Health and Community Services
COMPLAINTS COMMISSION

Annual Report 2016-17

Health and Community Services
COMPLAINTS COMMISSION

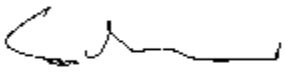
Nineteenth Annual Report (2016/17)

The Honourable Natasha Fyles 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 2017.

Yours sincerely



Stephen Dunham
Commissioner

27 October 2017

Glossary

AHPRA	Australian Health Practitioner Regulation Agency
AMSANT	Aboriginal Medical Services Alliance Northern Territory
ATSI	Aboriginal and Torres Strait Islander
CAHS	Central Australian Health Service
CALD	Culturally and Linguistically Diverse
COAG	Council of Australian Governments
Commission	Health and Community Services Complaints Commission
CVP	Community Visitor Program
DCLS	Darwin Community Legal Service
DoH	Department of Health
ED	Emergency Department
GP	General Practitioner / General Practice
HCE	Health Complaints Entity
IdA	Integrated Disability Action
ISP	Individual Support Plan
NAAJA	North Australian Aboriginal Justice Agency
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NDS	National Disability Service
NTMHS	Northern Territory Mental Health Service
OoD	Office of Disability
OPG	Office of the Public Guardian
PBSP	Positive Behaviour Support Plan
PPHCS	Prison Primary Health Care Service
PRN	Pro Re Nata
TEHS	Top End Health Service
TEMHS	Top End Mental Health Service

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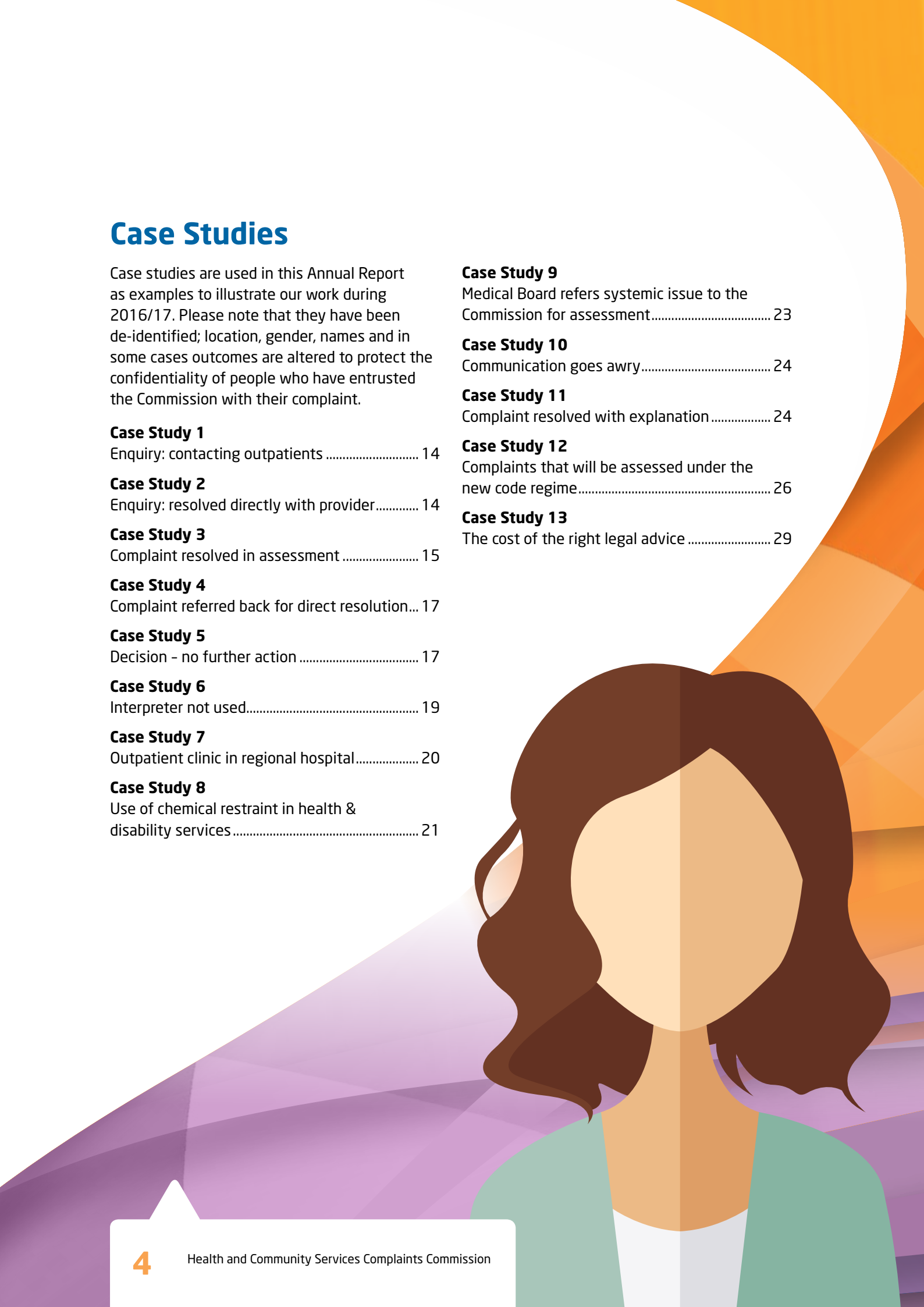
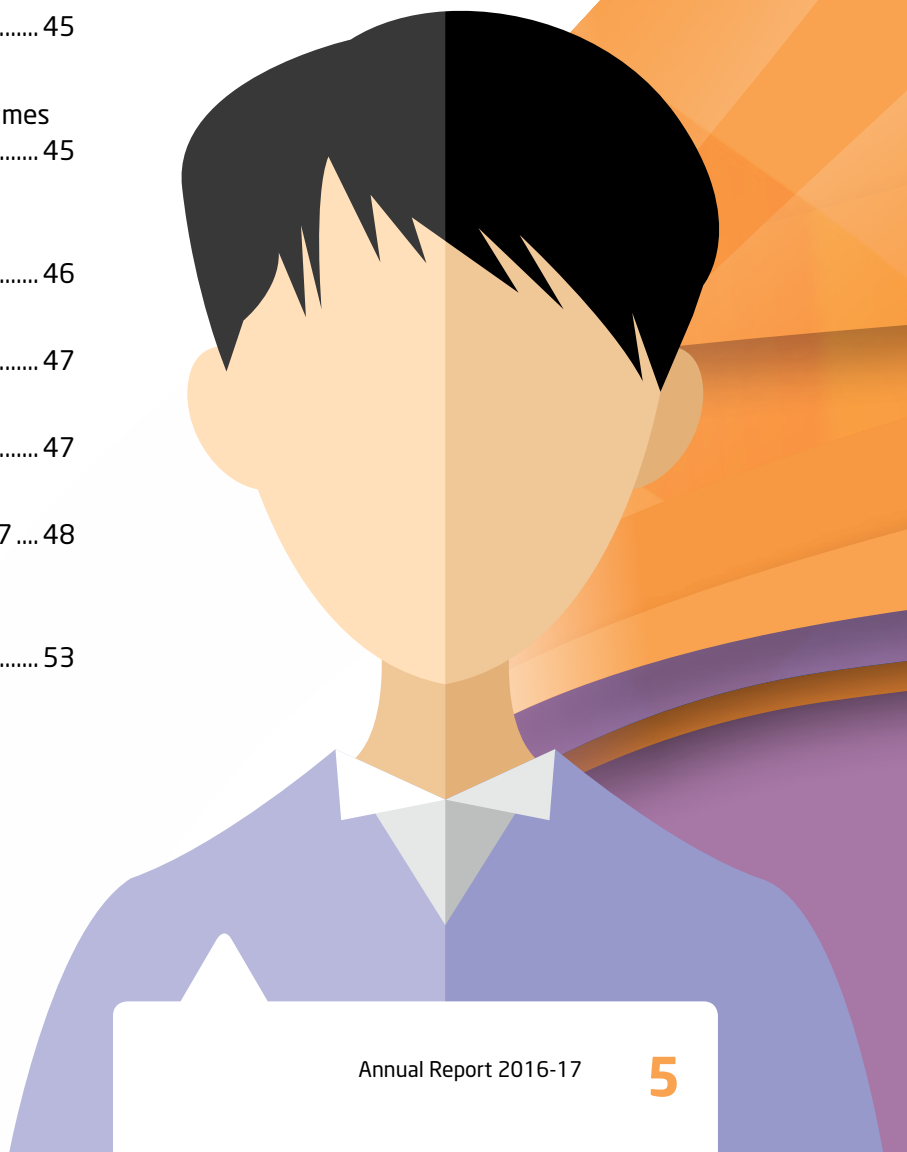
Case Studies

Case studies are used in this Annual Report as examples to illustrate our work during 2016/17. Please note that they have been de-identified; location, gender, names and in some cases outcomes are altered to protect the confidentiality of people who have entrusted the Commission with their complaint.



Figures



Tables

Commissioner's Report

I consider it an honour to have been appointed as Commissioner and I am mindful of the community expectations and legislative requirements for me to approach my work with confidentiality, impartiality, and to use the independent statutory office for the benefit of the people of the Northern Territory. It is reasonable for these high benchmarks to be tested.

This Annual Report gives me an opportunity to reflect on the past year and report to those with an interest in the Commission's work.

In this regard the data in this report provides some basis for an understanding of the volume, complexity and worth of the Commission's work. I note the intention of Parliament to interrogate the annual reports of all departments and authorities with the Commission scheduled for 29 November 2017, and I look forward to providing further expansions at this time.

I will again offer briefings to all Members of the Legislative Assembly or their staff and I hope to get the same take up rate to this offer as last year.

Increases to workload... a good news story

The year in review has again been marked by changes, challenges and increases to workload. Many of the changes directly arise from the need to cope with the workload, which has almost doubled since the Commission became a stand-alone independent office (450 in 2010/11 and 823 in 2016/17) and is up 33% over the previous year (see table 1). This in turn has required the Commission to focus on finding better and more efficient ways of doing business and to fundamentally review our "business". I outlined a number of strategies to enhance the Commission's activities in last year's Annual Report and can report that all have been operationalised with discernible positive effect.

Although it is recognised that there are many reasons why people contact the Commission there is no doubt that the increases to workload are partly a result of the Commission's efforts to fulfil its statutory obligations to:

- promote the rights of users of health services and community services; and
- encourage an awareness of the rights and responsibilities of users and providers of health services and community services

Community engagement, an essential part of the Commission's operations

The Commission's staff have all undertaken community engagement activities throughout the year and in this way have reached hundreds of people to promote the Commission's work and objectives (see Appendix 2). This practice is a departure from previously where the lack of dedicated funding for specialist community engagement resources was a continual impediment to optimal community engagement. All Commissioners have tried to meet this obligation while balancing competing priorities as I observed in last year's Annual Report:

"There is little doubt that the pressing and urgent work of direct complaints resolution can result in a lesser priority for the other two imperatives, ...(promotion of rights and improvements in services)... particularly in the face of increasing numbers of contacts with the Commission, and static staffing levels."

The obvious nexus between people being aware of their rights to complain about poor or substandard services and acting on this to address their grievances and improve services is amply demonstrated here. For this reason the Commission is pleased to see the increases in contacts as it vindicates the investment put into community engagement. The relatively low numbers of complaints emanating from the disability sector is a matter of concern and this will continue to be an area of focus for the Commission.

Why do people complain? (...and why they don't)

The Commission's data provides ample scope for analysis of the rationale for complaints, the basis for their grievances and the factors which influence people to contact the Commission.

The invitation for feedback following the finalisation of a complaint is also an important source of data to guide the Commission (see table 6).

The lack of "own motion" powers means that the Commission responds to external requests from people who are able to navigate the "complaints system". It is constrained in only looking at those issues nominated as points of complaint and engages with providers on the specific outcomes sought.

The Commission is limited in its understanding of the factors which dissuade people from complaining and often continuing to accept services which are inarguably below what is accepted as reasonable. The Australian Commission on Safety and Quality in Health Care is in a position to scrutinise in detail the national data and perspectives relating to potentially dangerous practice. It reports that one in 10 patients are harmed while in hospital in Australia, with harm caused by a range of errors or adverse events, such as medication errors, patient falls and hospital acquired infections, estimated to cost up to $896 Million per annum. "Serious harm" which includes death is estimated to occur at a rate of 0.04% annually, or 1,782 people across Australia. While some could argue that the rate of 0.04% is so small as to be almost insignificant or even "acceptable", the people who suffer the consequences of serious harm obviously have a different view. There is little doubt that many changes to practice are wrought from complaints.

Approaches to the Commission are a small portion of those Territorians who have been subjected to poor service provision. It is acknowledged that some service providers such as Royal Darwin Hospital have put greater emphasis on safety and quality initiatives and complaints handling. This "in house" effort accords with the legislative intention of the *Health and Community Services Complaints Act* ('the Act') and often fully satisfies the concerns of complainants without any involvement of the Commission. The Commission has devoted significant effort into assisting providers to develop greater and more effective capability to respond to complaints and will make this a focus in the coming year.

In the two years I have been in this role I have come to understand that in many cases, taking the step to complain is an act of bravery and in the vast majority of cases, the sole altruistic motivating factor is to improve systems so "...it doesn't happen to anyone else".

Disability focus

The Commission has increased its engagement with the disability sector and has good relationships with peak bodies, government agencies and service users. The roll out of the NDIS sees the Commission receiving funds to provide information to the sector regarding safety, quality and rights. As is evident in the Commission's other investments in community engagement, this will lead to greater awareness of the Commission and an increase in contacts and complaints. This project has been approved at the year's end and will be fully operational during 2017-18. It is further expanded in Chapter 3 of this report.

The Commission will work productively and collaboratively with the multitude of agencies involved in the rollout of the NDIS and notes that some 6 500 people will receive services under this scheme. The ABS has identified 20,700 people with disabilities in the Northern Territory (2015 figures), and the Commission will make every effort to ensure that the quality and safety protections provided under the NDIS are replicated for the large majority of people with disability who will not receive services via this scheme.

Making things better, another essential part of the Commission's operations

It is a truism that complaints present an opportunity for improvement.

The *Health and Community Services Complaints Act* is unambiguous in its objective to:

"*...establish a health and community services complaints system that...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...*"

Improvements to services result from the majority of complaints received and some substantial modifications to process and practice can be directly attributed to the involvement of the Commission (see figure 12). While the necessity to maintain confidentiality means that few people see the detail of the changes, the Department of Health (DoH) readily acknowledges the improvements which accrue from complaints. The Department has provided a seconded staff member on a 12 month rotating basis during the year as a tangible demonstration of the need to invest in complaint resolution as a service improvement imperative. This initiative is one of the highlights of the year and is expanded on further in this report.

The Commission's capability

The prime factors which render the Commission capable are its personnel and corporate ethos. The people who make up the staff of the Commission bring dedicated, focussed and professional expertise to bear in the pursuit of the objectives of the Act. I must use this opportunity to record the respect and gratitude I owe the past and present staff whose work is largely unseen and unsung in their efforts to advance essential health services, services for people with a disability and aged people.

All staff contribute to the regular planning workshops which take stock of our circumstances and jointly sign on to the corporate directions and priorities. The focussed recruitment strategy of the Commission over recent years has endowed the organisation with a mix of skills and experience and a strong people centred approach to our business. The addition of a seconded clinician from the Department of Health has added to this skill repertoire and all staff with specialist capability provide in house training, advice and mentoring to others. In this way the span of competence in such a small organisation is assured.

Again this year I must thank all of the staff of the Commission and single out Judy Clisby the Deputy Commissioner who has extensive experience in the work of the Commission and has proposed and implemented numerous changes to enhance practice. The Commission is tasked with ensuring complaints lead to improvements and must embrace culture of continuous improvement in its own systems.

Being a small office, it is reasonable that I should use this occasion to personally name and thank all of the staff of the Commission during the 2016-17 year:

- Judy Clisby the Deputy Commissioner;
- Leigh Kinsela, Liz Keith, Jodie Mather, Ruth Bresland, Anne Lade, Robynne Lower the Senior Conciliation and Investigation Officers;
- Brendan Schultz the Business Manager;
- Ashlee Edwards and Izel Thomas the Resolution/ Administration Officers; and
- Lisa Tiernan the Administration Support Officer.

