HEALTH AND COMMUNITY SERVICES COMPLAINTS COMMISSION

Ninth Annual Report 2006-2007

The Honourable Christopher Burns, MLA
Minister for Health
Parliament House
DARWIN NT 0801

Dear Minister

As stipulated by Section 19(1) of the *Health and Community Services Complaints Act 1998*, the Ninth Annual Report of the Health and Community Services Complaints Commission, for the year ending 30 June 2007 is submitted to you for tabling in the Legislative Assembly.

Yours sincerely

Carolyn Richards
Commissioner

October 2007

Inquiries about this report, or any of the information or references contained within, should be directed to:

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Commissioner
Health and Community Services Complaints Commission
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STATEMENT OF ACCOUNTABLE OFFICER

As an Accountable Officer I advise that, to the best of my knowledge and belief:

(a) proper records of all transactions affecting the Commission were kept and that employees under my control observed the provisions of the *Financial Management Act*, the *Financial Management Regulations* and *Treasurer's Directions*;

(b) procedures within the Commission afforded proper internal control, and a current description of these procedures can be found in the *Accounting and Property Manual* which has been prepared in accordance with the *Financial Management Act*;

(c) no indication of fraud, malpractice, major breach of legislation or delegations, major error in or omission from the accounts and records existed;

(d) in accordance with Section 15 of the *Financial Management Act* the internal audit capacity available to the Commission is adequate and the results of internal audits were reported to me;

(e) the financial statements included in this Annual Report have been prepared from proper accounts and records and are in accordance with Part 2, Section 5 of the *Treasurer's Directions* where appropriate;

(f) all actions have been in compliance with all Employment Instructions issued by the Commissioner for Public Employment; and

(g) The Commission has complied with Section 131 of the *Information Act*.

In addition, I advise that in relation to items (a) and (e) the Chief Executive Officer (CEO) of DCIS has advised that to the best of his knowledge and belief, proper records are kept of transactions undertaken by DCIS on my behalf, and the employees under his control observe the provisions of the *Financial Management Act*, the *Financial Management Regulations* and *Treasurer's Directions*.

The CEO also advises all financial reports prepared by DCIS for this Annual Report, have been prepared from proper accounts and records and are in accordance with *Treasurer's Directi*ons Part 2 Section 5 and Part 2 Section 6, where appropriate.

Carolyn Richards
Commissioner

October 2007

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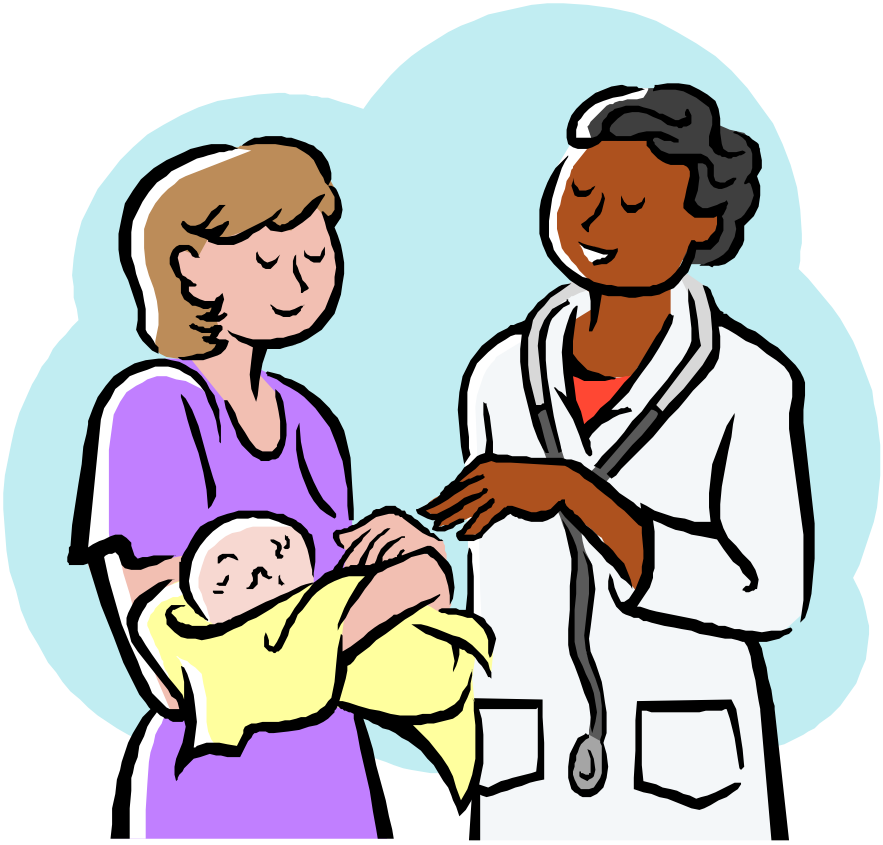


CHAPTER 1

FORWARD AND OVERVIEW

COMMISSIONER'S FOREWORD

For the second year running there has been a reduction in the number of approaches to the Commission. This reduction was associated with the number of enquiries as the number of formal complaints actioned by the Commission only reduced by 3, from 97 to 94. Despite the workload associated with the resolution of formal complaints remaining similar to the previous year, significant productivity gains were made this year. These gains included:

- Average time to finalise all approaches (enquiries and complaints) – reduced by 50%.

- Average time to finalise complaints only – reduced by 35%.

- Number of cases carried forward into the next year – reduced by 40%.

I can only speculate as to why it is that people are not approaching the Commission in the numbers they did in the first six years. Possibilities include:

- **Use of the Commission's website:** The average number of weekly visits has increased by 60% and, as a result, people are obtaining the necessary information on line to assist them to deal with their complaint direct with the provider without any further reference to the Commission.

- **Improved complaint handling by service providers:** Service providers such as the Department of Health and Community Services and the Royal Darwin Hospital have placed considerable importance over the past few years in having transparent and effective internal complaint handling process in place. The better these processes are the less likely people are to approach the Commission to resolve their complaints.

- **Minimal community engagement activities:** For the past three years the Commission has been restricted in the number of activities it has been able to undertake to promote the role and functions of the Commission throughout the Territory. Restrictions to these activities (access and awareness visits, promotional pamphlets and videos, group presentations and media advertising) may have an unfavourable impact on people's awareness of the Commission and there likelihood of accessing its services.

PERFORMANCE OVERVIEW

The key performance indicators for the 2006/07 period were:

- The number of approaches to the Commission decreased by 20% when compared to 2005/06.

- The average time taken to close all approaches (whether enquiries or complaints) reduced by 20% when compared to last financial year.

- The number of outstanding matters carried forward to the next financial year reduced from 30 in 2005/06 to 18 this financial year – a reduction of 40%.

- There continued to be a significant reduction in access and awareness activities. Presentations made by the Commission have reduced by 60% and the use of media by 50% over the past three years.

- Training and staff development opportunities increased significantly from 8 training hours and 2 training opportunities in 2005/06 to 111 training hours and comprised 7 training opportunities in 2006/07.

- 80% of complainants and 100% of providers were satisfied with the manner in which the Commission handled complaints.

This snapshot of the Commission's activities over the 2006/07 financial year demonstrates that it has continued to improve its performance while maintaining a high standard of service delivery. Improvements continue to be made in reducing the average time taken to finalise matters (from 88 days in 2005/06 to 44 days in 2006/07) and the number of outstanding matters carried forward (88 in 2004/05 to 19 in 2006/07).

NEED FOR PROTECTION FROM 'CHARLATANS'

Currently, the public clearly has no protection against unscrupulous unregistered providers. New South Wales recently introduced legislation (*Health Legislation Amendment (Unregistered Health Practitioners) Act)* and some of its key features were:

- A code of conduct for unregistered providers to be made by the Minister for Health.

- The Health Care Complaints Commission (similar to the NT Commission) can investigate a complaint that an unregistered health service provider has breached the code of conduct.

- Where, following an investigation by the Commission, it is found that the unregistered health service provider breached the code the Commission may:

- Issue an order prohibiting the person from providing health services for a period of time; and
- Provide a warning to the public about the person and his or her services.

- It is an offence for an unregistered health service provider to continue to provide a health service in breach of a prohibition order.

During this reporting year two instances came to the Commission's notice. One was the subject of a report relating to the "Addiction Doctor". This provider advertised that he could "cure cancer" and other conditions including various addictions. There were a series of complaints received about his activities which, when investigated, disclosed that the "Addiction Doctor" was not qualified in any area of medicine or science, had no qualifications of any sort and offered cures that could not be achieved but were designed to attract the desperate and the vulnerable.

A summary of the investigation appears at page 47 of this report and the full report was tabled in the Legislative Assembly on 3 May 2007.

The *Health and Community Services Complaints Act* prohibits the information and evidence obtained during the investigation from being used in any civil or criminal proceedings and that is, in my opinion, detrimental to the public interest.

The second instance was a report from a man whose elderly father had terminal cancer. The cancer sufferer was referred by a para medical provider interstate to a service in the Territory. The service was offered by persons not registered as any health professional by the Health Professions Licensing Authority. The treatment offered was scientific nonsense and consisted of shining bright lights into the patient's body. The cancer sufferer's son would not agree to any contact being made with his father and, after the initial contact, wanted no further action taken. His reason was that the prospect of relief from the "cure" gave his father hope and he did not want to deprive him of that in his last days. The cost of the treatment was $10,000 in addition to the expense of travelling to Darwin. The Commission could not undertake any investigation as the *Health and Community Services Complaints Act* (the Act) does not enable an investigation on the Commissioner's own motion.

The Act was reviewed by an independent review panel which reported to the Minister for Health in 2004. One of the recommendations was that the Commission be able to investigate matters of public health and safety that are significant without the need for some person to pursue a complaint.

These two cases in the last twelve months may be a precursor of the situation in other States where a number of unscrupulous unregistered persons offer cures to those who are desperate to believe in and pay for anything that offers some hope. It is because of the prevalence of such "cures" that New South Wales has enacted the new legislation outlined above. I urge the Territory Government to take the opportunity of the review of the Act to give Territorians similar protections.

Finally I pay tribute to the wonderful staff who work for the Commission. Their skills, experience and professionalism are responsible for the high satisfaction rate both complainants and providers have with the standard of service provided by the Commission. Their ability to work with complainants and providers to resolve their concerns as informally and quickly as possible has resulted in nearly 90% of complaints being finalised in this way. Not only have they maintained excellent relationships with complainants and providers, they have significantly improved the efficiency of the Commission through the productivity gains they have made.

CAROLYN RICHARDS
COMMISSIONER FOR HEALTH AND COMMUNITY SERVICES COMPLAINTS

CHAPTER 2

ABOUT THE COMMISSION

The Commission operates under the *Health and Community Services Complaints Act 1998*.

POWERS AND FUNCTIONS OF THE COMMISSIONER

The functions of the Commissioner are:

(a) to inquire into and report on any matter relating to health services or community services on receiving a complaint or on a reference from the Minister or the Legislative Assembly;

(b) to encourage and assist users and providers to resolve complaints directly with each other;

(c) to conciliate and investigate complaints;

(d) to record all complaints received by the Commissioner or shown on returns supplied by providers and to maintain a central register of those complaints;

(e) to suggest ways of improving health services and community services and promoting community and health rights and responsibilities;

(f) to review and identify the causes of complaints and to —
- (i) suggest ways to remove, resolve and minimise those causes;
- (ii) suggest ways of improving policies and procedures; and
- (iii) detect and review trends in the delivery of health services and community services;

(g) to consider, promote and recommend ways to improve the health and community services complaints system;

(h) to assist providers to develop procedures to effectively resolve complaints;

(i) to provide information, education and advice in relation to —
- (i) this Act;
- (ii) the Code; and
- (iii) the procedures for resolving complaints;

(j) to provide information, advice and reports to —
- (i) the Boards;

(ii) the purchasers of community services or health services;
(iii) the Minister; and
(iv) the Legislative Assembly;

(k) to collect, and publish at regular intervals, information concerning the operation of this Act;

(l) to consult with —
(i) providers;
(ii) organisations that have an interest in the provision of health services and community services; and
(iii) organisations that represent the interests of users;

(m) to consider action taken by providers where complaints are found to be justified;

(n) to ensure, as far as practicable, that persons who wish to make a complaint are able to do so; and

(o) to consult and co-operate with any public authority that has a function to protect the rights of individuals in the Territory consistent with the Commissioner's functions under this Act.

SERVICE STANDARDS

The Commission requires its services be of the highest quality, open to scrutiny and accountable. To achieve this, the Commission has established service standards against which it can be judged. These can be found at Appendix 1.

STAFFING

Table 1: Commission's establishment – By gender and position level

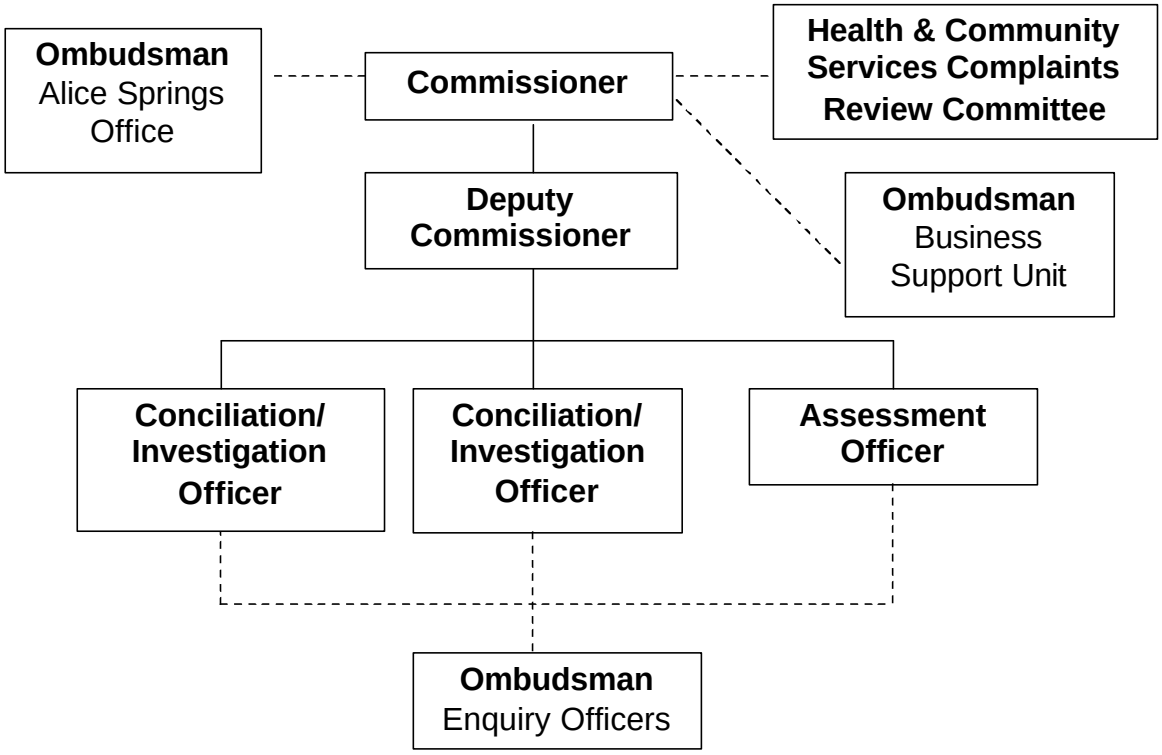
Position Level	Male	Female	Total
Commissioner (ECO5)	0	1	1
Deputy Commissioner (ECO2)	1	0	1
Administrative Officer 7	0	3[1]	3[2]
Administrative Officer 6		1	1
Total	**1**	**5**	**6**[3]

The Commissioner and Deputy Commissioner for Health and Community Services Complaints are also the Ombudsman and Deputy Ombudsman for the Northern

[1] One position is staffed by two people on a part-time basis.
[2] 2 x full time equivalent positions
[3] 5 x full time equivalent positions

Territory and approximately 25% - 33% of their time is associated with Commission activities.

ORGANISATIONAL STRUCTURE



Administrative support (through the Business Support Unit) and the handling of some enquiries (through the Enquiry Officers) is undertaken on behalf of the Commission by the Office of the Ombudsman, with which it is co-located.

The Commission also utilises the experience and expertise of two Ombudsman's representatives in Alice Springs to provide initial support and contact for those in the southern region wishing to make a complaint or enquire about health services or community services.

FINANCES

Detailed financial statements for the Commission are not provided with this Annual Report as they form part of the overall financial statements of the Office of the Ombudsman and are included in its Annual Report. The Commission's actual expenditure for 2006/07 (when compared to the previous two years) was:

	2004/05	2005/06	2006/07
• Personnel Costs	$390,108	$416,592	$427,679
• Operational Costs	$163,543	$104,564	$ 94,090
Total	**$553,651**	**$521,156**	**$521,769**

I must continue to highlight the impact the annual reduction associated with the "efficiency dividend" is having on the amount of funding available to the Commission for operational purposes. The only option available to absorb these reductions is to reduce the amount of funds available for operational expenses. This option is further restricted in that only 'discretionary items' are able to be reduced.

It can be seen from the above figures that operational expenditure over the past three years has reduced by over 40% ($163,543 to $94,090). This reduction has mainly occurred in the discretionary items of communication, training and study and consultancy fees. This is impacting on the Commission's ability to carry out its community engagement activities in a satisfactory manner.

HEALTH AND COMMUNITY SERVICES COMPLAINTS REVIEW COMMITTEE

A Health and Community Services Complaints Review Committee (the Committee) is established under the Act to:

- review the conduct of a complaint to determine whether the procedures and processes for responding to the complaint were followed and, as it thinks fit, to make recommendations to me in respect of the conduct of the complaint;
- monitor the operation of the Act and make recommendations to the Commissioner in respect of any aspect of the procedures and processes for responding to complaints; and
- advise the Minister and the Commissioner, as appropriate, on the operation of the Act and the Regulations.

