Health and Community Services
COMPLAINTS COMMISSION

Annual Report
2011-2012

DRIVING
improvement

Health and Community Services
COMPLAINTS COMMISSION

Fourteenth Annual Report 2011/12

The Honourable David Tollner MLA
Minister for Health
Parliament House
DARWIN NT 0800

Dear Minister

In accordance with the requirements of section 19(1) of the *Health and Community Services Complaints Act*, I am pleased to present the Annual Report of the Health and Community Services Complaints Commission for the year ending 30 June 2012.

Yours sincerely

Lisa Coffey
Commissioner

9 October 2012

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FROM THE COMMISSIONER

This year the Health and Community Services Complaints Commission (HCSCC) has clearly articulated a plan for meeting the key objectives of the Health and Community Services Complaints Act (the Act), namely the resolution of complaints, improvement of services and promotion of rights. I am pleased to provide details of the development of our new Action Plan and the adoption of mission, vision and values set out later in this report.

We have also released new information brochures to inform people about the role of the HCSCC, how to access us and what to expect from our services. In our new publications we encourage service providers to take a problem solving approach to complaints and see them as an opportunity to help users to understand their care and treatment; to reflect on and improve their services; and to protect and enhance their reputation. Service users are encouraged to raise concerns and complaints, be clear and realistic about the outcomes they are seeking and seek assistance whenever they need it.

Our commitment to impartial and independent service, protection of confidentiality, accessibility, provision of advice and assistance to all parties to a complaint, and to allowing parties the opportunity to be heard through our processes is highlighted in our brochures. It is central to the way we carry out our business.

Enquiries and Investigations

In 2011/12 there was an increase in the total number of people approaching the HCSCC raising concerns about health, disability and aged services. The numbers of both complaints and enquiries have risen this year, but it is worth highlighting the way in which we have assisted parties to resolve concerns in an informal way through our enquiry process. More detail on this process can be found later in the report, but it is pleasing to note that we have been able to deal with more concerns informally, and in less time.

To ensure that we measure quality as well as quantity and timeliness, we are currently undertaking a review of the way we handle enquiries. During this review we will seek feedback from parties to matters handled through our informal processes; and consult with stakeholders, including bigger institutional providers. We will also look at best practice in other jurisdictions. From this information we will test that this process meets the objectives of the Act and the needs of the parties involved, and make the required improvements to our service. It is an exciting exercise and we look forward to reporting on it in 2012/13.

At the other end of the spectrum, we have completed sixteen investigations and continue to monitor the implementation of recommendations in nine. This is a major achievement for a small office and represents not only the finalisation of almost all of the older matters referred to in the last report, but also completion of new investigations covering a wide variety of concerns. Details of some of issues we investigated follow later in the report.

Planning

In 2011/12 the HCSCC developed and put into place a new Plan to guide our work through to the end of 2013. Our new vision and mission and our stated values reported on page 6 reflect our commitment to our work and to making a substantial and sustained contribution to improvement of services in the NT.

The plan also reflects our ambition to be more effective in aged and disability sectors and remote communities; to continue to increase the robustness of our internal processes; increase our visibility and accessibility; develop our skill in conciliation; and drive improvement by ensuring that recommendations for change are effective and effectively implemented. The value we place on being a learning organisation is also highlighted by the planned development activities, the training and reviews undertaken in the past year and our plan to improve feedback mechanisms at the conclusion of complaints.

We look forward to reporting against these goals in the coming year.

Meeting of Health and Disability Services Commissioners, Darwin

One of the highlights of the year for me was the convening of both the Disability Service Commissioners' meeting and the Health Services Commissioners' meeting in Darwin in May. Topics covered at the meetings are documented later in the report and as always these meetings provided an invaluable opportunity to hear from a variety of stakeholders, researchers, experts in a number of fields; as well as share experiences, and discuss developments and positions with other Commissioners from around Australia and New Zealand.

Prior to the Disability Services Commissioners' meeting, we were very fortunate to have the Victorian Commissioner, Laurie Harkin, and his deputy, Lynne Coulson-Barr, visit our office to share some of their knowledge and experience in the field of disability complaints and conciliation. I would like to again express my thanks to both Laurie and Lynne for their generous contribution to the development of our expertise in this area. Further detail of the lessons we took from this visit are outlined later in this report.

Farewell and Thanks

This year was Deputy Commissioner Vic Feldman's last at the HCSCC. Vic has been with the HCSCC since its beginning, working on the development of the Act and being integral to the establishment of the HCSCC within the Ombudsman's Office back in 1998. After nearly 40 years of public service, Vic retired in July 2012. I would like to record my thanks to Vic for his support of me over the past two years and for his contribution to the work of the HCSCC over the last 14 years. While we miss his humour, experience and expertise, we wish Vic and Geraldine all the best in their retirement.

I also wish to acknowledge the team at the HCSCC. We have had a busy, productive year, with much to show for our efforts, not least of all the clearly articulated vision for the coming year. I am proud to work with such a committed group, dedicated to not only to driving improvement of the services we oversee, but also their own practice. I look forward to a successful 2012/13.

Finally, as always I pay tribute to the people and organisations that have used our services in the past year. It takes courage to engage in the complaints process; to hear and address concerns, to hear and understand answers; to be open, honest and direct; and to accept an outcome that might not always be what is hoped for. One of the most common reasons people give for making a complaint is to ensure that an experience is not repeated. One of the most powerful outcomes is acknowledgement of experience and commitment to learn. These are the practical precursors to improvement and make an enormous contribution to the realisation of our vision of quality services in the NT.

LISA COFFEY
COMMISSIONER

October 2012

PERFORMANCE OVERVIEW FOR 2011/12

Key performance outcomes for 2011/12 period:

- A 13% increase in the number of approaches to the HCSCC compared to the previous year (509 up from 450). This included a 12% increase in enquires (458 up from 408) and an 8% increase in complaints (101 from 94).
- 95% of approaches finalised during the year (90% in 2010/11).
- Average time taken to finalise a complaint increased from 109 days last year to 140 days this financial year. However the average time taken to finalise enquiries decreased from 11 days to 9 days.
- Average time taken to assess a complaint increased from 53 days to 97 days (includes time taken for AHPRA consultation) or 76 days (not including AHPRA consultation). 50% of complaints were assessed within the legislated 60 days, down from 66% last year but an improvement on previous years.
- 87% of approaches to the HCSCC were resolved without a formal investigation, conciliation or referral process.
- Seven investigations finalised; nine investigations closed and waiting confirmation that the recommendations have been implemented; and a further 10 investigations are ongoing.
- 77 formal recommendations made at the conclusion of investigations.
- Five conciliations finalised, with 4 matters in conciliation at the end of the year.

This snapshot of the HCSCC's activities over the 2011/12 financial year demonstrates that the overall workload of the HCSCC increased, as did our effectiveness.

ABOUT US

Administrative Arrangements

The HCSCC is established under the *Health and Community Services Complaints Act* (the Act) and is made up of the Commissioner and staff. The Commissioner is appointed by the Administrator and is required to act independently, impartially and in the public interest in the exercise of her powers. The Commissioner reports annually to the Minister for Health, as the responsible minister, on the exercise of her powers and the performance of her functions. For administrative purposes the HCSCC is located within the Department of the Attorney-General and Justice.

Vision

Quality health, disability and aged care services delivered equitably to all Territorians.

Mission

Drive improvement by providing accessible, impartial, independent, quality advice, education and complaints resolution.

Values

Integrity – impartial, transparent and accountable at all times; fair, ethical, respecting confidentiality.
Respect – person centred, listen, act in a caring manner, value diversity, be reasoned and reasonable.
Professional Excellence – expert, hard working, committed to learning; demonstrating leadership & building relationships.
Responsiveness – accessible, timely, appropriate to need, culturally aware, inclusive, flexible, leading to practical outcomes.
Courage – rights based; act independently and in accordance with the Act; make and communicate decisions.

Objectives

The objectives of the HCSCC are set out in section 3 of the Act. It requires that the HCSCC establishes a health and community services complaints system that:

- provides an independent, just, fair and accessible mechanism for resolving complaints between users and providers of health services and community services;
- encourages and assists users and providers to resolve complaints directly with each other;
- leads to improvements in health services and community services and enables users and providers to contribute to the review and improvement of health services and community services;
- promotes the rights of users of health services and community services; and
- encourages an awareness of the rights and responsibilities of users and providers of health services and community services.

Powers and Functions

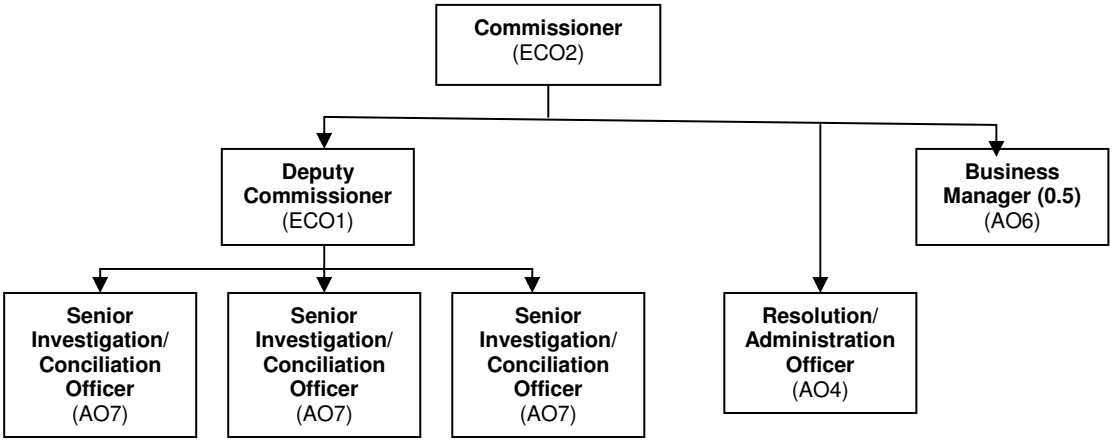
The Commissioner has the following powers and functions as set out in section 12 of the Act:

(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.

Organisational Structure

The HCSCC receives support from the Department of Attorney-General and Justice in areas such as human resources, finance, procurement, record management and information technology. The HCSCC is co-located with the Office of the Children's Commissioner.

The organisational structure of the HCSCC is as follows:



Human Resources

As at 30 June 2012 the HCSCC had a total of 6.5 staff, including the Commissioner. Included in the staff numbers is the position of Business Manager (AO6) which is shared between the HCSCC and the Office of the Children's Commissioner.

