Health and Community Services
COMPLAINTS COMMISSION

Annual Report 2018/19

Health and Community Services
COMPLAINTS COMMISSION

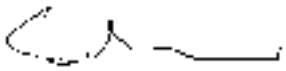
Twenty-First Annual Report (2018/19)

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 2019.

Yours sincerely



Stephen Dunham
Commissioner

9 January 2020

Glossary of Terms

AHPRA	Australian Health Practitioner Regulation Agency
AMSANT	Aboriginal Medical Services Alliance Northern Territory
ASCC	Alice Springs Correctional Centre
ATSI	Aboriginal and Torres Strait Islander
CAHS	Central Australia Health Service
CALD	Culturally and Linguistically Diverse
COAG	Council of Australian Governments
Commission	Health and Community Services Complaints Commission
Complaints	Unless otherwise specified, complaints include matters received by the HCSCC on which a formal decision was made and Notifications to AHPRA in which formal decisions were made at consultation
CVP	Community Visitor Program
DAGJ	Department of the Attorney General and Justice
DCLS	Darwin Community Legal Service
DoH	Department of Health
ED	Emergency Department
GP	General Practitioner / General Practice
HCE	Health Complaints Entity
Holtze	Darwin Correctional Centre
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
NTCAT	Northern Territory Civil and Administrative Tribunal
NTMHS	Northern Territory Mental Health Service
NTCS	Northern Territory Correctional Services
OoD	Office of Disability
OPG	Office of the Public Guardian
PPHCS	Prison Primary Health Care Service
RDH	Royal Darwin Hospital
SIO/CO	Senior Investigation and Conciliation Officer
TEHS	Top End Health Service
TEMHS	Top End Mental Health Service

Table of Contents

Case Studies

Case studies are used in this Annual Report as examples to illustrate our work during 2018/19. 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

My appointment is due to end on 11 June 2020 and thus, this will be my last Annual Report as Commissioner.

In addition to changes to improve the efficiency of the Commission, I leave the position in the confident knowledge that a number of beneficial changes have occurred to the health system and to services for people with disabilities. The confidential nature of the Commission's work means that only those with an involvement in the efforts to resolve complaints will have some insight into these systemic improvements. Nevertheless, some data in this report provides eloquent perspectives of the last five years.

Workload and resourcing data graphically demonstrates the current pressure on the Commission.

The 2018/19 appropriation is $1.116 million, a $0.89 million reduction from the budget when I commenced in 2014/15. This represents a 7% decrease. The erosion of the dollar value estimated by the Australian Bureau of Statistics over the four years to 2018/19 is 6.8 per cent, at an average annual inflation rate of 1.7 per cent.

Thus, the Commission has incurred a real cut of nearly 14% to its budget while simultaneously managing a near doubling of workload since I was appointed in 2015.

The Commission has recorded the numerous efficiency measures instituted to cope with these straitened circumstances in previous Annual Reports and they will not be recited again in my report. Suffice to say that the biggest risk to the independence of the Commission is a lack of staff and facilities to enable me or my successor to properly perform my functions.

One critical feature of the changes to processes, which has yielded great efficiency, is the focus on resolution occurring between the parties, without the involvement of the Commission. This has always been a statutory objective, but I recognise the increased emphasis on this essential first step, particularly by the Department of Health and the General Practice clinics in Darwin. Obvious benefits include increased acceptance of the positive impact of complaints on system improvement; good client relationships and obviating the progression of disputes to this Commission and AHPRA. This deliberate strategy is evident in our statistical data with the rate of enquiries growing faster than the rate of complaints.

I have departed from the norm for this report and have included a contribution from the Deputy Commissioner Judy Clisby who is due to retire in early September 2019. Judy has authored many of the efficiency changes over the last several years and has a unique perspective on these. She has a vast knowledge of the Commission's work and the improvements directly attributable to complaints over the years.

I am grateful for the outstanding contribution Judy has made to the work of the Commission during her time here. This work has tangibly improved health services and services for people with disabilities and aged people.

It has been my custom to use the Annual Report to personally recognise the contribution of all staff and to thank them. The small team of people who make up the Commission have a wide range of skills, enthusiasm and a common desire to advance its objectives. The throughput of the office in handling a large complex caseload is remarkable and deserving of this mention. Elizabeth Keith, Hiltrud Kivelitz, Kiarna Murray, Bintang Daly, Brendan Schultz, and Leigh Kinsella and Robynne Lower who left us during the year, are thus thanked and acknowledged.