However it is not authorised to:

- investigate a complaint;
- review a decision made by me to investigate, not to investigate, or to discontinue investigation of, a complaint; or
- review a finding, recommendation or other decision by me, or of any other person, in relation to a particular investigation or complaint.

The Review Committee consists of a Chairperson, two provider representatives and two user representatives who are appointed by the Minister for Health.

Only one application for a review was received by the Review Committee in the reporting year.

CHAPTER 3

THE COMPLAINT PROCESS

TAKING, RECORDING, RESOLVING AND ASSESSING COMPLAINTS

The Commission works independently and impartially, and has a supportive and primarily non-adversarial focus. Support is provided to consumers to make their complaints in the most productive way and to providers to respond appropriately to complaints. The aim is to have the complainant, where possible, resolve the matter directly with the provider without the need for the Commission to formally intervene.

A complaint may be made electronically, orally or in writing, however it must be reduced to a written form that contains sufficient details to enable it to be responded to and assessed. Once received by the Commission the complaint may move through any one of a number of stages.

On receipt, the Commission will make one of the following decisions:

1. That the person wants information only. Once the information has been provided the enquiry will then be closed.

Information about the Commission sought

A person from the Philippines Society rang requesting copies of the Commissions brochures and seeking advice as to what assistance could be provided when those with English as a second language wished to make a complaint to the Commission. The Commission provided the brochures (particularly the one in multiple languages and advise that the use of interpreters could be arranged.

2. That the complaint is out of jurisdiction and therefore take no further action.

Contents of a medical report not agreed to

A person rang to complain that the medical report his GP had provided to the Motor Vehicle registry was flawed and as a result it had a detrimental effect on him being able to renew his driving licence. He was advised the Commission could not accept his complaint as it related to the content of a medical report and was therefore exempt under the Act and out of jurisdiction.

3. That the complaint should be referred to another body/organisation/agency and therefore assist the complainant with the referral. Once referred the complaint will then be closed, as the Commission has no further authority to consider the matter.

Aged care complaint referred elsewhere

The complainant worked at a facility housing elderly Aboriginal people. She contacted the Commission stating that she was unhappy that the residents were dressed in 'white mans' clothing from OP Shops which was insensitive and not in accordance with their cultural backgrounds. When asked if the residents themselves had complained to her she said that they couldn't, mainly because of language barriers. The complainant stated that she used the residents own money and purchased appropriate clothing for them, but the staff at the centre still dressed them in Op Shop clothes. She had bought her concerns to the attention of management, but stated the staff just laughed it off. The Commission consulted with the Aged Care Complaints Resolution Scheme as to jurisdiction and they agreed to manage the complaint. As a result, and with the agreement of the complainant, the complaint was referred to the Aged Care Complaints Resolution Scheme.

Patient confidentiality breached

A doctor from a remote health clinic called to complain about a colleague (not prepared to provide name) who he alleged had released the medical records of a patient to the media. The complainant advised that he did not actually have any proof but he knew that it was this person who breached the patient's confidentiality. The named doctor had been interviewed by the media but claimed that he had never divulged any information about this patient. The media had published the details contained in the patient's medical record in a number of newspapers. The complainant also advised the Commission that Police were investigating the breach of confidentiality and that a complaint has been made directly to the Department of Health and Community Services and the Health Professionals Licensing Authority. As the complaint related to a breach of a patient's privacy by another health professional, the Commission determined that in accordance with Section 104 of the *Information Act* the complaint would be referred to the Information Commissioner. The complaint was referred and the Commission took no further action.

4. That the complaint is within jurisdiction and the complainant, with their agreement, can approach the provider direct without the need for any assistance from the Commission. Once the direct approach is agreed the complaint will be closed.

Aboriginal health service restricts appointments

The complainant who was a registered nurse was concerned that an aboriginal health service appeared to be instituting a new policy of not accepting referrals from the school she worked for. She said the last advice she had been given was that the health service would reserve two appointments a day for their students, subject to ringing first thing in the morning. Despite ringing as required, the complainant advised that for the last three weeks she has not been able to get appointments. The complainant wanted to know if a surgery could decide who they saw and who they didn't. The complainant said she was contacting the Commission to get any information or advice she could before contacting the health service. After some discussion the complainant agreed to contact manager of the health service to discuss her concerns directly before taking the matter further. It was also agreed that should the complainant not be able to resolve her concerns directly with the provider, she would return to the Commission. The complainant confirmed she did not require any assistance in following up directly with the health service.

5. That the complaint is within jurisdiction and the complainant, with their agreement, requires assistance from the Commission to approach the provider direct. The complaint will be registered and the Commission will assist the complainant to resolve the matter directly with the provider (at point of service).

Money refunded by Optometrist

The complainant approached the Commission with concerns about the standard of care and treatment he was provided by an optometrist. The complainant alleged that he was given incorrect prescription glasses and was told by the optometrist to continue to wear them until such time as his eyes adjusted to the change. The complainant did so, but still experienced problems and returned again to the optometrist. The complainant alleged the optometrist was frustrated by his insistence that the lens was incorrect and told him again to persist with wearing the glasses. The complainant attended another optometrist, who discovered an error in the prescription of the first provider. The complainant was contacted by the initial optometrist once he became aware of the error. The complainant was angry that the first optometrist 'did not believe him' and wanted his money back and an apology. The Commission facilitated indirect communication between the parties by relaying information at interviews and over the telephone. This lead to the optometrist apologising for the error and refunding back the complainant's money. As the complaint was resolved the Commission could take no further action.

Couple's dental concerns resolved through mediation

The complainant contacted the Commission with concerns about a range of services provided to her and her husband by a public health dental service. After discussions with the Commission they were happy to contact the dental clinic direct to try to resolve their complaint at point of service. The complainant wrote to the Director of the dental service and the Minister for Health and copied in the Commission.

The Complainant received a letter of response from the Minister for Health and was not satisfied. The complainant again contacted the Commission. The Commission discussed the complaint with a health department representative and it was decided by all parties that the matter be resolved through a resolution meeting involving the complainant and her husband, the health department representative and the Clinical Manager of the dental service. The Commission prepared for the mediation meeting through the conduct of several written and telephone negotiations with both parties. As a result of these preliminary negotiations an agenda was drawn up for the mediation meeting held at the Commission. The mediation meeting resulted in a negotiated Outcome Agreement which was signed by all parties. All parties expressed satisfaction with the outcome and process.

6. That the complaint is within jurisdiction and cannot be resolved at 'point of service' but may be resolved with the help of the Commission. In these cases the complaint will be registered and the Commission will attempt to facilitate the resolution of the complaint by:
   - providing information;
   - organising meetings;
   - facilitating/mediating meetings; and
   - providing advice and options.

Agencies cooperate to provide home care

The complainant approached the Commission with concerns about the level of service he was receiving from a number of agencies involved in his ongoing personal care and home help. The complainant expressed a generalised dissatisfaction with all service providers. The Commission assisted the complainant in clarifying his main concerns - which related to the coordination of service delivery - and the specific outcomes he hoped to achieve by making a complaint. The Commission facilitated direct communication between the complainant and the service organisations and a meeting was held to discuss the various case management issues. As an outcome of his complaint the complainant was provided with a written record of his meetings with the various service providers. A new service contract was developed in consultation with the complainant in relation to home care from community health and he was also provided with a letter explaining the processes in place to assist him in addressing any future concerns directly with the case management service. An apology for inconveniences caused by staff shortages was also extended to the complainant. As the complaint had been resolved the Commission could take no further action.

7. That the complaint is within jurisdiction and after taking into account its issues, **will not be** resolved expeditiously by directly approaching the provider or through facilitation. These complaints will be registered, preliminary inquiries will be undertaken and they will be formally assessed. Tasks undertaken during preliminary inquiries can include:
   - notifying various parties of the complaint;
   - exploring and arranging resolution options;
   - gaining responses to complaint issues;
   - obtaining relevant documents and information, eg medical records, x-rays, etc;
   - interviewing the parties
   - initiating and/or facilitating meetings; and
   - obtaining independent clinical advice.

The objective of the Assessment process is to find out whether the complaint warrants further enquiry or investigation and the Commission has 60 days in which to make this decision. On completion of preliminary inquiries the Case Officer makes a recommendation to the Commissioner as to what further action should be taken and this can be to:

- take no further action;
- conciliate;
- investigate; or
- refer to a Professional Registration Board or other body.

Once the assessment determination is made by the Commissioner, all parties to the complaint are advised.

Of all complaints received by the Commission, 85% were resolved or finalised during the assessment process.

Prescribing issues raised in Coronial finding

The Pharmacy Board of the Northern Territory referred certain issues raised in a coronial finding to the Commission and requested that it undertake an assessment of the matter and report back to the Board. The autopsy found that the deceased had taken an overdose of pethidine which had caused her death. In particular, the Deputy Coroner's findings made reference to the actions of a pharmacist, noting dispensing errors of Schedule 8 drugs which were unable to be explained. The Commission wrote to the pharmacist seeking a response to the issues outlined in the complaint and obtained copies of the deceased's records including; medical records and patient history; and prescription records under Section 36(3) Poison's & Dangerous Drugs Act. The Commission's assessment concluded that it was more likely than not that the pharmacist did incorrectly dispense the prescriptions of the Schedule 8 drug. As the Commission was only required to conduct an assessment of the matter and report to the Board, documents obtained by the Commission along with a copy of the assessment report were referred back to the Pharmacy Board for their consideration in accordance with the *Health Practitioners Act 2004*, advising them to consider referring the matter back to the Coroner with a view to holding an inquest into the death of the deceased person.

Dispensing error by Pharmacist

The complainant was prescribed tablets by his GP to help his kidneys remove excess fluids. He was required to take these twice a day. The complainant took the prescription to a Pharmacy and was dispensed a larger dose than prescribed. The complainant consumed the medication according to the directions on the prescription for the specified three day period. The complainant had an 'enlarged

heart', and was on the transplant list at an interstate hospital. During a consultation at the interstate hospital they discovered that he had been taking the incorrect dose of the tablets. He subsequently complained to the Commission about the actions of the Pharmacist. The Commission wrote to the Pharmacy advising of the issues of the complaint and they initially responded with a letter apologising for the dispensing error and sought to meet with complainant to discuss the incident and apologise in person. This response was forwarded onto the complainant. In the meantime the complainant had secured legal representation and they advised the Commission that the complainant wanted to conciliate in respect to seeking compensation. The Pharmacist was advised of the complainant's willingness to conciliate and he subsequently obtained legal representation. Inquiries by the Commission into the complaint revealed that consumption of the large doses of the medication by the complainant had not resulted in any serious or permanent harm. However the impact of taking large doses of the tablets, combined with the complainant's medical condition, placed the complainant at enormous risk and could have resulted in his death. Efforts by the Commission to gain the agreement of both parties to resolve the complaint through conciliation were unsuccessful and the Commission therefore determined to refer the matter to the Pharmacy Board to consider the issue relating to the failure of the Pharmacist to properly dispense the tablets as a professional conduct matter.

TAKING NO FURTHER ACTION ON COMPLAINTS

The Commission will take no further action on a complaint if it is satisfied that:

- the complainant is not eligible to make the complaint;
- the complaint does not relate to a matter covered by the Act;

The complainant had issues with how an Incorporated Association he worked for was being run. He was advised the matter was outside the Ombudsman's jurisdiction, referred to the Department of Justice website and provided with copies of fact sheets and specific sections from the Associations Act.

The complainant called regarding goods she purchased from a store and wanted to receive a refund. She was referred to Consumer and Business affairs.

The complainant had issues with a restaurant not providing a non- smoking area. He was referred to the Environmental Health Unit of department of Health and Community Affairs.

- the user became aware of the circumstances giving rise to the complaint more than 2 years before the complaint was made and doesn't have an exceptional reason for the Commissioner to exercise a discretion to consider it;

Alleged inappropriate conduct

The complainant stated that she had an ear infection and went to see her local GP. During the consultation the complainant alleged the GP asked her to lie on the examination table for a check up and pulled her skirt up over her underpants and brushed his hand over her legs lightly and quickly. The complainant alleged that this was the extent of the examination. This incident had allegedly occurred some four years previously and the complainant was unable to provide a reason for the delay in making the complaint. After careful consideration and because the length of time since the alleged incident took place was more than 2 years, the Commission determined that no further action would be taken as complaint pursuant to S 30 1 (c) of the *Health and Community Services Complaints Act*.

- the complainant has not taken reasonable steps to try and resolve the complaint with the provider;

- depending on the circumstances and the enquiries made, there is no justification, or it is unnecessary, to investigate the matters raised by the complaint further;
- the complaint lacks substance;
- the complaint is vexatious, frivolous or was not made in good faith;
- the complaint is resolved;
- the user has commenced civil proceedings seeking redress for the subject matter of the complaint and the court has begun to hear the substantive matter; or
- the complainant fails to provide additional information or documentation when requested to do so by the Commissioner.

CONCILIATING COMPLAINTS

Cases involving serious or complex issues or substantial disputes that warrant compensation or a detailed explanation will normally be recommended for referral to a Conciliator. The functions of a Conciliator are clearly defined in the Act.

The conciliation process has statutory privilege. This means that anything discussed during conciliation, or any document prepared specifically for conciliation remains confidential and cannot be used in another forum. In addition, the process is non-adversarial, free of charge and stands as an alternative to civil litigation where claims for compensation form part of the substantive complaint.

Enforceable agreements, documenting the outcome of conciliation, can be made as part of the conciliation process.

During the course of the financial year the Commission finalised six (6) conciliations. It would be a breach of faith and of confidence to describe the facts of the cases concerned. It is important that parties have confidence that disclosures made during conciliation will not subsequently be disclosed either in an Annual Report or even in an application under the *Information Act*.

INVESTIGATING COMPLAINTS

An investigation using statutory powers is likely to be instigated in complaints:

- which are not suitable for informal resolution or conciliation, eg. patients may be at imminent risk, or serious misconduct is alleged;
- where conciliation has been declined or failed and further investigation is warranted;
- that appear to raise a significant question as to the practice of the provider; or
- that appear to raise a significant issue of public health or safety or public interest.

The Commission has wide powers during the investigation process and may propose remedies, or make recommendations which are usually furnished in a report and a

notice is provided to the complainant and the appropriate provider or body able to implement the actions.

Any information, documents, reports, etc produced as a result of an investigation cannot be used for any other purposes, eg. as evidence in a court of law.

During the course of the financial year seven (7) investigations were completed. Examples of these investigations can be found at Chapter 4, Activity 3.

REFERRING COMPLAINTS TO RELEVANT REGISTRATION BOARD

Complaints involving the practice or procedures of registered providers will, in most cases, after consultation with the relevant Registration Board, be referred to them to exercise their powers as appropriate. Once referred to a Board the Commission can no longer take action in relation to the complaint unless formally referred back by the Board and the file is therefore closed.

This financial year forty (40) complaints were finalised following referral to an appropriate Board. A large majority of these were a carry over from the previous financial year.

CONCLUSION

The Commission's objective is to finalise complaints as quickly and informally as possible. Only a small number of complaints (less than 10%) are assessed as requiring one of the more formal processes under the Act, that is either investigation or conciliation.

The success of this expeditious resolution process can be attributed to the excellent work undertaken on receipt of a complaint by the Enquiry Officers, Assessment Officer and Investigation/Conciliation Officers through their skills in communication, negotiation and mediation, combined with flexibility and common sense.

CHAPTER 4

CASE STUDIES

KNEE REPLACEMENT SURGERY QUESTIONED

The complainant underwent right knee replacement surgery at a public hospital. After the operation the complainant, with the help of physiotherapy, made steady progress and had been able to cease use of his walking stick. After the physiotherapy stopped, around the middle of 2004, the complainant developed severe pain in the knee again. He went back to see his GP who believed the problem was due to osteoarthritis in the back of his knee cap. The GP recommended he have his knee cap removed. The complainant saw another GP who organised for him to see an orthopaedic specialist at the public hospital, for a second opinion. The specialist advised that in his opinion the pain related to the artificial joint which had slipped rather than to arthritis of the knee cap and organised some further tests including a CAT scan, which were conducted at an interstate hospital. The complainant believed it was unacceptable that the joint replacement should fail in this way, so soon after the previous surgery.

The complainant raised his concerns directly with the public hospital who performed the initial operation and received a written response from the General Manager which he was not happy with. The complainant then wrote to the Commission. In assessing the complaint the Commission facilitated a number of meetings between the complainant, his doctor and staff of the public hospital to try and resolve his issue as expeditiously as possible. These inquiries and meetings resulted in a satisfactory explanation being provided in relation to most of the issues, an apology being provided and an agreement being reached with the hospital with regard to the complainant's ongoing concerns with his knee. The Commission took no further action on the complaint.

PRISONER SEEKS PAYMENT FOR ORTHODONTIC TREATMENT

The complainant, who is currently in a correctional centre, received orthodontic treatment prior to being incarcerated. He was on a scheduled payment plan however since being incarcerated was unable to meet any of the scheduled payments resulting in the likelihood of his treatment being ceased and his braces removed. He sought assistance in meeting his payments for the orthodontic treatment from the Correctional Centre and this was being refused. The issues of complaint were initially referred to the independent prisoner health service to be resolved but they advised they did not have control over dental services. The matter was then referred to Correctional Services who advised that this was an issue that had not been dealt with previously.

Advice was subsequently received from Correctional Services that they had not approved the complainant's request for them to meet the costs of his orthodontic braces. This decision was made based on information obtained from the Department of Health and Community Services (DHCS). They advised that while Correctional Services aimed to provide health services equivalent to those provided to the general community, orthodontic care was not generally provided within the public health system and that they only provided orthodontic services to school age children (not adults) under strict health related criteria. Correctional Services further advised however that they would be more than happy to assist the complainant with his orthodontic treatment by ensuring that he attends every appointment with his orthodontist at a cost to Correctional Services.