Table 1: Staffing Profile as at 30 June 2011

Position Level	Male	Female	Total
Commissioner (ECO2)	0	1	1
Deputy Commissioner (ECO1)	1	0	1
Administrative Officer 7 (AO7)	1	2	3
Administrative Officer 6 (AO6)	0.5	0	0.5
Administrative Officer 4 (AO4)	0	1	1
Total	**2.5**	**4**	**6.5**

Performance Measures

The HCSCC's performance for 2011/12 is measured through a set of agreed parameters as set out below. These performance measures are intended to present an overview of the operations of the HCSCC over the 12 month period. More detail on performance can be found later in this report.

Key Deliverables	2010/11	2011/12
Enquiries & complaints received	502	559
Enquiries & complaints closed	411	485
Complaints resolved within 180 days of receipt	78%	78%

RESOLUTION OF COMPLAINTS

The Process

One of the three key objectives of the HCSCC is to provide an independent, just, fair and accessible mechanism for the resolution of complaints between users and providers of health and community services.

As the HCSCC is impartial, we do not represent parties in a dispute but will encourage and assist the parties to resolve the issues of complaint wherever possible.

Enquiries

Most matters that come to the HCSCC start with a phone call, but people also contact us via the web, letter, email or through another person. Once contact is made, a Senior Investigation / Conciliation Officer will listen to the concerns raised and let them know how these concerns can be dealt with. The officer will discuss options for resolving the concerns with the caller, including the possibility of contacting the service provider directly to discuss the issues raised or having the HCSCC contact the provider on the caller's behalf.

The focus at this stage of the process is on resolving the complaint as informally as possible. If it is not possible or appropriate to resolve concerns at this level, we send a complaint form or confirm the complaint in writing so that more formal action can be taken.

If the HCSCC cannot deal with the issues raised, we will refer the caller to someone else who can assist them with their concerns.

Complaints

For matters that cannot be resolved through our enquiry process, or are too complex and require a written response, a formal complaint can be made to the HCSCC. A formal complaint can be made in writing, on a complaint form, on-line, via email, telephone or in person. Once the details of the complaint are received and the basis for the complaint is clear, the complaint is registered and assessed. During the 60 day assessment period the HCSCC officer may notify the parties of the complaint, seek further information about the complaint, and speak to advisors about the matter. The officer will continue to assist the parties to work to resolve the complaint where appropriate. A clear and open response from the provider and an apology (where appropriate) will often resolve the complaint at this stage.

The purpose of the assessment process is to allow the Commissioner to determine the best way to deal with the complaint. The actions available to the Commissioner are: to conciliate the complaint, investigate the complaint, refer the matter to another body such as a health practitioner's registration board, or take no further action.

Australian Health Practitioner Regulation Agency (AHPRA)

If the complaint involves a registered provider, such as a doctor or a nurse, the HCSCC must provide the relevant National Health Practitioner (Registration) Board, via its administrative arm AHPRA, with the details of the complaint, including the name of the provider. The Boards and the HCSCC are subject to the terms of the Health Practitioner Regulation National Law (NT) (the National Law), which requires that when either organisation receives a complaint that would also fall within the jurisdiction of the other, the organisations must consult before deciding what action to take on that complaint.

Consultation regarding complaints lodged with the HCSCC occurs after the assessment process is complete, but prior to the final determination being made. This ensures that the Boards have the chance to review the proposed decision of the Commissioner and express a view on its appropriateness, including in some cases, which organisation is best placed to investigate a matter. Often where a complaint raises only issues of professional conduct of

an individual, the HCSCC will agree to refer that matter to the relevant Board. We are then unable to take any action on that complaint unless the Board refers the matter back to us.

Referral

If the Commissioner forms the opinion following assessment that the issues in a complaint would be better dealt with by another body, she may decide to refer it to that body. Other possible referral bodies include the Ombudsman, the Anti-Discrimination Commission, the Information Commissioner and Consumer Affairs.

No Further Action

The Commissioner can decide to take no further action on a complaint at any time. Under the Act no further action may be taken for various reasons, including when a complaint has been resolved, lacks substance, or is over two years old. At times we will take no further action if there is nothing to be gained by further investigating the complaint (that is all the issues are known and no further outcomes likely), or the person making the complaint has failed without good reason to take reasonable steps to resolve the complaint.

Conciliation

Conciliation is a voluntary, confidential and flexible process that gives the parties to the complaint the opportunity to openly and frankly discuss the issues in dispute, with the aim of reaching agreement about how they can be resolved. Matters referred to conciliation will often be ones in which the user is seeking a detailed explanation of what has happened, an apology or some form of compensation. The conciliation process is confidential and privileged, meaning that nothing said or done during conciliation can be used in another forum such as a court or tribunal or in any later investigation by the HCSCC.

Parties will usually meet face-to-face with a HCSCC Conciliator, but the process is flexible and can be designed to suit the circumstances of each matter, depending on complexity, seriousness, outcomes sought and the views of the parties. The aim of the conciliation process is to encourage an agreed settlement of the complaint and where appropriate, bring about improvement.

If a settlement cannot be reached through conciliation, the Commissioner will end the process and re-assess the matter to determine what further action, if any, should be taken in relation to the complaint.

Investigation

The Commissioner is likely to investigate a complaint where the issues identified during the assessment process appear to raise a significant question as to the practice of the provider, are complex, or raise significant issues of public health or safety or public interest.

The HCSCC has a range of statutory powers that may be exercised during the investigation process, including the ability to interview people and seize documents. At the conclusion of the investigation the HCSCC may propose remedies or make recommendations to protect the health and wellbeing of service users, or improve the safety and quality of a service.

The HCSCC's aim is to finalise enquiries and complaints as quickly and informally as possible. In doing so, it must not lose sight of its overall objective of contributing to improvements in the delivery of health services and community services in the Northern Territory.

New Approaches 2011/12

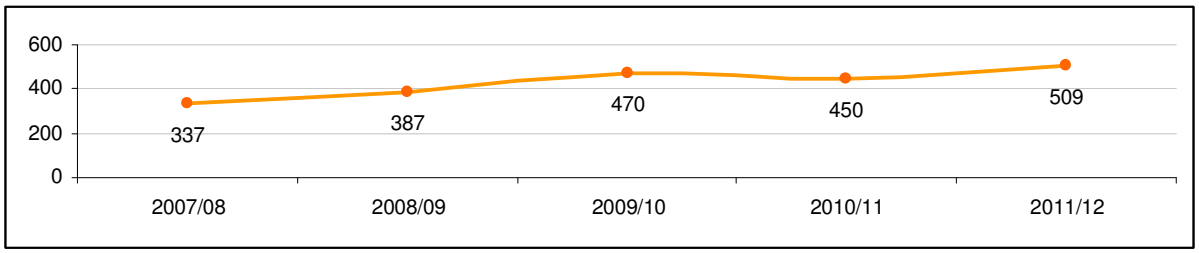
To put the process outlined above in perspective, a total of 458 enquiries and 101 complaints were received during 2011/12. As 50 enquiries became complaints, the net approaches made to the HCSCC were 509 (refer to explanation below).

Explanation Regarding Approaches

Approaches registered as an enquiry	458
LESS enquiries moved to a complaint	50
Net enquiries received	408
Approaches registered as a complaint	51
PLUS enquiries moved to a complaint	50
Total complaints received	101
Total approaches for 2011/12	509

A comparison of approaches over the past five financial years follows:

Figure 1: Approaches



Of all the approaches made to the HCSCC in 2011/12:

- 50% were female and 50% male;
- 67% were made by phone;
- where the location of the complainant was known, 64% came from Darwin, 15% from Alice Springs, 11% from interstate and the remainder from other parts of the Territory;
- 52% related to private providers and 48% to public providers.

Enquiry and Complaint Activity During 2011/12

ENQUIRIES

All enquiries, whether made electronically, by phone or in person, are entered on the enquiry database. An analysis of enquiries received for the reporting year is shown below.

In 2011/12 there was an increase in the number of enquiries received from 408 to 458 (12%) and an increase in finalised enquires from 334 to 391 (17%).

Figure 2: Enquiries Received

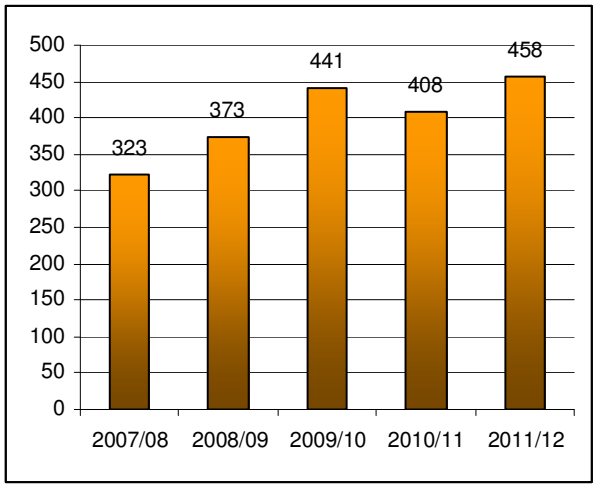
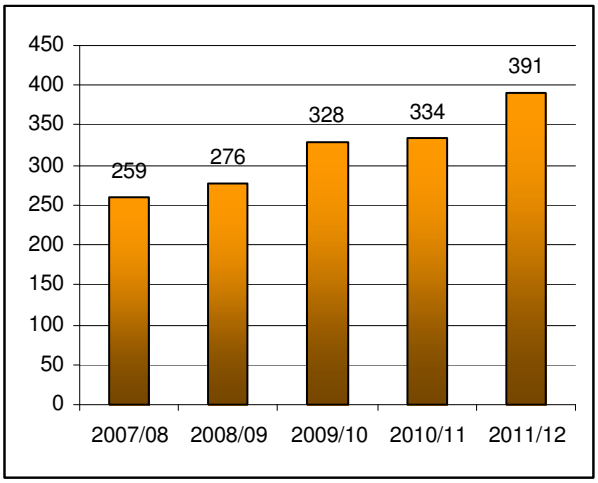


Figure 3: Enquiries Closed



Although the majority of enquiries do not become formal complaints (11% this financial year) they represent a substantial proportion of the HCSCC's workload. Importantly many potential complaints to the HCSCC were resolved or referred back to the provider of the service at this early stage.