Stephen Dunham
Commissioner

Deputy's Report

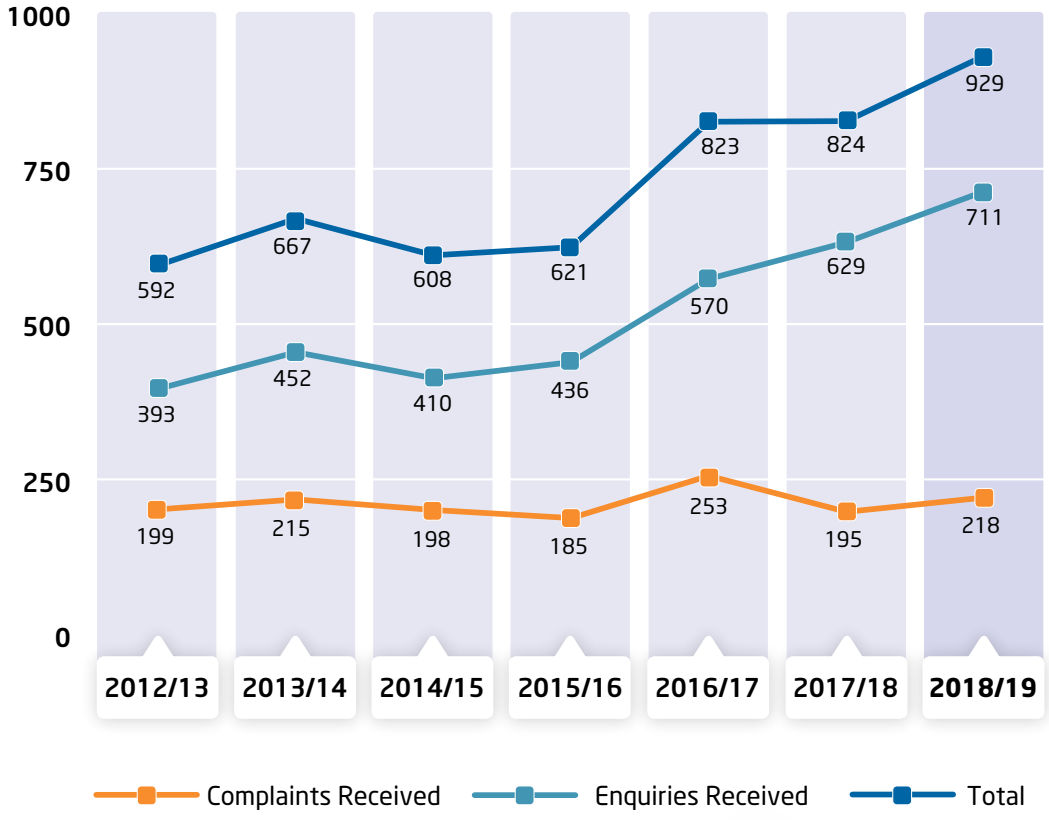
I retire on 2 September 2019 after spending seven years as Deputy Commissioner in the Health and Community Services Complaints Commission. In this section of the Annual Report, I am taking the opportunity to look back over my time here and the changes that have occurred in the Commission since I first commenced work in September 2012.

The Commission is a dynamic organisation, during my time it was led by two very different dynamic leaders with very different approaches to achieving the same goal. It has been a changing environment, supported by a team who willingly embrace change, resulting in a more effective service.

The most obvious change is the increase in workload from 2012 until now, demonstrated by ***Figure 1*** below:

The graph demonstrates the 57% increase in complaints and enquiries received from 592 in 2012/13 to 929 in 2018/19. It also clearly demonstrates the Commission's focus on managing matters as informally as possible with the 10% increase in matters handled as a complaint during this period compared with the 81% increase in matters handled as enquiries, and the proportion of matters handled as enquiries increasing from 16% in 2012/13 to 76% in 2018/19.

Figure 1: Complaints and Enquiries Received 2012/13 - 2018/19



Other changes, in this period, are outlined below:

1 ***2014/15: Resolve database implemented. The initial configuration acted as the blueprint for Commission workflows. Since that time:***

- the initial configuration has been re-designed to simplify the steps and save time;
- screens have been re-designed to reinforce expected staff practice using Resolve and reinforcing time frames for stages of complaint management;
- the system has been continuously updated so that the Commission is able to measure the efficacy of objectives set during business planning;
- business rules have been implemented to ensure that all work is documented and described on the database; and
- reports have been designed to reflect and reinforce counting rules.

Brendan Schultz, Business Manager for the Commission, undertook many Resolve modifications. He saved the Commission a considerable sum of money and ensured access to a usable and functional complaints system.