Stephen Dunham
Commissioner

2016/17 at a Glance

Table 1: Key deliverables 2015/16 - 2016/17

Key deliverables	2015/16	2016/17
Enquiries and complaints received	621	823
Enquiries and complaints closed	647	795
% Complaints closed within 180 days	85%	87%
% Complaints closed as a proportion of complaints received	104.2%	96.6%

Enquiries

- More enquiries were closed (574) than were received (570).
- In 2016/17, the Commission closed the highest number of enquiries ever (previous maximum 468 in 2013/14).
- Despite this the average number of days taken to finalise enquiries decreased from 13 days in 2015/16 to 7.7 days in 2016/17.
- 82% enquiries were closed within 14 days compared with 68% in 2015/16.

Complaints

- In 2016/17, 253 complaints were received comprising 491 complaint issues.
- 221 complaints were closed (87% of complaints received).
- The proportion of complaints closed within 180 days decreased to 75% (benchmark is 80%).
- 41% complaints were closed within 60 days compared with 58% in 2015/16. The ability to close complaints quickly was adversely affected by increased staff workload.

Resolution focus

- The proportion of complaints resolved at enquiry stage was maintained at 70%.
- The proportion of enquiry issues resolved increased from 25% in 2015/16 to 28% in 2016/17.
- The proportion of complaint issues resolved more than doubled from 9% of all issues closed in 2015/16 to 19% in 2016/17.
- 427 Practitioners and Managers attended training offered in customer service and complaints management in 2016/17.

Service improvement

- Four Investigations were completed.
- 63 recommendations involving 9 distinct service providers were monitored.
  31 recommendations were closed.
- Quality improvement was recorded as a complaint outcome on 90 occasions.

Community engagement

- Staff engaged in 63 separate community visits / community events in 2016/17.

Chapter 1: The Commission

OUR MISSION

Independent, just, fair and accessible complaints systems which promote the rights of service users and contribute to safety and quality improvement in health, disability and aged care services in the NT.

OUR VISION

High quality, responsive, person centred health, disability and aged care services throughout the Territory.

OUR VALUES

The Commission is guided by the following values:

- Accessibility
- Accountability
- Fairness
- Innovation
- Person-centredness
- Professionalism

OUR HISTORY

The Health and Community Services Complaints Commission (Commission) was established in 1998 with the passage of the *Health and Community Services Complaints Act.* It sat with the Ombudsman's Office until 2010 when the Commission became a stand-alone entity with an independent Commissioner.

The Commission was set up to provide an independent, just, fair and accessible mechanism for the resolution of complaints between users and providers of health, disability and aged services. The focus of the Act is on the resolution of complaints, the improvement of services and the promotion of the rights and responsibilities of both service users and providers.

OUR FUNCTIONS

The Commissioner's powers and functions as set out in s3 of the Act include:

- Encouraging and assisting users and providers to resolve complaints directly with each other
- Leading to improved services and promoting rights and responsibilities
- Providing information, advice and reports to Boards, service users, the Minister and the Legislative Assembly
- Consulting with providers, organisations and users of health and community services and
- Enabling users and providers to contribute to the review and improvement of health services and community services.

OUR STRATEGIC OBJECTIVES

1. Quality Complaints Management
2. Promote capacity
3. Improve Systems
4. Advise government
5. Educate the NT community
6. Governance and Resources Management

OUR TEAM

The Commission receives support from the Department of Attorney-General and Justice in areas such as human resources, finance, procurement, record management, and office accommodation and information technology. The Commission is co-located with the Office of the Children's Commissioner and shares one staff member, the Business Manager.

ORGANISATIONAL STRUCTURE

Commissioner
Stephen Dunham

Deputy Commissioner
Judy Clisby

SI/CO
Ruth Bresland

SI/CO
Leigh Kinsela

SI/CO
Elizabeth Keith

TEHS Secondment
Robynne Lower

Business Manager
Brendan Schultz

Table 2: Staffing profile as at 30 June 2017

Position Level	Male	Female	TOTAL
Commissioner (ECO2)	1	0	1
Deputy Commissioner (ECO1)	0	1	1
Administrative Officer 7 (AO7)	0	3	3
Secondment TEHS N5	0	1	1
Administrative Officer 6 (AO6)	0.5	0	0.5
Administrative Officer 4 (AO4)	0	1	1
Administration Support Officer 1 (AO1)		0.19	0.19
Total	**1.5**	**6.19**	**7.69**

Resolution AO
Ashlee Edwards

Admin Support Officer
Lisa Tiernan

Chapter 2: Quality Complaints Management

ACHIEVEMENTS 2016/17

Increased proportion of matters resolved

Section 12(1)(b) of the Act states that one of the Commissioner's functions is to *encourage and assist users and providers to resolve complaints directly with each other*. Section 86 requires that the Commission treat all its matters "with as little formality and technicality" as possible and as quickly as possible while still ensuring a fair process. These provisions, along with a focus throughout the Act on complaint resolution, require that complaints received by the Commission are resolved directly between the parties if at all possible, and, if the Commission is involved, as informally and quickly as possible.

The Commission has increased its focus on resolution over the past two years. Strategies have included the development of training and resources for service providers to assist with complaints resolution; asking complainants to resolve their complaint directly with providers before lodging a complaint with the Commission; coaching parties through the complaint process with a view to assisting them reach resolution; and using a range of resolution options in Commission enquiry and complaints management to resolve matters that do come before the Commission.

28% enquiries resolved

The most informal way of dealing with complaints is through our enquiry, or informal complaint system. Whenever a complaint is received, it is assessed to determine whether it can be resolved informally. In 2016/17, as in the previous year, 70% of all issues dealt with by the Commission were managed informally. Of these, 28% were resolved.

Table 3: Categories and percentage enquiry outcomes 2016/17 [1]

Enquiry Outcomes	No.	%
Enquiry – complaint form sent	3	0
Enquiry – information provided	133	20
Enquiry – referred back	135	21
Enquiry – resolved	184	28
Enquiry – other	36	5
Enquiry – referred elsewhere	71	11
Enquiry – referred to Commission complaints process	94	14
Total	**656**	**100**

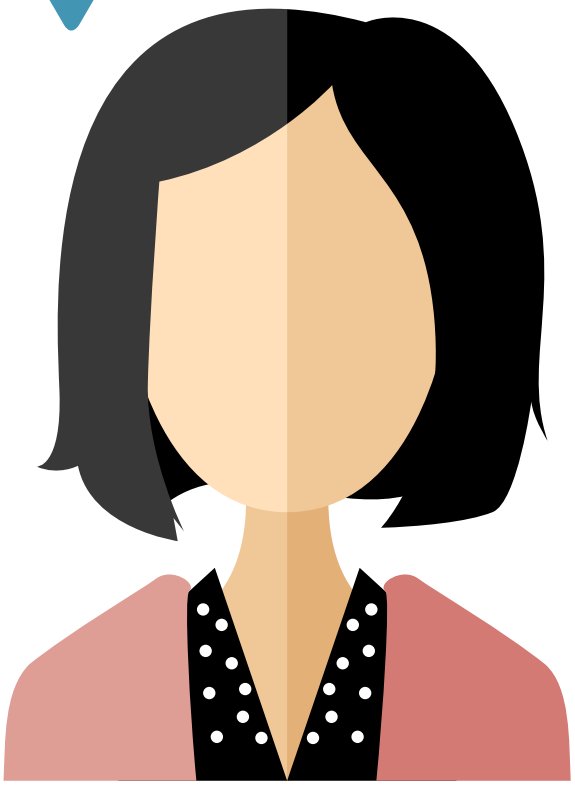
1 Cannot be compared to 2015/16 as two new categories: *other* and *referred elsewhere* were introduced 2016/17. In addition, more than one issue per enquiry is counted in 2016/17.

Case Study 1
Enquiry: contacting outpatients

May's GP referred her to the local hospital for a specialist appointment to follow up some abnormal blood results. May did not know if she had an appointment, or when it might be. She tried to ring the hospital to find out but despite several attempts over a month, she had no success. May contacted the Commission because she was really worried about her health, and the waiting and not knowing was making her worry more.

Staff of the Commission will always tell callers that the Commission will not ask for wait times to be shorter, however contact can be made with the hospital to find out if there is an appointment, and when it is likely to be.

With May's permission, the Commission contacted the Patient Advocate and was informed that a specialist appointment had now been made. The enquiry resolved when May was provided with this information.



Case Study 2
Enquiry: resolved directly with provider

Jessica saw her GP believing the pain in her foot was serious as she has diabetes. Her GP referred Jessica for an X-ray. The next day, Jessica rang the GP surgery and was told the results were there, and that the doctor would look at them and contact her.

Jessica still hadn't heard the following day, and so she contacted the surgery again. She was advised to book an appointment as the doctor still hadn't looked at her results. Jessica asked to speak to the doctor as she was in pain and could barely walk, and wanted to know whether she should go to the hospital.

When she still didn't hear from the GP surgery, Jessica contacted her specialist who made an appointment for her, telling her to bring the X-rays. To organise this, Jessica rang the GP Surgery, and was told by the receptionist that her daughter could collect the X-rays. When she went to do so, the receptionist had gone home and her daughter was told that only Jessica could collect them.

Commission staff talked to Jessica about how she might resolve her complaint by contacting the service provider, advising her to speak to the practice manager. Jessica contacted the practice manager who apologised and told her that the X-ray results would be faxed to the specialist. The practice manager also said she would speak to staff about a more consistent and reliable process for patient access to results.

19% complaint issues resolved

If a concern cannot be resolved at enquiry level, it is dealt with as a complaint. This is a more formal process in which information is gathered with a view to deciding whether further action is necessary. With every complaint, staff of the Commission will consider how it might best be resolved, keeping in mind the goal of resolving all complaints as informally and quickly as possible.

Complaints numbers each year comprise complaints received by the Commission and notifications received by AHPRA. In 2016/17, the Commission closed 221 complaints. Every complaint contains at least one complaint issue, with some large and complex complaints containing many more. Thus the number of complaint issues will always be greater than the number of complaints. In 2016/17 outcomes were recorded for 491 issues in the 221 matters finalised.

The Commissioner consistently decides to take no further action with approximately 60% of complaint issues. In 2016/17, this proportion was far higher (71%[2]). This increase in decisions to take no further action can largely be attributed to an increase in the number of complaint issues resolved during assessment (s30(1)(h) of the Act states that the Commissioner must take no further action with a complaint if it is resolved). In 2016/17, 92, or 19% of all complaint issues were resolved during assessment compared with 9% in 2015/16. The increase in matters resolved in assessment reflects the Commission's focus on resolution.

2 Calculated after removing 129 issues from AHPRA Notifications dealt with by the relevant Board and not assessed by Commission.

Case Study 3

Complaint resolved in assessment

Jack attended the pathology lab for a blood test. He had fasted, but had a cup of tea that morning. The nurse at the lab told him that he needed to completely fast, which meant he should not eat or drink before the procedure.

Jack returned at a later date, having fully fasted by not eating or drinking prior to attending the lab. When he arrived, the nurse asked him to drink some water and then tried to take blood samples. Jack was so dehydrated that the nurse could not find his vein. He was not happy with his experience and contacted the Commission.

In its response to the complaint, the lab acknowledged that Jack had been given conflicting information. The lab promised to provide compulsory training to their staff and apologised to Jack.

Table 4: Reasons for closure: issues closed 2015/16 and 2016/17

Reason for closure	2015/16	2016/17
Conciliation complete	55	29
Dealt with by Board	184	189
Investigation complete	10	13
No further action	206	258
Referred to other entity	11	2
Total	**466**	**491**

Table 5: Reason for no further action: issues closed 2015/16 and 2016/17

Reason for no further action	2015/16	2016/17
No basis for complaint /Out of Jurisdiction	1	4
Complaint over 2 years old	1	
Failure to reasonably resolve with provider	13	12
Further investigation unnecessary and/or unjustified	99	90
Complaint lacks substance	16	1
Frivolous/vexatious	1	
Complaint is resolved	42	92
Complaint determined by a court, tribunal or board	3	9
Civil proceedings commenced		1
Required information not received	10	14
Complaint has been withdrawn	20	35
Total	**206**	**258**

Case studies 3 – 5 provide examples of different ways of managing complaints in assessment.

Case Study 4

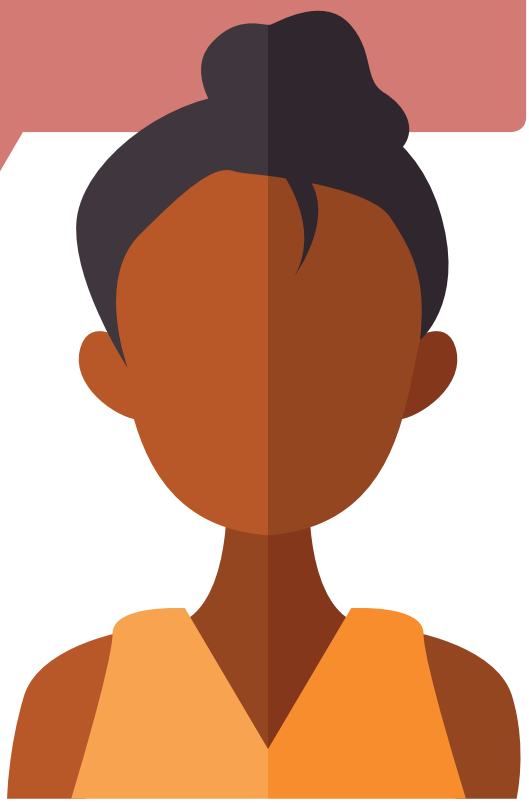
Complaint referred back for direct resolution

Marnie contacted the Commission with a complaint about an outpatient clinic. Her GP referred her to the clinic and an appointment 9 months later was cancelled at the last minute. A few months later, when she still hadn't heard from outpatients, Marnie contacted them for another appointment. This went ahead, and after assessment, Marnie paid for a series of treatments.

Six months later, Marnie received a call from outpatients advising her that the treatment had not been ordered, and her credit card was re-credited.

Marnie was frustrated. She was suffering, and needed to have the treatment. She complained to the Commission. Marnie agreed to her complaint being referred to the hospital to resolve directly with her, with the Commission's complaint file to remain open until it was finalised.

Marnie was satisfied with the outcome of the direct resolution, which included an explanation and re-referral for treatment at the outpatient clinic.



Case Study 5

Decision – no further action

Michael complained to the Commission that he was not provided with an appropriate place to provide a semen sample when he attended the pathology service. He said that he was told to obtain the sample in a public toilet, and then had to carry the sample in the jar in a clear plastic bag across a public area.

In response to the complaint, the pathology service advised that as the sample was not urgent, it could have been collected at home and then delivered to the collection centre. The service also advised that the toilet had a double locking door, and that this was an appropriate space as it was both secure and private.

The Commission sought advice from a division of the Commonwealth DoH which sets the standards for pathology centres. These standards state simply that a suitable place must be available.

The Commissioner agreed that the toilet was not a suitable place, and advised the pathology service to direct patients to collect these samples at home in future. As nothing more could be achieved by further Commission involvement, the Commissioner decided to take no further action with this complaint.

Highest number of matters closed

Figure 1 below depicts the increasing number of complaints and enquiries closed from 2012/13 until 2016/17. Given the 33% increase on matters received last year on the previous year, the ability to close so many matters demonstrates the effectiveness of workload management measures introduced by the Commission. These measures include referring enquirers and complainants back for direct resolution; resolving at the lowest level and with as much expedition as possible; consulting with AHPRA when a complaint is first received; and refining all workflows to remove all unnecessary actions when managing complaints.