Table 2 provides a breakdown of the types of provider subject to enquiries during the reporting year. Public providers accounted for 49% of the enquiries received, 38% of which were public hospitals and Corrections Medical Services 34%. Of the 51% of enquiries about private providers, 25% related to Medical Practitioners.

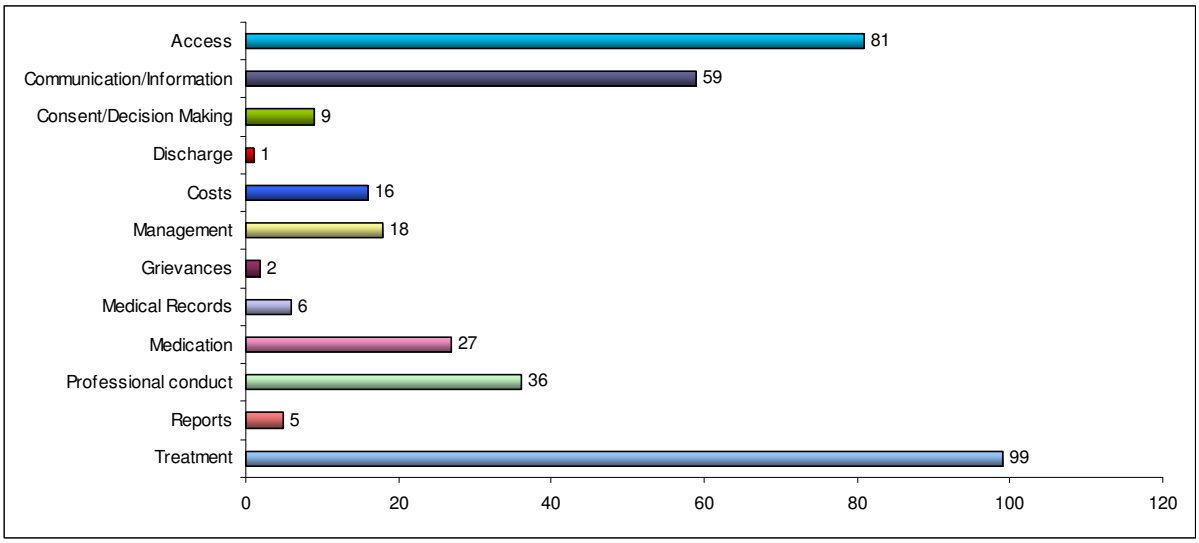
Table 2: Providers Subject to Enquiries

	2007/08	2008/09	2009/10	2010/11	2011/12
Private	156	173	173	178	232
Public	167	202	268	230	226
Total	**323**	**375**	**441**	**408**	**458**

Prisoners are able to contact the HCSCC direct via a dedicated secure phone line. The majority of these complaints are referred back to Corrections Medical Service to be resolved in accordance with agreed protocols. Of 80 prisoner approaches to the HCSCC, 96% were resolved in this way as enquiries.

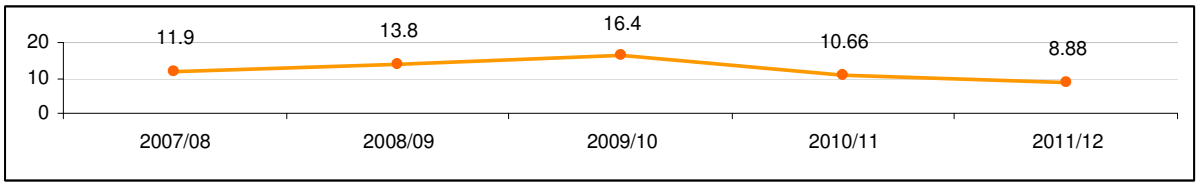
Issues raised in enquiries are also recorded and as Figure 4 indicates, issues associated with the standard of treatment and accessing services were of most concern.

Figure 4: Issues Raised in Enquiries



As seen in Figure 5 below, it is pleasing to note the average time taken to finalise enquiries has again dropped during the reporting period, from approximately 11 days to 9 days.

Figure 5: Time Taken to Finalise (Days)



Reducing the time taken to finalise an enquiry is a solid achievement for this year given that there was an increase in the number of enquiries finalised, and 12% increase in total numbers of enquiries (to 458 from 408). This represents a productivity gain which has been brought about by improved procedures and hard work by the HCSCC team.

COMPLAINTS

All complaints, whether made in writing, electronically, by phone, in person or moved from the enquiry database, are entered on the complaint database. An analysis of complaints received during the reporting year follows.

COMPLAINT ACTIVITY

One hundred and one complaints were received in 2011/12, an increase of 8% on the previous year (see Figure 6). Contrary to the prediction in last year's annual report that the large number of investigations being undertaken during 2011/12 would have a negative impact on the number of cases closed, numbers of finalised complaints also rose, from 77 to 94 (see Figure 7).

During 2011/12 the HCSCC commenced three new investigations. Seven investigations were closed in the reporting period, with a further nine completed and awaiting implementation of recommendations. At the end of 2011/12 there were 10 open investigations.

Figure 6: Complaints Received

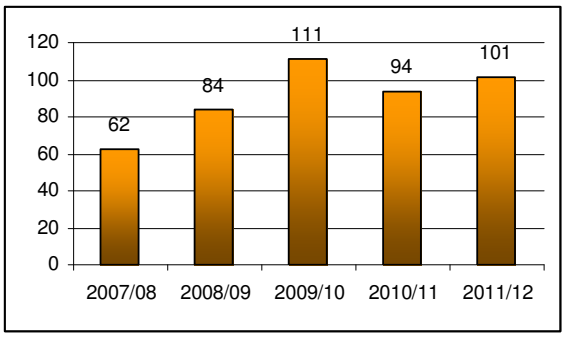
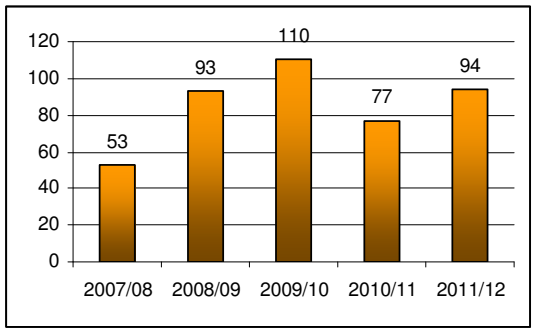


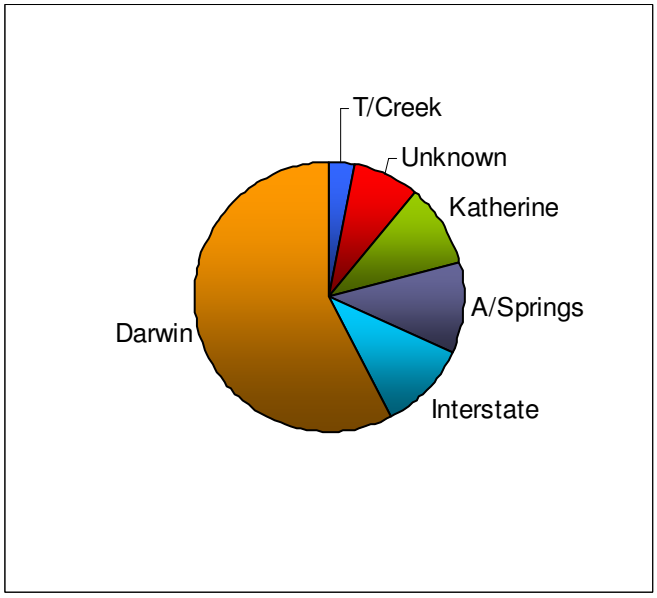
Figure 7: Complaints Finalised



WHO COMPLAINS?

It is usually the user of the health service or community service that makes the complaint. However the Act allows other people such as a parent or guardian or a person chosen by the user to make a complaint. The Commissioner can also accept complaints from the Chief Executive of the Department of Health, a service provider, the Minister for Health and any other person if the Commissioner considers it in the public interest.

Figure 9: Geographic Source



The majority of complaints came from the Darwin area (57%), followed by Alice Springs (11%). The total number of complaints received from other areas of the Territory increased to 13% from 7% in 2010/11. 11% came from interstate.

23% of complainants approached the HCSCC by written means and 14% by phone. Where the complaint is made by phone the complainant is asked to confirm it in writing. Where a complainant is unable to confirm a complaint in writing themselves, the HCSCC will reduce it to writing and provide a copy to the complainant as required under the Act.

WHAT SERVICES ARE COMPLAINED ABOUT?

Table 3 provides a breakdown of providers, both individual and institutional, subject to complaints during the reporting year. Private providers accounted for 60% of the complaints received, up from 50% last reporting period.

Table 3: Providers Subject to Complaints

	2007/08	2008/09	2009/10	2010/11	2011/12
Private	40	41	49	47	61
Public	22	43	62	47	40
Total	62	84	111	94	101

Figure 10 gives a breakdown of public sector complaints, with Medical Practitioners the subject of the greatest number of complaints (35%) followed by public hospitals (Acute Services) (22.5%).

Figure 11 shows that Medical Practitioners were subject to the greatest number of complaints (31%) in the private sector, followed by Nurses and Midwives with 16%.

Figure 10: Public Providers

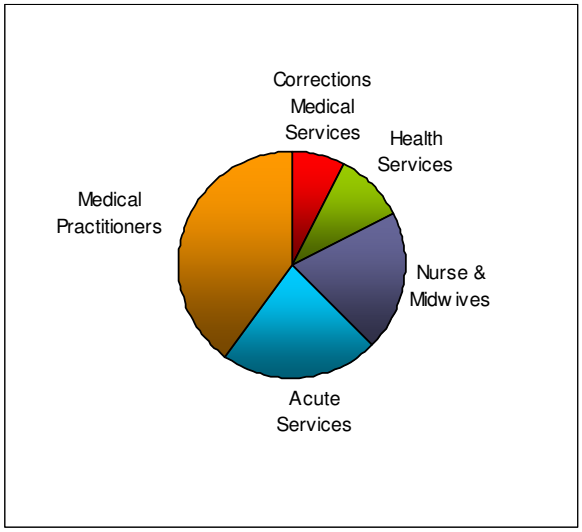
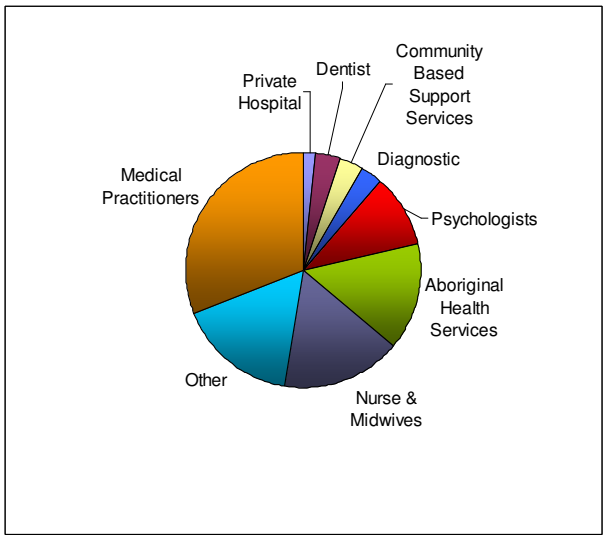


Figure 11: Private Providers



A further breakdown of complaints about services for aged people and services for people with a disability is set out in Table 4 below. Numbers of complaints in these areas remains low despite ongoing efforts to increase HCSCC's visibility in these sectors.