As the response and actions to be taken by Correctional Services were considered reasonable by the Commission it determined to take no further action as further investigation was unnecessary.

WRONG TOOTH TAKEN OUT

The Commission received the complaint from the Dental Board. The complainant stated that he broke his tooth on a seed and made an appointment with a dentist. He alleged the dentist took out the wrong tooth - his wisdom tooth and not the broken tooth. The complainant stated that the tooth bled for 30 hours afterwards. He returned to the dentist a few days later and was seen free of charge, had his tooth packed and was told that it was his fault the tooth bled. The complainant made an appointment with his "usual dentist" at a different surgery a day later where the dentist pulled the broken piece of tooth off and refilled the part of the tooth that was left.

The Commission assessed the complaint through obtaining information from the Dental Board, interviews with the complainant and the dentist, obtaining a written response from the initial dentist, obtaining a written response from the second dentist and obtaining clinical advice.

The Commission found that the initial dentist examined the complainant's teeth, found a decayed tooth and suggested that it be extracted. He alleged that the complainant made no objection. The dentist also had given post operative instructions about how to care for the tooth following the extraction. A review by a second dentist concluded that the treatment provided by the initial dentist was reasonable.

The dentist offered to refund the cost of the extraction as a gesture of good-will and this was accepted by the complainant, even though he was still of the belief that the dentist extracted his tooth unnecessarily. The Commission provided the Dental Board with a report outlining the Commission's findings and reasons for determining no further action.

WRONG ADVICE REGARDING AN STD DURING PREGNANCY

The complainant had an appointment with her GP to confirm a positive pregnancy blood test. The complainant waited in the waiting room for some 90 minutes before she was called in to see the doctor. The doctor retrieved her notes, had a quick look at the blood tests and then looked at the complainant and asked "have you ever had a STD before?". The complainant answered "no". The doctor replied that she had tested positive to an STD and that she had contacted it from her partner. The doctor then explained that having the STD during pregnancy was harmful to the baby and the complainant would need to have a repeat blood test in two weeks. The complainant asked if there was anything that could be done sooner as she did not think she could cope for another two weeks with this problem on her mind. The GP replied that there was nothing she could do until she had the repeat blood test and the results were back. The complainant continued to question the doctor as she was concerned about the health and wellbeing of her unborn baby and herself and asked if the second blood test came back positive what would be the next step. The complainant alleged that the GP advised her that she would need to have an abortion as the STD would harm the baby. The complainant was then advised by the doctor that she was out of time and to make another appointment to come back and get the results from the second blood test. The complainant departed the doctor's surgery in shock and didn't make a follow up appointment. The complainant was upset the whole way home and upon arriving at home had an argument with her partner based on the doctor's advice that he was the carrier of the disease.

Later a friend advised her to visit Clinic 34 and make an appointment for another blood test which the complainant did. During the appointment at Clinic 34 the complainant raised her concerns regarding her pregnancy and the disease and was advised there was a course of antibiotics that she could take to prevent further symptoms and that there was no need for an abortion. The complainant's second blood test at Clinic 34 came back negative for the STD.

The complainant was appalled at the manner in which her GP dealt with her and felt that he treated her in a heartless manner by not offering her any help or the name of someone to contact in the event

that she needed counselling. The complainant's relationship with her partner had also been affected due to the incident with her GP.

The Commission wrote to the GP and sought a response to the issues raised by the complainant and the outcomes sought. In his response the GP acknowledged and apologised to the complainant for the distress he caused her and her family due to the information he gave her. The GP also undertook in future to balance the information he provided in relation to the potential implication of STD's during pregnancy with the fact that the diagnosis needs to be confirmed by a repeat blood test. In respect to the issue of the GP's failure to provider the complainant with options for support and counselling, the provider gave evidence that he had referred the complainant to the antenatal clinic at the public hospital as a category one referral on the same day so that she could be managed by a gynaecologist/obstetrician and receive any counselling that she may need. The complainant did attend the hospital. The complainant was satisfied with the response from the provider.

As the matter was resolved no final determination was made.

HOSPITAL SHOWS NO RESPECT FOR PATIENT

The Commission received a complaint in respect of a former patient at a public hospital. The complainant's friend had been complaining to doctors at the hospital for a number of years about a pain in his arm which was never investigated. Since then the complainant's friend had died as a result of a cancer that was located in the site of the pain.

The complainant wanted the Commission to investigate why the hospital had not responded to her friend's complaints, seek improvement and changes in respect to how patients are treated and the ongoing disrespectful attitude of hospital staff towards patients. The complaint also included issues associated with an interstate hospital and these were referred to the appropriate interstate health complaints commission.

The complainant requested that her identity remain confidential as she did not want the complaint to impact on her receiving future treatment at the hospital. She was advised that it was not necessary for her name to be released to the hospital for the complaint to be assessed. In order to complete the assessment, the Commission undertook preliminary enquiries. It sought a response to the complaint and obtained the patient's medical records from the hospital.

The Commission's enquiries in respect to the treatment of the patient revealed that he had developed a rapidly growing cancer which the hospital had diagnosed and treated accordingly and in a timely manner. The Commission also found that the patient's health had been complicated by other medical conditions and his health rapidly deteriorated after his surgery and he died of respiratory failure.

The Commission's enquiries in respect to the issue that staff of the hospital were dismissive of the patient's complaints, revealed that the patient had an extensive clinical history and that every effort had been made by the hospital to provide him with timely care and treatment on each occasion he had presented to the Hospital.

It was determined by the Commission that no further action be taken in respect to the complaint as investigating further the issues raised was unjustified.

COMPLAINANT NOT PREPARED TO ACCEPT DECISION

The complainant had an ongoing dispute with various medical practitioners who had supported a diagnosis of epilepsy and that the diagnosis was a deliberate act of malice on the part of an unknown party. The diagnosis of epilepsy had resulted in the complainant's license being

suspended some ten years previously. The complainant had been engaged in a conflict with the Motor Vehicle Registry and various doctors over those years because they continued to support a license suspension.

The complainant approached the Commission with concerns about the service provided by a specialist neurologist at a public hospital. He was concerned that the specialist did not make a full assessment of him, and had based his assessment on erroneous records held at a district hospital. The complainant also alleged that the specialist withheld test results that would negate the diagnosis of epilepsy.

Inquiries were made by the Commission into the complaint and included a review of the documents provided by the complainant, a review of the medical records, a review of previous complaints to the Commission, a review of recent research literature, and consultation with the specialist. Discussions with the complainant also occurred on a number of occasions during the course of the inquiries.

Based on the information gathered as a result of these inquiries, the Commission determined that no further action would be taken because there was adequate evidence supporting the complainant having had a history of epileptic seizures. In regard to the report provided by a specialist to the Motor Vehicle Registry, the complainant was advised that the Commission had no jurisdiction in relation to the content of the health status report, as it did not constitute a health service as defined by the Act.

UNABLE TO IDENTIFY THE DENTIST

While previously residing in Darwin some four years ago the complainant visited a dental surgery and was advised that a filling needed replacement. At the end of the procedure, the complainant was advised that the filling had been replaced and the first stage of a root canal had commenced. The complainant questioned the root canal procedure as she had not been consulted about it and thought that she was undergoing a simple filling replacement. When the complainant went to pay, the invoice showed an amount for the first stage root canal treatment, which she again questioned. The dentist confirmed that it was just a simple replacement and so the complainant paid for the filling and left.

The complainant, who resides interstate, visited her local dentist and was advised that the same filling required replacement. X Rays showed that the tooth was "dead", and plans were put in place to undertake a complete root canal. During treatment, the complainant's Dentist removed a cotton wool pack from inside the same tooth. The dentist advised the complainant that a root canal treatment had previously been commenced but not completed. It therefore appeared that the cotton pack had been left in there since the Darwin visit. The pack had become very infected and the complainant now faced the disappointing prospect of losing the tooth.

The complainant was extremely unhappy about the situation and complained to the Commission about the practices of the Darwin dentist in that she did not provide consent for a root canal procedure to commence nor was she consulted about undergoing a Root Canal procedure and she was not provided with treatment options, a treatment plan or a cost management plan for a root canal procedure. In addition she alleged that a dental student worked unsupervised on her and that the student's work and diagnosis were not checked by a registered practitioner. The complainant wanted the Darwin dentist to assume responsibility for any dental bills associated with the current repair of the tooth and costs associated with extraction and provision of a plate.

The Commission assessed the complaint and found that there were three dentists registered in the NT with the same surname. One being first registered after the complainant's visit to the dental surgery. The other two dentists advised that they did not have a record of the complainant and they had not employed a dental student. They were asked to search their records twice at the request of the Commission and could not locate any records relating to the complainant.

The inquiries undertaken by the Commission during assessment could not establish whether or not

the complainant had been a patient of either of the dentists which made it impossible for the Commission to investigate the issues raised in the complaint and assess the complaint adequately. As a result the Commission determined that no further action would be taken.

EXPECTATIONS NOT MET

The complainant had plastic surgery performed on her breasts and stated it was not performed according to what she had requested and paid for. The complainant stated that she was not given an appointment to review her operation and that her stitches were infected and itchy after being removed by the provider's nurse two weeks after the surgery. The complainant stated that after raising her concerns with the provider, he advised that he would perform revisional surgery "free of charge". However on the day of the revisional surgery, the complainant was advised by the provider that she would have to meet the hospital and anaesthetist costs. As a result, she did not go ahead with the operation that day. The complainant was not happy that she was required to pay for part of the revisional surgery.

The provider responded to the complaint advising that it was his "normal practice policy" to perform revised surgery using Medicare item numbers and bulk bill the procedure and that he had also discussed this with the case anaesthetist who agreed to do likewise, however the complainant would still need to meet the hospital costs as she had elected not to have private insurance. The provider further advised that as he was not returning to Darwin and that he would refer her to another surgeon capable of performing the procedure.

Given that the complainant was seeking to have the money she paid reimbursed and the provider was willing to conciliate to some extent in respect to the issue of the money, there appeared to be potential for the complaint to be resolved. The Commission undertook inquiries into the complaint which included obtaining a response from the provider, examining the complainant's medical records held by the provider and her GP, as well as seeking clinical advice.

The assessment undertaken by the Commission supported the complainant's view that the provider had failed to perform the surgery according to what she had asked and paid for and had failed to provide the complainant with a follow-up appointment to review the surgery. The Commission's attempt to resolve the complaint through assisted resolution with both parties was unsuccessful and it was determined that further investigation of the complaint was unwarranted. The assessment by the Commission however raised questions regarding the clinical practices and procedures of the provider and it was determined that the matter be referred to the Medical Board for their consideration.

COMPLAINANT EMPOWERED TO TAKE CONTROL

The complainant attended a public hospital on hearing that her father was unwell. She complained that the nurses and doctors in Emergency Department displayed a lack of courtesy and sensitivity to herself and her mother. The complainant also raised concerns about the brevity of the explanations given by the doctors and the standard of care and treatment provided to her father. The complainant stated that her father was discharged from the hospital without medication despite the concerns of the complainant, and he had to return the same evening. The complainant was also frustrated by the unhelpful manner of administrative staff in trying to make an appointment for her father for a test ordered by the hospital doctor.

The complainant was assisted in clarifying the issues of complaint and the outcomes she was seeking. Resolution options were discussed and the complainant agreed to attempt to resolve her concerns at point of service. The Commission facilitated contact between the hospital complaints manager and the complainant and a meeting was organised. The hospital complaints manager agreed to convey the issues raised to the emergency department and hospital management and requested that a written response be provided to the complainant.

The complainant was dissatisfied with the provider's written response. She noted some inaccuracies and said she perceived the letter to be biased in favour of the doctors. The complainant saw no benefit in continuing to try to resolve her complaint at point of service. Resolution options were discussed and it was agreed that the complainant would respond in writing to the hospital, pointing out the inaccuracies and the impact of the suggestions made in the response.

The complainant advised she did not need any further assistance from the Commission in drafting this response or in resolving the complaint and thanked the Commission for their assistance to date. The Commission determined to take no further action on the complaint.

DIFFERING VERSIONS, UNABLE TO RESOLVE

The complainant attended a medico-legal assessment at the request of her insurer and raised a number of concerns with the Commission regarding the conduct of the assessment. These concerns included the doctor being rude and rough, treatment being painful, use of inappropriate questions, no background history being referred to and no explanation as to the purpose of any examination or what he would be assessing.

The complainant's main outcome was that the doctor knew she was dissatisfied with the care and treatment he provided and that she had made her concerns known. She hoped that by making a complaint the doctor might think about what he did and prevent the doctor from treating other patients in a similar manner.

The Commission clarified the issues of complaint with the complainant, requested a response to the issues from the doctor and sought the complainant's comments.

The doctor's response, which provided a different version of events to that of the complainant, did not resolve the complaint. In fact, the letter served to inflame the complainant's concerns. However, the complainant agreed that there was little else that could be done to try to resolve the complaint given the differing accounts of the circumstances of the complaint. The Commission determined to take no further action.

COMMISSION WORKS WITH COMMUNITY VISITOR PROGRAM TO RESOLVE MENTAL HEALTH PATIENT'S CONCERNS

The consumer, who had an existing heart condition, voluntarily admitted himself to an in-patient mental health service. While an in-patient, the consumer suffered pain and swelling in his left knee and complained of chest pain and feeling unwell. The knee was assessed and the doctor requested that he be seen by a cardiologist. The consumer continued to complain of knee pain and was seen by a different doctor the next day. After three days of symptoms, the consumer became very ill and collapsed. He was transferred via ambulance to the hospital and admitted to ICU.

The complainant, a friend of the consumer, expressed concern that the consumer's complaints of pain were not taken seriously and his agitation was interpreted as a symptom of his mental illness. The complainant was also concerned that the risks associated with the existing heart condition were not recognised or appreciated by staff at the mental health facility. The other main concern related specifically to the standard of medical assessments conducted by the doctors on the ward. The complainant and consumer sought acknowledgment, apology and changes to practice and procedures as the outcome of making their complaint to the Commission.

On receiving the complaint the Commission consulted with the consumer regarding consent, issues of complaint, and roles and responsibilities re the Commission and the Community Visitor Program. The

Commission then sought a response from the mental health service and consulted with the Community Visitor Program to see if they might be able to assist in resolving the complaint.

The response from the mental health service was not acceptable to the complainant and consumer and they wrote to the service saying so. After receiving the letter from the consumer, the mental health service wrote another letter offering an apology which was accepted.

Although the Commission took no further action with regard to the complaint the Community Visitor Program advised that they had planned a meeting with new agency staff regarding the systemic issues surrounding this complaint.

ASSISTANCE BY COMMISSION ALL IN VAIN

The complainant was diagnosed with chronic pancreatitis and had visited a public hospital a number of times over the past 12 months. At least four of the visits resulted in the complainant being admitted to the hospital and prescribed Endone when discharged. The complainant had been seeing the same GP during this time and was provided with scripts for the Schedule 8 (S8) medication. The GP however abruptly stopped issuing the scripts.

During the complainant's last visit to hospital he was informed that they were not there to supply his S8 prescriptions and that he needed to have his dosage increased. The complainant informed his GP of the advice from the hospital, including a letter from them stating that he required the S8 medication. The GP advised the complainant of the surgery's practice of not prescribing S8 medication and provided him with prescriptions for other medication, which the complainant subsequently misplaced.

The complainant contacted the Commission because he was concerned that he had been placed on the "doctor shopper list" and was refused a prescription for S8 despite requiring one after discharge from the hospital. The complainant was also concerned that he had been banned for life from the surgery without any support or assistance.

The Commission contacted the Poison's Branch who advised that it was a requirement under the Poisons and Dangerous Drugs Act for a doctor to notify them of each patient they prescribe S8 medications to if the treatment was to last longer than a few weeks or if high doses were prescribed. They stated that they did not maintain a "doctor shopper list" as such in reference to the complainants concern that he had been placed on one.

The Commission contacted the surgery and the manager reviewed the complainant's records and advised that the GP had refused to issue further prescriptions to the complainant due to concerns he had regarding improper use - referring to the complainant's irregular visits to the clinic and requests for replacement prescriptions. The Manager also confirmed that the surgery was no longer issuing prescriptions for S8 medication.

Attempts by the Commission to contact the complainant to discuss the issues and outcomes sought by the complainant and to assist the complainant to resolve his complaint with the provider by telephone were unsuccessful as the number provided by the complainant was disconnected. The Commission subsequently wrote to the complainant requesting that he contact the Commission, but the complainant failed to do so. The Commission therefore determined to take no further action in accordance with Section 30(6)(a) because the complainant had not provided information as required under the Act.

AGGRESSIVE BEHAVIOUR LEADS TO WITHDRAWAL FROM METHADONE PROGRAM

The complainant had been on the public health Methadone Program for the last 18 months. However an incident occurred where he became aggressive and abusive with one of the doctors providing the service and, due to the service's zero tolerance policy on aggressive behaviour, he was terminated from the program. The complainant advised the Commission that he had attempted to apologise to the staff but they refused to accept his apology.

Following his termination from the program the complainant began using opiates which he had obtained "off the street" as a remedy for his sudden withdrawal from the methadone program. The complainant also visited a withdrawal service but, because it was linked with the public health methadone program, it refused to treat him. The complainant then visited a number of different private doctors but they were unwilling or unable to assist him as they either did not prescribe Schedule 8 drugs or they did not have any vacancies for new patients.

The public health methadone program was notified of the complaint and in their response they advised that this had not been the first time the complainant had demonstrated unacceptable behaviour however they would be prepared to reassess the complainant and would advise him of this. The Commission then contacted the complainant and advised him of the response and emphasised that he could request a re-assessment although it did not mean that he would be placed back on the Methadone Program.

The complainant advised that he had been contacted by Alcohol and Other Drugs Service and was advised that he would be able to commence a residential treatment program once he had been re-assessed which would not happen for at least another week. The complainant was not happy with this response as he was experiencing enormous pain and on one occasion had to be rushed to the hospital because of the effect the drugs were having on his heart condition.