2 ***Focus on resolution commenced 2014/15. Outcomes include:***

- the development and publishing of the HCSCC Guide to Complaints Resolution;
- the development of training in complaints resolution for front-line staff and managers. Supporting a private provider to deliver training, with 500 health staff in the Top End participating in the training;
- development of a matrix to describe resolution mechanisms to be used (i.e. informal enquiry, resolve in assessment, early conciliation, conciliation) and the circumstances in which these mechanisms might be most appropriate;
- change in language and focus of Commission staff managing complaints to resolving rather than assessing complaints (except in high risk situations, when public interest issues are evident or there is a pattern of complaints);
- updating the Complaints Policies and Procedures and associated workflows to reflect the change in focus; and
- increasing focus on coaching service users and service providers.

Ruth Bresland, formerly an Investigation/ Conciliation officer, played a major role in the development of the complaints resolution training. Ruth formerly held a significant medico-legal role in Victoria, and this experience was invaluable. Surya Silva worked with Ruth to develop the training and later delivered it in her very special conversational style and has contributed greatly to its success.

3 ***Changed work practices to become more effective and efficient. Strategies include:***

- managing matters informally whenever possible (see introduction to this section of the report);
- referring matters back for direct resolution, with the expectation that service providers will ensure they have the capacity to resolve complaints directly whenever possible. This strategy has led to a dramatic reduction in complaints received from prisoners; and
- reviewing all work flows to remove all unnecessary steps; and using email whenever possible to communicate.

4 ***Changed management of complaints about registered health providers:***

- in 2015/16, the NT participated with Victoria and Western Australian in a trial of a consultation matrix. In the Northern Territory, this trial also encompassed a change in the way the Commission and AHPRA consult on complaints received by the Commission and notifications received by AHPRA;
- consultations with AHPRA now occur weekly and decisions made as to which agency is best suited to manage complaints or notifications. This is essentially a "one-door approach". Notifications received by AHPRA may now be referred to the Commission if this is the more appropriate jurisdiction;
- there is limited chance of double handling – the consultation process means that if AHPRA receives a notification and the Commission receives the same complaint, it will only be handled in one jurisdiction; and
- there is a demonstrated improvement in the length of time taken to assess complaints about registered providers.

Staff from AHPRA, State Managers firstly Jill Huck and then Eliza Collier along with Inta Tumuls, Director of Notifications, have worked collaboratively with the Commission to improve written communication processes between the two agencies and to ensure a cohesive working relationship.

5 ***Focus on Disability – aim to increase complaints and enquiries received from people with disability:***

- relationships built with key players and people in disability networks in the NT; in particular Office of Disability (OoD), the National Disability Service (NDS), NT National Disability Insurance Scheme (NDIS), Disability Advocacy Service (DAS), and Integrated DisAbility Action (IdA);
- developed Bec's Story – starring the Commission's own Lisa Tiernan. This is an interactive computer story targeting people with cognitive impairment which teaches the reader how to make a complaint;
- attended workshops throughout the Territory to increase recognition of the Commission and its role. There was a significant effort from the Commission in 2017/18 resulting in an increase in enquiries received which carried through into 2018/19; and
- developed a project plan and framework and applied successfully for Sector Development Funding from the NDIS. This enabled the Commission to work with Dr Christine Fejo-King in 2017/18. Dr Fejo-King travelled the NT consulting with Aboriginal people with disability, families and service providers to determine how the Commission could provide its message about the right to complain effectively. This led to the development of the TALK UP! message and videos now available at *https://www.hcscc.nt.gov.au/about/talk-up/*.

6 ***Changed to paper free office:***

- all complaints managed paper free from 1 July 2016;
- the Commission is entirely paper free from early July 2019 with all files entered on HP Record Management;
- information between service providers and the Commission, and between the Commission and external experts or investigations is transferred using secure FTP Boxes; and
- all documents, including emails are electronically stored. This is faster than printing and placing on paper files. As a result, all Commission information is classified and stored appropriately.

A key attribute of the Commission and its staff is its focus on Commission values. This focus is genuine. The Commission provides a service which is proudly impartial and which at the same time strives to be responsive to the people involved in the complaints process: service users and service providers. It has resulted in the development of an electronic survey for service users and service providers and the results are used to inform practice in the Commission.

From 2012 – 2019, the Commission has conducted many investigations which have potentially led to huge improvements to service provision in the Territory. Only investigations which have been tabled in Parliament can be named, in particular the investigation into the Prison Health Service of February 2016 which has resulted in considerable, sustained improvement in services provided to prisoners. Similarly, an investigation into services provided by the Top End Mental Health Service, tabled in Parliament in August 2019, should ensure improved protections of the rights of people detained to treatment facilities in the Territory.

I have been fortunate to work with and learn from two Commissioners: Lisa Coffey and Stephen Dunham and I thank them both. I admire them both greatly, and will forever be grateful that I had the opportunity to work with them. I have also been fortunate to work with some amazing people in the Commission.