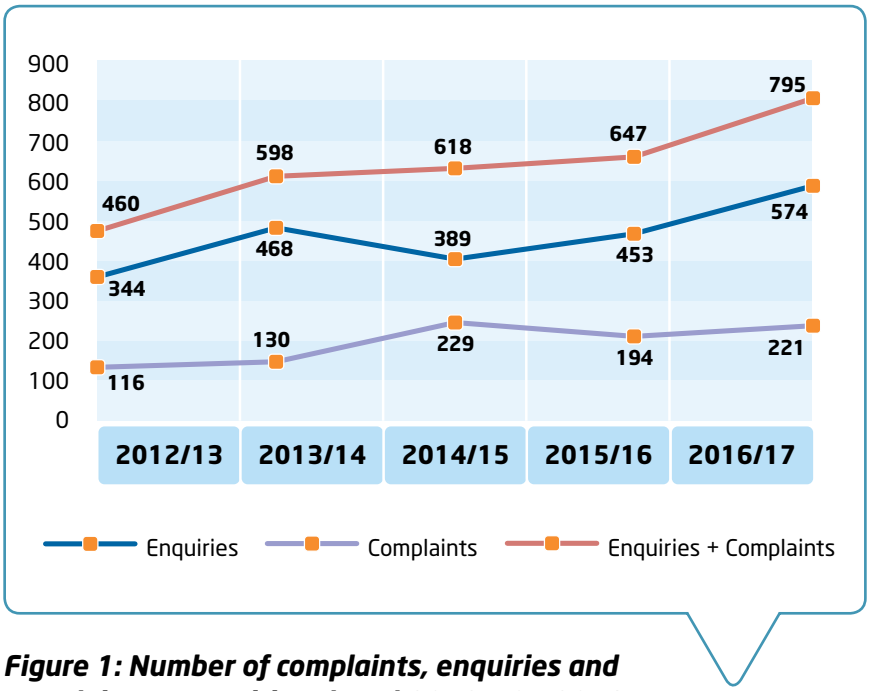


Figure 1: Number of complaints, enquiries and complaints + enquiries closed 2012/13 - 2016/17

Enquiries closed faster

There had been an increase in the average time taken to close enquiries from an all-time low of 6.63 days in 2014/15 to 13.04 days in 2015/16. A renewed focus on enquiry management, along with a higher proportion of enquiries being referred back for direct resolution resulted in a significant reduction of average time taken to finalise enquiries in 2016/17.

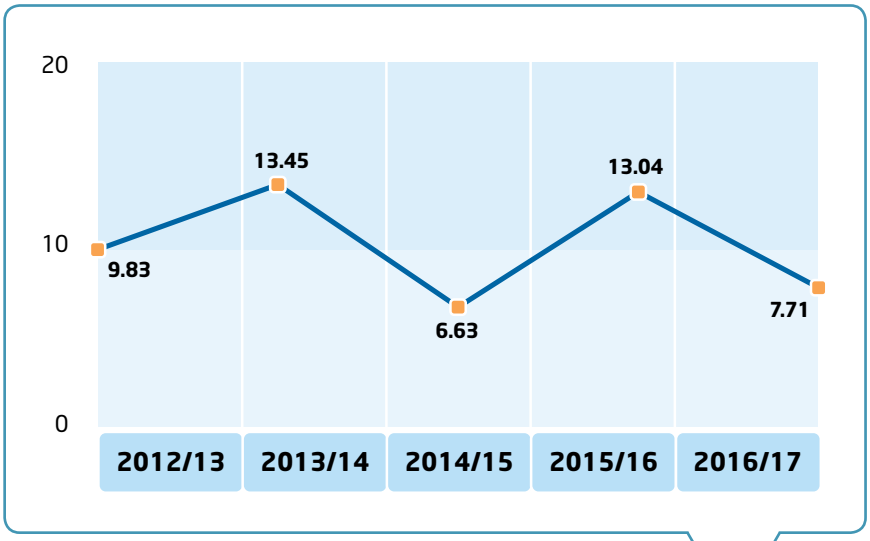


Figure 2: Average time to finalise enquiries (days) 2012/13 - 2016/17

Conciliations

One option available to the Commission to assist parties resolve complaints is conciliation. Conciliation is a form of alternate dispute resolution in which parties come together to discuss the issues of complaint in a confidential environment with the aim of settling the dispute. It is a voluntary, flexible process in which parties are encouraged to discuss issues frankly and openly. It can be used as an alternative to medico-legal processes, often resulting in explanations being provided to parties, along with apologies where appropriate. In many cases agreements reached through conciliation can lead to improvements in services, even resolving issues that are assessed as potentially affecting public safety and avoiding a time consuming and costly investigation. In 2016/17, 13 complaints were finalised by conciliation.

Part 6 of the *Health and Community Services Complaints Act*

Part 6 of the Act which sets out the conduct of Conciliations is ambiguous and difficult to interpret. In 2016/17, Elizabeth Keith, a Senior Investigation/Conciliation Officer with the Commission conducted an in-depth examination of Part 6 and prepared a brief for legal advice.

Issues clarified with legal advice include defining of what is meant by the term "conciliation process"; when conciliation commences; what activities are covered and how this affects confidentiality and privilege of information in conciliation. Clarification was also sought regarding whether it is possible to reach agreement in a complaint if one party refuses to include an outcome such as compensation within the scope of conciliation. In addition, the Commissioner received advice on how to enforce agreements which do not involve compensation. These matters will all benefit from amendment to the Act and will be considered when that exercise is undertaken

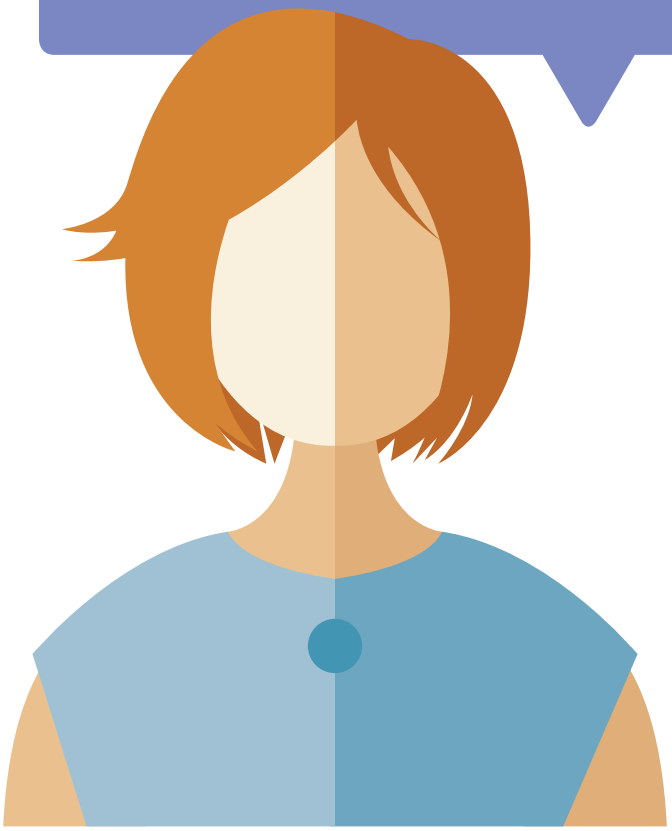
Case Study 6

Interpreter not used

A complaint was received from a lawyer acting for Jasmine, a young woman with cognitive impairment and schizophrenia who was interviewed without an interpreter being present.

Jasmine, who is largely uncommunicative, heard English for the first time when she was 12 years old. For this reason, an interpreter was present at the conciliation which was also attended by staff from the health service, Jasmine, Jasmine's lawyer and her guardian.

Outcomes from the conciliation included agreement that interpreters would be used whenever possible in all future interactions between the health service and Jasmine, the service would make every effort to include the guardian in decision-making. All staff would be required to undertake training in the use of interpreters.

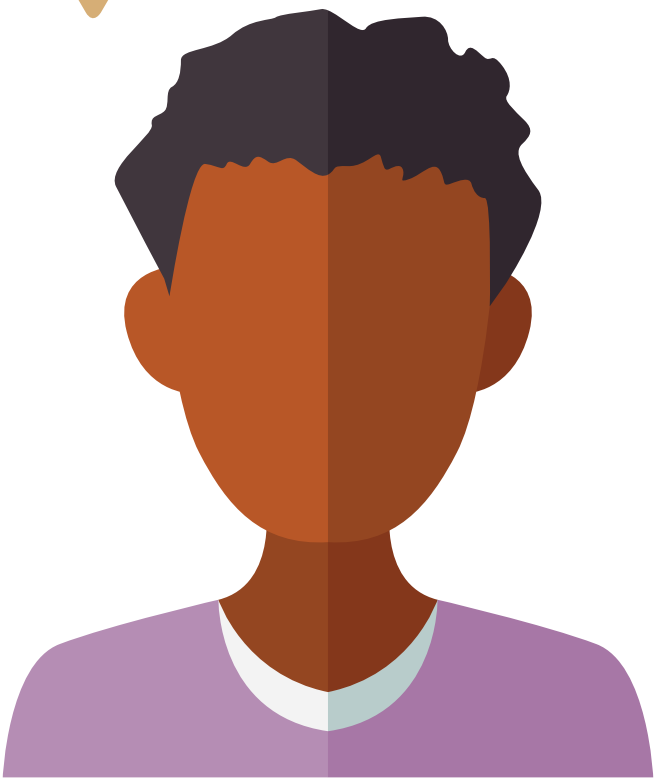


Case Study 7

Outpatient clinic in regional hospital

Gavin's 8 year old son Taylor broke his leg and was treated in the local regional hospital. Gavin was told that Taylor should have a follow up X-Ray and that the only way he could get the X-Ray results was to go to the Emergency Department (ED) of the hospital. He would be triaged, and ED doctors would phone the Consultant Orthopaedic specialist. Gavin took Taylor to ED, but had to wait hours with a child who was becoming increasingly upset. Gavin could not understand why he could not get the results from his GP.

The complaint was resolved at conciliation when hospital representatives informed Gavin that a new Tele-health Outpatient Clinic would be established at the hospital. It would operate one day/week and enable access to results and feedback by phone.



Investigations

Four investigations completed in 2016/17

The Commissioner may decide to investigate a complaint, or series of complaints which raise significant issues of public health or safety, or public interest. Investigation is a formal process during which the Commissioner may interview people involved and seize documents.

One of the main aims of an investigation is to look into systemic issues and identify areas for service improvement. At the conclusion of an investigation the Commissioner will make findings and may make recommendations for action or change. The Commissioner may also approve the publication of elements of the investigation by way of tabling the anonymised report in parliament. All reports undertaken during the 2016/17 year remain confidential.

Where a recommendation is made, the party concerned will be advised of the recommendations and reasons for the decision. The provider is then required to advise the Commissioner of action to be taken to comply with the recommendation. The Commission then monitors implementation of the recommendations to ensure that undertakings are met and improvements made.

An investigation is a major body of work; difficult for Investigation/Conciliation Officers to complete when there are competing priorities such as responding to enquiries and complaints. The completion of four investigations, one of which comprised a major piece of work on a contentious issue (see case study 8) was a notable achievement. To ensure that investigations undertaken by the Commission will be completed, the Commissioner has foreshadowed that from 2016/17 investigations will be smaller with a sharper, single issue focus.

Case Study 8

Investigation into the use of chemical restraint in health and disability services

Terence started to transition from a Northern Territory custodial facility to the secure care facility in early 2014, attending several times each week. During this transition, which is still ongoing, Terence received care from prison primary healthcare service and disability services. A comprehensive Positive Behaviour Support Plan (PBSP) developed by the Office of Disability (OoD) provides a plan for the management of behaviours which place Terence or others at risk. It offers detailed strategies for promoting the development of appropriate communication skills and behaviour. The plan is intended to be used at both the prison and secure care. It involves a number of behaviour management strategies, including the administration of PRN (Pro Re Nata, meaning "as needed") medication, with a lower threshold for its administration at the secure care facility.

The investigation concerned decision-making and appropriateness of use of medication in the management of behaviour for people with challenging behaviours. It questioned whether the use of medication in cases such as Terence's constitutes chemical restraint.

The Commissioner found that:

- In this case, administration of PRN medication as part of the Positive Behaviour Support Plan (PBSP) assists with the regulation of Terence's emotional state and ultimately manages his behaviour. It is not for the management of a mental illness, and therefore meets the criteria for definition as chemical restraint;
- Safeguards associated with the use of restrictive interventions such as chemical restraint must be in place and must be in use. This supports the human rights framework inherent in the *National Framework for the Reducing and Eliminating the Use of Restrictive Practices* as well as policy directions in national disability services. The Commissioner found that protections inherent in the *Disability Services Act* are not available to Terence in either the prison or disability settings, and that this is a situation which must be addressed;
- Documentation is inadequate. Behavioural strategies developed specifically for Terence to avoid the use of PRN medication are either not used, or are used and not documented. There is therefore insufficient justification in the notes for its use; and
- At least some of the staff involved in Terence's care were unaware of the legal authority for his sedation and there is no clear policy on the use of chemical restraint within the correctional services and secure care environments.

The Commissioner recommended that if there is any question that medication may be used at least in part for behavioural management (ie if it is included in a PBSP and not prescribed for the treatment of mental disorder or mental illness) that:

- staff must know the legal basis for its use;
- safeguards must be in place (as required by the *Disability Services Act*); and
- behavioural management strategies must be used prior to administering PRN medication and documented.

Relationship with AHPRA maintained

Section 68 of the Act states that if the Commission receives a complaint about someone classified as one of the 14 health professions which comprise registered providers, the Commissioner must notify the relevant Board as soon as practicable after the complaint is received. This is achieved by writing to the Director of Notifications of the Australian Health Practitioner Regulation Agency (AHPRA) which is the administrative arm of all the National Boards.

In the past, the Commission would write to AHPRA to notify it that a complaint had been received, assess the complaint about the registered provider and then consult with the Board about how the complaint should be handled. For registered providers, this could take some time as they would need to wait while the Commission assessed the complaint, and then wait for up to a further 6-8 weeks for the Board to consider the assessment and to either agree or disagree with the Commission's recommendation.

As reported in the 2015/16 Annual Report, this consultation now occurs during weekly meetings between the Director of Notifications AHPRA and the Deputy Commissioner of the HCSCC. At this time, a decision is made as to which agency is best suited to assess it. This decision takes into account the functions of the two agencies – for example, the Commission will work with the parties to a complaint with a view to resolving it with a focus on quality improvement, whereas the Board's focus is the practitioner, including the practitioner's conduct and the safety of practice. It is these factors which are considered at consultation.

This has resulted in much faster complaint process for the majority of practitioners who are subject to a complaint. Anecdotally however, it appears that registered practitioners prefer a complaint to be handled by the Commission, finding this less threatening as there are no registration ramifications from the Commission's complaint process. Despite providing information that the Boards have always been involved in consultation about complaints received by the Commission, it has been difficult to dispel these fears. One strategy for providing correct and consistent information to practitioners who are subject to a complaint is the TEHS seconded position to the Commission.

The closer working relationship between AHPRA and the Commission has had other benefits. A Board may decide to take no further action in relation to a complaint[3] or notification about a registered provider on the basis that the issue relates to systems rather than to an individual provider's practice. In these circumstances, the Board may refer the matter to the Commission for assessment. Case study 9 details one such referral that resulted in considerable systemic improvement. In addition, it is now not unusual for matters received by AHPRA to be referred to the Commission at consultation or for complaints and notifications to be "split", with the Board assessing clinical practice and conduct issues and the Commission assessing more systemic issues.

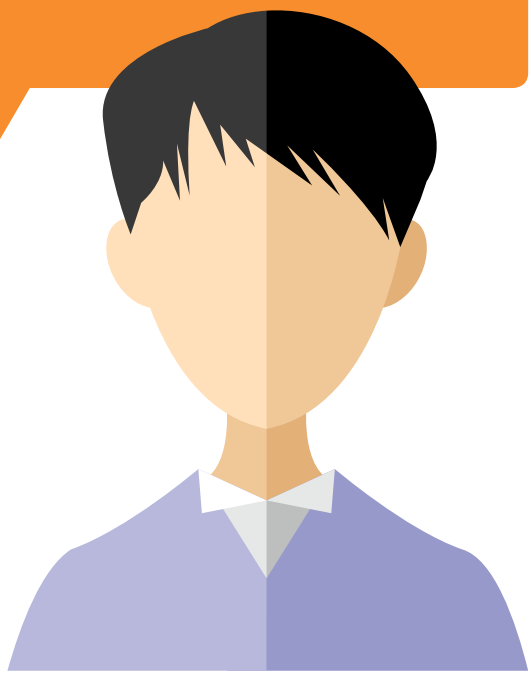
3 When a matter is received by the Commission, it is called a complaint. When it is received by AHPRA, it is called a notification.

Case Study 9

Medical Board refers systemic issue to the Commission for assessment

A notification had been made to the Board regarding the performance of a senior staff person at a remote, Aboriginal Controlled Health Clinic. It was alleged that new staff did not receive sufficient orientation in emergency procedures. The Board decided to take no further action in relation to the practitioner, and referred possible issues related to the organisation's emergency procedures protocols to the Commission for assessment.

The Commission wrote to the organisation, and was advised that while it is not a formally endorsed standard, the NTG's *Remote Health Atlas* ('the Atlas') is generally regarded as an acceptable practice guideline for remote practice in the NT. Accordingly, the clinic's practice against the Atlas was assessed and further questions asked.This organisation has a strong quality focus, and as an outcome of this referral from the Board has produced an updated Emergency and Evacuation Protocol which sets out Information of the kind referred to in the Atlas. The Atlas has also been made easily accessible to staff via clinic desktops.