The Commission contacted the public health methadone program regarding their response to the complainant and were advised that they were extremely busy and no earlier date was available. They further advised that if there was a cancellation they would contact the complainant. The complainant was advised of the Commission's discussion with the public health methadone program and he was satisfied with the response and thanked the Commission for their assistance.

SPECIALIST REMINDED OF RESPONSIBILITY TO PROVIDE SERVICES IN A TIMELY MANNER

The complainant approached the Commission concerned about the lack of response from a specialist about vaccinations for her son who suffers from rheumatic heart disease. The complainant was also concerned that she had sought a repeat script for antibiotics for her son from the same specialist and had not received any response for over a week. A day after contacting the Commission the complainant advised that she had received a response from the specialist to the requests.

The Commission wrote to the specialist concerned outlining the nature of the complaint and enclosed a copy of the Code of Health and Community Rights and Responsibilities as it related to Principle 1a) which states *Users have a right to the timely access to care and treatment*. The Commission acknowledged that the complainant had now received the information and service requested from the specialist and advised that it would be taking no further action on the matter.

REMAINING STICHES REMOVED WITH ASSISTANCE OF HOSPITAL

Complainant called on behalf of his wife who had given birth at a public hospital. He alleged that his wife tore in labour, was stitched and then discharged without follow up. Some days later they

attended the family planning association to have the stiches removed but this wasn't possible due to the wife's pain levels and they were told to attend the Emergency Department at the public hospital. A number of attempts were made by different doctors at the hospital to remove the stiches but this was unsuccessful due to the pain. The wife remained in hospital overnight and the next day the stiches were removed. The complainant's wife was again discharged without follow up and, it became apparent, without all the stiches being removed. They called a private hospital who advised them that they wouldn't admit the wife because it was something the public midwives should do. As they were desperate and the wife was in significant pain and very distressed and traumatised they contacted the Commission.

The Commission contacted the complaints consultant at the public hospital, advised her of the situation and requested that the hospital assist the wife to have the remaining stitches removed. The result was that the complainant's wife was booked in to see the specialist at the hospital the following week, the stitches were removed, medication was administered and prescribed and a follow up appointment was scheduled for the following week. The complainant and his wife were very happy with the outcome and thanked the Commission and the hospital for its assistance.

NT TAXI SUBSIDY SCHEME ELIGIBILITY QUESTIONED

The complainant was 78 years of age and had been receiving assistance from the NT Taxi Subsidy Scheme, a scheme funded and administered by the Department of Health and Community Services. The complainant had been advised by the department that in order to continue receiving assistance under the scheme she would have to be medically reassessed by a doctor to determine if she was still eligible to receive financial assistance.

The complainant stated that she recently suffered a stroke which had left her partially paralysed, was partially blind (glaucoma) and deaf, suffered from memory loss which severely restricted her mobility and as a result could not use the bus. The complainant wanted to know why she needed to be reassessed every year when she had already been assessed as eligible for the scheme, especially given her age and the unlikelihood of her conditions improving.

The complainant was referred to the department so that her complaint could be dealt with by them in the first instance. The complainant was satisfied with this approach. The department explained that applicants for the NT Taxi Subsidy Scheme (NTTSS) required their doctors to complete a medical assessment and that it was the information provided by the doctor and contained in the assessment which determined the level of assistance granted to individuals under the scheme. The department advised that the complainant only had a temporary membership of the scheme for 12 months based on the information given by her doctor at the time, but that the complainant would be eligible to receive membership for the maximum period of five years if she was reassessed by her doctor as eligible.

The complainant was satisfied with the advice given by the department and stated that she would arrange to see her doctor in order to be reassessed.

GP REIMBURSES PATIENT FOR PROVIDING WRONG SCRIPT

The complainant called regarding the fact that a GP had given him a wrong script. He did not realise the mistake until after the script had been filled by a Pharmacy and he was out of town. The complainant worked out in the sun a lot and the cream (for his face) was better than the ointment (wrongly prescribed and dispensed) because it soaked straight into his skin and did not leave his face all sweaty. The complainant had to use some of the ointment however because his face had gone all red - the usual symptom for him to use the cream.

On his return to Darwin the complainant called the surgery and explained the problem. The surgery

re-issued the script (for the cream) and waived the usual $5 re-issue fee. He then went to the pharmacy and explained the situation, however the pharmacist advised that there was nothing they could do but fill the new script and charge him. The complainant was not happy with that and walked out. He also called the drug company and they advised they could do nothing. The complainant then called Consumer and Business Affairs who said it was nothing to do with them and recommended he call the Commission.

The complainant was sick of being passed from pillar to post and just wanted to not be out of pocket for having the wrong script dispensed.

On receiving the complaint the Commission consulted the pharmacy who advised that legally they could only dispense what had been prescribed and that they would not seek reimbursement from the distributors. After advising the complainant of this he then made a complaint against the GP. The Commission then contacted the surgery who advised that they had already provided him with a new script and waived the $5 fee. On explaining to the GP that the complainant was happy with this and would like to be reimbursed $50, the GP reconsidered their response, accepted responsibility and agreed to reimburse the complainant. As the complaint had been resolved the Commission took no further action.

QUICK RESPONSE LEADS TO COMPLAINT RESOLUTION

The complainant attended her usual GP at the appointed time but the GP was running late. Another patient arrived, with an appointment time 45 minutes later than hers and was seen before the complainant. Having waited for nearly an hour, the complainant approached the receptionist and complained that the other patient had been seen first. The complainant stated that the receptionist only replied that that was the way things go and, when asked to do so, said sorry. The complainant waited to see the GP and did not take the matter any further.

Two weeks later the complainant contacted the surgery for an appointment. She was told there was an appointment that afternoon and when asked her name was put on hold. The complainant was then told that there was no appointment and that no future appointments would be made for her.

The complainant was very upset by this action. She believed it was unfair and a deliberate act to punish her for pointing out the receptionist's error at her previous visit. She said she did not consider that her behaviour was aggressive or inappropriate - she believed she had a right to let the receptionist know she had made a mistake.

The Commission discussed resolution options with the complainant, including the option of the Commission contacting the surgery, letting them know a complaint had been received, and asking them to contact her directly. The complainant was not confident this would happen, nor was she comfortable with dealing with the matter alone. The complainant agreed to complete a complaint form and then discuss complaint resolution options in more detail.

Before the Commission could take any further action the GP contacted the complainant without any intervention by the Commission and offered her a sincere apology and continued service. The complainant advised the Commission that the complaint had been resolved and no further action was taken.

UNABLE TO OBTAIN METHADONE BECAUSE OF BREACH OF CONTRACT

The complainant called stating that both she and her husband had been 'kicked off' the methadone program by their GP. The complainant was banned from a shopping centre and was unable to obtain

her methadone from a chemist there. The complainant then went to see the GP to tell her that she would not be able to collect her methadone from that chemist and the reason why.

The complainant alleged that the GP said she 'had had enough', wouldn't treat her or her husband anymore and that the pharmacist had told her that the complainant's partner often came to collect the methadone intoxicated. The complainant also alleged that the GP told her that her husband had missed a number of doses (which they disputed) and that this was the reason why her partner's methadone program would be ceased.

The complainant claimed that she still had some scripts left for her methadone and could not access it as she had been banned from the shopping centre.

The complaint was referred to the GP who responded that the complainant had breached the Schedule 8 agreement (a copy of the contract was sighted). The response from the GP was forwarded to the complainant who did not respond. As the Commission was satisfied that the treatment provided to the complainant was reasonable and in accordance with the *Poisons and Dangerous Drugs Act* the Commission took no further action on the complaint.

DENTAL THERAPIST AUTHORISED TO DO THE DENTAL WORK

The complainant wrote to the Commission stating that their young daughter had a sore tooth which required filling. The complainant obtained an appointment for her daughter and was informed by the Dental Practice that as her daughter's teeth had not been cleaned in the last 6 months she would need to see a dental hygienist first. They then made an appointment for their daughter.

The complainant's husband accompanied their daughter to the appointment and stated that the dental therapist informed them that the daughter would require two fillings and a scaling. The complainant stated that a dentist also examined her daughter and confirmed the proposed treatment. The dental therapist then performed both the dental clean and the fillings. The complainant stated that at no time was consent given for the dental therapist to perform other than dental hygiene work. The complainant also stated that at no time were they informed that the hygienist appointment had finished and the dental appointment had started. They were also informed that their daughter would need to see an orthodontist and were invoiced $30 for a referral.

The complainant believed the dentist behaved in a fraudulent manner by putting his provider number on the invoice when he did not carry out the work. She also stated that the dentist charged them for a referral to the orthodontist that was not necessary and that they had not received a copy of this referral. The complainant also believed that the Dental Practice acted in a false and misleading manner by allowing a dental therapist to carry out dental work on their daughter when they specifically requested a dentist appointment and were advised that this was arranged.

The complainant wanted a refund for all the work carried out by the dental therapist except for the clean. She also stated that they needed to take their daughter to another dentist to check that the tooth fillings were carried out properly. The complainant also believed that they should be partially refunded for the work carried out by the dental therapist because they were billed as if the dentist carried out the work.

The complaint was resolved at point of service through the Dental Practice providing a letter of explanation to the complainant with a copy of the Code of Practice for Dental Therapists and Dental Hygienists. This information confirmed that the dental therapist concerned was qualified to carry out dental hygiene plus the amalgam work under supervision of the registered Dentist; and that the dental therapist had introduced herself to the parent as a dental therapist and had explained the treatment plan to the parent and child. This explanation had not met with the parent's disapproval at the time of the appointment. The letter also explained why the dental therapist's provider number was not listed on the invoice and why the dentist's name must be listed as a health fund requirement. The Dental Practice also refunded the cost of the referral letter to the Orthodontist which was not sent given the

circumstances of the complaint.

As a result of the information received from the Dental Practice and the refund provided, both parties and the Dental Board were informed of the Commissioner's written determination to take no further action.

CHAPTER 5

PERFORMANCE

OVERALL PERFORMANCE OF THE COMMISSION

Performance Measures	Unit of Measure	04/05	05/06	06/07
Quantity	1. Number of access and awareness sessions 2. Number of enquiries/ complaints received	32 404	10 380	12 312
Quality	1. % of reviews of decisions requested 2. Consumers and providers satisfied with service: • Consumers; and • Providers	0% 80% 100%	2% 85% 100%	>1% 80% 100%
Timeliness	1. Percentage of inquiries & complaints closed within 180 days of receipt.	84%	93%	94%
Cost	1. Total output costs ($)	553,650	521,156	521,769

ACTIVITY 1: COMMUNITY ENGAGEMENT

OUTPUTS

1. Distribute Commission brochures to users and providers.
2. Provide a brochure in 10 different ethnic languages.
3. Give presentations to user and provider groups on the Commission's role and functions.
4. Utilise the media (radio, television and newspaper) to educate the public and increase awareness about the Commission.
5. Educate users and providers about their rights and responsibilities under the Code.
6. Monitor provider's adherence to the Code.

PERFORMANCE

Performance Measures	Unit of Measure	04/05	05/06	06/07
Quality	1. Different brochures and information available for:			
	• user groups;	Yes	Yes	Yes
	• provider groups; and	Yes	Yes	Yes
	• ethnic groups.	Yes	Yes	Yes
	2. The 10 languages in the "Ethnic Brochure" represent the majority of NT's ethnic community[4].	Yes	Yes	Yes
Quantity	1. At least 1000 brochures distributed.	1000	500	500
	2. Brochures provided to at least 10 different groups.	10	5	5
	3. At least 20 presentations are given.	32	10	12
	4. Utilise the media:			
	• newspaper X 40	20	10	10
	• radio X 5	0	0	0
	• television X 2	0	0	0

OVERVIEW

As no additional funding was provided during 2006/07 for this purpose, priority could not be given to this activity and therefore the Commission's ability to engage the community in educational and awareness activities was less than ideal.

[4] Not including Aboriginal people who make up approximately 30% of the NT population.

HIGHLIGHTS

MAINTAIN ACCESS AND AWARENESS AT THE NATIONAL LEVEL

The National Council of Health Complaints Commissioners consists of Commissioners and Deputy Commissioners from each state and territory, the New Zealand Commissioner and the Private Health Insurance Ombudsman. They meet on average every six months. These meetings enable the Commissioners to develop national strategies, set common goals and objectives, and discuss issues of common and national importance.

During 2006/07, two meetings of the National Council were held. The first in Melbourne, Victoria on 15 November 2006 and the second in Sydney, NSW on 4 April 2007 Specific agendas are drawn up and actioned for each meeting. This financial year some of the matters discussed included:

- Reports from Commissioners
- Draft National Minimum Standards for Prison Health Services
- The Productivity Commission's recommendations regarding the national registration of health professionals
- The new NSW *Health Legislation Amendment (Unregistered Health Practitioners) Act 2006*
- Complaint Data Collection and Health Complaints Information Systems
- Open Disclosure
- Investigations into Unregistered Providers
- Incident Reporting Data – Confidentiality Issues
- Managing Unreasonable Conduct

ACCESS AND AWARENESS THROUGHOUT THE TERRITORY

Access and Awareness Sessions

During the year, staff from the Commission undertook minimal education sessions throughout the Territory. Specific visits were undertaken in Darwin, Alice Springs, and Batchelor. A total of 12 presentations (10 in 2005/06) on the role and operation of the Commission were held. The participants came from agencies such as Department of Health and Community Services, community support services, ethnic groups and Aboriginal health services.

Written Material

The Commission has continued to distribute its pamphlets throughout the Territory, to consumers, targeted organisations and consumer groups. Around 500 pamphlets were distributed to 5 groups throughout the year.

As reported last financial year, there continues to be a need for the Commission to update its pamphlets, brochures and other written material and to develop material that is more appropriate for our ethnic and indigenous populations. This objective cannot be achieved without additional one off funding in the order of $60,000 being provided specifically for this purpose. A number of submissions have been made over the years without any success.

Advertising

The Commission did place some newspaper advertising during the year. No use was made of television or radio advertising. The Commission placed a total of 10 newspaper advertisements in Territory publications during the year at a total cost of $1,541. These advertisements aim to increase public awareness of the Commission's existence and advise people on how they can access the Commission.

Website

People throughout the Northern Territory, and indeed worldwide, can access the Commission through our website at www.hcscc.nt.gov.au. By logging onto the site people can access the Commission's Complaint Form to make a complaint, access information (including the latest Annual Report and Brochures), review our legislation or ask questions without the need to formally contact the Office.

The chart below is testament to the number of people accessing the website during 2006/07:

	2004/05	**2005/06**	**2006/07**
Total visits:	6,835	11,180	10,226
Total page views:	13,240	20,748	22,113
Average visits per day:	19	31	28
Average visits per week:	133	214	197

The large number of visits to the website may account for a decline in direct approaches to the Commission. By empowering consumers with information to resolve their complaints direct with the service providers, they only approach the Commission as a last resort.

ACTIVITY 2: RESOLUTION OF COMPLAINTS

OUTPUTS

1. Accept enquiries and complaints.
2. Refer complainants to point of service for resolution.
3. Assess complaints in a timely, fair and independent manner.
4. Conciliate complaints.
5. Investigate unresolved complaints in a timely, thorough and independent manner.
6. Report to the complainant and provider and to other interested parties the results of an investigation in a clear and concise manner.

PERFORMANCE

Performance Measures	Unit of Measure	04/05	05/06	06/07
		%	%	%
Quality	1. % enquiries/ complaints finalised	84	92	92
	2. % enquiries/ complaints informally resolved	84	90	94
	3. % recommendations supported	100	100	100
Quantity	1. Number of enquiries and complaints received	404	380	312
	2. Number of enquiries and complaints finalised	410	427	320
	3. Number of approaches	362	329	265
	4. Number of investigations finalised	13	14	7
	5. Number of conciliations finalised	4	5	6
Timeliness	1. Average time to close a complaint	236 days	166 days	105 days

HIGHLIGHTS

APPROACHES

Enquiries and complaints are received in person, by telephone, in writing or electronically. Many of these can be handled quickly and are recorded on a separate database as enquiries. A total of 218 enquiries were received during 2006/07 of which 47 (21%) became registered complaints. An additional 47 registered complaints were received which were not the subject of an initial enquiry to the Commission, but may have resulted from a visit to the Commission's office or receipt of a written or electronic complaint.

Of the 265 approaches (refer to explanation below) to the Commission, 35% resulted in a formal complaint being registered (30% in 2005/06).

There has been a decrease in the number of approaches this financial year, from 329 to 265. In numbers that is a 20% decrease. Of particular interest is the fact that although approaches were down the number of formal complaints actioned by the Commission reduced very little (from 97 in 2005/06 to 94 in 2006/07). Therefore the actual workload undertaken by the Assessment Officer and Conciliation/Investigation Officers did not reduce.

Explanation regarding approaches

Approaches registered as an Enquiry	218
LESS Enquiries moved to a complaint	47
Net Enquiries received	171
Approaches registered as a complaint	47
PLUS Enquiries moved to a complaint	47
Total complaints received	94
Total approaches for 2005/06	265

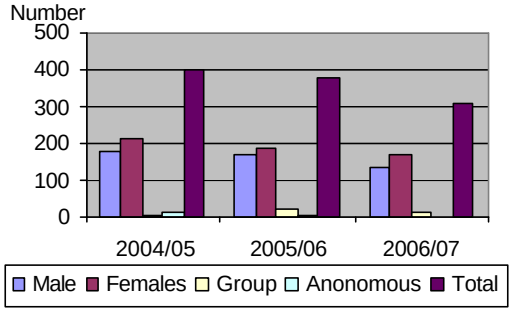
Although the complaint workloads remained the same, substantial productivity and efficiency gains were made during the year. For example:

	2005/06	**2006/07**
Average time taken to finalise all approaches	88 days	44 days
Number of approaches informally resolved	90%	95%
Average time taken to finalise a complaint	166 days	105 days
Number of cases carried forward	30	18

It should be noted that the statistics which follow have been extracted from the Enquiry database and the Complaint database and the numbers quoted relate to the gross figures in each instance, ie the 218 enquiries or 94 complaints.