Judy Clisby
Deputy Commissioner

2018/19 at a Glance

Key deliverables

Table 1: Key deliverables 2017/18 - 2018/19

Key deliverables	2017/18	2018/19
Enquiries and complaints received	824	929
Enquiries and complaints closed	843	909
% Complaints closed within 180 days	76%	86%
% Complaints and enquiries closed/complaints and enquiries received	102.3%	97.8%

Enquiries

- Record number of enquiries received in 2018/19 (711 in 2018/19 compared with 629 in 2017/18 and 570 in 2016/17).
- Maintained high proportion of total complaints and enquiries handled at enquiry level (77% in 2018/19 compared with 76% in 2017/18 and 69% in 2016/17).
- A record 702 enquiries were closed. This is the highest number of enquiries ever closed and is an increase of 12% on the previous maximum of 626 in 2017/18.
- Despite this, the average number of days taken to finalise enquiries remained relatively steady at 8.98 days compared with 8.65 days in 2017/18 and 7.7 days in 2016/17.

Complaints

- 218 complaints were received, a slight increase on the 195 complaints received in 2017/18. Complaints were less complex than in the previous year with 404 issues closed compared to 602 in 2017/18.
- 207 complaints were closed, slightly fewer than the 217 closed in 2017/18.
- 86% of complaints were closed within 180 days. The benchmark for closure of complaints within 180 days is 80%.
- Of matters formally assessed in 2018/19, the KPI of 80% assessed within 60 days was not met despite this being a focus in 2018/19. The 64% assessed within 60 days is however a significant improvement on the 2017/18 figure of 36%.

Community engagement

- Complaint timelines have improved at the expense of community engagement activities. In 2018/19, the HCSCC attended 31 events compared with 93 in 2017/18.
- The number of complaints and enquiries about disability services and mental health services were slightly lower than the previous year, reflecting reduced community engagement activity.

Chapter 1: The Commission

OUR VISION

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

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 VALUES

The Commission is guided by the following values:

- Accessibility
- Accountability
- Fairness
- Innovation
- Person-centred
- 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:

- Providing an independent, just, fair and accessible mechanism for resolving complaints between users and providers of health and community services
- 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. Provide a quality accessible and transparent complaints assessment, resolution and investigation service.
2. Promote the capacity of the health, disability and aged services sectors to resolve complaints directly with service users.
3. Analyse complaints to identify causes, detect trends and contribute to systemic improvement.
4. Provide independent advice to government on matters affecting health, disability and aged care services in the Territory.
5. Operate the office in accordance with good governance and resource management practices.

OUR TEAM

The Commission receives support from the Department of Attorney-General and Justice in areas such as human resources, finance, procurement, record management, 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.

The organisational structure of the Commission as at 30 June 2019 is as follows:

Commissioner
Stephen Dunham

Deputy Commissioner
Judy Clisby

SIO/CO
Hiltrud Kivelitz

SIO/CO
Elizabeth Keith

Complaints Officer
Kiarna Murray

Business Manager
Brendan Schultz

Admin/Resolution Officer
Bintang Daly

Admin Support Officer
Lisa Tiernan

Table 2: Staffing profile as at 30 June 2019

Position Level	Male	Female	TOTAL
Commissioner (ECO2)	1	0	1
Deputy Commissioner (ECO1)	0	1	1
Administrative Officer 7 (AO7)	0	2	2
Administrative Officer 6 (AO6)	0.5	1	1.5
Administrative Officer 4 (AO4)	1		1
Administration Support Officer 1 (AO1)		0.29	0.29
Total	**2.5**	**4.29**	**6.79**

Chapter 2: Quality Complaints Management

ACHIEVEMENTS 2018/19

Monitoring quality improvement

The Commission has three primary functions; the promotion of service quality, the promotion of the rights and responsibilities of service users and service providers and the resolution of complaints.

Two separate mechanisms are employed to promote quality improvement. The first is to encourage service providers to reflect on the issues which led to a complaint or enquiry, and to improve service quality to reduce the likelihood of other, similar complaints. These outcomes are recorded on Resolve, the Commission's complaint management system. The Commissioner making suggestions for quality improvement when closing a complaint achieves the second mechanism. To determine the effectiveness of its focus on quality, the Commission decided to monitor quality improvements made through complaints in 2018/19.

Quality Improvement outcomes recorded

In 2018/19, the Commission recorded 27 separate quality improvement outcomes from complaints across health, disability and aged care services. The Commission is unable to report on some of these outcomes because to do so would divulge the identity of the provider involved. However, an example is provided in ***Case Example 1*** below.