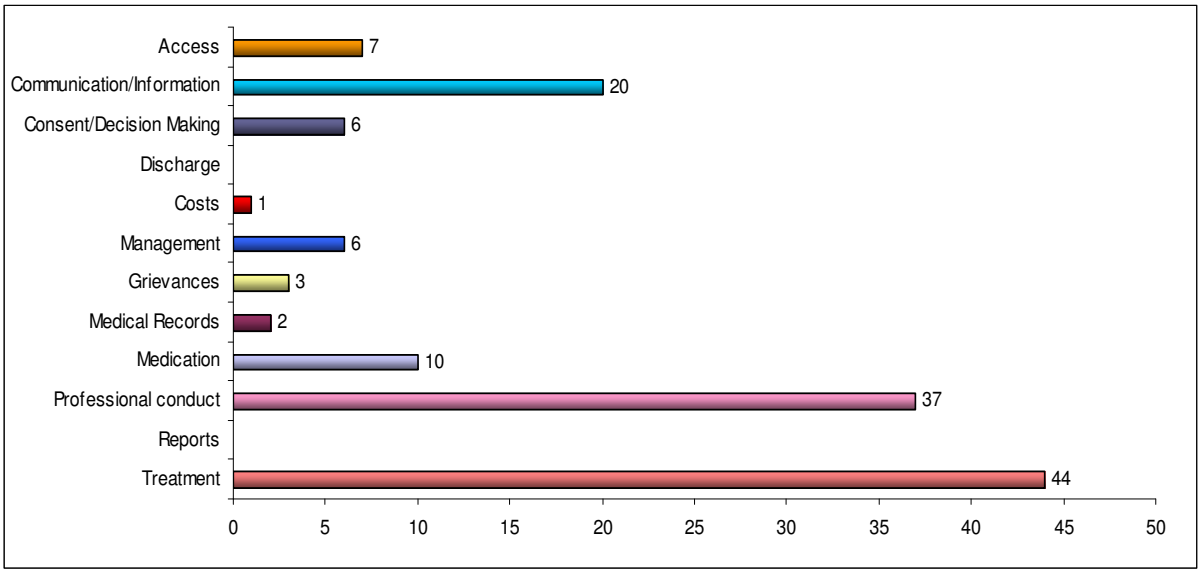
Table 4: Aged and Disability Services Complaints

Provider Type	2009/10	2010/11	2011/12
Hostel/Supported Accommodation	0	0	1
Nursing Homes	0	0	1
Aged and Disability services (public)	1	2	1
Mental Health Services (public)	4	3	1
Community Based Support - Disability	1	0	2
Total	**6**	**5**	**6**

WHAT ISSUES ARE COMPLAINED ABOUT?

Each issue described in each complaint received by the HCSCC is recorded for reporting purposes, with some complaints raising more than one issue. Issue categories are used consistently across Australia to allow for comparison. Table 12 below provides an outline of the numbers of issues raised in each of the complaint categories.

Figure 12: Issues Raised in Complaints Closed



As in previous years, treatment was the most commonly identified area of complaint, accounting for 44 of the 136 issues raised in all closed complaints (32%). This was followed by issues associated with professional conduct (27%) and communication (15%). These are consistently the three top areas of concern year to year. Tables 5 to 16 provide further breakdown of the content of each of the major issue categories.

Table 5: Access Category

ACCESS	09/10	10/11	11/12
Access to subsidies	2	0	0
Refusal to admit or treat	5	3	4
Service unavailable	4	7	1
Waiting list delay	1	1	2
Total	**12**	**11**	**7**

Issues relating to Access made up 5% of issues complained about. The major issue complained about was failure to admit or treat (57%), followed by waiting list delay (28%).

Table 6: Communication & Information Category

COMMUNICATION & INFORMATION	09/10	10/11	11/12
Attitude and manner	13	18	12
Inadequate information provided	7	4	7
Incorrect/misleading information	2	1	1
Special needs not accommodation	1	2	0
Total	**23**	**25**	**20**

Issues relating to communication and information made up 15% of all issues complained about. Complaints associated with the attitude and manner of a provider continue to be the most significant communication issue (60%) followed by inadequate provision of information (35%).

Table 7: Consent Category

CONSENT	09/10	10/11	11/12
Consent not obtained/inadequate	3	2	4
Involuntary admission or treatment	0	3	2
Uninformed consent	2	0	0
Total	**5**	**5**	**6**

Issues relating to consent constituted 4% of all issues complained about.

Table 8: Discharge & Transfer Arrangements Category

DISCHARGE & TRANSFERS	09/10	10/11	11/12
Delay	0	1	0
Inadequate discharge	1	5	0
Mode of transport	1	0	0
Patient not reviewed	0	1	0
Total	**2**	**7**	**0**

There were no issues relating to discharge and transfer in complaints closed in 2011/12.

Table 9: Environment & Management of Facility Category

ENVIRONMENT & MANAGEMENT	09/10	10/11	11/12
Administrative processes	1	2	1
Statutory obligations/accreditation	0	1	1
Physical environment of facility	0	0	1
Cleanliness/hygiene of facility	3	1	2
Staffing and rostering	2	1	1
Total	**6**	**5**	**6**

Complaints in this category relate to administration rather than the care/treatment component of the service. Issues in this category constituted 4% of all issues raised in complaints. Most issues of this nature are resolved at the enquiry stage.

Table 10: Fees, Cost & Rebate Issues Category

FEES, COSTS & REBATES	09/10	10/11	11/12
Billing practices	0	3	0
Cost of treatment	0	2	1
Financial consent	0	0	0
Total	**0**	**5**	**1**

Issues relating to cost of service constituted 1% of issues in complaints finalised.

Table 11: Grievance Category

GRIEVANCE	09/10	10/11	11/12
Inadequate or no response	0	2	2
Complaint information not provided	0	0	1
Total	**0**	**2**	**3**

Issues of grievance and complaint handling made up 2% of all issues complained about.

Table 12: Medical Record Category

MEDICAL RECORDS	09/10	10/11	11/12
Access to/transfer of records	2	2	0
Record keeping	1	1	2
Total	**3**	**3**	**2**

The medical record category accounted for only 1% of all issues complained about.

Table 13: Medication Category

MEDICATION	09/10	10/11	11/12
Administering medication	5	2	2
Dispensing medication	3	2	0
Prescribing medication	5	4	6
Supply/security/storage	0	1	2
Total	**13**	**9**	**10**

Medication related concerns made up 7% of all issues in 2011/12. Of particular concern was the prescribing of medication, making up 60% of these types of complaint.

Table 14: Professional Conduct Category

PROFESSIONAL CONDUCT	09/10	10/11	11/12
Assault	1	1	1
Boundary violation	1	1	7
Beach of condition	3	0	0
Competence	7	17	21
Discriminatory conduct		0	0
Emergency treatment not provided		1	0
Financial fraud	1	1	1
Illegal practice	4	0	5
Impairment	1	0	1
Inappropriate disclosure of information	5	1	1
Misrepresentation of qualifications	1	2	0
Sexual misconduct	1	0	0
Total	**25**	**24**	**37**

Issues relating to professional conduct made up 27% of all issues complained about. The majority of these matters were dealt with in conjunction with AHPRA in accordance with the consultation requirements under the National Law. The main issue complained about was the competence of a provider (57%), followed by boundary violation (19%). Where these allegations relate to the conduct of a registered provider, they are likely to be referred to the relevant National Registration Board for consideration.

Table 15: Reports/Certificates Category

REPORTS/CERTIFICATES	09/10	10/11	11/12
Accuracy of report/certificate	0	1	0
Timeliness of report/certificate	0	1	0
Total	**0**	**2**	**0**

There were no issues raised in relation to reports or certificates in 2011/12. It should be noted that the HCSCC has no jurisdiction over the process of writing, or the content of, a health status report.

Table 16: Treatment Category

TREATMENT	90/10	10/11	11/12
Attendance	0	0	0
Coordination of treatment	6	2	3
Delay in treatment	4	3	2
Diagnosis	8	7	12
Inadequate consultation	1		1
Inadequate treatment	23	12	9
Infection control	2		0
No/inappropriate referral	1	1	2
Rough & painful treatment	1	4	0
Unexpected treatment outcome	10	4	8
Withdrawal of treatment	3	2	2
Wrong/inappropriate treatment	5	5	5
Total	**64**	**40**	**44**

Issues relating to treatment constituted 32% of all issues complained about in 2011/12. Issues associated with diagnosis (27%) were of major concern in this category, followed by inadequate treatment (20%)

HOW ARE COMPLAINTS FINALISED?

Reasons for closure of complaints under the Act are summarised in Table 17.

Table 17: Reasons for Closure[1]

REASONS FOR CLOSURE	09/10	10/11	11/12
Investigation completed	-	-	7
Conciliation completed	-	-	5
Complaint is resolved	27	14	4
Investigating further is unnecessary	32	28	26
Not resolved with provider	2	1	0
Been before court, tribunal or board	2	0	2
Information under sec 25 not received	5	0	1
Complaint lacks substance	0	1	0
Complaint has been withdrawn	5	2	4
Complaint over 2 years old	0	0	2
Referred to other entity	23	29	6
Dealt with by Board pursuant to MOU[2]	-	-	40
Frivolous, vexatious, not in good faith	0	0	0
Not a matter referred to in Sec 23	0	2	0
Not a prescribed service	0	0	0
Total	**100**	**77**	**97**

27% of complaints were finalised because further action was found to be unnecessary or there was insufficient justification to continue with any investigation. 41% of complaints were subject to consultation between the relevant registration board and the HCSCC, following assessment by the HCSCC or notification by the Board.