WHO COMPLAINS?

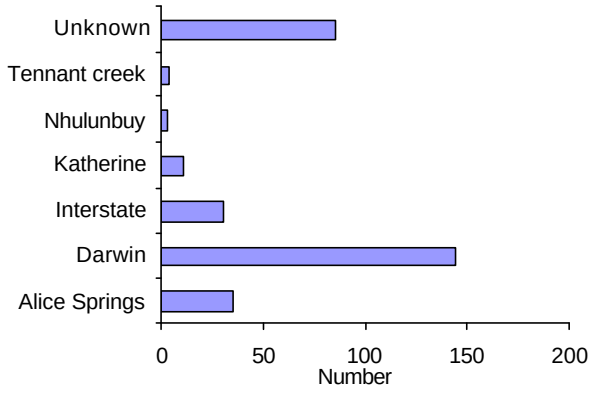
Chart 1: *Gender Breakdown*



The male:female ratio over the past seven years has hovered around the 45:55 mark. As depicted in Chart 1, this year the ratio is 44:56 compared with 48:52 last year. This ratio is similar to that experienced by other Health Complaints Commissions.

GEOGRAPHIC SOURCE OF COMPLAINT

Chart 2: *Geographic source of complaint*

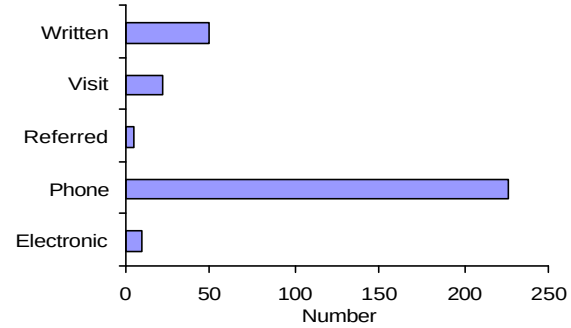


The majority of enquiries/complaints came from Darwin (46%), then Alice Springs (11%) and interstate (10%). The total number of enquiries/ complaints received from Katherine, Tennant Creek and Nhulunbuy are still very low (5%). This will not improve until community engagement activities associated with education, access and awareness are undertaken throughout these areas. At least one visit to each of these areas should be made each financial year.

HOW DO PEOPLE MAKE THEIR COMPLAINT

People approach the Commission in a number of ways. As depicted in Chart 3, 72% do so by phone.

Chart 3: *Manner of Approach*

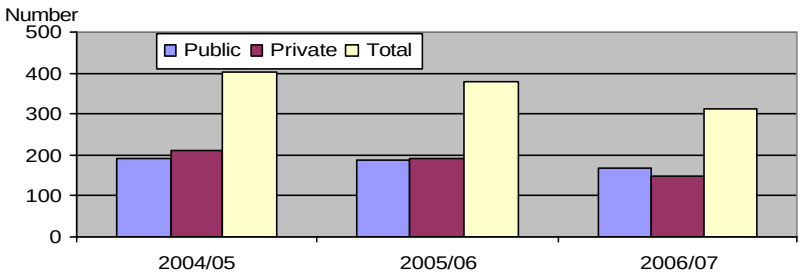


The majority of approaches to the Commission were made via the telephone (72%). The number of written approaches remained similar at 16%. Only 6% of complainants made their complaint in person.

WHICH SERVICES DO PEOPLE COMPLAIN ABOUT?

Public providers received 53% of enquiries/complaints this financial year.

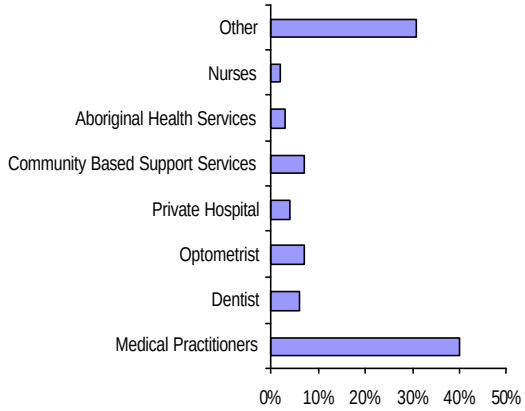
Chart 4: *Public/Private Enquiries/Complaints*



A breakdown of the type of public or private provider complained about follows:

PRIVATE PROVIDERS

Chart 5: *Private provider respondents*

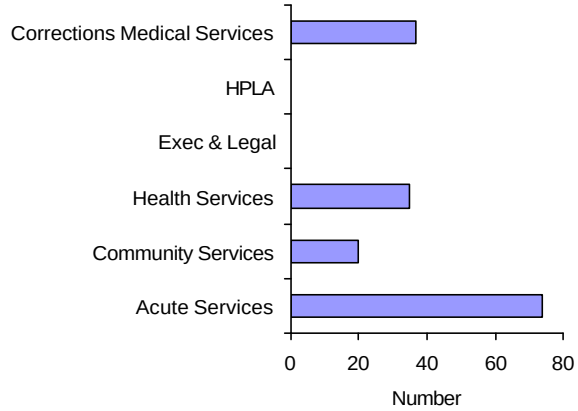


The greatest number of private sector enquiries/complaints (40%) were about medical practitioners, the same as last financial year. Optometrist's complaints increased while Pharmacists decreased.

The category "Other" includes complaints received about Chiropractors, Nursing Homes, Optometrists, Naturopaths, Alcohol & Other Drug Services, Radiographers, Practice Managers and Osteopaths.

PUBLIC PROVIDERS

Chart 6: *Public provider respondents*

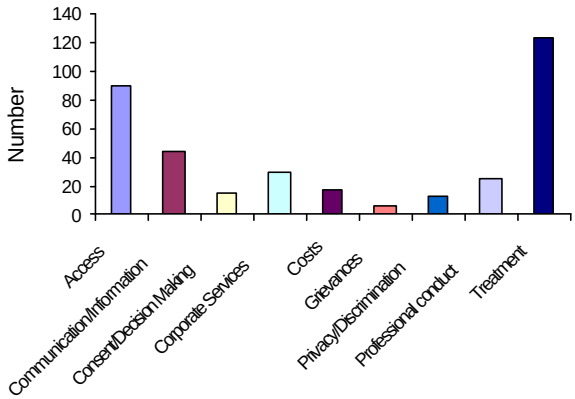


The greatest number of enquires/complaints about the public sector related to services provided by public hospitals (45% of all public health complaints). This is a reduction from last financial year when it was 49%.

There has also been a 30% increase in the number of complaints received about Correctional Medical Service (CMS) when compared to 2005/06.

WHAT ISSUES DO PEOPLE COMPLAIN ABOUT?

Chart 7: *Issues Raised in Enquiries/ Complaints*



Information is recorded about the issues described in every enquiry and complaint and there can be more than one issue per complaint. Chart 7 provides a summary of the issues complained about during 2006/07.

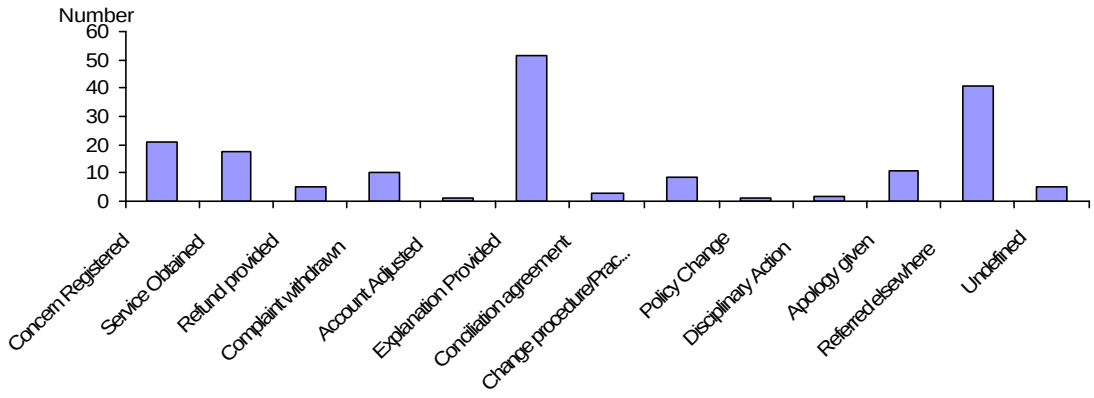
It can be seen that issues associated with treatment were the major concern (33%) followed by access issues (24%). These are similar results to last year.

Issues relating to communication made up 11% of the complaints received (13% 2005/06). It is the Commission's experience however that poor communication underlies many of the other issues of complaint. For example, if providers were to spend more time providing an adequate and understandable explanation of what they plan to do and what happened as a result of the procedure, many of the complaints I receive about poor treatment would be reduced because the patients would be better informed and their expectations would be more realistic.

OUTCOMES OF FINALISED COMPLAINTS

OUTCOMES ACHIEVED

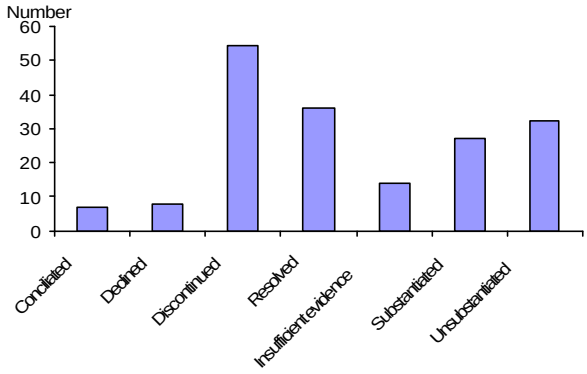
Chart 8: *Outcome Achieved*



Being provided with an explanation was the outcome most achieved (29%), followed by referred elsewhere (23%) and having their concern registered (12%). This is consistent with the fact that most people complain because they have not been given an adequate explanation by the provider of what happened in the first instance. It should be noted that there were 150 complaints closed during the year and 177 outcomes. The reason for this is that a complaint can have more than one outcome.

EXTENT TO WHICH OUTCOME FAVOURED THE COMPLAINANT

Chart 9: *Extent to which outcome favoured the complainant*



30% of complaints were discontinued either because the Commission lost contact with the complainant or because the complainant at some stage decided they no longer required the services of the Commission. I also note that 20% of issues were resolved direct between the provider and complainant thanks to the assistance of the Commission.

PRESCRIBED PROVIDER RETURNS

A number of health service and community service providers are required under the *Health and Community Services Complaints Act 1998* to implement effective internal complaints procedures (Section 100) and to lodge Annual Returns to the Commissioner containing particulars of all the complaints that they have received (Section 99). The providers prescribed under the legislation are:

- Anyinginyi Congress, Tennant Creek
- Central Australian Aboriginal Congress, Alice Springs
- Danila Dilba Biluru Butji Binnilutlum Medical Service, Darwin
- Darwin Private Hospital (DPH)
- Miwatj Health Service, Nhulunbuy
- Department of Health and Community Services (DHCS)
- Wurli Wurlinjang Aboriginal Health Service, Katherine

Tables 2 and 3 provide an overall summary of all enquiries and complaints received by the Prescribed Providers and the Commission.

ISSUES OF COMPLAINT

Table 2 provides an overall summary of the primary issues of all complaints received by prescribed providers and the Commission. Unfortunately Danila Dilba Biluru Butji Binnilutlum Medical Service, Darwin did not provide a return.

Table 2: *Comparison Between Commission and Prescribed Providers - Issues*

CATEGORY	HCSCC	DHCS	DPH	A/S Con	Wurli	Miwatj	Anyi	Total
Access to Services	90	375	2	3	1	0	1	472
Commun/Information	43	111	1	2	0	0	1	158
Consent/Dec Making	15	4	0	0	0	0	0	19
Corporate services	30	88	3	0	0	0	1	122
Costs	18	17	1	0	0	0	0	36
Grievances	6	3	0	1	0	0	0	10
Privacy/Discrimination	13	49	0	4	0	0	0	66
Professional Conduct	25	30	3	1	0	0	0	59
Treatment	123	145	5	1	1	0	0	275
Total[5]	**363**	**822**	**15**	**12**	**2**	**0**	**3**	**1217**

[5] Some complaints have more than one issue

Issues associated with accessing services (39%) and the quality of treatment (23%) are the major concerns of users of health services and community services throughout the Northern Territory. Complaints about poor communication make up 13% of issues complained about.

I note that of the total 1217 enquiries and complaints received from the above organisations, only 10 or 0.8% relate to a grievance about the manner in which a complaint was handled. This would tend to suggest that internal complaints mechanisms set up as a result of the legislation are working effectively.

COMPLAINT OUTCOMES

Table 3 provides an overall summary of the outcomes of all complaints received by prescribed providers and the Commission.

Table 3: *Comparison Between Commission and Prescribed Providers – Outcomes*

OUTCOME	HCSCC	DHCS	DPH	A/S Con	Wurli	Miwatj	Anyi	Total
Service obtained	2	244	3	0	0	0	0	249
Explanation provided	93	332	6	2	1	0	3	437
Apology given	6	74	0	2	0	0	0	82
Counselling/mediation	0	16	1	0	0	0	0	17
Concern registered	115	58	5	2	0	0	0	180
Change in procedures/practice	4	20	0	0	0	0	0	24
Policy change effected	3	1	0	0	0	0	0	4
Account adjusted	8	2	0	0	0	0	0	10
Disciplinary action	18	1	0	0	0	0	0	19
Conciliated	4	7	0	0	0	0	0	11
Compensation paid	0	3	0	0	0	0	0	3
Complaint Withdrawn	1	2	0	2	0	0	0	5
Resolved	14	0	0	3	0	0	0	17
Referred Elsewhere	98	13	0	1	1	0	0	113
Other - Pending	0	0	0	0	0	0	0	0
- Unresolved	12	14	0	0	0	0	0	26
- Unknown	14	0	0	0	0	0	0	14
Total[6]	**392**	**787**	**15**	**12**	**2**	**0**	**3**	**1211**

The data at table 3 highlights the fact that complainants are more likely to obtain a practical resolution to their complaint if they take up their concerns and issues directly with the provider in the first instance. For example only 0.5% of the outcomes achieved by the Commission resulted in the complainant obtaining a service, whereas in complaints made direct to the service provider 30% resulted in the service being obtained.

The most effective means of resolving complaints was to provide an acceptable and reasonable explanation (36%).

[6] Some complaints have more than one outcome

PROVIDER AND COMPLAINANT SATISFACTION SURVEY

As a means of assessing the quality of our service, the Commission seeks feedback from providers and complainants as to their satisfaction with the complaints process. Survey forms are sent to both complainants and providers when they are formally notified that their file will be closed following assessment, investigation or conciliation.

During the year 36 surveys were sent out to complainants and 44 to providers. 5 complainant surveys and 12 provider surveys were returned.

SATISFACTION WITH OUTCOME

The first section of the survey sought to measure participant's *satisfaction with the outcome of a complaint.*

- Of the provider responses, 75% were satisfied and 25% were very satisfied.
- Of the complainant responses, 25% were not satisfied and 75% were satisfied.

Respondents were asked *how clear were the reasons that were given for the outcome of the complaint.*

- Of the provider responses, 40% indicated clear and 60% very clear.
- Of the complainant responses, 80% clear, and 20% very clear.

SATISFACTION WITH THE COMPLAINT PROCESS

The second section of the survey sought to measure participant's *satisfaction with the complaints process.*

Providers

- Providers found it easy (60%) or very easy (40%) to contact Commission staff.
- They found Commission staff were not prompt (10%), prompt (60%) or very prompt (30%) in responding to letters and phone calls. They were also found to be not polite (10%), polite (40%) or very polite (50%) and they either listened well (50%) or very well (50%).
- Providers found staff explained the complaint process and role of the Commission not clearly (10%), clearly (50%) or very clearly (40%).
- They found that staff kept them informed of the progress of their complaint not well (15%), well (50%) or very well (35%).
- Overall, providers were either satisfied (50%) or very satisfied (50%).
- 80% would feel comfortable about using the Commission again.

Complainants

The complainant responses seemed to indicate less satisfaction however responses were still mainly positive.

- 20% indicated it was not easy to contact Commission staff, with 40% indicating easy and 40% indicating very easy.
- In responding to letters and phone calls, 20% considered staff were not prompt, 20% considered staff were prompt and 60% very prompt.
- 80% found staff to be either polite or very polite (69%). 80% also found staff to listen well or very well.
- When explaining the complaint process and the role of the Commission 60% of respondents indicated the explanation was provided clearly and 40% very clearly.
- Staff were found to have kept complainants informed of the progress of their complaint either well (20%) or very well (80%).
- Overall satisfaction with the way the complaint was handled was 20% of respondents indicating not satisfied, 60% satisfied and 20% very satisfied.
- 100% were comfortable with using the Commission again.

SURVEY COMPARISON

It can be seen from the tables below that, as was the case last financial year, 100% of providers were either satisfied or very satisfied with the outcome of their complaint. On the other hand there has continued to been an increase in the overall percentage of complainants satisfied or very satisfied with the outcome of their complaint when compared to last year.