Commissioner Suggestions

A second mechanism for promoting service improvement is the use of Commissioner's suggestions made under section 12(1)(e) of the Act. This states that the Commissioner is "to suggest ways of improving health services and community services and promoting community and health rights and responsibilities". There has been increased focus on this role in 2018/19 with 18 suggestions made to service providers.

As with quality improvements, it is difficult to provide information about all suggestions made, however the case study below is sufficiently de-identified to ensure that the service user cannot be identified.

Case Example 1: Quality improvement

Abby notified AHPRA about the poor standard of cleaning in a hospital in the NT, complaining in particular about three allied health staff who she believed to be responsible. At consultation, it was agreed that the Commission should manage the complaint, as the issues appeared to be systemic in nature. The Commission contacted Abby who agreed that it would be useful to withdraw her complaint about the registered providers, and to manage the complaint systemically. While the Commissioner decided to take no further action in this matter, Abby was pleased to learn that the hospital had made two significant changes to the Cleaners' Manual to ensure that guidelines for cleaning particular equipment were incorporated into the Manual and that the Manual now reflects Australian cleaning standards. Both quality improvements were recorded on the Commission's complaints management database.

Case Example 2 - Suggestions to service provider

Police arrested Brian in a remote community in the NT. It was clear at the time that Brian had a medical condition, which required immediate treatment. He was assessed at the local hospital, and then transferred to the major centre where planned hospital treatment could be provided. In order for this to occur, Police planned to hand Brian over to Correctional Services who would then liaise with the relevant prison health service to arrange a hospital admission. However, a mix up meant that when Brian arrived at the Correctional Centre, his health information was not reviewed and he was not referred to hospital. Instead, after five days he was transferred back to his home area for his court case without his medical condition being addressed.

The service acknowledged the error, and instituted system changes with a view to preventing a recurrence of this incident. In addition, the Commissioner suggested that the service provider consider ways in which:

- reliance on hard copy medical information being 'handed over' by Police and Corrections as a means of communicating information from one health service to another could be minimised; and
- direct communication between health agencies providing services to prisoners could be enhanced.

The Commissioner suggested that options include:

(i) Enabling relevant services to use a common electronic system.

(ii) Enabling important attachments on the electronic record to be 'flagged' when a client's record is first located (e.g. at an initial reception health screen).

(iii) Developing processes to ensure the Prison Health Service is advised of any important medical information, which needs to be handed over.

(iv) Developing processes to ensure other Health Service teams (e.g. an acute hospital) advise of treatment plans or other important handover information.

Enquiries

Increasing proportion of complaints handled as enquiries

The Commission has continued its focus on resolving matters at the lowest level possible by managing the majority of matters referred to it as enquiries. The increasing area between complaints closed and enquiries received in the graph below demonstrates the increasing proportion of matters being managed informally as enquiries. In 2018/19, 77% (compared with 76% in 2017/18) of the 929 matters received were managed as an enquiry.

Serious matters can be handled informally, and some should be handled this way when a fast outcome is desirable. Factors which are considered when deciding whether to handle a matter informally include whether the issue is current, whether it can be resolved and whether relationships are important and need to be maintained. Irrespective of the above, high risk matters are always handled formally as a complaint. The case study below is an example of a matter, which was assessed as low risk and at the same time relatively serious. It was a current issue and assessed at the outset as being one which could be resolved. The Commission assessed that a fast outcome was important for Cathy, and therefore that it was appropriate to handle the complaint informally.