[1] Note: complaints can be split, resulting in more than one outcome per file.
[2] Matters dealt with by the National Boards following MOU consultation with HCSCC (previously considered referrals).

Table 18 details the outcomes achieved from closed complaints. The major outcome from complaints was an explanation (40%). In 36% of cases, at least one aspect of the complaint was referred elsewhere. These numbers include matters that resulted in referral to the Medical Board at the conclusion of an investigation. Single complaints can have more than one outcome.

Table 18: Outcomes of complaints closed

OUTCOME	09/10	10/11	11/12
Account adjusted	0	0	0
Apology given	2	4	6
Change in procedures/practice	8	3	4
Compensation paid	2	1	1
Complaint withdrawn	5	2	5
Concern registered	17	2	0
Conciliation agreement reached	5	0	4
Counselling	0	1	0
Disciplinary action taken	2	6	1
Discontinued	0	1	1
Explanation provided	52	45	57
Policy change effected	2	1	2
Referred elsewhere (incl to Board)	34	32	51
Refund provided	0	2	0
Service obtained	12	4	2
Undefined	5	2	7
Total	**146**	**106**	**141**

TIME TAKEN TO FINALISE COMPLAINTS

Figure 13 shows the average time taken to finalise complaints. There has been an increase in the average time taken due to the complex nature of the complaints received and the time and skill required to undertake an increased number of investigations. The time taken for the consultation process between the Boards and the HCSCC has also contributed to an increase in time taken to finalise complaints. In many matters, time to completion has doubled as the HCSCC is required to wait for the Board to express a view after we have completed our assessment process.

Figure 13: Time Taken to Finalise (Average Days)

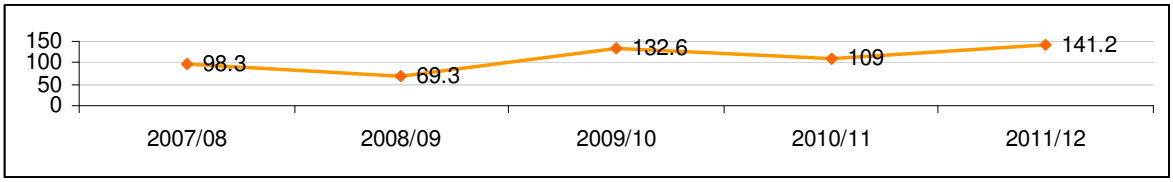
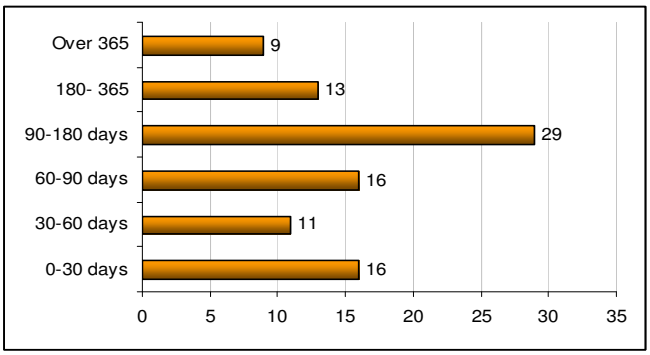


Figure 14 shows the time taken to finalise complaints when grouped over a period of time. As can be seen only nine cases took over one year to be finalised and 77% were closed within 180 days. The benchmark for closure within 180 days is 70%.

Figure 14: Time Taken to Finalise (Period of Time)



Review Committee

At the conclusion of a complaint, a complainant, provider or the Commissioner may request that the Health and Community Services Complaints Review Committee (the Review Committee) review the way in which the HCSCC dealt with the matter.

The Review Committee is established under the Act to:

- review the conduct of a complaint to determine whether the procedures and processes were followed and to make recommendations to the Commissioner 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; and
- advise the Minister and the Commissioner, as appropriate, on the operation of the Act and the Regulations.

The Review Committee is not authorised to:

- investigate a complaint;
- review a decision made by the Commissioner to investigate, not to investigate, or to discontinue investigation of, a complaint;
- review a finding, recommendation or other decision made by the Commissioner, 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, all appointed by the Minister for Health.

There were no applications for a review received in the reporting year.

IMPROVING HEALTH AND COMMUNITY SERVICES

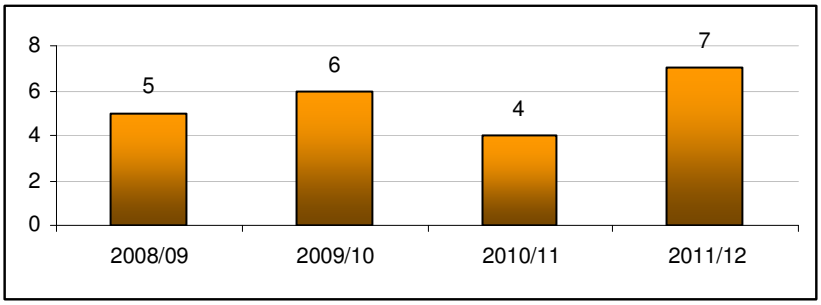
Overview

A major objective of the HCSCC is to provide a complaint system that leads to improvements in health services and community services and enables users and providers to contribute to that review and improvement[3]. This objective is often supported by complainants who seek an assurance that what happened to them will not happen to others.

Seven investigations were finalised during the course of the year and a further nine have been completed, with the HCSCC now monitoring the implementation of recommendations made in these matters. These 16 investigations resulted in a total of 77 recommendations being made to providers. All recommendations were accepted in principle.

The number of investigations finalised over the past three years is depicted in Figure 16 below.

Figure 16: Investigations finalised



In addition to change achieved through recommendation at the conclusion of an investigation, complaints that are finalised without progressing to a full investigation can also result in positive change in policies, procedures or access to services. During the financial year there were 141 outcomes recorded against 94 closed complaints.

Achieving Service Improvements

The HCSCC contributes to improvement of services in a number of ways at all stages of our process.

Enquiries and Complaints

Firstly, this is achieved in a more informal manner through both enquiry and complaint assessment processes. In each of these processes the focus is on resolution of concerns and in many matters, as stated above, the person making the complaint wants to make sure that others do not have the same unhappy experience that they have had.

With this objective in mind, with the assistance of the HCSCC, parties will often agree on the need for improvement in a particular area and implement change in practice, policy or procedure to effect that improvement. In many cases, this commitment to change and improvement will allow the concerns to be resolved. At the conclusion of a matter, even where no further formal action will be taken, the HCSCC will often identify areas of potential

[3] Refer to section 3 of the *Health and Community Services Complaints Act*

improvement and make suggestions to providers of ways in which they could avoid future complaints. While these are not formal recommendations under the Act, they do provide an opportunity for providers to review and improve their services, and in the process build their reputation for quality service.

Conciliation

A second avenue for service improvement is through the conciliation process. Conciliation is voluntary and confidential, and nothing said or done in that process can be used in other forums. For this reason it is a valuable opportunity for free and frank discussion to identify what, if anything went wrong in the service provision. Once problems or shortcomings are identified, solutions can be developed and necessary changes identified to ensure that problems are not repeated. Any agreed changes can be made binding via a signed agreement.

Investigation

Finally, investigations are undertaken where the Commissioner decides that allegations made by the complainant and/or any issues identified during the assessment process appear to raise a significant issue of public health or safety or public interest; or a significant question as to the practice and procedure of the provider. These investigations often result in formal recommendations being made to the provider to improve their policies, procedures and systems. Where the findings of the investigation raise questions related to the practice of an individual registered health practitioner they are referred to the relevant registration Board for consideration of disciplinary action.

Where the HCSCC makes recommendations, the provider has 45 days in which to advise the HCSCC of the action it is taking or has taken to comply with the recommendations. If the Commissioner is not satisfied with the action taken by the provider, she can provide a report to the Minister for Health and it must be tabled in the Legislative Assembly.

In addition to the process of investigating and making recommendations, in the past year the HCSCC has focussed on monitoring the implementation of recommendations to ensure that changes that should be made as a result of an investigation are in fact made. Recommendations now include expected completion or compliance dates, and regular reports are sought on progress towards implementation to ensure that the work of the HCSCC is relevant and effective.

Improvements Made

A number of sustained improvements are expected to flow from the 77 recommendations made by the HCSCC and accepted by providers during the financial year. Some completed and ongoing examples of change are outlined below.

INFORMED CONSENT TO MEDICAL PROCEDURES

A complaint was made regarding the care and treatment provided to a patient while at both the Royal Darwin Hospital and Darwin Private Hospital. During his lengthy stay in hospital the patient was very ill necessitating many operations; some of a minor nature and others that were significant and at times life saving. For the majority of this time the patient could not give consent prior to the operations. During the course of the HCSCC's investigation the medical records were reviewed.

The HCSCC concluded that full and informed consent as required by law was clearly evidenced in only two of the sixteen procedures undertaken; and no consent was obtained for two of the procedures. We also concluded that the consent forms and the policies and procedures used by both RDH and DPH were inadequate and in need of review.

The HCSCC recommended that both RDH and DPH make changes to their consent forms to ensure that details such as the diagnosis, the treatment, the risks and complications, and alternatives to the proposed treatment be documented. We also recommended that they update their consent to medical treatment policies to ensure they reflected the case law requirements about providing adequate information, and the requirements of the Emergency Medical Operations Act (NT).

Both hospitals agreed with the recommendations and are in the process of implementing the necessary changes. Education programs are also being undertaken with all surgeons practising in public hospitals to ensure they have a proper understanding of their responsibilities under the Emergency Medical Operations Act (NT). In addition, past Consent to Procedure forms are being audited and any deficiencies are being drawn to the attention of the responsible medical practitioner, with specific training then provided to upgrade their knowledge and skills in this regard.

CORRECTIONAL SERVICES – MEDICATION SYSTEM

In last year's report the HCSCC stated:

> *Prisoners have consistently complained to the Commission about their medication. The issues have included missed medication rounds, medication not provided, wrong dosage, poor stock control and non-renewal of medication. Because of the seriousness of these allegations and the health and safety issues it raises for the prisoners, the Commission has determined to undertake an investigation into the adequacy of Corrections health service medication system and anticipates that a report will be finalised by the end of 2011.*

The investigation has now concluded, with the HCSCC findings including that the processes followed with regard to medication rounds for prisoners was inconsistent, conflicting and unsafe; the overall medication management system (ordering, storage, dispensing and administration) did not comply with internal policies or the Northern Territory Poisons and Dangerous Drugs Act; prisoners were often left without adequate pain relief; and processes did not ensure that the right prisoner got the right medicine, at the right time, every time. The HCSCC also concluded that there was a lack of awareness among prisoners as to the correct processes to follow to access medical attention.