New clinical position seconded from Top End Health Service

For the first time, a clinician was seconded from the Top End Health Service (TEHS) to work with the Commission for twelve months, in what is intended to be an ongoing arrangement. Robynne Lower, formerly Manager of the Prison Primary Health Care Service (PPHCS) for TEHS, is a patient-centred practitioner with extensive experience working as a Registered Nurse in primary health care. This includes working in a prison environment in Australia and overseas. In addition she has acute inpatient experience. The Commission has benefited from her clinical experience, along with her knowledge of quality systems. The bonus is Robynne's knowledge of disability services gained from long experience working as a carer in the disability sector.

The arrangement is mutually beneficial. TEHS will benefit from Robynne's time with the Commission. At the end of her twelve month secondment, she will return to TEHS with training in complaints management, including training and practice in assessing and conciliating complaints. She will have investigations experience, having been mentored to develop an investigation plan, interview relevant parties and prepare an investigation report. Robynne will also have an enhanced understanding of complaints from an impartial viewpoint, and an understanding of the AHPRA/Commission consultation and referral process.

Robynne started work with the Commission on 13 February this year. From that time until 30 June, her colleagues at the Commission sought her clinical advice on 32 separate complaint and enquiry files. By 30 June, Robynne closed 7 complaints and 33 enquiries. Her focus on quality outcomes and ability to work with complainants and providers to resolve complaints is apparent in the above two case studies.

Case Study 10

Communication goes awry

Jane needed a care plan for chronic arthritis, and attended her local health clinic on three occasions. Something seemed to go wrong every time she attended the clinic, so that even after three appointments, Jane still didn't have a care plan.

On assessment, it was apparent that Jane was frustrated in her contact with the clinic, and she made her discontent clear to the staff. As a result, the clinic receptionist was flustered in her dealings with Jane and made mistakes with appointment bookings. Jane became even more frustrated.

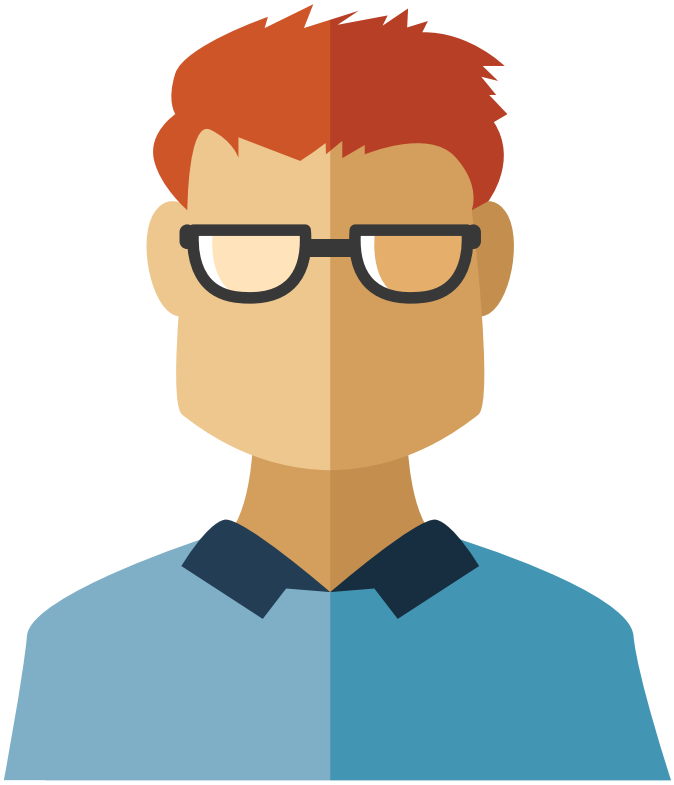
The complaint resolved by unravelling the communication problems and the development of a patient brochure explaining care plan processes.

Case Study 11

Complaint resolved with explanation

Bruce had a test at a private pathology centre. The test results, which showed some abnormal cells had been found by a nurse at his GP clinic 4 months later. Bruce complained because he believed that there could have been a serious outcome had the nurse not found his results.

This complaint was fully resolved with an explanation about procedures for handling results at the pathology centre; and the provision of evidence that Bruce's results had in fact been sent to the GP clinic on the same day they were available, ie there had been no delay notifying the GP of the results.



Person-centred complaints management in practice

When closing a complaint, the Commission surveys all parties to the complaint by post or email. In 2016/17, responses were received from 31 complainants and 14 service providers. The average response to each question is set out in the table below. "Strongly Agree" with the statement scores 5 and "Strongly Disagree" scores 1, so that the closer the score is to '5', the higher the level of satisfaction.

Table 6: Survey responses 2016/17

Survey statements	Complainant	Provider
Commission staff were polite	4.79	4.38
Commission staff listened to what I had to say	4.71	4.15
Commission staff understood what I had to say	4.61	4.00
Commission staff kept me informed of the progress of the complaint	4.68	4.08
Commission staff responded promptly to my enquiries	4.50	3.77
I had a clear understanding of what I could reasonably expect from making my complaint	4.39	N/A
The Commission officer explained the complaint process so I understood the next steps	4.54	N/A
I could understand letters and emails sent by the Commission	4.68	4.31
I could understand information given over the phone	4.54	4.31
My views were taken seriously	4.46	3.92
I understand the reasons for the decision	4.0	4.38
The decisions took all available information into account	3.96	4.38
The decisions took all points of view into account	4.04	4.32
The length of time to finalise the complaint was reasonable	3.79	3.92
I am satisfied with the way the complaint was handled	4.83	3.77
I am satisfied with the outcome of the complaint	3.89	4.15
I would use the Commission's services again	4.39	4.08

Survey outcomes consistently demonstrate a high level complainant and provider satisfaction with their interactions with Commission staff.

While a reasonable response rate is received to the survey (slightly more than 30%), it is apparent that participants are most likely to be those people who are either very satisfied with the Commission complaints process or very dissatisfied. Irrespective of their satisfaction with complaint outcome, those responding to the survey rate their interactions with staff as 'good' to 'very good'.

Results indicate that a continued focus on managing expectations is important along with working with parties to ensure that they understand the reasons for the Commissioner's decisions.

Implementing the National Code of Conduct

On 15 April 2015, Australian Health Ministers issued a Communique announcing their intention to give effect to a code regulation regime for all health care workers not registered under the National Registration and Accreditation Scheme for health practitioners. The National Code of Conduct sets standards for expected conduct and practice for unregistered health workers, and will be implemented consistently in each State and Territory. It will apply to practitioners such as massage therapists; social workers; counsellors; naturopaths; and hypnotherapists amongst many others.

It is intended that where there is a breach of the code and where the practitioner's conduct/practice places the public at serious risk, sanctions in the form of prohibition orders may be imposed. This includes conditions on practice or in some circumstances prohibiting practice may be imposed. To protect the public, prohibition orders will be published on the website of the health complaints entity in the state or territory where the breach occurred, as well as on a national website. Australian Health Ministers also agreed that there would be a common framework for the collection and reporting of data.

Preparation in the NT

DoH is leading preparations in the NT, and in this role has met regularly with representatives from the Commission and the Department of Attorney-General and Justice. The purpose of these meetings was to define the policy parameters for the introduction of the National Code of Conduct in the NT.

While it is unlikely that the code regime will be in place in 2017/18, the Commission has set up a new taxonomy of complaints and service types on Resolve (the Commission's complaint data base).

Case Study 12

Complaints that will be assessed under the new code regime

Sam contacted the Commission with a complaint about a massage therapist. She had been going to the one agency for some time, and had always been very happy with the service she received. On this occasion though, the therapist was new and was the only staff member there at the time of Sam's massage. Sam said that she felt very threatened and scared when the massage therapist began. She had never been touched inappropriately in this way by a therapist before. Sam left, and contacted the police.

A complaint such as this will be managed under the new Code regime once it is in legislated and in place in the NT. In this case, it wasn't necessary - the massage therapist was prosecuted successfully by Police, and the Commission is investigating his employer's practices recruiting and supervising staff.

At the end of 2017/18 the Commission will be able to report enquiries and complaints that would have been treated under the code regime had it been in place. This will allow comparability of data between the NT and other jurisdictions.

Participated in National Working Groups

The Commission has actively participated in two national groups throughout 2016/17: the National Implementation Working Group and the National Data Subset Working Group. The National Implementation Working Group, led by a project team in Victoria, has been responsible for overall policy discussions and decision-making. Outcomes include plans to set up and host a National Web Portal, prepare explanatory materials for practitioners and the general public and develop a taxonomy of complaints and service types that can be used for consistent collection and reporting of data.

THE YEAR AHEAD: 2017/18

Workload management

Despite the 33% increase in complaints and enquiries received in 2016/17, staff of the Commission managed to close the highest number of complaints and enquiries ever, up 23% in 2015/16 from 647 to 795.

This has been achieved through improvements in complaints handling processes as well as changes to the way the Commission deals with complaints and enquiries.

1 Improvements in process: Over the past two years all unnecessary engineering was removed from the Resolve complaints management system to reduce time spent on unnecessary administrative functions. Similarly, all workflows have been redesigned to eliminate unnecessary and redundant steps, while still retaining important aspects of complaint handling including fairness. In 2017/18, the Commission will increase its focus on resolving complaints as expeditiously as possible, including resolution informally as enquiries.

2 Complaints handling decisions: Increasingly, complaints about TEHS and CAHS have been referred back for direct resolution with the Commission's oversight. This oversight will reduce during 2017/18, with complainants asked to return to the Commission if the complaint is not resolved.

Conciliation and compensation

The second reading speech for the Act which established the Commission in 1998 sets out the intentions of Part 6: Conciliation as follows:

Part 6 deals with voluntary, confidential conciliation of complaints which is emphasised as the focus of the bill for the purposes of resolving a matter. To encourage use of this process, and to avoid adversarial alternatives, all information produced in the conciliation stage will not be admissible in any other proceeding. Conciliation will be given a prime focus in the legislation. The willingness of parties to avail themselves of a confidential and non-adversarial environment in which to deal collaboratively with the complaint is the key to its success. Where agreement is reached, parties are able to enter into an enforceable contract. Once again, interstate commissions report favourable responses to, and outcomes from, this process, including settlement of quantum in negligence related claims[4].

The reason for this focus on the process of conciliation is that it has a number of significant benefits compared to litigation, and is a proven way of resolving complaints quickly, cheaply, confidentially and informally with relationships intact between the parties. Traditional legal

4 The Hon Mr Burke, Minister for Health, Family and Children's Services

adversarial approaches involving complex processes, open courts and extended time lines may thwart legitimate claims, particularly for people who are self-represented.

This section of the Annual Report should be read noting that the Commission has no investment in whether individual complainants are paid compensation. It is not the Commission's role to provide legal advice to complainants or to provide advice about whether compensation is warranted, noting that it is not unusual for compensation to be sought when there is no basis for this. The decision whether to pay compensation and the quantum is the provider's decision, and where there is a proper basis, a decision to be made in negotiation with the complainant. The Commission's role when conciliating a complaint is simply to ensure that a complainant's request is put to DoH, and that there is a response to the request.

The problem

Although complainants are able to seek financial compensation from any provider, predominantly this has related to the government provided services through DoH. Over the past few years, it has become increasingly difficult for the Commission to conciliate complaints where the complainant has sought compensation as an outcome of their complaint against the DoH. Problems experienced have included:

1 Lack of clarity of DoH decision-making and process: even when DoH indicates willingness to conciliate, the Commission experience is that sometimes (but not always), often when the matter is well into conciliation, DoH will state that it will only negotiate compensation "lawyer to lawyer" – that is, outside of the conciliation process. This is more likely to occur when the claim is for a larger sum of money, however it is not always the case. This position means that the Commission is no longer able to resolve all aspects of a complaint in conciliation.

2 Increasingly legalistic process: DoH's position is that in order to be considered, all claims will now need to be aligned with the provisions of *Personal Injuries (Liability and Damages) Act* (PILDA) or the *Compensation (Fatal Injuries) Act* (CFIA). This is the case because all claims for compensation must be addressed in accordance with the laws of the Territory. Both PILDA and the Act coexist with the latter predating PILDA by several years and unamended as a consequence of its commencement.

   The Commission's position is that people who are claiming large amounts of compensation on the basis of negligence or harm caused during an episode of care should seek legal advice for two reasons: to ensure that there is a basis for their claim and that they are not disadvantaged. Conciliators for the Commission would not proceed to conciliate a matter unless this advice has been received and put to the healthcare provider.

   However, the DoH now appears to require any person who wishes to make any financial claim, not just large compensation claims, to seek legal advice to enable the setting out of the basis of claim in a legal way.

   The view of the Commission is that the conciliation process should provide a forum where smaller claims can be considered without cumbersome legalistic requirements being imposed by the DoH. In regard to larger claims, depending on the size of the claim and whether it has a basis, it would be possible to negotiate outcomes with lawyers attending the conciliation to provide advice.

3 Delays: whenever a complainant mentions that s/he is seeking compensation as an outcome from a complaint, the DoH response is oversighted by the its legal team. This can mean a delay of up to 4 weeks receiving the DoH response. If the matter is referred to conciliation and the complainant is continuing

to seek compensation, s/he is asked to obtain legal advice to prepare the claim while the matter is in conciliation. This claim is then reviewed by the legal team prior to any decision being made by the DoH.

4 Requirement for negotiation prior to conciliation means that the person in the room does not have the authority to settle. Occasionally, even when the complaint is serious, admissions are made during a conciliation conference that are not made prior to the conciliation. These admissions occur when there is enhanced understanding of a complainant's experience. They occur in a climate of trust and openness between the parties which is engendered in a good conciliation process with parties willing and able to speak openly due to the protections afforded by the confidentiality of conciliation proceedings.

   The effect of current policy is that decisions about compensation are made by people external to the process who have no knowledge of the complainant experience and who may have only partial knowledge as to what occurred.

5 Disadvantaged complainants may be further disadvantaged: there is usually a cost involved to seeking legal advice; many people do not know how to access legal advice; and lawyers in the NT with medico legal expertise are limited. The process can take months, firstly because complainants do not understand the legal system and are frightened by it and secondly because it takes time for this advice to be provided, even for relatively small matters. It is not unusual for a complainant to consult a lawyer, and provide a claim to the Commission in terms which are not acceptable to DoH. Case study 14 illustrates the difficulties experienced by one such complainant.

Case Study 13

The cost of the right legal advice

Anne lodged a complaint with the Commission about problems when her bowel was perforated during a laparoscopic procedure, resulting in multiple surgeries, infection, wound burst and extensive scarring. After visiting her lawyer, Anne submitted a large compensation claim which included medical expenses, travel costs, future medical expenses and loss of past and future income.

The conciliation was held in December 2015. In the first week of April 2016, the Commission was advised that DoH would not correspond with the Commission about compensation, and the matter could be handled only "lawyer to lawyer".

The problem was that Anne did not have a lawyer at the time. In April 2017 she contacted the Commission seeking help. She said she had paid $6,000 for an expert report which did not answer all the questions which needed answering in order for her to make a claim. She then approached one of the few lawyers in Darwin with the necessary knowledge to assist, and was told that she would need to pay $20,000 for legal support and a medico-legal report. Anne had been unable to work full time since her surgery and could not afford further payment to legal firms.

Where to from here? 2017/18

Conciliation is a voluntary process for both parties to a complaint, and the Commission acknowledges that it is DoH's right to negotiate or not to negotiate compensation as part of the conciliation process. Indeed, this is the essential first condition of conciliation and all parties attend of their own accord. The Northern Territory's "Model Litigant Policy" gives support for the features of conciliation, such as avoiding delay and litigation, paying legitimate claims in accordance with legal principle and practice and admitting facts it knows to be true.The issues with the current process as outlined above do however need to be addressed. This will be a focus in 2017/18, with meetings with senior policy officers planned for the first half of the year.

1 The Commission will consider a number of options for resolving this problem and discuss them with DoH in 2017/18. These options will include:

2 People with a complaint about DoH who are seeking compensation as an outcome of their complaint will be advised that the Commission will not conciliate complaints involving compensation with DoH and advised to seek legal advice.