Chart 10: *Complainant - Outcomes*

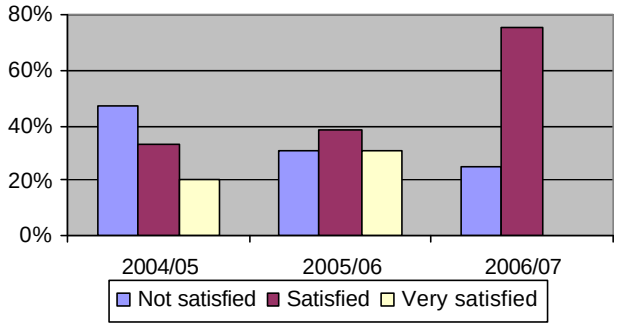
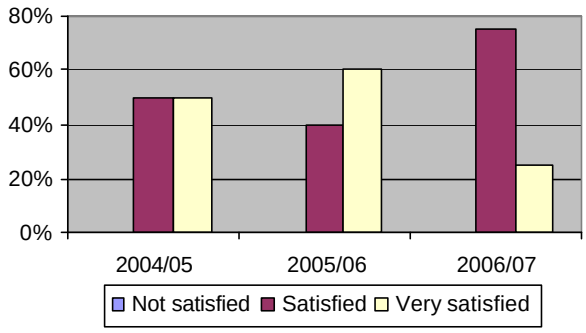


Chart 11: *Provider – Outcomes*



The percentage of providers satisfied with the way their complaint was handled remains at 100%, while the complainant's satisfaction rate decreased slightly from 85% to 80%.

Chart 12: *Complainant - Handling*

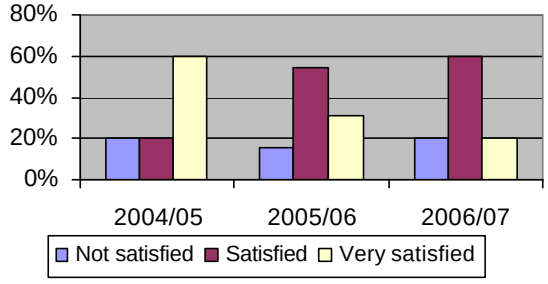
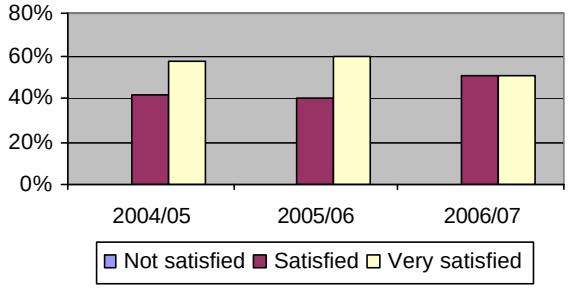
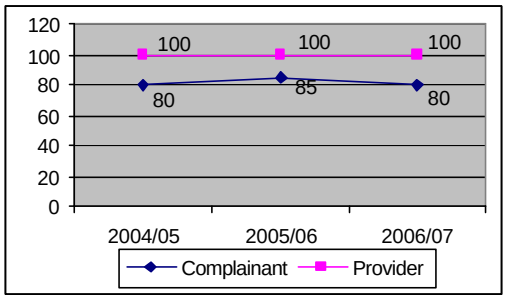


Chart 13: *Provider - Handling*



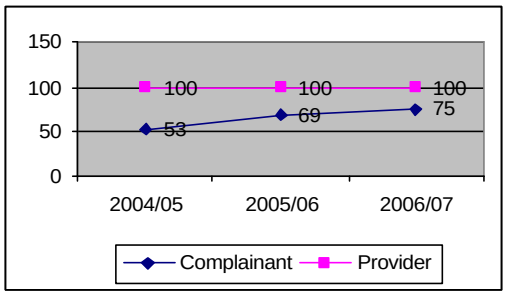
CONCLUSION

Chart 14: *Handling of Complaint*



As in previous years, providers overall are more satisfied with the complaint process than the complainant (100% provider and 80% complainant). This has remained steady over the past three years.

Chart 15: *Outcome of Complaints*



Providers remain 100% satisfied with the outcome of complaints while complaints satisfaction with their outcomes has continued to increase over the past three years (53% to 75%).

Of the respondents who completed the Satisfaction Survey, 100% of providers and 80% of complainants stated they would be comfortable about using the Commission again.

The results of this survey would indicate that the Commission is continuing to provide a quality service in complaints resolution.

ACTIVITY 3: IMPROVE HEALTH SERVICES AND COMMUNITY SERVICES

OUTPUTS

1. Make recommendations to providers and other appropriate bodies.
2. Refer professional conduct matters to appropriate registration boards.
3. Follow-up on implementation of recommendations.

PERFORMANCE

Performance Measures	Unit of Measure	04/05	05/06	06/07
Quality	1. Number of providers who improved their practice following implementation of investigation recommendations.	13	14	8
	2. Percentage of providers responding to recommendations.	100%	100%	100%
Quantity	1. Number of recommendations made following investigations.	52	34	21

HIGHLIGHTS

A major objective of the Commission is to utilise our complaint resolution processes to facilitate improvements in the provision of health services and community services. This objective is often supported by complainants who seek, as one of the outcomes to their complaint, an assurance that what happened to them will not happen to others.

I am pleased to report that the Commission has been very successful in identifying and recommending changes that, when implemented, will lead to improvements in the provision of services. During the course of the year 21 recommendations were made to providers.

I have included the following examples of investigations the Commission has undertaken to reflect the Commission's achievements in this regard during 2006/07.

THE 'ADDICTION DOCTOR' CEASES TO PRACTICE

BACKGROUND

A number of complaints were received by the Commission and also referred to the Commission by the *Office of Consumer and Business Affairs* (BACA) relating to services provided by a person who at that time called himself the *'Addiction Doctor'* and *'Spiritual Healer'*.

The 'Addiction Doctor' claimed to be a 'spiritual healer' who was able to cure cancers; diseases; illnesses; psychological problems and addictions including smoking, drinking, gambling and marijuana. His advertisements stated that he had a 100% success rate, however if a person was unhappy with their treatment an immediate refund would be offered.

Complaints received by the Commission related to the actions, advice and services provided by the 'Addiction Doctor'. The most serious complaint suggested that a person suffering from depression committed suicide 3 days after speaking with him. The Coroner's report into the matter indicated that the deceased had an appointment with the 'Addiction Doctor' where he told him that he had previously been seen by a GP. It was alleged that the deceased advised the 'Addiction Doctor' that he was not planning to take the medication prescribed by the GP. The 'Addiction Doctor' allegedly commented to the deceased that he should cut all contact with his good friend and business partner; that his business would never succeed because his friend had cursed him and that the deceased should sell his property otherwise he would remain sick. It was also reported that the 'Addiction Doctor' advised the deceased that there was no such thing as depression leading to the deceased deciding that he was not going to take the medication. The Coroner expressed the view that although the deceased was clearly in a *fragile state* and the 'Addiction Doctor' may have made some *insensitive comments* (that the deceased may have taken seriously), there was no evidence that he caused the deceased's death or was in a position to prevent it.

Of concern was the comment made by the 'Addiction Doctor' when interviewed by the Commission that should a person come to him with an addiction, sickness or injury he would not suggest to them that they should seek qualified medical assistance as in his opinion '*(doctors) can not cure anything'*. Further, that he might also provide advice to a person about the effectiveness of the medication they were taking.

One complaint to the Commission from a registered Psychologist advised that 50 of her clients had reported dissatisfaction and humiliation after receiving services from the 'Addiction Doctor'. Other complaints received by the Commission were the result of dissatisfaction with the 'Addiction Doctor' in that he had not cured their addictions. Further, that when some of these complainants sought refunds they were not provided.

ISSUES CONSIDERED BY THE COMMISSION

The investigation of the 'Addiction Doctor' considered the following issues:

- Whether he was providing a health service within the meaning of the *Health and Community Services Complaints Act*;
- Whether or not he was qualified to provide medical advice;
- Whether or not that service was unreasonable within the meaning of the *Health and Community Services Complaints Act*;
- Whether or not, in the public interest, under Section 65 of the *Health and Community Services Complaints Act* the preliminary inquiries be reported to the Legislative Assembly or the Minister.

THE INVESTIGATION

The 'Addiction Doctor' was summonsed to attend the Commission for interview and to bring with him and produce for inspection all records, papers, telephone records, bank statements, advertising material, taxation records and any other documents within his power, possession and control relating to his activities as the 'Addiction Doctor' for the previous two years.

The 'Addiction Doctor' attended the Commission for interview but failed to bring with him most of the requested documentation, stating that he did not possess records of his clients. What records he did have he stated he had destroyed.

When asked to describe his expertise, qualifications and business, the 'Addiction Doctor' stated *"Travelled Australia, found Darwin to be a nice place to stay, so I started here, stayed here. And I took a trip to the Philippines and I met an original old faith healer over there. And he introduced me to another world in which he, em, is not a part of our world and, with that introduction, I did a lot of study, a lot of work, have done for the last 7 years and I've fine tuned my knowledge and ability to now be able to do what I do".*

The 'Addiction Doctor' stated that what he studied was *'intangible'* and he did so with his *'thoughts'*. He had not attended, read or participated in any educational process relevant to the activities he was undertaking. He agreed during the interview that he was studying something that didn't exist except in the '*other world*'.

The 'Addiction Doctor' stated that he had treated over 1000 people in the past 18 months with each person paying him $250.00 for their treatment. He further stated that he was not running a business and that people saw him for *'nothing'*. His rationalisation for not issuing receipts or conforming to taxation requirements was that he provided no service and therefore there was no requirement for him to pay tax or issue goods and service receipts. In response to receiving this information, the Commission, pursuant to Section 57 of *the Act,* sent notification to the Australian Tax Office (ATO) about the activities of the 'Addiction Doctor'.

The 'Addiction Doctor', despite stating that he did not run a business, regularly advertised in the NT News. He also posted flyers in and around the Darwin area. He had also recorded his business in the Northern Territory Community Guide and Business Directory.

It was the opinion of the Commission that the 'Addiction Doctor's advertising was deceptive. The 'Addiction Doctor' did not provide any evidence that he possessed any qualifications, experience or skills to support his claims. His assertion that he had a 100% success rate in *'curing'* consumers was fraudulent. He continually contradicted himself throughout the interview supporting the premise that he was not always honest.

Section 8A of the *Consumer Affairs and Fair Trading Act* (CAFT Act) allows BACA to issue a public warning about:

- services which are considered to be supplied in an unsatisfactory way and the people who supply these services;
- commercial practices that are considered unfair and the people who engage in these practices; and
- anything else considered to adversely affect, or which may adversely affect, the interests of people in the acquisition by them of goods and services from suppliers.

Section 42 of the same *Act*, precludes a person engaging in conduct that is misleading or deceptive or is likely to mislead and deceive, while Section 44 makes it an actual offence (punishable by fine) to make false or misleading representation in relation to goods or services.

In addition, Section 48 of the Act was relevant to the 'Addiction Doctor's' activities. That Section is as follows:

> *A person shall not, in trade or commerce, engage in conduct that is liable to mislead the public as to the nature, the characteristics, the suitability for their purpose or the quantity of any services.*

As the 'Addiction Doctor' was not operating his business through a corporation, the Northern Territory consumer protection legislation applied to his business dealings and conduct, as opposed to the *Commonwealth Trade Practices Act.* The Commission therefore, pursuant to Section 57 of the *Health and Community Services Complaints Act,* notified the *Office of Business and Consumer Affairs* of the circumstances and requested that they investigate the 'Addiction Doctor's activities.

The 'Addiction Doctor' was advised by the Commission that using the title of *'Doctor'* in connection with his services was an offence under to Section 104 of the Health Practitioners Act which stated:

> *104 Unauthorised use of certain titles*

(1) A person must not practise a profession or trade under a title specified in Schedule 7, column 2 [eg doctor] unless he or she is registered or enrolled in a category of registration or enrolment in the category of health care practice specified opposite the title in column 1.

Penalty: 500 penalty units

Following his interview, the 'Addiction Doctor' responded in writing to the Commission. In this response, the 'Addiction Doctor' (who had changed his title *to "The Addiction Guru"*) reported that he did not provide a health service. He stated that what he now did was an *'activity'* which he had named *"intangible addiction banishment".*

RECOMMENDATIONS

The recommendations made by the Commission (some of which had already been actioned) as a result of undertaking this investigation were:

- Refer the 'Addiction Doctor's activity to the *Australian Tax Office*;
- Write to 'Addiction Doctor' warning him not to use the term *'Doctor'* in his advertising or name;
- Refer the 'Addiction Doctor's activities to the *Office of Business and Consumer Affairs.*

The Commission also recommended that a public statement/warning be issued and this matter be tabled in the Legislative Assembly pursuant to Section 19(3) of the *Health and Community Services Complaints Act*.

CONCLUSION

The 'Addiction Doctor' was sent a notice to cease and a copy of the investigation report including attachments to enable him to provide comment.

The Commissioner received a response from the 'Addiction Doctor' confirming that he had ceased his activity of 'Intangible Addiction Banishment', stopped advertising, stopped distribution of flyers and removed signage.

To enable the public to be warned about the "Addiction Doctor' and his activities, the Commission's report was forwarded to the Minister for Health and subsequently tabled in the Legislative Assembly on 3 May 2007. Despite the seriousness of the practices of the "Addiction Doctor" the report was never debated in the Legislative Assembly. In addition, a press release was issued by the Commission but the media gave no coverage to the report as tabled.

In a strange twist the "Addiction Doctor" is now the licensed proprietor of a tobacco shop.

COMPLAINANT NOT TREATED APPROPRIATELY FOR STD

BACKGROUND

The complainant consulted a GP after having contracted a Sexually Transmitted Infection (STI) whilst on holidays. He stated that the GP did not wash her hands before or after examining him, did not wear gloves for handling the urine sample and swab, did not inform him about Clinic 34, phoned him at home with the pathology results rather than phoning him on his mobile as he had requested, and prescribed a cocktail of five different antibiotics rather than the antibiotic injection, Ceftriaxone available from Clinic 34.

The complainant made an appointment to speak with the GP to try to resolve his concerns but was told by the Practice Manager that he would have to pay for the appointment and would need to speak with the Practice Owner (also a GP). The complainant felt he had a genuine complaint and did not believe he should have to pay for another appointment.

INVESTIGATION PROCESS

The investigation was carried out by reviewing the complainant's medical records and pathology test results held by the Surgery where his consultation took place, obtaining written responses from the GP and Practice Owner, undertaking telephone interviews with the Practice Manager and conducting face to face interviews with the complainant.

The Commission also contacted Clinic 34, obtained a copy of the Northern Territory (NT) Centre for Disease Control Guidelines for the Management of Sexually Transmitted Infections in the Primary Care Setting and obtained an Expert Opinion from a Public Health Physician.

ISSUES FOR INVESTIGATION

The issues investigated by the Commission were:

- The reasonableness of the treatment provided to the complainant by the GP; and
- The adequacy of complaint handling procedures at the Surgery

ISSUE 1 - THE REASONABLENESS OF THE TREATMENT PROVIDED TO THE COMPLAINANT BY THE GP

Findings

From the information obtained by the Commission in relation to Issue 1 it was able to make the following findings:

1. At his consultation the GP did not ask the complainant enough specific questions to get a clear understanding of the problem, where the STD had been contracted and from whom.

2. The GP should have conducted a more thorough physical inspection of the complainant's infected areas and skin.

3. Although it is a common convention to wear gloves, the fact that the GP did not do so did not compromise the quality of care, physical examination or the taking of the swab.

4. The GP ordered the appropriate blood and screening pathology tests.

5. The overall treatment given to the complainant was deficient in that it was not appropriate for the STD he had and there was a degree of over treatment.

6. At the initial consultation the complainant should have been advised of the STD he probably had and provided with some educative material about contacting anyone else he had been sexually involved with and what to do until the results of the tests were known.

7. The complainant should have been advised to return for re-assessment and have repeat blood tests in approximately 3 months time if the symptoms had not resolve in 48 hours.

8. Best practice indicates that the complainant should have been advised of his STI results face to face and not over the phone as they were positive results.

Conclusion

The Commission was of the view that, based on the independent opinion, the standard of care provided to the complainant was reasonable in some areas and less than adequate in others. The Commission appreciated that General Practitioners in busy practices may not be able to provide the same specialist care for STI's as that provided by a specialist clinic such as Clinic 34. While the pathology tests ordered by the GP were appropriate, the treatment offered was not adequate as it was not specific to the STI. It would also have been more appropriate for the complainant to have been informed face to face about the diagnosis of the STI so that advice could have been provided on the implications for himself and his sexual partner/s.

The Commission therefore concluded that there was a breach of the following principles of the *Code of Health and Community Rights and Responsibilities:*

> **Principle 1: Standards of Service**
> 1. Users have a right to:
> a) timely access to care and treatment which is provided with reasonable skill and care

Principle 2: Communication and the provision of information

1. Providers have a responsibility to:

a) provide accurate and up to date information responsive to the user's needs and concerns, which promotes health and well-being

d) provide information about other services, and as appropriate, how to access these services

ISSUE 2 - THE ADEQUACY OF COMPLAINT HANDLING PROCEDURES AT THE SURGERY

Findings

From the interviews and information obtained the Commission made the following findings:

1. The complainant was informed by the Surgery that he would be charged a standard consultation fee in order to make a complaint about the care and treatment he received.

2. The complainant was not asked to put his complaint in writing and the surgery made no attempt to address his concerns.

3. The complaint escalated to the point where the complainant had to approach the Commission which resulted in the Commission investigating the clinical issues relating to the complaint.

Conclusion

The Commission was of the view that, based on the Australian Standard for Complaints Handling (AS 4269 -1995), the complaint handling procedures at the Surgery were less than adequate. The Australian Standard listed 13 minimum essential elements of an effective complaints handling process and the Commission considered that the following elements were not adhered to:

- 1.2 **Commitmen**t – there shall be a commitment to efficient and fair resolution of complaints by people in the organisation at all levels. The policy on complaints handling shall be in writing.

- 2.5 **Visibility** – a complaints handling process shall be well publicised to consumers and staff, and shall include information to consumers about the right to complain.

- 2.6 **Access** – a complaints handling process shall be accessible to all and ensure that information is readily available on the details of making and resolving complaints. The complaints handling process and supporting information shall be easy to understand and use, and be in plain language.