Recommendations to address the problems with the medication system were made by the HCSCC. These included the need to develop procedures for the medication round, review of the nurse-initiated medication policy, replacement of the medication trolley, regular auditing of the paper based medical records and improvements to the education material available to prisoners in relation to accessing the medical system.

The HCSCC acknowledged that the delivery of health services in the correctional environment can be challenging. However it was clear at the conclusion of the investigation that there was a need to improve communication between the three key stakeholders (Department of Justice (as it then was), Department of Health and International SOS) for any improvements to be realised. Recommendations were made in this regard.

All recommendations were agreed to and are being implemented.

PUBLIC HOSPITAL NUTRITION PROGRAM

The HCSCC had received a number of complaints about the nutrition programs provided at a public hospital. In view of the nature of the concerns and the public interest issues they raised, the HCSCC undertook an investigation into the nutrition program, in particular the Home Enteral[4]/Parenteral[5] Nutrition Program (HEPN).

The HCSCC found that, despite the hospital having undertaken an audit of malnutrition levels in October 2010 that identified a high rate of malnutrition in inpatients, no action had been taken to improve the situation. In addition, the audit identified shortcomings in processes for referring patients with malnutrition to dieticians, but again no action had been taken to rectify this situation.

The HCSCC found the failure of the hospital to develop a management system to monitor HEPN clients unacceptable and an indication of the low priority given to the issue of malnutrition within the hospital. We concluded that the monitoring of clients' nutritional supplements/formula and consumables would not only assist the individual clients but would also allow for planning at the facility level, allowing for consumables to be purchased and stocked in accordance with evidence based usage. It was evident that the lack of systems and lack of a multi disciplinary team approach to client care would not see the hospital meet accreditation requirements of the Australian Council of Healthcare Standards (ACHS).

Twenty-three recommendations were made by the HCSCC that, once implemented, will dramatically improve the HEPN program and monitoring of all clients for malnutrition or nutrition deficiencies. These recommendations included the commencement of malnutrition screening for all patients, implementation of the 2010 malnutrition audit recommendations, development and commencement of an educational program for hospital staff, development of policies and guidelines for the delivery of nutritional care in hospitals, development of a computer HEPN client management database, development of educational material, introduction of client feedback and establishment of formula collection and distribution points.

The recommendations were accepted and steady progress is being made with their implementation.

PROVISION OF HEALTH INFORMATION ABOUT A PATIENT FROM A THIRD PARTY

The HCSCC received a complaint that raised concerns about communication between a nurse, her pregnant patient and the patient's partner. The patient's partner approached the nurse following a consultation involving both he and the patient. He provided further information and raised concerns about his partner's health with the nurse, but no action was taken on the information provided.

This raised a number of concerns for the HCSCC, namely:

- What is the responsibility/obligation of a health practitioner where he/she is provided with health information, outside of the consultation, about a patient from a third party?
- Does the health practitioner have a duty to document and act on the information provided?
- Does the location of the clinic and cultural factors have a bearing on what should happen?

[4] Tube feeding
[5] Intravenous feeding

Based on research and investigation we reached the following conclusions:

Consultation is when a health practitioner works with the patient, a partner, the family or relatives to solve a patients identified health needs and results in the health practitioner intervening by providing either support, limitation, medication or treatment for the patient's health need or preventative purpose.

Where third party information is received by a health practitioner, the health practitioner must take reasonable steps to ensure that the patient is made aware of the matter, except where doing so would pose a serious threat to the life or health of the patient.

For the health practitioner to act on the information received from a third party:

- *the individual must be a patient of the health service/health practitioner;*
- *the source must be genuine and reliable;*
- *the information must be:*
    - *relevant;*
    - *significant in terms of the risks to the patient; and*
    - *required to provide further health services to the patient.*

Health information should be documented:

- *when an event occurs to the patient that could effect his/her condition*
- *where there is a change in the condition of the patient*
- *where the information provided requires action by a health practitioner*
- *when it is necessary to inform and enable other health professionals to care and treat the patient*
- *during or immediately after the information and/or care has been provided*

The HCSCC recommended that the organisation concerned develop guidelines to assist health practitioners to deal with information received about a patient from a third party source. We also recommended that all remote area nurses without midwifery qualifications undertake a maternal emergency care course within 12 months of commencing employment. These recommendations were accepted and are being implemented.

PATIENT TRANSFER ARRANGEMENTS

A complaint was made about the care and treatment provided to a patient in a regional hospital who, because of complications resulting from an infection, needed to be transferred to another hospital.

The HCSCC concluded that the care and treatment provided to the patient was reasonable but his transfer between the two hospitals was inappropriate. We found that the transfer arrangements that were put in place caused extreme discomfort to the patient; and that communication between providers in the lead up to the transfer was insufficient and led to a missed opportunity for review before the transfer. The absence of detailed policies and procedures directing inter-hospital transfer and transfer of unaccompanied patients was found to be unacceptable and recommendations were made for the development and implementation of such policies.

It was pleasing to note that following receipt of the complaint it was acknowledged that the transfer arrangements for the patient could have been to a higher standard and new policy and procedures were completed prior to the finalisation of the investigation report.

On a similar note, after investigating a complaint which included an allegation that a medical practitioner had refused to arrange an interstate transfer for a patient at his family's request, the HCSCC recommended that the Department of Health develop guidelines for patient initiated/requested transfer to ensure that they have an appropriate policy and process in place to assist patients and medical practitioners.

RELATIONSHIP WITH PARENTS/CARERS

The parents of a child with a complex rare condition complained to the HCSCC about the care and treatment their child received while in hospital. Their concerns centred around the administration of medication and monitoring of the child's condition.

The HCSCC's investigation found that the administration of medication was reasonable and that while there was some failure in monitoring the child, this did not appear to cause actual harm to the child. The HCSCC acknowledged the parents' concern that the hospital did not take full advantage of the intimate knowledge they had of their child's condition, and was also concerned that the parents had not been given an adequate opportunity to find out what had happened in relation to their child's care and why. There was a failure to implement the general principles of open disclosure in this matter.

In order to address the findings in this investigation, the HCSCC recommended that appropriate staff from the hospital meet with the parents to discuss the matter. It was also recommended that the hospital develop policies to ensure they involve parents and carers in the care of patients, particularly in cases where the parents of children with an ongoing condition have an intimate knowledge of what is required to manage their child's health.

The recommendations have been accepted and a new policy has been developed.

COORDINATION AND COMMUNICATION OF PRISONER HEALTH SERVICES BETWEEN HOSPITALS AND INTERNATIONAL SOS

An investigation was initiated by the HCSCC following complaints by two prisoners, one from the Darwin Correctional Centre and the other from Alice Springs Correctional Centre, that appeared to raise systemic issues in communication between prison health providers and hospitals, and deficiencies in the coordination of care. In one case an apparent failure in communication between the hospital and the correctional centre meant that a prisoner was not advised of pre-surgery preparation requirements and as a result surgery was delayed. In a second case, issues regarding coordination of services and communication about referrals, appointment times and receipt of medical records were raised with the HCSCC.

The matters were initially referred for conciliation, however as no progress was made in this forum, the Commissioner determined that the issues raised in the complaints would be investigated.

Prior to the commencement of the investigation, the Department of Health requested that they be allowed to work with the prison health provider (International SOS) to develop an appropriate communication protocol to overcome the types of issues that were the subject of the investigation. The HCSCC agreed to this approach and provided guidance as to the factors that would need to be addressed in order to satisfy the issues raised for investigation.

The Communications Protocol was finalised in February 2012, following consultation on the draft. The HCSCC is satisfied that the protocol addresses the issues raised in the complaints, namely patient referrals, visits to the Emergency Department, specialist appointments, outpatient services and elective surgery; and should ensure that the issues do not arise again.

Investigations in 2012/13

In the 2010/11 Report we indicated that we expected to complete investigations into the following issues: admission of a patient to a mental health facility; disability care on remote communities; and staffing and supervision at a regional hospital. While progress has been made on all of these investigations, they have not yet been finalised. They will all be completed during 2012/13.

In addition, investigations into the following issues will be undertaken in 2012/13:

INTERPRETER SERVICES

The HCSCC reported last year that it had received a number of complaints which raised issues associated with the use of interpreters in the health setting. In particular, there were various allegations about Aboriginal patients from remote communities being asked to consent to procedures without any real understanding of what is to happen and why. This investigation was not able to be commenced in 2011/12 as the individual aspects of two complaints were subject to conciliation. Those matters have now been concluded and the investigation into the potential systemic issues will begin in 2012/13.

ELECTRONIC PRESCRIPTIONS IN REMOTE COMMUNITIES

The HCSCC has received a complaint about the electronic system used for issuing and monitoring of prescriptions in remote communities. This investigation will look at issues including health and safety of individual users, the identification of and response to system errors, the identification of adverse events, and communication with users following adverse events. The investigation will be completed during 2012/13.

GRIEVANCE PROCEDURES IN COMMUNITY HEALTH

Consistent with its aim of enabling resolution of complaints between users and providers of health, disability and aged services, the HCSCC is conducting an investigation into the grievance processes and procedures of a community health provider. This investigation aims to provide practical and constructive guidance on the operation of internal complaint mechanisms.

ACCESS AND AWARENESS; PLANNING AND DEVELOPMENT

National Perspective

A meeting of all Australian and New Zealand Health Complaints Commissioners is held twice a year. At these meetings Commissioners set common goals and objectives, and discuss issues of common and national significance.