3 DoH will be asked to provide a preliminary response, including whether it is willing to negotiate compensation at conciliation. If DoH states that negotiations will only occur "lawyer to lawyer", the parties will be offered a resolution meeting during the assessment phase of the complaint. The complaint will not be conciliated. If DoH states that there is no basis for compensation, the complainant will be asked whether s/he wishes to proceed to conciliation on that basis if the matter is suitable for resolution by conciliation, noting that this decision includes an assessment of the reasonableness of outcomes being sought.

4 The Commission will work with DoH to set out policy and procedures for the management of compensation claims, with a view to addressing the problems in the current process as outlined, including the possible admission of lawyers into the conciliation process. The ambition will be to ensure that the parties in the room are fully delegated to make binding final decisions relating to all aspects of the complaint.

A report as to the outcomes of this work will be set out in the 2017/18 Annual Report.

Chapter 3: Promote Capacity

ACHIEVEMENTS 2016/17

Service providers able to resolve matters directly with complainants

Enquiries

Resolve records of 2016/17 enquiry outcomes show that 135 enquiries (21% of all enquiries received) were referred back to the provider for direct resolution. This is an increase of 9% on 2015/16 and reflects the Commission's increased focus on enabling providers to manage their own complaints and enquiries.

Prison Primary Health Care Service (PPHCS)

Prisoners at Darwin Correctional Centre (Holtze) and Alice Springs Correctional Centre (ASCC) are able to contact the Commission to raise concerns about the health services they receive via a dedicated, secure phone line. In 2016/17, a total 258 enquiries (including 51 enquiries about the health care service at ASCC) were received, raising 323 separate issues. 80 issues were referred back to the PPHCS for direct resolution.

Table 7 details the number of contacts from prisoners. With the return enquiries removed (see note 5) prisoner enquiries as a proportion of all enquiries has remained relatively static since 2014/15.

Statistics of contacts from prisoners will continue to be monitored and analysed for trends in 2016/17. Early monitoring of 2017/18 trends is promising, demonstrating a 50% reduction in enquiries from prisoners for the first quarter of the 2017/18 financial year.

Table 7: Number and proportion enquiries about PPHCS 2013/14 - 2016/17

Year	Number	Proportion of all enquiries
2013/14	146	32%
2014/15	154	38%
2015/16	149	34%
2016/17	**205**[5]	**36%**

Table 8: Number of enquiries about PPHCS received first quarter 2016/17

Enquiries about PPHCS	Jul-Sep 2016	Jul-Sep 2017
ASCC PPHCS	7	5
Holtze PPHCS	49	23
TOTAL	**56**	**28**

Monitored "complaint prone" practitioners

A national study involving the analysis of 19,000 patient complaints about doctors received by the various health complaints bodies in Australia identified that 3% of doctors account for 49% of complaints about doctors[6]. The study found that the most significant predictor of a future complaint is the doctor's past history with complaints.

5 258 Enquiries received about PPHCS in 2016/17. Of these, 53 were referred back to the PPHCS for direct resolution and subsequently contacted the HCSCC regarding the same issue. Number of PPHCS enquiries is 205 (258 - 53)

6 Bismark MM, Spittal MJ, Gurrin LC, et al. Quality and Safety in Health Care Downloaded 10 October 2017 http://hsla.org.au/wp-content/uploads/Bismark-2013.pdf doi:10.1136/bmjqs-2012-001691

In a further study of complaints about doctors assessed by Australian health complaints bodies, researchers developed the PRONE (Predicted Risk of New Event) Score, a 22 point score which reliably predicts the likelihood that a complaint will be made about a doctor in the next two years[7]. The PRONE Score is based on four variables – area of specialty, gender, number of previous complaints and length of time since the most recent complaint. In a presentation to a national meeting of Health Complaints Managers in July 2016, Dr Bismark postulated that this work could be used to develop an intervention framework designed to prevent future complaints, similar to the work of Dr Gerald Hickson of Vanderbilt University. PRONE Scores might be used to predict whether an intervention is needed, and what form that intervention might take.

For the past 12 month, the Commission has been assigning a PRONE Score to doctors when a complaint is received. For example, after receiving two complaints about a particular general practitioner within a short period of time, and additional complaints about other GPs in that practice, the Commissioner wrote to the doctor as well as the Practice Principal suggesting that it might be helpful for doctors in that practice to undertake communication training. The practice subsequently undertook two training sessions with a goal of having no more complaints made to the Commission about its practitioners.

7 Spittal MJ, Bismark MM &Studdart DM. The PRONE Score: an algorithm predicting doctors' risk of formal patient complaints using routinely collected administrative data. BMJ Quality and Saftety 2015; BMJ Quality & Safety 2015; 24 360-368 Published Online First: 08 Apr 2015. doi: 10.1136/bmjqs-2014-003834

349 TEHS staff received customer service / complaints handling training

In 2015/16, the Commission reported that it had worked with a private consultant to develop customer service and complaints handling training for staff working in the health and disability sectors. In 2016/17, the consultant has been available to provide this training on a fee for service basis. The training is modified in consultation with the service requesting the training.

In 2016/17, 349 staff of the Top End Health Service were provided with the opportunity to attend training in customer service skills and complaints management. 88 staff of private health organisations also received training in customer service skills.

Resources developed for people with disability

The Commission has been fortunate to be able to employ Lisa Tiernan, a young person with a giant personality. The Commission employed Lisa on a two year contract commencing July 2015 with funding from the Disability Employment Program.

Lisa has worked with Commission staff to develop staff understanding of how to explain what a complaint is, and why it is important. Lisa has also helped to develop a range of marketing material designed for handing out at disability specific events. These handouts include (pictured below) a sticker which just simply gives the Commission's phone number and a tattoo happy face with the message: "It's ok to complain".

Sarah's Story

Sarah lives in a group home with 3 other people.

Sarah has lived at the house for 5 years. She likes her house. It has a big backyard and her bedroom is really comfortable. Sarah likes to spend time in her lounge room. She likes to watch cooking programs on the TV. She likes to cook and bake.

Last year, a new person moved into the house. His name was Joe. Sometimes Joe yelled at Sarah and the other people in the house. Sarah did not like it when Joe yelled.

Staff told Sarah to go to her bedroom when Joe was yelling.

Sarah did not like going to her room. She liked spending time in the lounge room. She liked to be able to watch her favourite cooking shows and to cook. She was not enjoying living in her house. She thought it was unfair for staff to tell her to go to her room.

Sarah decided to tell someone and to make a complaint. She phoned the Health and Community Services Complaints Commissioner and talked to Liz about Joe's yelling.

Liz spoke with Sarah's service to help them to understand why Sarah was unhappy. Liz, Sarah and her service talked about different ways to fix the problem. They agreed on changes that would be made so that everyone enjoyed living in the house.

If you are not happy in your group home, or you are have other problems with your service, you can call us on 1800 004 474

The HCSCC gratefully acknowledges the ODSC Vic for allowing us to use Sarah's story

Tom's Story

Tom lived in a group home.

His mum visited him every week. Her name is Jane. Jane was worried about Tom's health. She rang the office of the Health and Community Services Complaints Commissioner and spoke to Leigh (say it like "Lee").

Jane said that Tom had diabetes. She was worried because he was unwell. Jane said it was OK for Leigh to speak with the managers for Tom's house.

Leigh asked the managers lots of questions. They told her that Tom had not had a health check. Leigh talked to the managers about taking Tom to the doctor.

The managers organised for Tom to go to the doctors. The doctor said Tom was having too much medication. The doctor changed Tom's medication.

Tom felt much better. Jane said he was much better now.

It's okay to call us if you think your staff are not helping with your health. Our phone number is: 1800 004 474

The HCSCC gratefully acknowledges ODSC Vic for allowing us to use Tom's story

Lisa is responsible for the art concepts used in the two storyboards, Tom and Sarah, which also borrow heavily from the work of the Office of the Disability Services Commissioner in Victoria. The storyboards begin to gently illustrate circumstances which might lead to a decision to speak up about a problem.

Session with students from Project 21 where the storyboards were used to explain when a complaint might be made.

Similarly, the Commission has developed a story app which is suitable for downloading to a range of devices including iPads and mobile phones.

This app tells the story of Bec, who has a support worker who takes her bowling. Unfortunately, the support worker doesn't always come, and Bec misses out on bowling more and more often. The app sets out the different resolution options available to Bec and what the outcome might be. The app can be viewed at: *http://clisby.net/BecSpeaksUp/*

Funding for NDIS capacity building project obtained

Under the bilateral agreement, the Commission will retain responsibility for managing complaints from all people receiving disability services until transition to the National Disability Insurance Scheme (NDIS) is complete at the end of June, 2019. At that time, a national oversight body will be in operation and responsible for managing complaints from people receiving services from NDIS funded service providers.

The Commission is aware that many people with disability living in the NT are unaware of their rights, including the right to complain. In 2016/17 the Commission successfully applied for $200,000 funding through the Office of Disability's Sector Development Fund. The project's purpose is to enable people with disability to understand their right to safe, quality services and to assert that right.

When the project is completed, the Commission will have developed information about rights and how to access those rights in an accessible format. A contact list of services/people able to disseminate information to people with disability living in the NT will also be developed.

THE YEAR AHEAD 2017/18

Safeguards for people with disability

The primary focus of the Commission in 2017/18 will be further capacity building in the disability sector – working with providers and persons with disability and significant people in their lives to increase understanding and access to a complaints system.

Quality and safeguards project

The funding granted by the Office of Disability will be used to contract an Aboriginal consultant who has long term Territory connections. The consultant will research and work with people with disability and key community members to increase the understanding of rights and develop links to services. Commission staff will travel with the Consultant to provide research and administrative support, as well as to meet and talk to people with disability and learn first-hand from them. While travelling, Commission staff will engage with disability service providers to provide information about the Commission and how it might assist.

Zero tolerance to abuse and neglect

The National Disability Service (NDS) NT, in conjunction with VALID Victoria, has carriage of a project developed in partnership with people with disability to assist service providers understand and implement practices to safeguard the rights of people with disability. In the NT, the NDS will run five full day workshops in urban areas of the NT using resources developed for the Zero Tolerance project.

In 2016/17 the Commission was represented on a Reference Group for the purpose of ensuring the effectiveness of the workshops in the NT. In 2017/18, staff of the Commission will attend each of the workshops to support this important work. Staff will be available to service providers and people with disability and provide information about complaints management and how to access the Commission.

Liaise with the Office of Disability

In 2016/17 the Commission met regularly with senior staff of the Office of Disability (OoD). This provided the opportunity for the Commission to comment on aspects of the OoD's Quality and Safeguarding Framework as well as to provide input to the OoD's response to the proposed NDIS Quality and Safeguards proposals.

These meetings will continue into 2017/18, with a focus on protecting the safety of people with disability receiving services in the NT. Proposed strategies include the ability to exchange information, with the Commission advising the OoD of any significant complaints or series of complaints about particular service providers. The purpose of such advice is to assist the OoD to work with those service providers to improve safety and quality via the Quality and Safeguarding Framework.

Build capacity for service users and service providers to resolve complaints

Prescribed providers

Section 99 of the Act states that a "prescribed provider" must lodge a return to the Commissioner particularising complaints received from the Commission and complaints received directly by the organisation. In 2016/17, the Commissioner sought legal advice regarding how s99 of the Act could be used to most effect by the Commission; considering in particular whether it is possible for the Commission to use prescribed provider reporting to monitor complaints and complaints handling in complaint prone organisations. Consideration will also need to be given to the value of requiring disability service providers to report to the Commission while in transition to the NDIS.

Develop resources to help resolve complaints

Good complaints resolution lies with the service provider and the service user. For this reason, in 2017/18, plans are in place to develop resources for all parties to a complaint. For providers, the Commission will edit and update the Complaints Handling Manual, the Commission plans to develop and make available a model complaints policy and procedures, a guide to resolving complaints and draft apology letters.

For service users, the Commission will develop resources to help resolve complaints at point of service. This will include case scenarios, draft letters of complaint and information about how to go about making a complaint and what can be reasonably expected from it.

Chapter 4: Advise Government

ACHIEVEMENTS 2016/17

Briefings during the year

The election of the new Government in August 2016 necessitated a number of briefings relating to the Commission, its role and work for the incoming Minister.

The continuance of the portfolio arrangement which sees the Minister carrying both the Attorney General and Health responsibilities is of benefit to the Commission as, while the Commission sits within the Department of Attorney General and Justice, the Act is predominantly health focussed. Much of the new initiatives relating to the Commission derive from the meetings of the COAG Health Council and the Australian Health Ministers' Advisory Council. DoH has regular meetings with the Commission to obtain its views and input on such matters as the NDIS, changes to the National Registration and Accreditation Scheme and regulation of unregistered health providers. Each of these national initiatives has ramifications for the Commission and the people of the Northern Territory and the opportunity to contribute to the decisions will aid recognition of the Territory's unique circumstances and assist with transition arrangements.

By letter following the tabling of last year's Annual Report, all Members of the Legislative Assembly were offered a briefing on the Commission. Most accepted this invitation and the Commissioner has now briefed most members and/or their offices during the year. A similar invitation will be made following the tabling of this report.

How to report

The Commissioner has a number of options to communicate with the Government of the day. Obviously, the traditional and common method of regular oral briefings is effective and this has been employed over the last year on several occasions.

Additionally, the Commissioner can make more formal statutory reports, such as the report on the Investigation into the Prison Heath Service which was tabled during last year pursuant to s65 of the Act.

65 Reports

(3) The Commissioner may give a copy of a report of an investigation, other than an investigation carried out under section 48(1)(a), to any of the following...

(a) the Minister;

The Commission has considered using these powers for specific tightly focussed investigations or for feedback of issues of concern which aggregate in the Commission's data, so as to escalate these matters to the attention of Government.

This is under active consideration at present and will be the subject of discussions with the Minister during the 2017/18 year.

Chapter 5: Educate the Community

ACHIEVEMENTS 2016/17

As set out in Appendix 2 to this report, in 2016/17 the Commission was involved in 63 community visits / events, comprising contact with more than 1199 people. There was a focus on providing information about the Commission to people receiving disability services as well as to providers of disability services.

Health and Disability Complaints Commissioners conference held in Darwin

Health and Disability Complaints Commissioners meet twice yearly at alternating venues.

The Commission hosted the conference held August 31–2 September 2016. Speakers organised for the conference showcased the Territory, and included:

Dr Christine Connors
GM Darwin Region & Strategic Primary Health Care

Ms Vicki O'Halloran
President NDS Australia & CEO Somerville Community Services NT

Mr Tony Tapsell
CEO Local Government Association NT

Ms Colleen Gwynne
NT Children's Commissioner

Ms Colleen Rosas and **Derek Hunt**
Aboriginal Interpreter Service

Helen Bishop
Community Justice Centre

Themes for the conference included the NDIS and the National Code of Conduct for Health Care Workers.

One Mob, Different Country Dance Troupe in action

Commissioners and NT Commission staff enjoy opening by One Mob, Different Country Dance Troupe

Engagement with the disability sector

The photo above depicts staff of the Commission at a breakfast for the 2016 Disability Awareness Festival, where the Deputy Commissioner spoke on the topic: *Employing Lisa – It's Good Business*.

The star of the show was Lisa Tiernan who had the confidence to get up on stage and answer questions.

International Day of People with Disability

To celebrate the International Day of People with Disability, the Commission hosted students from Project 21.

Staff of the Commission gave a presentation based on learnings gained from Lisa to explain what a complaint is, and when it might be made. The message was "Tell someone you trust" when something is wrong.

Students attending the workshop had the opportunity to practise making a complaint, at the same time providing the Commission with the opportunity to trial our new, more accessible complaint form.

Lisa Tiernan reads Sarah's Story to Project 21 students.

Project 21 students trial the new complaints form.

PossAbilities Expo

The Commission planned to work with key disability agencies in 2016/17 to put on a disability expo to coincide with International Day for People with Disability. The plan was to give service providers the opportunity to showcase their services to prospective purchasers through the NDIS. As the date grew closer, it became apparent that there were far more urgent tasks for the disability sector as it prepared for the introduction of the NDIS in the NT, and the expo was put aside.

The Commission's work on the proposed Disability Expo led to the opportunity to participate in the PossAbilities Expo, an annual event hosted by Henbury School, and held this year in April 2017. One of its activities was a colouring in competition, with a ticket to the cinemas as a prize. This photo shows the winning entries which are now displayed in the Commission's office.

Lisa Tiernan & Leigh Kinsela exploring possibilities at the PossAbilities Expo

Commission staff Liz Keith and Leigh Kinsela at the PossAbilities Expo

Accessibility to the Commission for people with disability

Table 9 below tracks the number of complaints received about disability services, mental health services and aged care services over the past five years. What appears to be a declining trend in complaints about disability in 2015/16 has been reversed this year.