- 2.9 **Charges** – complaint handling shall be at no charge to the complainant, subject to statutory requirements

In this instance the complainant sought a refund for inappropriate treatment and wished to make a genuine complaint – a separate issue from seeking free medical attention through bulk billing.

The Commission concluded that there was a breach of the following principles of the *Code of Health and Community Rights and Responsibilities:*

> **Principle 1: Standards of Service**
> 1. Users have a right to:
> a) timely access to care and treatment which is provided with reasonable skill and care
>
> **Principle 8: Complaints and feedback**
> 1. Providers have a responsibility to:
> a) provide a mechanism for users to give feedback or make complaints about their care or treatment
> b) inform users of the complaint process and of how to make a complaint
> c) ensure that complaints are dealt in an open, fair, effective and prompt manner, and without reprisal or penalty

RECOMMENDATIONS

The Commission made the following recommendations:

1. That the Practice Owner and the GP note the findings of this Investigation Report and adhere in future to the Interim NT Guidelines for the Management of Sexually Transmitted Infections in the Primary Health Care Setting.

2. That the Practice Owner provides written evidence to the Commission of a revised written complaints handling process at the Surgery that adheres to the key elements of the Australian Standards for Complaints Handling.

   A copy of the Surgery's Complaint Handling Policy has since been provided to the Commission.

3. That the Medical Board of the Northern Territory be provided with a copy of the investigation report for consideration under the provisions of the *Health Practitioners Act 2004*.

PATIENT WITH CHEST PAIN NOT REFERRED IMMEDIATELY TO HOSPITAL

BACKGROUND

The complaint approached the Commission with concerns about the standard of care and treatment her father received from a GP. The complainant advised that her father presented to the GP with chest pain and that the GP failed to provide appropriate care. She complained that a definitive diagnosis was not pursued as a matter of urgency, and her father's condition remained undiagnosed until a day later when he was referred to the Emergency Department (ED) of the local hospital. Specifically, the complainant was of the view that her father should not have had to wait in the surgery waiting room and should have been assessed immediately via Electrocardiogram (ECG)[7] or referred immediately to ED for further assessment.

INVESTIGATION PROCESS

During the course of the investigation the Commission's inquiries included further consultation with the parties to the complaint, a review of the medical records, a site visit to the GP's Surgery, a review of relevant policy and procedural guidelines and a review of current research literature. The Commission also sought advice regarding the patient's subsequent treatment at the hospital and his current health outcome. Independent clinical advice assisted in consideration of all treatment issues. The draft investigation report was provided to the parties for their consideration and comment.

ISSUES FOR INVESTIGATION

The issues determined for investigation were as follows:

- Prioritisation of patient care by reception staff at the GP's Surgery
- The standard of care and treatment provided by the GP; and
- Degree of impact on the patient's long term health outcomes.

ISSUE I - PRIORITISATION OF PATIENT CARE AT RECEPTION

The complainant's concerns

The complainant stated her mother advised the receptionist at the Surgery by telephone that an appointment was needed for her husband who had experienced chest pains and she was concerned that her father was not encouraged by the receptionist to seek urgent medical care rather than attend the surgery. The complainant expressed further concern about her father not being assessed as a high risk patient when he presented to reception in person – her father waited for two hours before being seen by the doctor.

[7] Electrocardiogram – n. a recording of the electrical activity of the heart on a moving paper strip. It aids in the diagnosis of heart disease, which may produce characteristic changes in the ECG. Oxford Concise Medical Dictionary (2003) Oxford University Press

The Investigation

The Commission's inquiries did not resolve with any certainty what information was disclosed to the receptionist either over the phone or at presentation at reception. Despite a communication breakdown occurring between both parties to the complaint the Commission believed that there remained the opportunity for them to consider the factors that contributed to this miscommunication. These factors are discussed below.

- Information presented to the Commission indicated that the complainant's father was not experiencing chest pain at time his wife spoke on the phone or at the time he presented at the Surgery. He was not displaying behaviours consistent with someone needing emergency care or requiring priority above other patients.

- Underlying this impasse between the parties was the belief that the other party was either mistaken or being deliberately misleading. There was of course a third explanation, being that a genuine misunderstanding had occurred. In such circumstances each party has a responsibility to check for understanding, to ask questions, and to seek clarification

Conclusion

While no definitive determination could be made in relation to what information was exchanged over the phone or at reception between the complainant's parents and reception staff, it was clear that a communication breakdown occurred. Responsibility for this breakdown in communication must ultimately be shared.

ISSUE 2 - WAS THE STANDARD OF CARE AND TREATMENT PROVIDED BY THE GP REASONABLE IN THE CIRCUMSTANCES?

The complainant's concerns

The complainant detailed the efforts made by her parents to have her father seen by a doctor. Prior to attending the Surgery the complainant's mother had contacted the public hospital and her call had been diverted to NT Health Direct. Having spent considerable time communicating with this service, her father was referred on to an after hours general practice. On presentation to the Surgery, her father then experienced a wait of two hours.

The complainant's concerns escalated when she learned that her father had not been referred directly to hospital by the treating GP. These concerns were validated when she later learned that her father had indeed suffered a heart attack nearly three days earlier.

Findings in relation to care and treatment

The investigation found that the standard of care and treatment provided to the complainant's father by the GP was reasonable in the circumstances. The Commission assessed the management plan recommended by the GP in light of current clinical guidelines and found that there had been no breach of the Code of Health and Community Rights and Responsibilities. Understandably, the complainant and her parents had an expectation that any suspicion of a cardiac event would result in an emergency response. The evidence suggested however, that the time lag between the onset of pain and presentation to a medical practitioner is a determining factor of investigative options, and that patient delay is a significant determinate in long term health outcomes.

ISSUE 3 - WHETHER OR NOT EARLIER DIAGNOSIS WOULD HAVE IMPACTED ON THE CONSUMER'S HEALTH OUTCOME.

The complainant's concerns

The complainant expressed concern that the time elapsed between when contact was made with the Surgery and her father being admitted to the Emergency Department may have contributed to the damage done to her father's heart.

The outcome being sought by the complainant in relation to this aspect of her complaint was stated as follows:

> *"Resolution for my father for loss of earnings, unnecessary pain and suffering and possible future diminished quality of life."*

Conclusion

A review of the patient's medical records and consultation with a senior cardiologist at public hospital confirmed that the patient's father achieved a full return to good health. There was no indication that he had suffered an adverse outcome related specifically to the time lag between presentation to the Surgery and being admitted to hospital about 18 hours later.

The complainant's father was fortunate to have made a full recovery from his heart attack, despite the amount of time that had elapsed between the onset of symptoms and his presentation to a medical practitioner. While there was a further time lag between the tests recommended by the GP and the results being received by the complainant's father, there was no evidence to suggest that this wait for results contributed to an adverse outcome.

SUMMARY OF INVESTIGATION FINDING

1. No finding could be made regarding the information exchanged between the family and reception staff, either over the telephone, or in person.

2. Miscommunication contributed to the misunderstandings between the parties that prevented resolution of the complaint at an early stage.

3. The standard of care and treatment provided by the GP was determined to be reasonable in the circumstances.

4. The complainant's father had suffered no adverse health outcome attributable to the management plan recommended by the GP.

5. There was no breach of the Code of Health and Community Rights and Responsibilities.

RECOMMENDATIONS

The Commission recommended that the Medical Board of the Northern Territory be provided with a copy of the investigation report for consideration and any further action it might decided to take under the provisions of *The Health Practitioners Act (NT) 2004*.

ACTIVITY 4: MANAGEMENT OF COMMISSION

OUTPUTS:

1. Production of an Annual Report.
2. Compliance with the *Health and Community Services Complaints Act*.
3. Compliance with the *Financial Management Act and Public Sector Employment and Management Act*.
4. Compliance with policies and procedures associated with:
   - Equal Employment Opportunity;
   - Recruitment and appointment on merit
   - Work Life Balance;
   - Occupational Health and Safety; and
5. Compliance with the *Carers Recognition Act*
6. Compliance with the *Information Act*.
7. Management of resources.

PERFORMANCE

Performance Measures	Unit of Measure	04/05	05/06	06/07
Quality	1. Audit reports clear of major issues.	N/A	N/A	N/A
	2. Activities undertaken in accordance with Business Plan.	Yes	Yes	Yes
Quantity	1. Number of copies of Annual Report printed.	150	150	150
	2. Policies and procedures up to date for:			
	• Equal employment;	Yes	yes	Yes
	• Occupational Safety and Health;	Yes	Yes	Yes
	• Equity and Merit; and	Yes	Yes	Yes
	• Information Technology.	Yes	No[8]	Yes
Timeliness	1. Annual Business Plan prepared.	Sept 04	Sept 05	Sept 06
	2. Annual Report tabled at the Legislative Assembly's October sittings.	Dec 04	Oct 05	Oct 06
	3. Policies and procedures available to all staff at all times.	Yes	Yes	Yes

[8] For detailed explanation refer to page 60

CORPORATE GOVERNANCE

LEGISLATIVE FRAMEWORK

The Commission is responsible for the administration of the *Health and Community Services Complaints Act 1998*.

The Commissioner is the accountable officer for the Health and Community Services Complaints Commission and has responsibility under the *Financial Management Act* for the efficient, effective and economic conduct of the Commission.

Under the *Health and Community Services Complaints Act 1998*, the Commissioner is independent of the Government and is not accountable to a Minister, but rather to the Legislative Assembly. However, under the Administrative Arrangements Orders, the Minister for Health has administrative responsibility for the Commission.

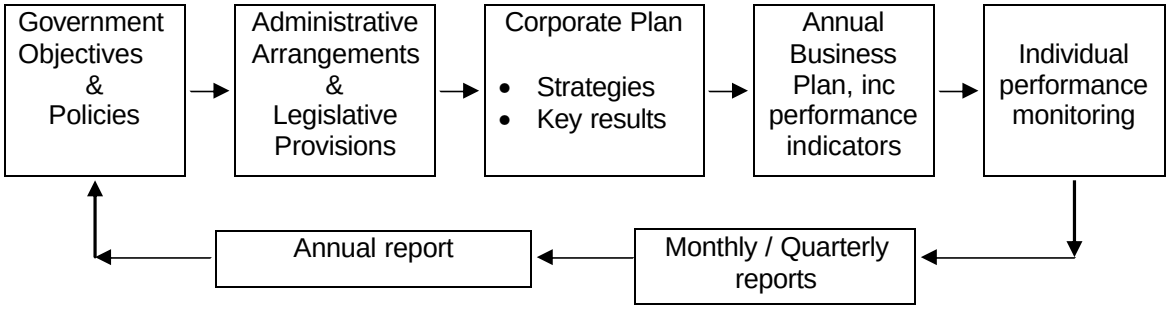
PLANNING AND REVIEW CYCLE

The Commission has developed and adopted a continuous planning and review cycle.

Diagram 1: *Planning and Review Cycle*

In relation to the strategic planning framework the Commission operates in the following way:

Diagram 2: *Strategic Planning Framework*



The Corporate Plan for the Commission was developed in mid 1998. It was reviewed in March 2002 and again in 2006. As a result of the review the Plan was amended slightly and provides direction for the next five years, that is until 2011. The Corporate Plan provides guidance for the Commission and is a reference point for all staff in relation to where we are heading and what we are trying to achieve.

An annual Business Plan is prepared and this provides specific direction and performance indicators and this in turn cascades down into individual performance plans. Performance reports are provided to the Management Board and overall performance of the Commission is reported annually to the Legislative Assembly.

PERFORMANCE MANAGEMENT SYSTEM

There are a number of ways that performance is monitored during the course of the financial year. These include the following:

- Short weekly meetings with staff to identify priorities and action required during the week.
- Open door policy to discuss day to day management of files and complaints.
- Fortnightly case meetings between each staff member and Deputy Commissioner to discuss and monitor progress on cases and, where appropriate, determine action on the more difficult cases.
- Monthly case meetings between each staff member and the Deputy Commissioner.
- As required, meetings between Investigation/Conciliation Officers and Director Investigations.
- Progress reports relating to the Business Plan being provided to the Management Board and Commissioner as required.
- Individual performance being measured at least annually against agreed performance indicators.
- Achievement of the detailed strategies and performance indicators being reported in the Annual Report.

INTERNAL ACCOUNTING CONTROL PROCEDURES

The internal control procedures expected to be adopted by accountable officers for their agency are defined in the *Financial Management Act and Treasurer's Directions*. Part 3 of the Treasurer's Directions defines the internal control procedures to be established and incorporated into an agency's Accounting and Property Manual.

The Commission has been incorporated into the Office of the Ombudsman's control procedures, which have been determined to conform with these requirements and are recorded in the Ombudsman's Accounting and Property Manual.

EQUAL EMPLOYMENT OPPORTUNITY MANAGEMENT PROGRAM

The Commission has been included in the Ombudsman's Equal Opportunity Plan because it is co-located with, and obtains its administrative support from, the Ombudsman's Office and a detailed report can be found in the 2006/07 Ombudsman's annual report.

In addition, the Commission, through the Ombudsman's Office has an Aboriginal and Career Development Plan and continues to examine how to better utilise the skills of those it employs to improve the Commission's ability to provide culturally appropriate services to Aboriginal people.

MANAGEMENT TRAINING AND STAFF DEVELOPMENT PROGRAMS

A performance appraisal framework has been implemented to meet the needs of the Commission. A major objective achieved through the implementation of this program is the design of individual annual training and development programs for all Commission staff.

The training and staff development program was implemented in 2006/07 as sufficient funds became available. It can be seen from the information below that the number of training opportunities significantly increased.

Expenditure on staff training and development during 2006/07 amounted to $6,300 ($401 in 2005/06). This is represented by a total figure of 111 training hours and comprised 7 training opportunities (8 training hours and 2 training opportunities in 2005/06).

OCCUPATIONAL HEALTH AND SAFETY PROGRAM

The Commission has been included in the Ombudsman's Occupational Health and Safety Management Plan because it is co-located with, and obtains its administrative

support from, the Ombudsman's Office and a detailed report can be found in the 2006/07 Ombudsman's annual report.

CARER RECOGNITION ACT REPORTING REQUIREMENTS

In accordance with Section 7 of the *Carers Recognition Act* the Commission reports that it has had no direct involvement with the provision of support and services to people with a disability, the aged, people with a chronic disease and those with mental illness by unpaid carers during the course of the financial year.

FOI ANNUAL REPORTING REQUIREMENTS

Section 11 of the *Information Act* sets out the information a public sector organisation must publish annually in relation to its process and procedures for accessing information. The Commission has been included in the Ombudsman's procedures for accessing information because it is co-located with, and obtains its administrative support from, the Ombudsman's Office and a detailed description of processes and procedures can be found in the 2006/07 Ombudsman's annual report.

During the financial year the Commission received no requests under the *Information Act*.

RECORDS MANAGEMENT

Part 9 of the *Information Act* relates to Records and Archives Management. This section sets out the obligations, standards and management of records and archives to be complied with.

In accordance with Section 134 of the *Information Act,* the Health and Community Services Complaints Commission:

(a) keeps full and accurate records of its activities and operations

(b) is in the process of implementing practices and procedures for managing its records necessary for compliance with the standards applicable to the organisation through the implementation of a Records Management Plan.

The Records Management Plan for the Ombudsman's Office incorporates the Health and Community Services Complaints Commission and is aiming to achieve the following objectives:

- records management staff fully trained;
- adopt new methods and technologies for keeping and managing records; and
- fully compliant with the *Information Act (*2003) and the NTG Standards for Records Management.

As reported in the last Annual Report, the software system used by the Ombudsman needs modifying to comply with the NT Archives Standards and these modifications

had stalled through lack of funds. The necessary funds to remedy the situation were allocated and in conjunction with the Ombudsman's Office, the Commission commenced a project to implement the whole of Government Information Management system TRIM in June 2007. It is estimated this project will be completed by June 2008. TRIM will enable the commission to manage their records effectively and assist in working towards being fully compliant with the *Information Act* (2003) and the NTG Standards for Records Management.

Appendix 1

SERVICE STANDARDS OF THE HEALTH AND COMMUNITY SERVICES COMPLAINTS COMMISSION

THE COMMISSION'S STAKEHOLDERS:

The Commission's stakeholders are:

- Users and providers of health services and community services in the Northern Territory.
- Health Professional Registration Boards, community and consumer groups and professional associations.
- The Minister for Health and Community Services.
- The Legislative Assembly of the Northern Territory.

THE COMMISSION'S COMMITMENT:

1. Visibility

The Commission will promote its opening hours, contact details and the services it provides in a manner which facilitates access to the Commission and takes into account the diversity of the Northern Territory population.

The Commission also undertakes to:

- take enquiries and complaints between 8 a.m. and 4.30 p.m. Monday to Friday; and
- visit each regional centre once a year to take complaints.

2. Accessibility

The Commission undertakes to provide services that are accessible and appropriate by:

- assisting those with special needs to prepare and lodge complaints;
- using trained interpreters as necessary;
- enabling complainants to lodge oral complaints;
- visiting regional centres regularly; and
- providing and advertising a toll free telephone number.

3. Fairness and Impartiality

The Commission will ensure fairness and impartiality in its operation by:

- not favouring either those making or those responding to complaints;
- giving equal regard to all complaints;
- being independent of any individual, group or organisation subject to a complaint;
- acting with respect for the interests of the public;
- promoting open and transparent decision making by providing reasons for its decisions and outlining the factors taken into account in reaching a decision; and
- providing an independent review mechanism.

4. Timeliness

The Commission will operate in a timely manner and will:

- answer calls and correspondence promptly;
- carry out assessment of complaints within 60 days; and
- give information to people involved in a complaint about the process of the complaint every six to eight weeks.

5. Lawfulness

At all stages of the complaint process the Commission will act within its statutory powers and abide by the principles of natural justice.