The first meeting was in Sydney, NSW in October 2011 and the second in Darwin in May 2012. Agendas were drawn up and actioned for each meeting. Some of the matters discussed included:

- Ten National Safety and Quality Health Services Standards and their use in complaints
- Regulation of unregistered providers
- Continuous quality improvement in Aboriginal health organisations
- National Complaints Project – prediction of risk
- Use of PBS data and role of Indigenous Liaison Officers - Medicare update
- Review of the Open Disclosure Standard – Australian Commission on Safety and Quality in Health Care update
- Revised Aged Care Complaints Scheme & role of the Aged Care Commissioner
- Review of the MOU with AHPRA

Disability Services Commissioners also hold a one day meeting twice a year. This year these meetings were held consecutively with the Health Commissioners meetings in Sydney and Darwin. Matters discussed at the meetings in 2011/12 included:

- National Disability Strategy – monitoring and implementation
- National Disability Insurance Scheme Quality and Safeguards Working Group
- COAG Reform Council findings
- Oversight in closed disability environments
- Disability sector training
- Conciliation and resolution of disability complaints
- Disability rights and cooperation with AHRC

The Deputy Commissioners and other complaint managers from throughout Australia meet annually. The purpose of this meeting is to exchange information, develop improved processes and procedures, and increase awareness of current and emerging issues. The meeting was held in Perth during May 2012 and the topics covered were:

- Suitability of matters for conciliation
- Opportunities for common training
- Key performance indicators
- National Indigenous Outreach Program

In addition to participating in the National Complaints Commissioner's Meetings and the manager's meetings, the HCSCC was consulted about and contributed to the development of a number of policies and positions at the national level and Territory level. These included:

- National Disability Insurance Scheme
- Review of the *Adult Guardianship Act*
- Registration for Paramedics

Community & Stakeholder Engagement

As the Territory's health watchdog, it is important for the HCSCC to engage with as many stakeholders as possible to promote our resolution model and service users' rights. These stakeholders include health services and community services, consumers, community groups, the wider community, parliamentary members and the media.

Expos, Meetings, Conferences and Visits

The HCSCC's engagement activities in 2011/12 ranged from participation in public expos and festivals; attendance at conferences such as the Language and the Law conference and Palliative Care Network conference; and stakeholder meetings with Auslan users, asthma support groups, and the regular Somerville forum for service providers. Meetings were held with representatives from the Department of Human Services (formerly Medicare), Menzies School of Health Research, legal service providers and rights advocates. HCSCC representatives also visited both Alice Springs Correctional Centre and Darwin Correctional Centre in the reporting period, with improvements in ease of access to HCSCC for prisoners wishing to make a health complaint made as a result.

Australian Health Practitioners Regulation Agency

Staff attended meetings and information sessions at the Australian Health Practitioner Regulation Agency (AHPRA) in Darwin; and the Commissioner met with the Medical and Nursing and Midwifery Boards of the Northern Territory. Staff from HCSCC were also invited to the celebration of the end of the NT Board era in June, when Occupational Therapists, Radiology and Aboriginal Health Worker Boards all joined the National Registration Scheme. The Commissioner and Deputy Commissioner continued regular meetings with the Director of Notifications at AHPRA as part of the mandatory consultation process established under the National Law.

Providers

The Commissioner addressed clinicians at Alice Springs and Royal Darwin Hospitals, as well as meeting with the RDH Board and attending a Clinical Governance Executive Meeting. Regular meetings with the Chief Executive, Department of Health continue.

Independent Officers

In addition to meetings and engagement with health and disability stakeholders, in 2011/12 regular meetings were held with other independent Commissioners who sit within what is now the Department of Attorney-General and Justice. These meetings were held quarterly and allowed for sharing of information, discussion of shared resources, and planning of joint events. They were a valuable addition to the network for all Commissions in the reporting year.

Remote Communities

Finally, this year was an exciting one for HCSCC, with trips to remote communities undertaken for the first time in a number of years. HCSCC staff travelled to Elliott Ali Curung, Kalkarinji, Lajamanu and Timber Creek, as well as Tennant Creek and Katherine with representatives from Consumer Affairs, Office of the Children's Commissioner and the Anti-Discrimination Commission. We acknowledge and thank Consumer Affairs for coordinating these trips. We look forward to reviewing the 2011/12 trip format in the coming period, with the aim of ensuring our efforts to spread our message in the more remote parts of the NT are as productive as possible.

Disability Services

As noted in the previous annual report, despite a broad jurisdiction that allows us to accept complaints about any service provided specifically for a person with a disability or their carer, complaints about these services remain rare. While there were increased numbers of enquiries in 2011/12, only 6% of formal complaints to the HCSCC related to the disability or aged service sector.

This low rate of complaint may be the result of a number of factors, including low visibility of the HCSCC within the sector, issues relating to access or confidence in our service. Users might also be reluctant to make a complaint about a service that they rely on for their everyday needs or independence.

In an attempt to overcome some of these barriers, we identified a number of strategies as part of our business plan to increase engagement with people with disabilities, their families and carers.

Our strategy is threefold: increase our knowledge and expertise in the area of disability service complaints; increase the accessibility and recognition of our service; and increase engagement with providers.

Increasing Knowledge and Expertise

To put this strategy into effect, in 2011/12 we were fortunate to welcome the Victorian Disability Services Commissioner, Laurie Harkin, and the Deputy Commissioner, Lynne Coulson-Barr to our office in Darwin. Commissioner Harkin gave us a valuable insight into the different approach that is required when handling disability services complaints, as opposed to health complaints; the benefit of a rights-based, person-centred approach in our work; and challenged us to think outside the box in our handling of disability complaints.

Deputy Commissioner Coulson-Barr delivered training to all Senior Investigation / Conciliation Officers on the use of conciliation in disability matters, again highlighting the different type of approach required in disability matters as opposed to health complaints. One of the key messages was the need to recognise that there is often a long-standing relationship between users and providers of disability complaints, and that understanding the history of that relationship may be crucial to assisting the parties to resolve disputes.

A further initiative was the independent review of the progress of a complaint received about a disability service. The complaint had been through conciliation but not resolved. The outcome of the complaint was not satisfactory for any of the parties involved or the HCSCC.

In order to learn from this experience, an independent expert was asked to review the conduct of the matter from the HCSCC perspective. A number of issues were identified including:

- The need to communicate directly with the service user, not just rely on the advocate/representative;
- The importance of timeliness in handling complaints;
- The need to meet with the complainant to ensure that we understand all of the issues of complaint – that is, not only the issues that were put on the complaint form, but any underlying issues that may form a barrier to resolution;
- The flexibility of the conciliation process and the need to focus on factors/developments that may assist the parties to enter into conciliation, rather than assessing suitability in concrete terms; and
- The need to consider wider options for resolution, including the possibility of independent reviews within the conciliation process.

All of these factors will be incorporated into the handling of future complaints and we will continue to learn and improve in 2012/13.

Increasing Accessibility and Recognition

As discussed below, in 2012/13 the HCSCC will launch a new brochure that is specific to users of disability services. We hope that this will be a further step to ensure our services are accessible to all who may need to use them.

In addition, for the first time in 2012/13 the HCSCC will participate in Darwin City Council's Disability Awareness Week celebrations as a member of the Disability Awareness Week Planning Committee. We plan to host a forum as part of the week's activities and attend various other functions and celebrations. This week is a great opportunity to meet a wide range of people who use, deliver, overview and plan disability services.

Increasing Engagement with Providers

Increasing engagement with providers is an aim across all areas of the HCSCC's activities, but in 2012/13 we aim to visit more disability service providers and promote the benefits of engaging in our processes.

Our planned conciliation training / information sessions and the planned on-line feedback tool will also be valuable tools in increasing our interaction with providers of disability services.

Information Brochures

We are pleased to report that the following set of information brochures were produced in the reporting period:

- Introduction to the HCSCC
- A Guide for Providers: Responding to complaints about your service
- A Guide for Users: Do you have a complaint about a health service?
- The Code of Health and Community Rights and Responsibilities (updated)

In addition we now have a poster that provides all of our contact details and an outline of our service.

In the coming period further brochures will be developed, including a plain English brochure and an introduction for users of disability services. Information sheets on conciliation, the HCSCC's relationship with AHPRA and our assessment processes are planned for 2012/13. Copies of our brochures and poster can be obtained by calling or emailing the HCSCC.

Website

Anyone can access the HCSCC through our website at www.hcscc.nt.gov.au. By logging onto the site people can access our 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 table below details the number of people who accessed the website during 2011/12:

Table 25: Website access

	2010/11	2011/12
Total visits:	2,017[6]	3,157

13% of complaints were received electronically in 2011/12 (6% in 2010/11).

[6] There were no figures available for a number of months and therefore this number is unreliable.

Strategic Direction

The HCSCC has finalised a review of its Corporate Plan, with the new Vision, Mission and Values detailed at Page 5 of this report.

An Action Plan for the period January 2012 to June 2013 was also developed, providing specific direction for the HCSCC that is able to be incorporated into individual performance plans and performance monitoring.

Some of the key aims and initiatives contained in the plan include:

- Review of internal policies and procedures;
- Focus on engagement with communities outside Darwin;
- Systematic monitoring of implementation of recommendations made following investigation;
- Continued participation in national forums and debates;
- Development of updates or bulletins on recurring themes in complaints;
- Review of prescribed provider lists and reporting requirements;
- Development of training / education program designed to promote the use of conciliation with providers.

We look forward to reporting against each of these aims in the coming reporting period.

Scrutiny

It is essential that the activities and performance of the HCSCC are adequately scrutinised. One means of doing this is through the tabling of the Annual Report. Our financial performance is scrutinised through monthly and quarterly reporting against the budget. Details of the HCSCC's budget and expenditure can be found in the Department of Attorney-General and Justice's Annual Report.

Feedback about our performance is also obtained through provider and complainant feedback. Once a complaint is finalised, parties to the complaint are provided with a standard feedback form addressing issues under four headings, and invited to fill it in and return it. Sixteen responses were received in 2011/12, with results shown in Table 22.

Table 22: Satisfaction Survey Results

Measure	Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree
Accessibility	37%	56%	2%	5%	0%
Timeliness	44%	44%	5%	0%	7%
Fairness	45%	47%	1%	1%	6%
Independence	51%	43%	2%	3%	1%

These figures indicate that the majority of survey respondents thought the HCSCC was accessible, provided services in a timely manner, was fair and independent and staff carried out their tasks in a professional manner.

In 2012/13 the HCSCC plans to develop an on-line feedback system to encourage more users and providers to report to us on their view of our performance.

CASE STUDIES

Enquiries

All case studies used in this section of the report have been modified. Names, conditions, types of providers and other details have been changed to protect the confidentiality of those involved.

The Importance of Communication Style

Jarrod phoned the HCSCC because he and his wife, Sue, were unhappy about the way Sue was treated when she attended an outpatient clinic. Sue was diagnosed with a serious illness and the junior doctor who examined her told her very bluntly about her diagnosis and what that would mean for her life. Sue was devastated and cried for several days.