Table 9: Aged and disability services complaints 2012/13 - 2016/17

Provider type	2012/13	2013/14	2014/15	2015/16	2016/17
Disability services	6	8	9	4	8
Mental health services	1	14	18	3	15
Aged services	1	1	1	3	6
Total	**8**	**23**	**28**	**10**	**29**

Increased visits to Commission website

Anyone can access the Commission through its website at *www.hcscc.nt.gov.au*. The website has links to our on-line complaint form, information which includes the latest Annual Report and brochures, complaints handling training, the Guide to Complaints Resolution and our legislation.

On-line complaints increased to 33% in 2016/17, compared with 28% in 2015/16 and 21% in 2014/15.

The website is becoming increasingly important to the Commission's business and needs modernising. In 2017/18, the Commission will review the website and try to implement changes without changing its basic structure. Information on the website will be reviewed and updated.

Table 10: Website access 2012/13 - 2016/17

Year	2012/13	2013/14	2014/15	2015/16	2016/17
Total visits	**2956**	**3802**	**4056**	**6185**	**6853**

THE YEAR AHEAD 2017/18

Retain focus on access for people with disability

In the coming year, the Commission will retain its focus on trying to increase participation from the disability sector. Most strategies are set out in Chapter 3 of this Annual Report. Other strategies include: collecting data from Enquirers and Complainants about how they heard about the Commission; and developing a policy regarding obtaining verbal consent. Commission staff will continue to engage with disability service providers in 2017/18.

Chapter 6: Governance & Resource Management

Health and Community Services Complaints Review Committee

Sections 78 – 84 of the Act set out the establishment, role and functions of the HCSCC Review Committee. Section 79 sets out its powers and functions as follows: to review the conduct of a complaint to determine whether procedures were followed and to make recommendations to the Commissioner; to monitor the operation of the Act and make recommendations to the Commissioner; and to advise the Commissioner and Minister on the operation of the Act and Regulations.

When a complaint is closed, all parties to a complaint (with the exception of Department of Health entities) are informed in writing of the right to have the conduct of the complaint reviewed. Very few chose to do so. However, the HCSCC Review Committee still met to consider some Applications for Review made under Section 80(2) of the Act.

The HCSCC Review Committee remains comprised of:

Mr Andrew George
Chairperson

Dr Joanne Seiler
Provider Representative

Ms Karyn Cook
Provider Representative

Ms Kiah Hanson
User Representative

Mr Robert Kendrick
User Representative

The HCSCC Review Committee is continuing to refine its practices and procedures so as to perform its full Section 79 functions as efficiently as possible.

L-R: Joanne Seiler, Andrew George, Karyn Cook, Robert Kendrick, Kiah Hanson

ACHIEVEMENTS 2016/17

Complaints system is paper free

All complaints and enquiries received by the Commission have been handled only electronically since 1 July 2016. In addition to saving on paper, the complaints free system saves time, with staff only needing to maintain one record (where previously, parallel systems, paper and digital, were maintained).

A paper free system has resulted in the Commission continuously improving its use of the Resolve complaints system. The improved use of the database has saved time and enhanced follow-up management and communication between staff.

Counting rules - reports set up on Resolve

The Commission finalised counting rules for statistical purposes a few years ago. Brendan Schultz, our Business Manager, has now set up reports on Resolve based on those counting rules. Most reports used in this Annual Report are now available at the press of a button!

Audit

In 2016/17 Audit Services for the Department of the Attorney General and Justice conducted a risk based audit focusing on procurement processes and workplace health and safety processes. The auditor also reviewed premises security, fraud awareness and risk processes.

The auditor found that there was poor adherence to pre-approval processes, although improved compliance was noted after April 2016. There was one instance where the transaction approver and expense approver were the same person. This occurred in exceptional circumstances, and the auditor was advised that great care would be taken to ensure this did not happen again. Useful suggestions such as setting up full year pre-approvals for ongoing small expenditures such as stationery have been implemented.

The auditor also found that while a Work Health and Safety Committee had been set up, no meetings had been held since December 2015. The Commission noted that when members of the committee had left, staff decided to hold the Work Health and Safety Meeting as a standing agenda item during monthly staff meetings. Minutes are kept of these meetings.

Premises security was found to be adequate for the protection of staff and confidential information. After-hours access to the building is controlled by fob keys and duress alarms are in place and checked regularly. Confidential information is stored in locked offices and in the server room after hours. The auditor suggested that the access codes on doors into the office should be changed more regularly.

No fraud was identified. The auditor noted however that issues with pre-approval of expenditure increased the risks. The auditor also found that no risk register was in place and recommended that a risk workshop be conducted and resulting register set up. This was completed prior to the completion of his report.

THE YEAR AHEAD 2017/18

Work towards a paper free office

The Commission planned to commence being entirely paper free from 1 July 2017 using TRIM as the database to manage all files other than complaint files. Due to the high workload in the office, and delays with proposed changes to Business Classification System in TRIM, this has been deferred. Tasks in 2017/18 will include a review of administrative policies and procedures; a review current file structures on the Commission drive and training staff on how to use TRIM.

Professional development for Commission staff

The Commission places high value on being a learning organisation. Staff development needs will be assessed and personal development plans put in place and reviewed regularly. All conciliators will have the opportunity to become accredited mediators, with time set aside for practice and reflection to ensure quality. Staff will also have the opportunity to receive formal training in investigation.

Monthly speakers will be invited to the Commission. This will provide development opportunities for staff as well as networking opportunities for the Commission.

Appendix 1: Performance

Enquiries /informal complaints

In 2016/17, the Commission managed 570 enquiries.

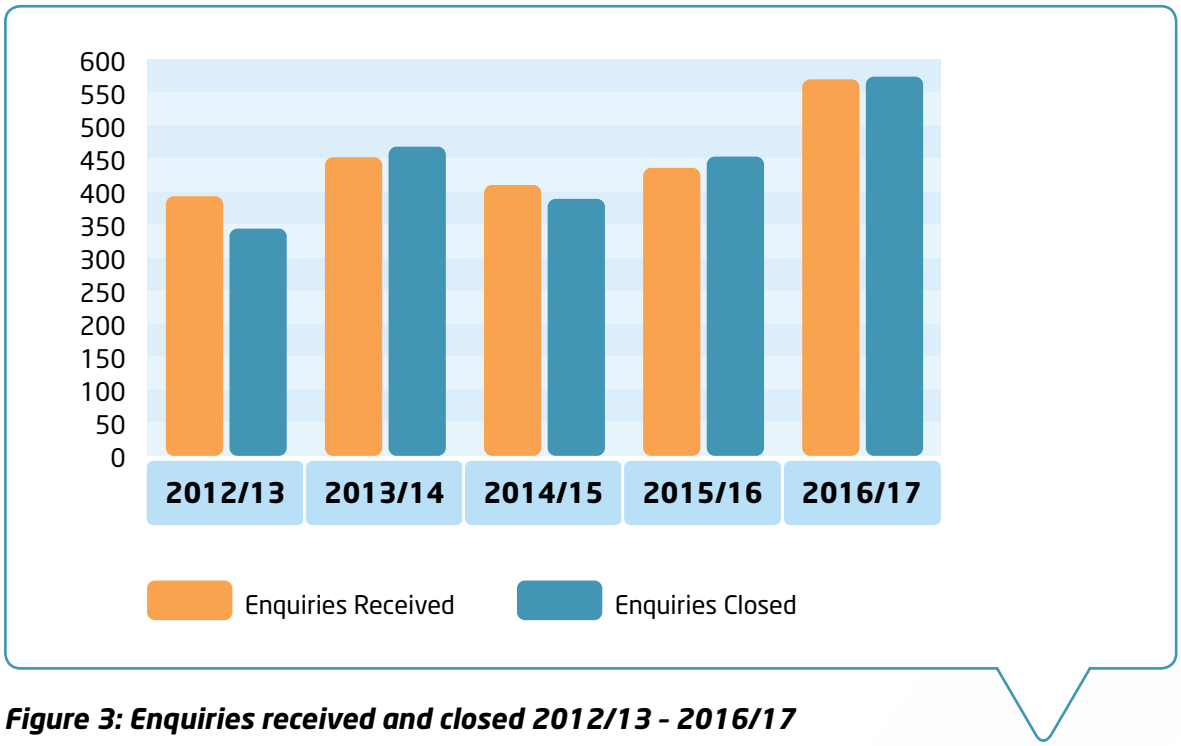


Figure 3: Enquiries received and closed 2012/13 - 2016/17

Although the majority of enquiries do not become formal complaints, they represent a substantial proportion of the Commission's workload. Public providers accounted for 78% of the providers about whom enquiries were received in 2016/17, a slightly lower proportion than in previous years.

Table 11: Providers subject of enquiries 2012/13 - 2016/17

Providers	2012/13	2013/14	2014/15	2015/16	2016/17
Private	198	163	95	75	131
Public	195	289	315	381	464
Total	**393**	**452**	**410**	**456**	**595**

Issues raised in enquiries

Often more than one issue is raised per enquiry. All issues were counted in 2016/17 as the Commission was able to ensure consistent recording practice. 652 issues were dealt with when assisting with the 570 enquiries received. As with previous years, the most common issues raised and dealt through our enquiry process were standard of treatment, access to services, and communication. Eighty eight issues were considered and found to be out of jurisdiction.

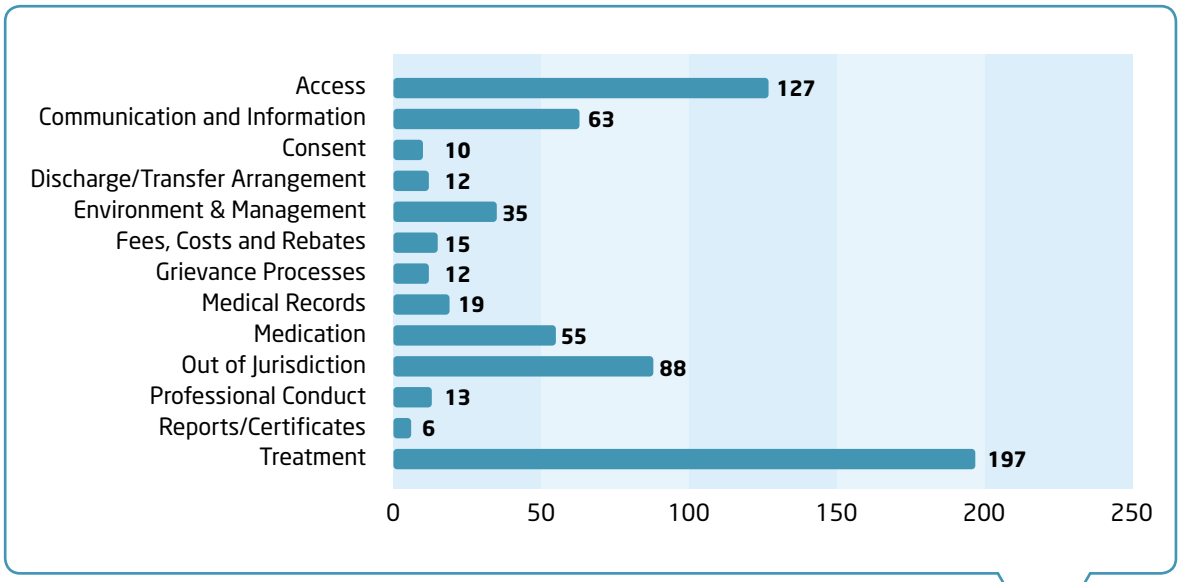


Figure 4: Issues raised in enquiries closed 2016/17

Complaints

Two hundred and fifty three (253) new complaints were received in 2016/17, representing a 37% increase on the number received in the previous year. Fewer complaints were finalised (221) than were received.

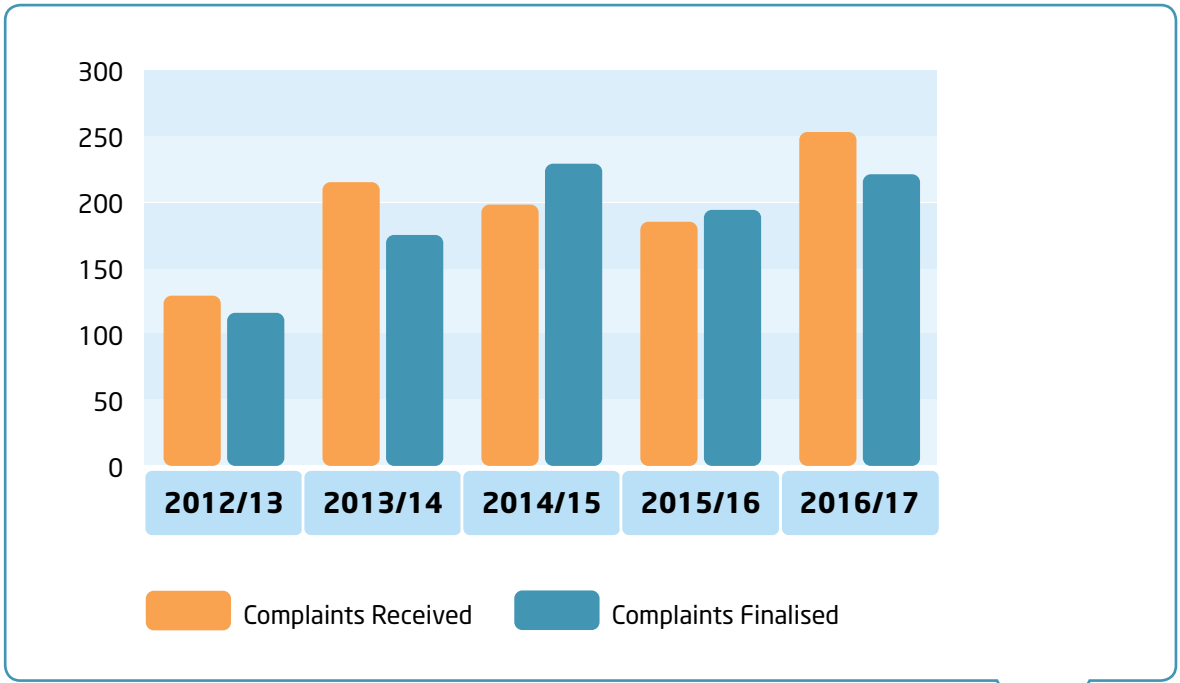


Figure 5: Complaints received and finalised 2012/13 - 2016/17

Time taken to finalise complaints increased

The average time taken to finalise complaints[8] (where complaints include complaints received by the Commission and notifications received by AHPRA subject to consultation with Commission) increased from 99 days in 2015/16 to 150 days in 2016/17. This is largely due to the workload of Commission staff which increased by 32.5% on the previous year.

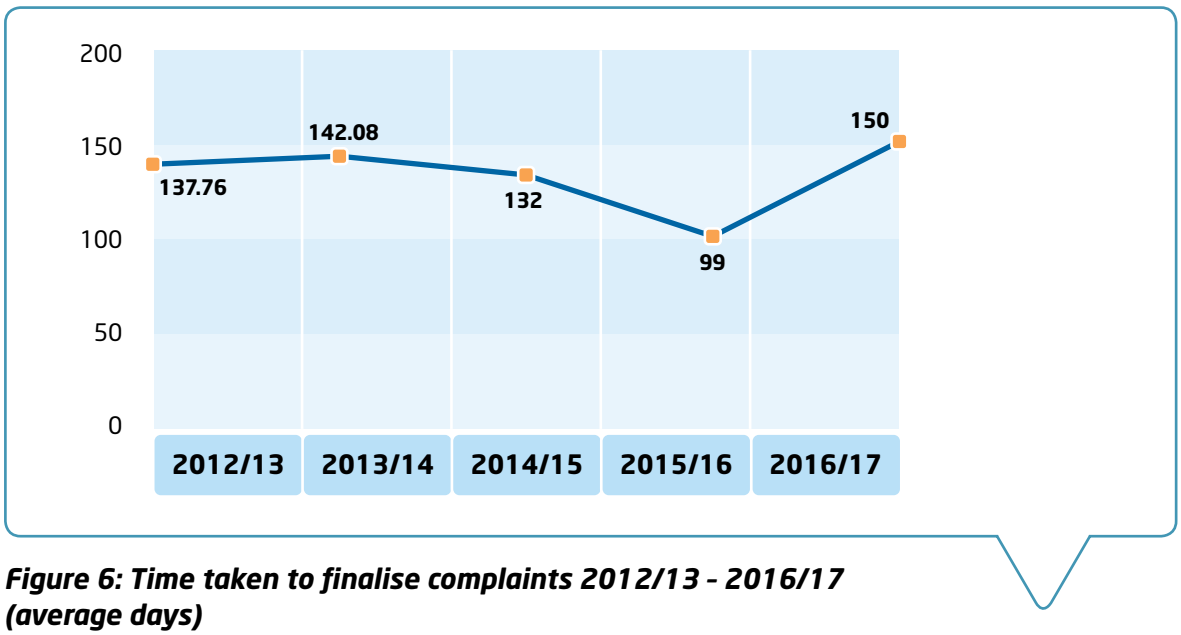


Figure 6: Time taken to finalise complaints 2012/13 - 2016/17 (average days)

As could be expected, the proportion of complaints closed within 30 days in 2016/17 was lower than in 2015/16 (26% in 2016/17 compared with 44% in 2015/16). 41% complaints were closed within 60 days in 2016/17 compared with 58% in 2015/16.