Case Example 3 - Resolved at enquiry level

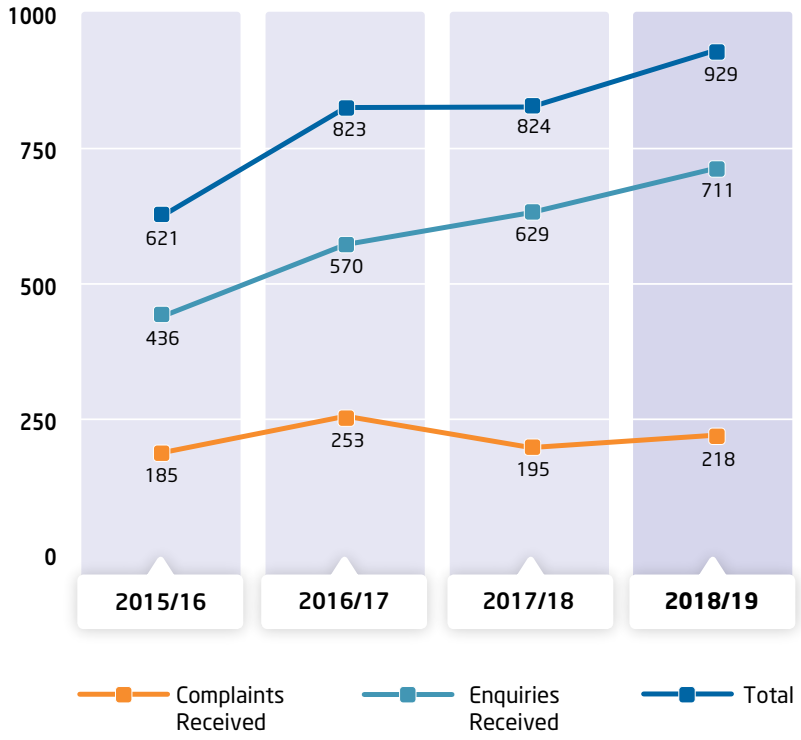
Cathy told the Commission that she is funded for certain equipment under the NDIS but that she could not obtain this equipment. An allied health worker from a private company recommended this piece of equipment for Cathy, which could be supplied by only one local agency. Apparently, the two agencies needed to collaborate to ensure the equipment would be useful for Cathy. Unfortunately, there was a history of conflict between key local staff in the two organisations, who were unwilling to work together. As a result, there were delays in Cathy obtaining the equipment she needed.

Cathy had already tried to resolve this by talking to both service providers, and with interstate management. While they seemed to understand her difficulty and her frustration, she received no follow up from her phone calls.

The Commission contacted interstate managers who agreed that they would follow up directly by contacting all parties (including Cathy). A few days later, they informed the Commission that the matter was resolved. Cathy also told the Commission that she was confident her equipment would be supplied in the next few weeks.

Highest number of enquiries received and closed

Figure 2: Number of complaints and enquiries received 2015/16 - 2018/19



In 2018/19, 711 enquiries were received, an increase of 13% on the previous high received in 2017/18. Our aim is to close enquiries within 14 days. In 2018/19, this goal was achieved in 79% of matters (slightly less than the 82% recorded in 2017/18).

Figure 3: Number of complaints and enquiries closed 2015/16 - 2018/19

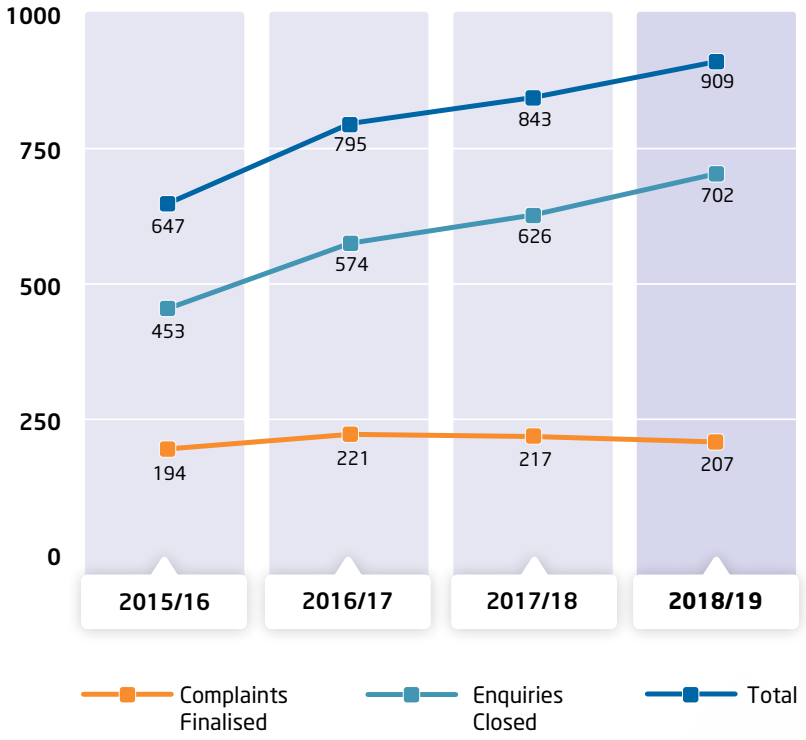


Figure 3 depicts the increasing number of complaints and enquiries closed from 2014/15 until 2018/19. Given that the total number of complaints and enquiries handled by the Commission continues to increase year on year, the ability to close so many matters demonstrates the effectiveness of workload management measures introduced by the Commission and the focus of Commission staff.

When assessing enquiries, Commission staff may handle several separate issues in the one file. For example, Jane might complain about the billing practice of her GP. If she complained to the practice manager about these billing practices and was unhappy with the response and the way it was delivered, she might also complain about the way her complaint was handled. Thus, there would be one enquiry, but two issues.