Later, Sue attended the clinic again and saw a senior consultant who confirmed the diagnosis. The consultant was very professional and caring, and Sue said that if the first consultation had been carried out this way, she would have coped much better.

An officer from the HCSCC contacted the consultant who said that he had spoken to his staff, including the doctor involved, and provided training on how to communicate difficult information to patients. Sue and Jarrod were satisfied that Sue's experience would not be repeated.

Referral to Interstate Specialist

Ralph attended the health clinic in his remote community because he was worried about a skin lesion. He told an officer from the HCSCC that the GP in the clinic refused to refer him directly to a specialist, saying that he would need to see a GP in his home town Adelaide who could then refer him to a specialist. Ralph alleged that the reason the GP wouldn't refer him directly to a specialist was that he was not Indigenous.

The HCSCC contacted the Manager of Remote Health NT who replied that a high proportion of non-Indigenous people live in this community, and that everyone living in the community has an equal right to a service from the health centre. If Ralph had been prepared to see a specialist in Darwin, the GP could have referred him directly and he would have been eligible for financial assistance through the Patient Assistance Travel Scheme (PATS). As Ralph insisted on seeing a specialist in Adelaide, the GP should still have referred him to a specialist, although Ralph would not have been eligible for help from PATS. Apparently Ralph saw a visiting GP who didn't know local processes. The complaint was resolved with a referral to a specialist in Adelaide.

Interim Medicare Card Not Honoured

Allie's partner Dave is not yet a permanent resident, and so has an interim Medicare card. He had no problems using it until he and Allie moved to remote NT. When he went to the Health Clinic in his new home town, Dave was told he was not eligible for a Medicare rebate.

The Health Clinic advised that a number of their patients have interim Medicare cards, and that they do not give a rebate on these cards. The HCSCC learned that generally people with an interim Medicare card are eligible for Medicare benefits. The complaint was resolved and Dave received all benefits he was entitled to.

Bathroom Facilities Repaired to Improve Independence

Adrian has multiple disabilities including severe mobility impairment. As a result, he can only get around in a wheelchair. He also has a cognitive impairment, and the combination of this and his physical disability affects his speech. Adrian lives in the community, with care from a non government organisation funded to provide this care. Jan, Adrian's mum and guardian, phoned the HCSCC because the tap in Adrian's bathroom was not accessible to him. The cabinet under the tap meant that it was impossible for Adrian to wheel up close enough for him to reach the tap. Jan had approached the organisation responsible for Adrian's accommodation asking them to move the tap, but no action had been taken. It was important because while Adrian could ask support staff for help, Jan felt that that the more Adrian could do for himself, the more independent he could be.

The HCSCC raised the issue with the accommodation provider and after enquiries were made, were told that extensive refurbishment was needed for Adrian to be able to reach and use the tap. The plumbing in the bathroom was also a problem. The provider agreed to do the refurbishment and within six weeks of the enquiry being raised, the plumbing had been repaired and Adrian was able to reach and use the tap.

Dental Work Repaired at No Cost

Lara received some extensive dental treatment and some days after the procedure she was still in pain. Lara said that her tooth never felt really comfortable in her mouth. After a few weeks, Lara made an appointment with the senior dentist at the practice who took an x-ray and told her that she had been given the wrong treatment. Lara was told that she would need further extensive work on the tooth, or that it would need to be removed. Lara was still paying off her account for the first treatment and was reluctant to keep paying that bill as well as pay for more treatment for the same tooth. Lara told the HCSCC that she would like to have the money she had already paid refunded, and her tooth fixed. Her complaint was resolved when the dentist agreed to do the further treatment at no charge. Financial arrangements were set up so that Lara could pay her existing bill without too much financial hardship.

Complaint about Cost of Blood Tests Resolved

Colin's doctor referred him to a pathology lab for some blood tests. When he arrived, he was asked to sign a Medicare form and told there would be no charge, so Colin was surprised when, a week later, he received an account from the pathology lab. Colin told the HCSCC that he wanted to know what had happened to the Medicare form he had signed. The accounts section of the pathology lab was contacted - apparently there had been a mix up with Colin's Medicare form. They advised that Colin could tear up his account letter and they would recoup their money from Medicare. Colin was pleased with this outcome and thanked the officer for her help.

Patient Travel Accommodates Health Needs

Marjory has multiple health conditions and as a result has had several recent admissions to hospital. Despite her relatively young age, Marjory is very frail and can only walk with the help of a walker. Her health is not likely to improve. Marjory lives in remote NT, and is grateful that she receives support from the Patient Assistance Travel Scheme (PATS) so that she can get home after being discharged from hospital.

Unfortunately, whenever Marjory's transport home is booked, she is always booked to travel on the bus. This is hard for her because her health makes it difficult to sit comfortably on the bus for long periods of time.

An officer from the HCSCC contacted the Department of Health to make enquiries about other travel options for Marjory. The Department looked into the matter and informed the HCSCC that there had been some problems with the way Marjory's information was stored on two separate information systems. Once the problem was identified and fixed, Marjory was assured that she would always be booked to travel home by plane.

Prescription for Medication Not Renewed

Jack suffers back problems and was prescribed twice daily pain medication by the prison medical service to manage his chronic pain. He complained to the HCSCC that his medication had been ceased over the weekend. When he tried to discuss this with staff, he said they didn't listen, telling him he no longer needed the medication.

The HCSCC spoke to the doctor from the medical service. Apparently the prescription for the medication had mistakenly not been renewed. The doctor apologised to Jack and spoke to staff about the way Jack's concerns had been handled.

Patient Care in Hospital Improved

Mick complained about the standard of nursing care he received when he was admitted to hospital after breaking his leg playing football. For example, he said no-one offered to wash him in the three days he was in hospital. One nurse asked if he was going to shower – Mike said he would like to but he couldn't get his plaster wet. The nurse brought a wash pan for him, but didn't put any water in it. Mick also said he had to ask about toileting, his bed was never changed and food was left out of reach.

Mick agreed that his complaint could be passed on to the hospital so they could contact him directly to resolve the complaint. The manager of the section told Mick that a program designed to address the problems he encountered while in hospital had already been developed and nursing staff were being trained so that they would provide a better service. After seeing a copy of the program, Mick was satisfied that his complaint had been addressed.

Assessment

Unregistered Providers

The HCSCC was contacted by Kyla, a young woman who had made an appointment to see Mr Z, who had been advertising his 'Quit Smoking Program' in the NT News. Kyla thought that the Mr Z must be a psychologist, because he was claiming that he used a number of different therapies, including Neuro Linguistic programming (NLP) and Emotional Alignment Therapy (EAT) to help people with various problems. Kyla contacted Mr Z because she wanted to stop smoking.

Before her appointment, Kyla researched Mr Z and on the basis of her research, decided to cancel her appointment. She did so because she realised he was not a qualified psychologist as she first thought when reading his advertisements. Kyla included some of his advertising material with her written complaint to the HCSCC. Mr Z's advertising material offered one session therapies such as: "Quit Smoking", "Quit Drinking" and, of real concern, "Quit Eating Disorders". If read carefully, the reader could see that no actual claims were being made, the reader was simply being asked if he or she wanted to quit smoking or drinking.

After assessing the complaint, the Commissioner determined that no further action could be taken because Kyla did not actually receive a service. Because Mr Z's advertising may be designed to mislead, the complaint was referred to Consumer Affairs.

Surgery after Wrong Diagnosis

Jane was experiencing some pain and swelling under her arm. Over a few days the pain got worse and the area became quite swollen. A doctor told Jane that the pain and swelling was an allergy and prescribed treatment. A few days later, her arm was so sore that she went to the Emergency Department, where she was told it was an abscess that required surgery. There were two complaints. Firstly, Jane complained that surgery would not have been necessary if the doctor had examined her properly; and secondly she complained that he should have diagnosed her abscess. This would have prevented further pain and her having to undergo surgery.

The doctor said that when Jane came into his surgery, he took a detailed medical history from her, learning that she had a history of allergic reactions to products such as deodorants. The doctor examined the site which appeared slightly reddened. Although Jane said it was sore, she did not flinch when touched. There was no evidence of fever or that Jane was feeling generally unwell. The doctor did not believe that there were clinical signs of an abscess at the time he examined Jane. He did however apologise to Jane for any distress she suffered, while maintaining that his opinion was based on comprehensive examination at the time.

The HCSCC sought advice from a clinical advisor. The advisor commented that the doctor's record of consultation failed to meet the standards required of it; that is there was no record of the examination that took place, of any diagnosis at the time or of any follow up plan. The advisor expressed the opinion however that the abscess would have been difficult to diagnose from the symptoms present at the time Jane went to see her doctor.

After considering all of the materials gathered in assessment process, the HCSCC referred the apparent deficiencies in consultation notes to the Medical Board and took no further action on the complaint regarding diagnosis as further investigation was not justified.

Conciliation

New Early Warning Score Policy Now In Place

When Edna experienced severe abdominal pain, she was admitted to hospital and the problem repaired with surgery.

In the week following her surgery, Edna's pain worsened and her condition deteriorated. It was several days before she was diagnosed as having developed an infection. While she eventually went home, Edna was not impressed that she had spent so long in pain and that the infection was not recognised and treated earlier.

Edna and the hospital agreed to resolve the complaint by conciliation. In general, people complain to the HCSCC because they don't want anyone else to have the same experience as them. Edna was no different.

A direct outcome of the conciliation is the introduction of a policy and system to ensure that clinical deterioration will be recognised early and that this will trigger a response. Edna also received a written apology for the unnecessary pain she suffered.

No Interpreter Used to Seek Consent

After two of Jim's toes were crushed in a work accident in remote NT, he was flown to hospital for surgery. Both toes were removed in this surgery.

Jim contacted the HCSCC because when he agreed to the surgery, he did not understand that his toes might be removed. He thought that they were going to be repaired.

Jim has only been living in Australia for a few years, having moved here from South America. He has sufficient, basic English for him to get by in the mines, but he has no understanding of complex English terms.

When Jim arrived at the hospital, he was shocked and in pain. In these circumstances, his English was even worse. Staff from the hospital said there was no interpreter available at the time.

Both parties agreed to conciliation of this complaint. An interpreter was booked and present during the conciliation. Jim received a written apology for the distress caused when medical staff did not make sure he understood that his toes would be removed. The service also promised to review and improve their systems so that interpreters would be routinely used to ensure consent is fully informed.