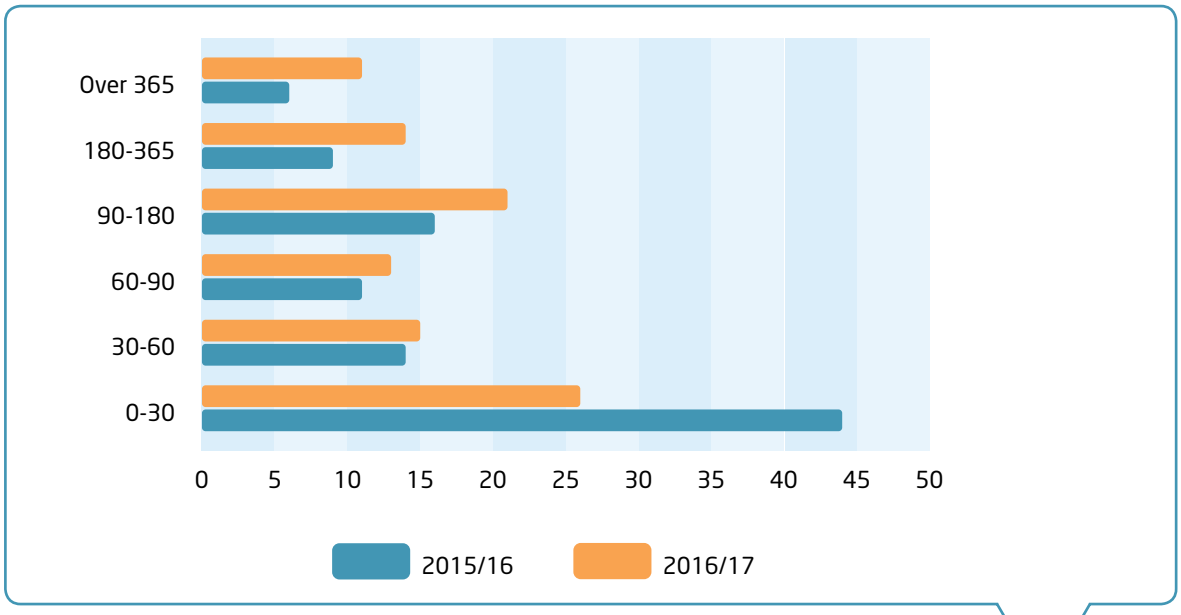


Figure 7: Percentage complaints closed and time frames 2015/16 and 2016/17

8 Time taken to finalise complaints is measured from the date it is entered on Resolve to the date it is closed, and may include additional actions including investigations and conciliations.

In 2016/17, 87% of complaints were closed within 180 days, marginally more than the 85% closed within 180 days in 2015/16. The benchmark for closure within 180 days is 80%.

Location of services complained about

As expected, the majority of services subject to a complaint are located in Darwin (72%). There is a reduction in complaints received about services in Alice Springs in 2016/17 at 7% of complaints down from 17% in 2015/16.

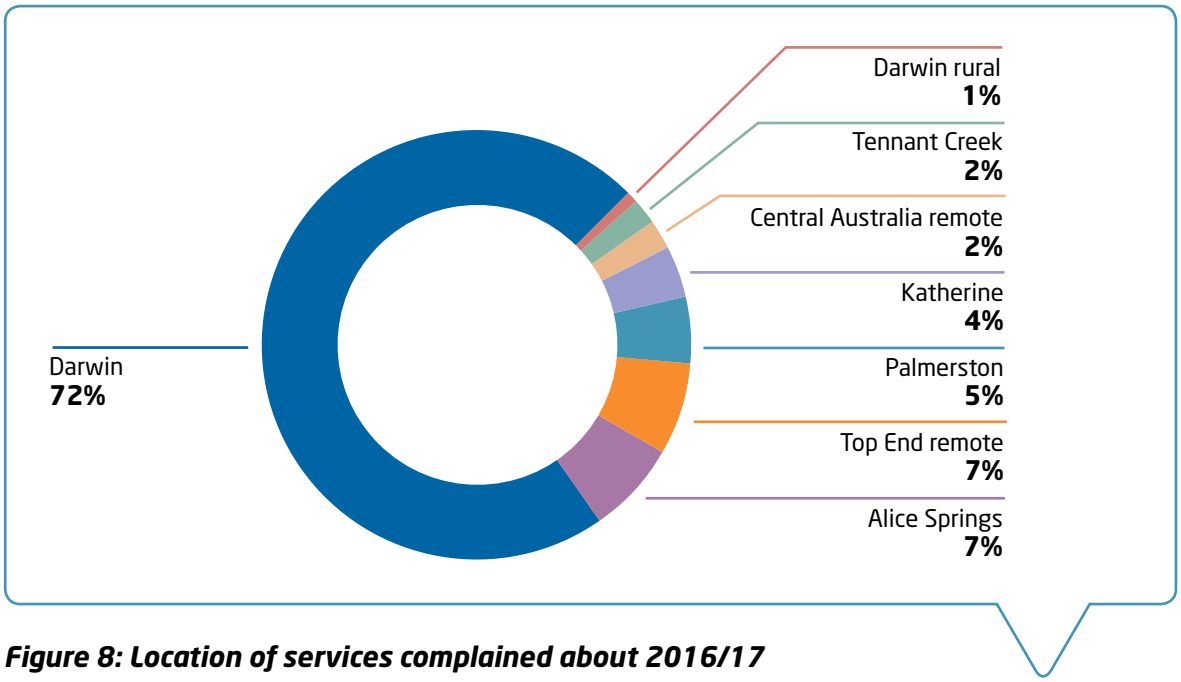


Figure 8: Location of services complained about 2016/17

How are complaints received?

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, the Commission will reduce it to writing and provide a copy to the complainant as required under the Act.

In 2016/17, of the 147 complaints made directly to the Commission, 79% of complainants approached the Commission by electronic means (46% by email and 33% by the Commission website), 11% complaints were received by mail and 8% in person. The remaining complaints were taken by phone (2%).

In 2016/17, 106 (42%) of complaints originated with the relevant Practitioner Registration Board.

What services are complained about?

For the purpose of this report, organisational and individual providers are counted only once in each complaint even though there may be multiple issues against each; however the same provider may be involved in several complaints and in this sense is counted several times. For example, Jill lodges a complaint about organisational provider Busy Hospital Inc. In this complaint, Jill alleges that:

1. she waited too long in ED;
2. when she was admitted to the hospital she was placed in an inappropriate ward; and
3. Interpreters were not used to gain her consent to treatment.

This comprises three complaint issues, however Busy Hospital Inc is counted once for this complaint. On another occasion, a second person, Zac, also makes a complaint about Busy Hospital Inc. A second complaint file is opened, and Busy Hospital Inc is counted again.

In 2016/17, there were a total 325 providers involved in the 253 complaints managed by the Commission. Of these, 202 (62%) were public providers and 123 (38%) private.

Figure 9 gives a breakdown of public sector complaints organised into two sections; organisational provider types and individual provider types. Thirty percent (30%) of all public sector complaints were about hospitals, with doctors receiving the highest number of complaints about individual practitioners (26% of all public sector complaints) followed by nurses and midwives (17% down from 25% in 2015/16).

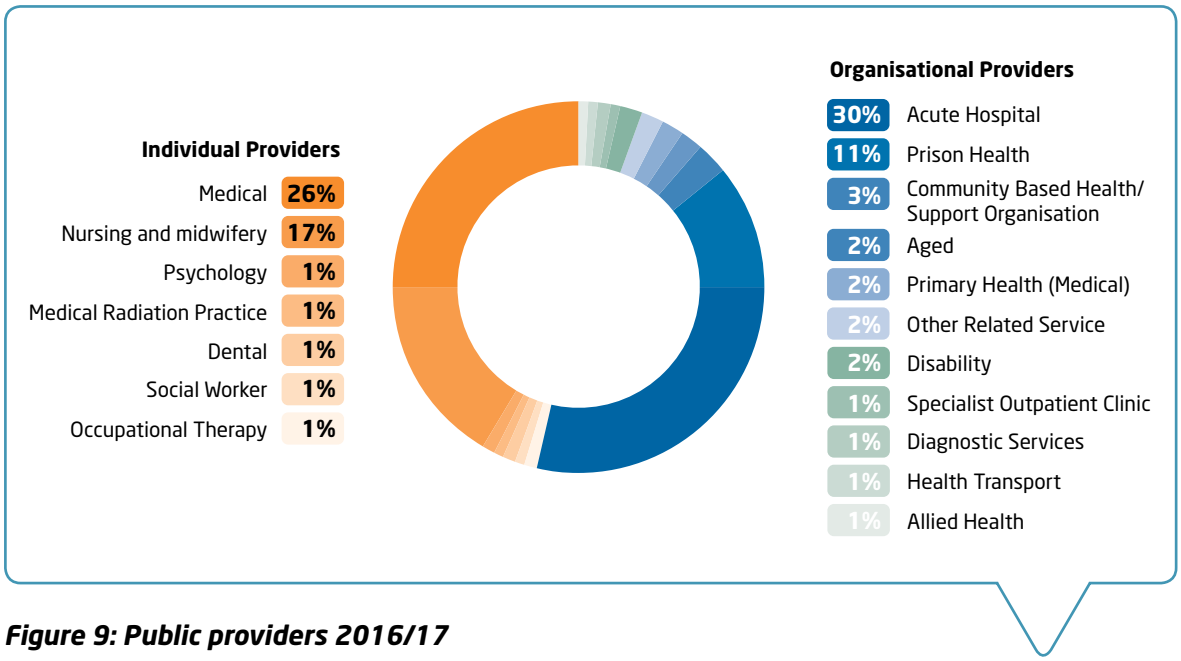


Figure 9: Public providers 2016/17

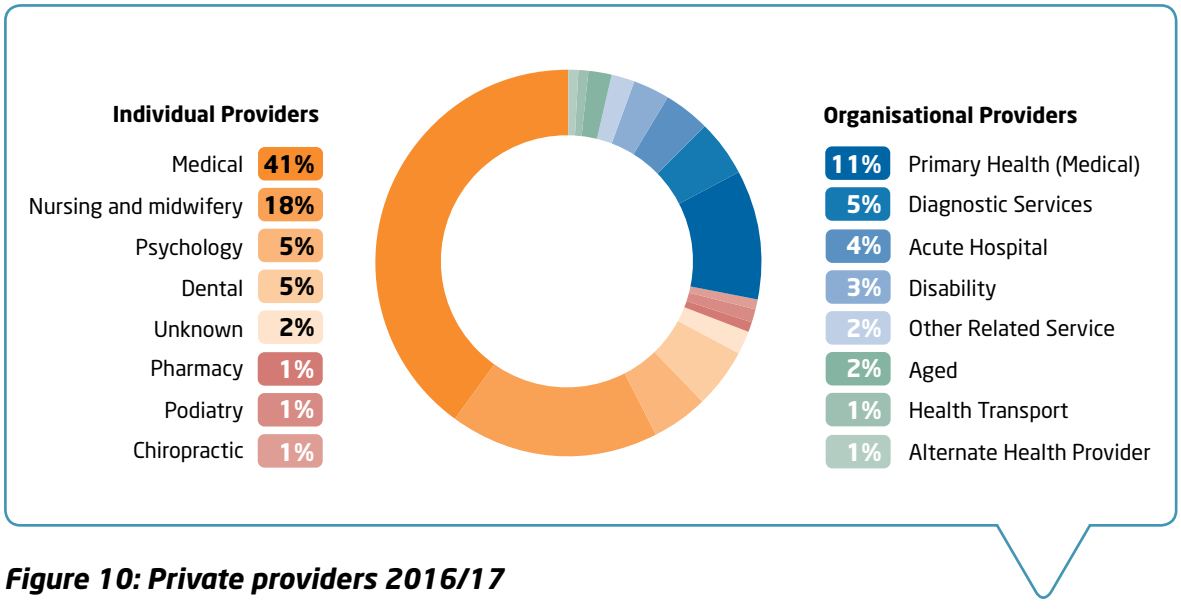


Figure 10: Private providers 2016/17

Figure 10 shows that in the private sector, the highest number of complaints about organisations were about services offered by GP Clinics (11% of all private sector complaints). Medical practitioners were subject to the greatest number of private sector complaints about individual practitioners (41%), followed by Nurses and Midwives (18%) and Psychologists and Dentists (both 6%).

What issues are complained about?

Each issue described in each complaint received by the Commission is recorded for reporting purposes, with some complaints raising more than one issue. Issue categories are used relatively consistently across Australia to allow for comparison. 491 issues were assessed in 2016/17.

Issues are recorded against all complaints received by Commission, including AHPRA notifications. This method of reporting allows for a more complete picture of the types of issues complained about in the Northern Territory, and is consistent with practice in most other Australian jurisdictions.

While the top three issues: treatment, communication and conduct remain consistent year on year, most conduct matters are dealt with by the National Health Practitioner Boards.

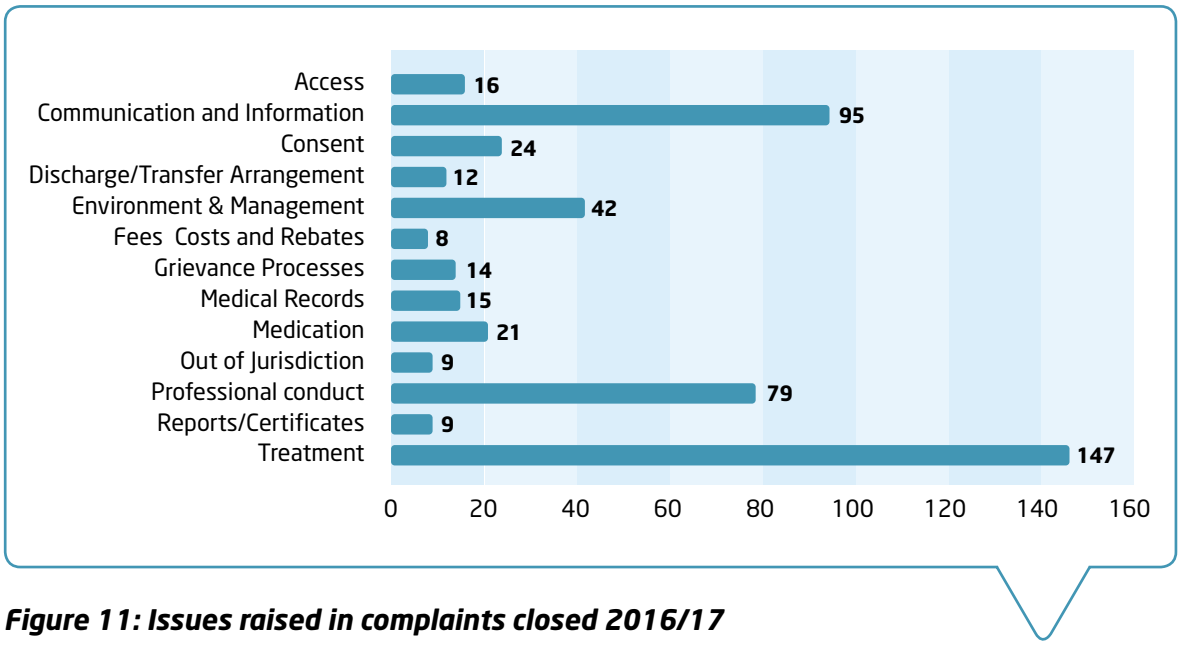


Figure 11: Issues raised in complaints closed 2016/17

A further breakdown of each of the categories of complaint issue and a comparison with previous years can be found below.