Table 3: Categories and percentage enquiry outcomes all issues 2018/19

	2017/18		2018/19	
Enquiry Outcomes	**No**	**%**	**No**	**%**
Enquiry - information provided	111	13	234	24
Enquiry - referred back	233	27	231	24
Enquiry - resolved	185	22	190	20
Enquiry - other	43	5	56	6
Enquiry - referred elsewhere	148	17	145	15
Enquiry - referred to Commission complaints process	136	16	103	11
Total	**856**	**100**	**959**	**100**

Figure 4: Average time to finalise enquiries (days) 2015/16 - 2018/19

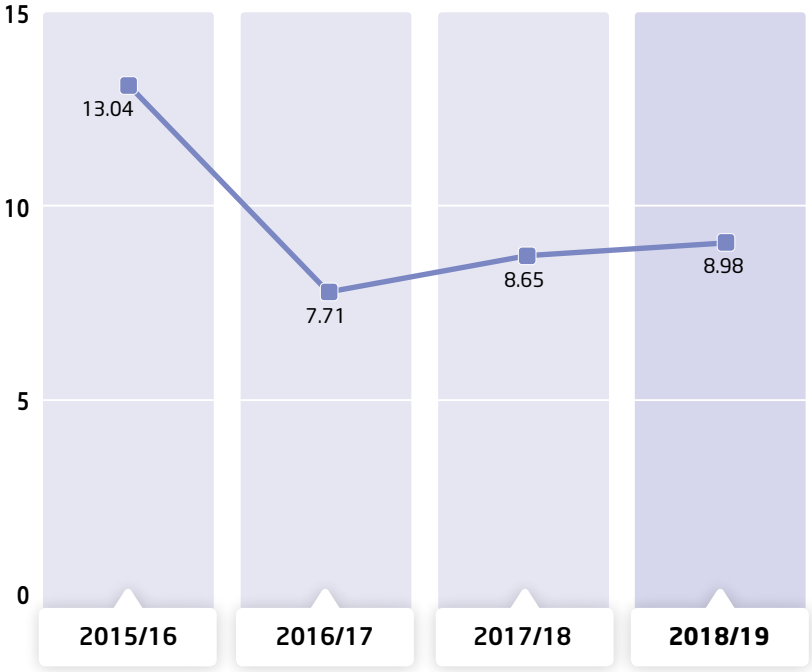


Figure 4 depicts the average time taken to close enquiries for the past five years. This increased slightly to 8.98 days in 2018/19 compared with 8.65 days in 2017/18.

Person-centred approach to enquiries

A person-centred approach requires that Commission staff are aware of the impact of a situation on all parties to a complaint. In the case study below, the Commission received a complaint that a young man was in considerable pain and was deteriorating quickly. It was assessed as current and high impact on the person involved. While the issue was not necessarily deemed one which could be resolved, it was a matter, which on the face of it, might be improved with better communication.

Case Example 4 - Referred back for direct resolution while monitoring outcomes

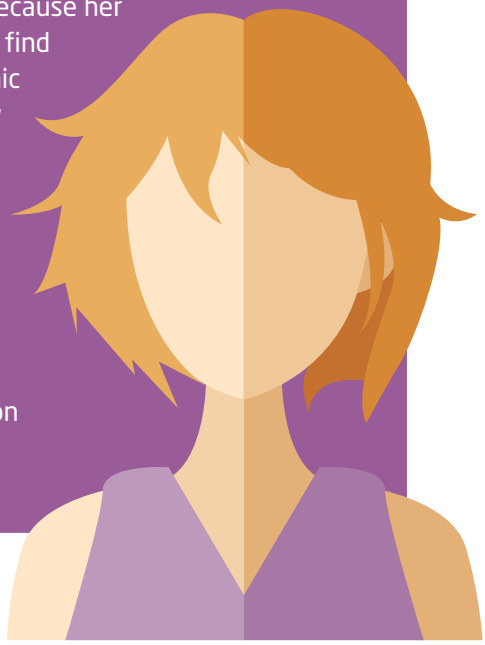
David had a back condition, which required surgery. He was in considerable pain, and his situation was worsening so that he was becoming less and less mobile. David had seen a neurosurgeon, however he was informed there would be delays in conducting surgeries, which would be carried out according to urgency. David wanted to know whether he could be sent interstate for his surgery.

The Commission does not interfere in hospital decisions about appointments or surgeries on the basis that these decisions are made by clinicians based on their knowledge of the cases before them. In this case, Commission staff believed that David would benefit from an advocate. Accordingly, the Commission referred him to the Patient Advocate so that she could help David navigate the system and get answers to his questions and concerns. The Patient Advocate was contacted, and the file remained open until Commission staff knew that the Patient Advocate had contacted David and was working with him to address his concerns.

