring of trended aggregated incident data may also identify and prioritise issues requiring a practice improvement project.
3	**Medium** risk – management responsibility must be specified – Aggregate data then undertake a practice improvement project. **Exception** – all financial losses must be reported to senior management.
4	**Low** risk – manage by routine procedures – Aggregate data then undertake a practice improvement project.

NB – An incident that rates a SAC 2, 3 or 4 should only be reported to the DoH if there is the potential for media interest or requires direct notification under existing DoH legislative reporting requirements or NSW DoH Policy Directive.

STEP 3 SAC Matrix

LIKELIHOOD \ CONSEQUENCE	Serious	Major	Moderate	Minor	Minimum
Frequent	1	1	2	3	3
Likely	1	1	2	3	4
Possible	1	2	2	3	4
Unlikely	1	2	3	4	4
Rare	2	3	3	4	4

Every incident assessed against the Severity Assessment Code Matrix should be scored separately for both their actual and potential consequence or outcome

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NSW HEALTH

Appendix 5 – Australian Charter of Healthcare Rights

See table on following page

AUSTRALIAN CHARTER OF HEALTHCARE RIGHTS

The Australian Charter of Healthcare Rights describes the rights of patients and other people using the Australian health system. These rights are essential to make sure that, wherever and whenever care is provided, it is of high quality and is safe.

The Charter recognises that people receiving care and people providing care all have important parts to play in achieving healthcare rights. The Charter allows patients, consumers, families, carers and services providing health care to share an understanding of the rights of people receiving health care. This helps everyone to work together towards a safe and high quality health system. A genuine partnership between patients, consumers and providers is important so that everyone achieves the best possible outcomes.

Guiding Principles

These three principles describe how this Charter applies in the Australian health system.

1 Everyone has the right to be able to access health care and this right is essential for the Charter to be meaningful.

2 The Australian Government commits to international agreements about human rights which recognise everyone's right to have the highest possible standard of physical and mental health.

3 Australia is a society made up of people with different cultures and ways of life, and the Charter acknowledges and respects these differences.

For further information please visit
www.safetyandquality.gov.au

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTHCARE

What can I expect from the Australian health system?

MY RIGHTS	WHAT THIS MEANS
Access	
I have a right to health care.	I can access services to address my healthcare needs.
Safety	
I have a right to receive safe and high quality care.	I receive safe and high quality health services, provided with professional care, skill and competence.
Respect	
I have a right to be shown respect, dignity and consideration.	The care provided shows respect to me and my culture, beliefs, values and personal characteristics.
Communication	
I have a right to be informed about services, treatment, options and costs in a clear and open way.	I receive open, timely and appropriate communication about my health care in a way I can understand.
Participation	
I have a right to be included in decisions and choices about my care.	I may join in making decisions and choices about my care and about health service planning.
Privacy	
I have a right to privacy and confidentiality of my personal information.	My personal privacy is maintained and proper handling of my personal health and other information is assured.
Comment	
I have a right to comment on my care and to have my concerns addressed.	I can comment on or complain about my care and have my concerns dealt with properly and promptly.