6. Staff of the Commission

The Commission undertakes that its services are provided by staff who are courteous and professional and will:

- identify themselves and provide their contact details in telephone calls and correspondence;
- perform their work conscientiously, with honesty and integrity;
- be competent to carry out the tasks required of them; and
- clearly inform those who contact the Commission of the limits of their powers and resources, and the services they are unable to provide.

7. Information

The Commission, through its staff, promotional material, web site and annual reports, undertakes to provide:

- accurate and reliable information on its services, policies, procedures and statutory authority;
- information on the complaints process and the options available within the process; and
- information on alternative services and how to access these services.

8. Accountability

The Commission is committed to continuous improvement and undertakes to:

- develop and implement a system for gathering feedback from those who access the Commission;
- inform all users and providers of the mechanism for reviewing the process by which the Commission handles complaints and reaches decisions;
- monitor the adequacy of action taken by providers in response to Commission's recommendations; and
- provide, in its annual report, information on the Commission's effectiveness in securing compliance with recommendations.

9. Privacy and Confidentiality

The Commission will maximise the privacy and confidentiality of those using its services by:

- handling material provided to the Commission with consideration as to the effect it may have on both individuals and organisations;
- subject to legislative requirements, releasing information only with the prior permission of the individual or organisation providing that information; and
- publishing data which does not identify those using the Commission's services.

Appendix 2

DETAILED COMPLAINT STATISTICS FOR 2006/07

ENQUIRY/COMPLAINT STATISTICS 2006/07

A detailed breakdown and analysis of the enquiries and complaints received follows.

ENQUIRIES RECEIVED

1. Number of Enquiries Open During the Year

As detailed in Table 4, a total of 218 new enquiries were registered during the year.

Table 4: *Enquiries Movement During 2006/07*

ITEM	2005/06	2006/07
Enquiries open as at 1 July	4	7
Enquiries received during the year	283	218
Total active enquiries for the year	**287**	**225**
Enquiries finalised during the year	227	160
Enquiries becoming formal complaint	53	47
Enquiries still open as at 30 June	**7**	**18**

Of all the active enquiries, 71% were finalised (79% in 2005/06), 21% became formal complaints (19% in 2005/06) and 8% remained open (2% in 2005/06).

3. Providers Subject to Enquiries Received

Table 5 below provides a breakdown of providers which have been the subject of enquiries over the past year.

Table 5: *Providers Subject to Enquiries*

PROVIDER	2004/05	2005/06	2006/07
Public Providers:	**137**	**143**	**122**
Acute Services	71	66	53
Community Services	8	15	13
Health Services	19	33	29
Exec & Legal	1	1	0
Health Professionals Licensing Auth	1	1	0
Corrections Health Service	37	27	27
Private Providers:	**136**	**140**	**96**
Medical Practitioners	76	54	40
Medical Centres	0	4	0
Ambulance service	0	3	0
Audiologist	0	3	0
Medical Insurance	0	0	0
Practice Manager	1	5	0
Counselling Service	1	0	0

Community Based Support Groups	10	2	5
Dentist	14	9	10
Pharmacists	7	8	1
Nurse	0	4	1
Aboriginal Health Services	4	3	4
Alcohol and Drug Services	1	1	3
Naturopath	0	1	1
Diagnostic Services	1	1	1
Hospital	3	5	7
Chiropractors	0	2	2
Hostel/Supported Accommodation	0	5	1
Masseuse	0	1	0
Nursing Home	3	3	0
Occupational Therapist	0	0	0
Optometrists	2	3	4
Alternative Therapist	3	1	0
Psychologist	1	5	1
Radiographer	1	0	0
Osteopath	1	0	0
Other	7	17	15
Outside Jurisdiction:	**0**	**0**	**0**
TOTAL	**273**	**283**	**218**

Of the total enquiries received during the year under review, 56% related to public providers (49% in 2005/06) and 44% to private providers (51% in 2005/06).

43% of public provider enquiries were about the public hospital system (compared to 46% in 2005/06) while 42% of private provider enquiries were about medical practitioners (compared to 39% in 2005/06).

FORMAL COMPLAINTS RECEIVED

1. Number of Complaints Open During the Year

As detailed in Table 6, 94 new complaints were received during the year. Of the 124 total active complaints for the year, 106 or 85% were closed (83% in 2005/06).

Table 6: *Complaints Movement During 2005/06*

ITEM	2005/06	2206/07
Complaints open as at 1 July	83	30
Complaints received during the year	97	94
Total active complaints for the year	**180**	**124**
Complaints closed during the year	150	106
Complaints still open as at 30 June	**30**	**18**

As at 30 June 2007 the age breakdown of the open complaints was as follows:

	2005/06	2006/07
• Under 6 months	19	12
• 6-9 months	4	1
• 9-12 months	3	1
• Over 12 months	3	3

2. Providers Subject to Complaints Received

(a) Breakdown of providers subject to complaints received

Table 7 below provides a breakdown of providers that have been the subject of complaints over the past year. Of the total complaints received during the year under review, 47% related to public providers (45% in 2005/06) and 53% to private providers (55% in 2005/06).

Table 7: *Breakdown of providers subject to complaints received*

PROVIDER	2004/05	2005/06	2006/07
Public Providers:	**54**	**44**	**44**
Acute Services	30	28	21
Community Services	5	5	7
Health Services	12	10	6
Exec & Legal	0	0	0
HPLA	1	0	0
Corrections Health Service	6	1	10
Private Providers:	**77**	**53**	**50**
Medical Practitioners	44	23	27
Practice Manager	1	0	1
Ambulance Service	1	0	0
Community Based Support Groups	2	2	1
Aboriginal Health Services	3	3	1
Alcohol and Other Drugs	1	0	0
Pharmacists	6	6	0
Private Hospital	2	0	3
Hostel/Support Accommodation	0	2	0
Dentists	5	4	5
Naturopath	0	0	0
Psychologist	1	0	1
Radiographer	1	0	0
Nurse	4	9	3
Chiropractors	2	2	1
Diagnostic Service	0	0	0
Optometrist	0	0	4
Alternate Therapist	0	1	0
Occupational Therapist	0	0	1
Carer	1	0	0
Other	3	1	2
Outside jurisdiction:	**0**	**0**	**0**
TOTAL	**131**	**97**	**94**

48% of public provider complaints were about the public hospital system (compared to 63% in 2005/06) while 54% of private provider complaints were about medical practitioners (compared to 43% in 2005/06).

(b) Complaints about hospitals

Around 26% of all complaints related to the hospital system (23% in 2005/06) and, as Table 8 illustrates, 67% of these were against Royal Darwin Hospital (RDH). Darwin private Hospital also received complaints (3) for the first time in three years.

Table 8: *Complaints about hospitals*

HOSPITAL	2004/05	%	2005/06	%	2006/07	%
Royal Darwin Hospital	20	67	24	86	16	67
Alice Springs Hospital	8	27	2	7	1	4
Katherine Hospital	0	0	2	7	2	8
Darwin Private Hospital	0	0	0	0	3	13
Tennant Creek Hospital	1	3	0	0	2	8
Gove District Hospital	1	3	0	0	0	0
Total	**30**	**100**	**28**	**100**	**24**	**100**

To put the above figures in perspective, RDH is the principal acute care and tertiary referral hospital in the Northern Territory and its Emergency Department is the trauma centre for the Top End.

(c) Complaints received by medical specialty

Around 29% of all complaints related to medical practitioners (23% in 2005/06) and, as Table 9 illustrates, 59% of these were against General Practitioners.

Table 9: *Complaints received by medical specialty*

MEDICAL SPECIALITY	2004/05	%	2005/06	%	2006/07	%
General Practitioner	32	74	17	74	16	59
Emergency Medicine	0	0	0	0	0	0
Surgeon	2	4	0[9]	0	0	0
Plastic/Cosmetic Surgeon	3	8	0	0	2	6
Physician	0	0	2	9	1	4
Orthopaedics	1	2	0	0	1	4
Psychiatrist	2	4	1	4	1	4
Pain Management	0	0	0	0	0	
Sports medicine	1	2	0	0	0	
Paediatrics	1	2	0	0	1	4
Endocrinologist	0	0	2	9	1	4
Cardiologist	0	0	0	0	0	
Ophthalmologist	0	0	0	0	0	
Dermatologist	0	0	0	0	1	4
Anaesthetist	0	0	0	0	0	
Urologist	0	0	0	0	1	4
Obstetrician/Gynaecologist	2	4	1	4	2	7
Total	**44**	**100**	**23**	**100**	**27**	**100**

I should also point out that many of the complaints received about the public health system (as identified in Table 7 above) often name a specific registered provider such as a Surgeon, Anaesthetist, etc, but these named providers are not reflected in the figures at Table 9.

[9] A number of Surgeons were named in complaints against the public health system (such as the Royal Darwin Hospital) and although these providers were also notified to the relevant registration board, the complaint is recorded against the hospital and not the named provider.

(d) Complaints received about aged and disability services

As the Commission can receive complaints relating to aged services and services for people with a disability it is appropriate that a record is kept of the number of complaints relating to these services. These are detailed in Table 10.

Table 10: *Aged and Disability Services Complaints*

PROVIDER TYPE	2004/05	2005/06	2006/07
Hostel/Supported Accommodation	1	2	0
Nursing Homes	0	0	0
Mental Health (Public)	3	3	4
Community Based Support - Disabilities	1	2	1
Disability Services (Public)	1	0	1
Total	**6**	**7**	**6**

The number of complaints against specific disability and aged services has remained similar for the past 3 years. However, in addition to the above identified aged and disability services complaints, there are a number of these types of complaints recorded as against the public hospital system.

COMPLAINTS CLOSED

1. Reason for Closure

The *Health and Community Services Complaints Act 1998* allows for complaints to be closed under certain circumstances and information recorded by the Commission about the reasons for such closure. These reasons are summarised in Table 11.

Table 11: *Reasons for Closure*

REASONS FOR CLOSURE	2004/05	2005/06	2006/07
Enquiry concluded	20	7	5
Complaint is resolved	47	28	36
Investigating further is unnecessary	27	33	33
Failed to resolve complaint with provider	6	3	0
Issues determined by court, tribunal or board	1	33	1
Info. required under sec 25 not received	0	1	3
Complaint lacks substance	4	1	1
Complaint has been withdrawn	6	3	5
2 years before the complaint was made	0	0	1
Referred to relevant Board	35	37	20
Frivolous, vexatious or not made in good faith	0	0	0
Court began to hear the substantive matter	0	3	0
Not a person referred to in Sec 22	0	1	0
Not a matter referred to in Sec 23	2	0	0
Not a prescribed service	1	0	1
Total	**149**	**150**	**106**

The Commission, following preliminary enquiries, found that in 31% of cases it was unnecessary or there was insufficient justification to continue with any investigations into those cases (22% in 2005/06). Around 34% of complaints were closed during

assessment because the issues identified in the complaints were satisfactorily resolved between the complainant and the provider (18% in 2005/06). 19% of complaints were referred to the relevant Board (24% in 2005/06).

2. Outcomes of Complaints

(a) Complaints resolved by stage

Table 12 shows the stage when complaints were resolved.

Table 12: *Complaints resolved by stage*

STAGE OF COMPLAINT PROCESS	2004/05	2005/06	2006/07
Enquiry	1	4	0
Point of Service	9	14	40
Facilitated Resolution	4	0	14
Assessment	75	40	25
Referred to Board	35	69[10]	14
Conciliation	4	5	6
Investigation	21	18	7
Total	**149**	**150**	**106**

If closures relating to Board referrals are discounted, 86% of all other complaints were resolved without the need to revert to the more formal processes of referral, conciliation or investigation (73% in 2005/06).

(b) Outcomes of complaints closed

Table 13 notes the outcomes achieved from closed complaints.

Table 13: *Outcomes of complaints closed*

OUTCOME	2004/05	2005/06	2006/07
Concern registered	22	8	21
Apology given	9	6	11
Service obtained	3	2	18
Change in procedures/practice	27	4	8
Account adjusted	1	0	1
Compensation paid	0	0	2
Conciliation Agreement Reached	5	4	3
Explanation provided	68	66	52
Policy change effected	6	3	1
Disciplinary action taken	10	18	2
Refund provided	2	8	5
Referred elsewhere	40	39	41
Complaint withdrawn	10	3	10
No further action taken	0	2	0
Not accepted	0	0	0
Other	0	0	0
Undefined	12	13	3
Total	**215**	**176**	**178**

[10] A large proportion of complaints referred to the relevant Board in previous years were closed during the financial year. The practice now is that once a complaint has been referred to the relevant Board it is closed.

The major outcome received by complainants was to be given an explanation (29%).

ISSUES IN ENQUIRIES/COMPLAINTS RECEIVED

Information is recorded about the issues described in every enquiry and complaint, and often more than one issue is recorded against a complaint. Standard issue descriptions are used and these are grouped under categories.

An understanding of the issues raised in complaints can serve to highlight areas where service improvement is warranted. The information provided in Table 14 below provides an overview of all issues identified in relation to the total numbers of enquiries (218) and complaints (94) received as recorded against the ten major categories.

Table 14: *Primary Issues Raised in Enquiries/Complainants by Category*

CATEGORY	2004/05	%	2005/06	%	2006/07	%
Treatment	121	27	137	33	123	33
Access	108	24	93	22	90	24
Communication/Information	59	13	43	10	43	12
Privacy/Discrimination	21	5	27	6	13	3
Costs	27	6	18	4	18	5
Corporate Services	26	6	33	8	30	8
Professional Conduct	52	11	44	10	25	7
Consent/Decision Making	17	4	9	2	15	4
Grievances	14	3	3	1	6	2
Out of Jurisdiction	3	1	17	4	8	2
Total	**448**	**100**	**424**	**100**	**371**	**100**

As was the case last year, issues dealing with treatment were the major reason why people made enquiries and complaints to the Commission. This was then followed by access issues.

Tables 15 to 23 which follow, provide details of the issues as identified in the formal complaints received by the Commission under each major category. Issues identified in enquiry have not been included.

ACCESS

An analysis of the particular issues is provided at Table 15.

Table 15: *Access Issues*

ISSUES	2005/06	2006/07
Attendance	2	1
Delay in admission or treatment	7	7
Discharge or transfer arrangements	2	5
Inadequate or no service	7	12
Referral	1	1
Refusal to admit or treat	2	4

Service Unavailable	0	0
Transport	0	0
Waiting list delay	0	0
Total	**21**	**30**

Delays in treatment and inadequate or no service continue to be the major issues complained about in this category.

TREATMENT

An analysis of the particular issues raised are provided at Table 16.

Table 16: *Treatment Issues*

ISSUES	2005/06	2006/07
Treatment Coordination	3	2
Diagnosis	10	9
Treatment Inadequate	14	13
Infection Control	1	0
Medication	15	16
Treatment Negligent	3	2
Treatment Rough/Painful	4	0
Treatment Withdrawn/Denied	0	2
Treatment Wrong/Inappropriate	0	7
Total	**50**	**51**

Issues associated with inadequate treatment and medication were of major concern.

COMMUNICATION/INFORMATION

An analysis of the particular issues is provided at Table 17.

Table 17: *Communication/Information Issues*

ISSUES	2005/06	2006/07
Attitude	9	17
Information inadequate	6	4
Interpreter/Special needs services	1	0
Information Wrong/misleading	4	5
Total	**20**	**26**

Complaints associated with the attitude of a provider continue to be by far the most significant communication issue complained about.

It would be fair to say that there are elements of communication problems in just about every complaint received by the Commission and this continues to be a problem in the subsequent resolution of complaints.

PRIVACY/DISCRIMINATION

An analysis of the particular issues is provided at Table 18.

Table 18: *Privacy/Discrimination Issues*

ISSUES	2005/06	2006/07
Access to records	0	0
Cultural appropriateness	0	0
Discrimination	1	0
Discrimination public/private patient	0	0
Inconsiderate service	4	1
Privacy/confidentiality	2	1
Total	**7**	**2**

COSTS

An analysis of the particular issues is provided at Table 19.

Table 19: *Cost Issues*

ISSUES	2005/06	2006/07
Billing practices	0	0
Government subsidies	1	1
Information on costs	0	0
Over servicing	0	1
Overcharging	0	0
Private health insurance	0	0
Public/private election	0	0
Total	**1**	**2**

CORPORATE SERVICES

These complaints are more about how services are run than the medical or health care/treatment component of the service. An analysis of the particular issues is provided at Table 20.

Table 20: *Corporate Service Issues*

ISSUES	2005/06	2006/07
Administrative practice	4	3
Catering	0	1
Cleaning	0	1
Facilities	1	1
Hygiene/environmental standards	0	1
Policy/procedures	2	2
Security	1	1
Standard of hospital/institute practice	1	2
Total	**9**	**12**

PROFESSIONAL CONDUCT

An analysis of the particular issues is provided at Table 21.

Table 21: *Professional Conduct Issues*

ISSUES	2005/06	2006/07
Accuracy/inadequacy of records	1	2
Advertising issues	1	0
Assault	2	1
Certificate/reports	1	2
Competence	7	6
Financial fraud	0	0
Illegal practice	4	3
Impairment	11	2
Sexual misconduct	1	1
Total	**28**	**17**

It is pleasing to note that complaints about the professional conduct of providers substantially reduced this financial year.

CONSENT/DECISION MAKING

An analysis of the particular issues raised is provided at Table 22.

Table 22: *Consent/Decision Making Issues*

ISSUES	2005/06	2006/07
Consent invalid	1	1
Consent not informed/failure to warn	0	0
Consent not obtained	2	4
Failure to consult consumer	1	2
Involuntary admission	0	1
Total	**4**	**8**

GRIEVANCES

An analysis of the particular issues raised is provided at Table 23.

Table 23: *Grievance Issues*

ISSUES	2005/06	2006/07
Inadequate or no response	1	5
Reprisal/retaliation	0	0
Total	**1**	**5**

It is disappointing that there has been an increase in complaints about how providers handle concerns about their service direct with the complainant.

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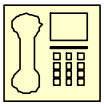

or

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