Table 12: Complaints about access 2012/13 - 2016/17

ACCESS	2012/13	2013/14	2014/15	2015/16	2016/17
Access to facility	1	0	3	0	0
Access to subsidies	1	0	2	0	3
Refusal to admit or treat	5	8	7	4	4
Service availability	6	12	9	5	8
Waiting list	3	5	2	1	1
Total	**16**	**25**	**23**	**10**	**16**

Issues relating to access made up 3% of all issues raised in complaints in 2016/17. Concerns about access to services however comprised 19% of all enquiry issues, largely due to the high proportion of contacts from prisoners.

Table 13: Complaints about communication & information 2012/13 - 2016/17

COMMUNICATION & INFORMATION	2012/13	2013/14	2014/15	2015/16	2016/17
Attitude and manner	20	38	42	41	**44**
Inadequate information provided	12	16	37	31	**31**
Incorrect/misleading information provided	2	4	12	4	**11**
Special needs not accommodated	4	3	6	5	**9**
Total	**38**	**61**	**97**	**81**	**95**

Issues relating to communication and information made up 19% of all issues complained about. This appears to be consistent year on year (17% in 2015/16).

Table 14: Complaints about consent 2012/13 - 2016/17

CONSENT	2012/13	2013/14	2014/15	2015/16	2016/17
Consent not obtained or inadequate	3	9	17	21	**16**
Involuntary admission or treatment	0	2	1	3	**4**
Uninformed consent	1	1	1	4	**4**
Total	**4**	**12**	**19**	**28**	**24**

Issues relating to consent constituted 5% of all issues complained about.

Table 15: Complaints about discharge and transfers 2012/13 - 2016/17

DISCHARGE & TRANSFERS	2012/13	2013/14	2014/15	2015/16	2016/17
Delay	0	1	0	0	**1**
Inadequate discharge	6	3	17	9	**9**
Mode of transport	0	0	1	1	**2**
Patient not reviewed	1	1	0	0	**0**
Total	**7**	**5**	**18**	**10**	**12**

Two per cent of issues raised in 2016/17 related to discharge and transfer arrangements.

Table 16: Complaints about environment & management of facility 2012/13 - 2016/17

ENVIRONMENT & MANAGEMENT	2012/13	2013/14	2014/15	2015/16	2016/17
Administrative processes	4	3	16	10	19
Cleanliness/hygiene of facility	2	0	10	5	3
Physical environment of facility	0	2	7	3	5
Staffing and rostering	2	6	3	1	6
Statutory obligations/accreditation standards not met	2	3	6	11	9
Total	**10**	**14**	**42**	**30**	**42**

Complaints in this category relate to administration rather than the care/treatment component of the service. These issues made up 9% of all issues raised in complaints.

Table 17: Complaints about fees, costs & rebates 2012/13 - 2016/17

FEES, COSTS & REBATES	2012/13	2013/14	2014/15	2015/16	2016/17
Billing practices	1	7	9	11	6
Cost of treatment	0	0	0	0	1
Financial consent	1	0	1	0	1
Total	**2**	**7**	**10**	**11**	**8**

Issues relating to cost of service constituted 2% of issues in complaints finalised.

Table 18: Complaints about grievance procedures 2012/13 - 2016/17

GRIEVANCE	2012/13	2013/14	2014/15	2015/16	2016/17
Inadequate/no response to complaint	6	5	19	16	10
Information about complaint procedure not provided	1	0	2	1	2
Reprisal/retaliation as a result of complaint lodged	2	0	2	6	2
Total	**9**	**5**	**23**	**23**	**14**

Issues related to grievance procedures and complaint handling made up 3% of all issues complained about, consistent with previous years.

Table 19: Complaints about medical records 2012/13 - 2016/17

MEDICAL RECORDS	2012/13	2013/14	2014/15	2015/16	2016/17
Access to/transfer of records	0	2	7	3	5
Record keeping	6	5	7	10	7
Record management	0	1	5	1	3
Total	**6**	**8**	**19**	**14**	**15**

The medical record category includes complaints about errors and inadequacies in medical records. They accounted for 3% of all issues complained about in 2016/17.

Table 20: Complaints about medication 2012/13 - 2016/17

MEDICATION	2012/13	2013/14	2014/15	2015/16	2016/17
Administering medication	5	7	7	8	6
Dispensing medication	4	3	3	11	3
Prescribing medication	6	6	9	10	11
Supply/security/storage of medication	2	3	7	4	1
Total	**17**	**19**	**26**	**33**	**21**

Medication related concerns made up 4% of all issues in 2016/17.

Table 21: Complaints about professional conduct 2012/13 - 2016/17

PROFESSIONAL CONDUCT	2012/13	2013/14	2014/15	2015/16	2016/17
Assault	2	12	6	2	5
Boundary violation	4	5	4	4	7
Breach of condition	0	2	2	1	4
Competence	20	60	53	42	42
Discriminatory conduct	2	5	2	5	2
Emergency treatment not provided	0	0	0	1	3
Financial fraud	0	1	1	3	1
Illegal practice	6	14	6	8	6
Impairment	3	1	3	1	0
Inappropriate disclosure of information	8	12	14	10	5
Misrepresentation of qualifications	1	4	0	2	2
Sexual misconduct	4	1	1	2	2
Total	**50**	**117**	**92**	**81**	**79**

Issues relating to professional conduct made up 16% of all issues complained about. The majority of these matters were dealt with by the relevant Board after consultation had occurred as required by the National Law.

Table 22: Complaints about reports/certificates 2012/13 - 2016/17

REPORTS/CERTIFICATES	2012/13	2013/14	2014/15	2015/16	2016/17
Accuracy of report/certificate	2	3	7	6	5
Costs of reports/certificates	0	0	1	0	0
Inadequate/no consultation	0	1	1	0	0
Refusal to provide reports/ certificates	0	0	0	1	1
Report written with inadequate or no consultation	0	0	0	1	2
Timeliness of report/certificate	0	0	0	1	1
Total	**2**	**4**	**9**	**9**	**9**

Complaints about reports and certificates made up 2% of issues in complaints closed in 2016/17. The Commission has no jurisdiction over the process of writing, or the content of, a health status report.

Table 23: Complaints about treatment 2012/13 - 2016/17

TREATMENT	2012/13	2013/14	2014/15	2015/16	2016/17
Attendance	0	1	1	1	0
Coordination of treatment	1	11	18	5	20
Delay in treatment	1	9	11	7	16
Diagnosis	8	12	13	19	12
Excessive treatment	3	0	3	1	1
Inadequate consultation	0	4	5	10	3
Inadequate treatment	7	17	39	54	58
Infection control	2	2	5	4	1
No/inappropriate referral	4	0	9	7	4
Public/Private election	2	0	0	3	1
Rough & painful treatment	0	1	4	4	3
Unexpected treatment outcome/ complications	8	4	13	10	9
Withdrawal of treatment	3	1	4	1	2
Wrong/inappropriate treatment	2	9	13	8	17
Total	**41**	**71**	**138**	**134**	**147**

Issues relating to treatment constituted 30% of all issues in complaints closed in 2016/17. Inadequate treatment is identified as the primary concern within this category.

Outcomes of issues complained about

When complaints are finalised the outcome of each issue identified in the complaint is recorded. The outcome of notifications received by AHPRA and managed within that jurisdiction are not included in the outcomes below.

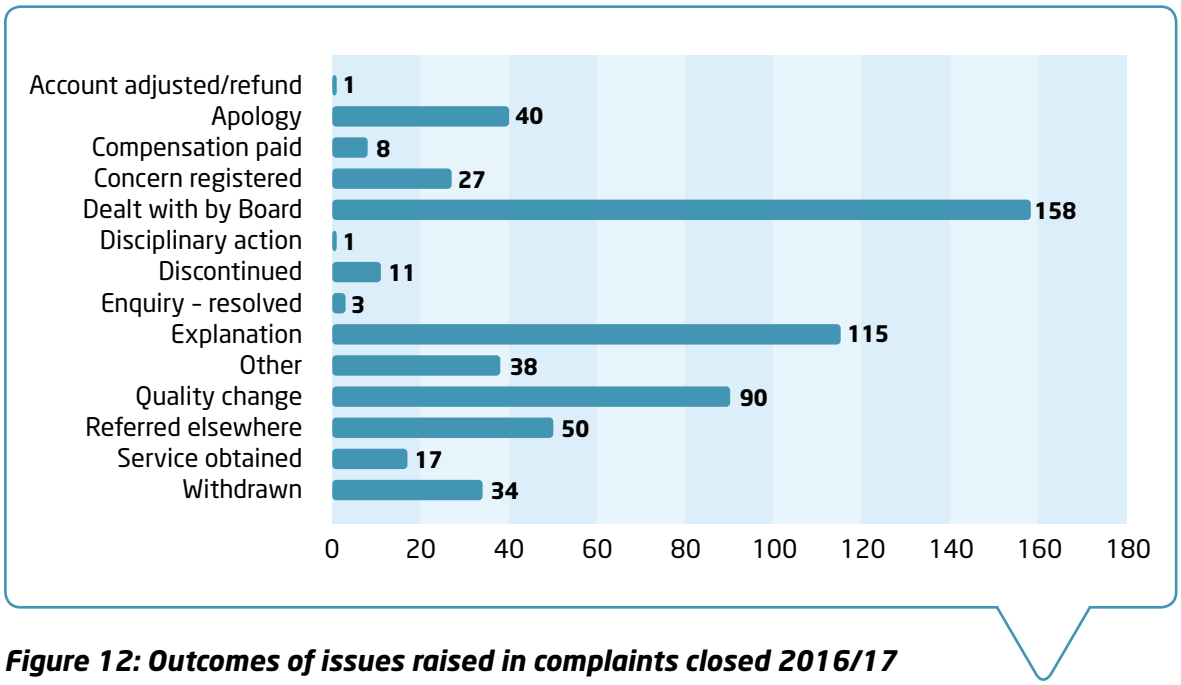


Figure 12: Outcomes of issues raised in complaints closed 2016/17

The most common outcome from issues closed by the Commission was an explanation (26%). Twenty percent of matters resulted in a quality improvement (up from 12% the previous year) and 11% were referred elsewhere.

Appendix 2: Community Engagement Activities 2016/17

COMMUNITY ENGAGEMENT ACTIVITIES 2016/2017

	Date	Organisation	Activity	Approx no. attendees
1	7 July 2016	RDH	Senior staff meeting	5
2	21-22 July 2016	National Health Complaints Managers	Annual Conference	15
3	10 Aug 2016	Somerville Community Services	Guest speaker staff advisory forum	12
4	23 Aug 2016	NDS Zero Tolerance Forum	Key note speech	30
5	23 Aug 2016	KPMG consulting for the Office of Disability	NDIS Quality and Safety assessment	57
6	24 Aug 2016	Disability Awareness Festival	Breakfast presentation	85
7	31 Aug 2016	Disability Complaints Commissioners	Conference	10
8	1-2 Sept 2016	Health Complaints Commissioners	Conference	15
9	5 Sept 2016	RDH	Grand Rounds presentation	50
10	8 Sept 2016	Department of AG	R U OK? Day BBQ Esplanade	40
11	15-16 Sept 2016	Somerville Community Services and Katherine Friendship Assoc	Presentation to parents, carers and people with disabilities	25
12	12 July, 26 July, 23 Aug, 13 Sept 2016	CDU, Youthworx, IdA, NDS, Somerville, Down Syndrome Association, Upton Consultancy	Planning Disability Expo. Deferred to May 2017	9
13	26 Sept 2016	DoH CEO	Regular briefing	4
14	28 Sept 2016	TEMHS	Youth Inpatient - briefing	3
15	6 Oct 2016	Battle of the Professionals - HPA and CPA	Presentation and judge	35
16	4 Nov2016	TEHS/RDH	Regular meeting with senior staff	5
17	7 Nov 2016	Minister	Brief Minister and staff	5
18	8 Nov 2016	Darwin Correctional Precinct	Meeting and familiarisation	20
19	18 Nov2016	Disability Employment Program focus group OCPE	Planning session and look back	30
20	25 Nov2016	AHPRA meet with current and former manager	Future focus and handover	4
21	2 Dec 2016	Project 21	Rights and What is a complaint	16
22	2 Dec 2016	DoH Serious Noncompliance Team	Meeting / briefing	6
23	7 Dec 2016	TEHS/RDH	Regular meeting with senior staff	3
24	12 Dec 2016	Katherine Hospital	AHPRA information session for KH Medical Practitioners	8

25	9 Jan 2017	TEHS	Regular meeting with senior staff	4
26	16 Jan 2017	Leader of the Opposition Mr Higgins MLA	Brief on role of Commission	2
27	17 Jan 2017	Baptist Church	Funeral Pauline Wilson previous Chief Medical Officer RDH	150
28	20-21 Feb 2017	Barkly Regional Alcohol and Drug Abuse Advisory Group	Short discussion with CEO Distributed pamphlets and posters on complaint management	1
29	21 Feb 2017	Tennant Creek Hospital (CAHS)	Tour of hospital Discussion with senior staff about HCSCC Posters/pamphlets provided	13
30	22 Feb 2017	Lifestyle Solutions (Tennant Creek)	Discussion with manager re HCSCC role, provided posters/ pamphlets	2
31	22 Feb 2017	ITEC Health (Tennant Creek)	Discussion with Administration Manager, provided pamphlets/ posters	1
32	22 Feb 2017	Cheeky Bum Nappies	Discussion with business owner, provided pamphlets	1
33	22 Feb 2017	Member for Spillett	Briefing on activities and Act	2
34	23 Feb 2017	Minister's office	Briefing	5
35	1 Mar 2017	Member for Drysdale	Briefing on activities and Act	2
36	7 Mar 2017	Member for Nelson	Briefing on activities and Act	2
37	15 Mar 2017	Darwin Correctional Precinct	Brief senior prison staff	15
38	17 Mar 2017	Department of Health	Discuss adverse events data	3
39	22 Mar 2017	NDS	Reference Group Zero Tolerance for Abuse	10
40	24 Mar 2017	TEMH Cowdy Ward	Grand Round presentation with AHPRA	30
41	28 Mar 2017	CASA Alice Springs	Discussion Complaints, NDIS	2
42	28 Mar 2017	MHACA Alice Springs	Complaints, NDIS, Mental Health	1
43	28 Mar 2017	ASH	Presentation HCSCC overview and AHPRA	20
44	28 Mar 2017	ASH Allied Health	HCSCC and the Code of Conduct	3
45	29 Mar 2017	ITEC Health	Brief meeting, brochures left	1
46	29 Mar 2017	Carers NT	Meeting, NDIS, complaints, brochures	1
47	29 Mar 2017	Central Australian Aboriginal Congress	Information left for medical staff	26

48	29 Mar 2017	Central Australian Mental Health Service	Presentation – HCSCC and AHPRA	17
49	30 Mar 2017	OPG	Catch up – issues with disability services Central Australia	1
50	30 Mar 2017	LWB	Disability, safeguards, Apps	1
51	30 Mar 2017	CAHS Prison Primary Healthcare Service	HCSCC and AHPRA	20
52	31 Mar 2017	CVP AS	Meeting, Information left	1
53	3 Apr 2017	RDH	Grand Rounds presentation	50
54	6 Apr 2017	Henbury Av School	PossAbilities expo	100
55	10 Apr 2017	TEHS	Regular meeting with senior staff	2
56	27 Apr 2017	Carpentaria Disability Services	Briefing to Board and senior management	6
57	2 May 2017	Australian and NZ Disability Commissioners conference, Sydney	Semi-annual conference	20
58	3-4 May 2017	Australian and NZ Health Commissioners conference, Sydney	Semi-annual conference	30
59	8 May 2017	Minister Wakefield	Briefing on activities and Act	4
60	12 May 2017	Nurses and Midwives Union	Presentation	60
61	9 June 2017	RDH Quality Awards	Award presentation	50
62	20 June 2017	Estimates Committee hearings	Hearings	10
63	29 June 2017	Regis Aged Care	Presentation about HCSCC for care recipients and carers	28
64	30 June 2017	CEO AHPRA	Meet Mr Fletcher	10

Health and Community Services
COMPLAINTS COMMISSION

For more information about the HCSCC, including more information about how to resolve complaints, how to make a complaint or how to respond to a complaint, please contact the HCSCC or visit our website.

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