Case Example 5 - Outpatients

Ellen told the Commission that she was receiving treatment from an outpatient clinic at her local hospital. The treatment was authorised by the clinic but administered by her GP. Ellen told the Commission that her GP sends a request when new treatment supplies are needed, the clinic reviews the case to find out what further treatment is needed and then contacts Ellen so she can pay for that treatment.

On this occasion, the GP contacted the clinic two months prior to Ellen contacting the Commission. The clinic did not contact Ellen. Ellen was worried because her treatment supplies were running low so she phoned the clinic to find out what was happening. She was surprised to hear that the clinic had no records of the new GP request. The staff member initially also could not find any records of previous orders, but then did. She asked Ellen if she knew what should be ordered.



Ellen stated that this was a matter for the specialist. She was hoping for follow-up from the clinic to review her current status and for appropriate treatment to be organised.

The Commission contacted the hospital who followed up and reported back that the clinic had contacted Ellen and the situation was resolving.

Referring back

The HCSCC is increasingly referring complaints back for direct resolution. Where there have been previous attempts to resolve, or undertakings given but not followed up, as in the case study above, Commission staff will keep the enquiry open until aware that the complaint has been resolved.

Complaints

If a concern cannot be resolved at enquiry level, it is dealt with as a complaint. Commission processes for assessing and resolving complaints have gradually changed over time so that while a formal structure is retained, staff are able to work with parties to a complaint, sometimes informally, to bring about resolution. 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.

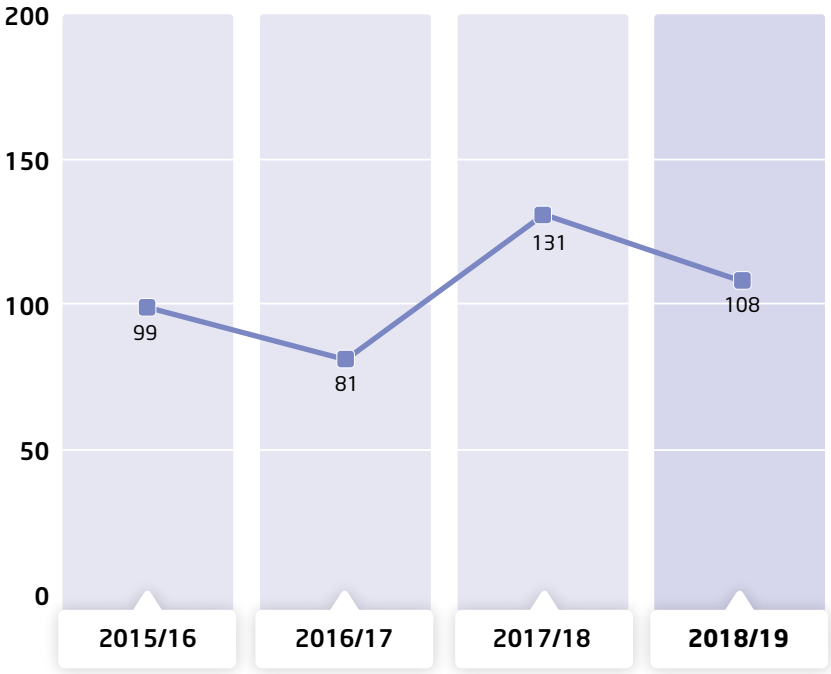
Complaints numbers each year comprise complaints received by the Commission and notifications received by AHPRA. In 2018/19, the Commission closed 207 complaints (118 received by the Commission and 89 received by AHPRA). Every complaint contains at least one complaint issue, with some large and complex complaints containing many more. The number of complaint issues will therefore always be greater than the number of complaints. In 2018/19, outcomes were recorded for 404 issues in the 207 matters finalised. This is considerably less than the 602 issues assessed in 2017/18. This may reflect a focus in 2018/19 in reducing the number of issues assessed to ensure that the primary concerns of the complainant are given sufficient weight in the complaints process.

Improved Timelines

Priorities identified for 2018/19 include improving consistency of complaints handling practice between Commission staff, primarily by using meetings, case examples and developing resources as mechanisms to achieve this goal. Workload is a key reason for an increase in the time taken to assess complaints, and the Commission expected these to blow out further in 2018/19 due to the loss of the seconded TEHS clinician in February 2019.

The reduction in time taken to finalise complaints in comparison to 2017/18 demonstrates the success of measures, which include weekly reporting and increased scrutiny during fortnightly file meetings. 86% of complaints were closed within 180 days. The Commission exceeded its KPI of 80% complaints closed in this period.

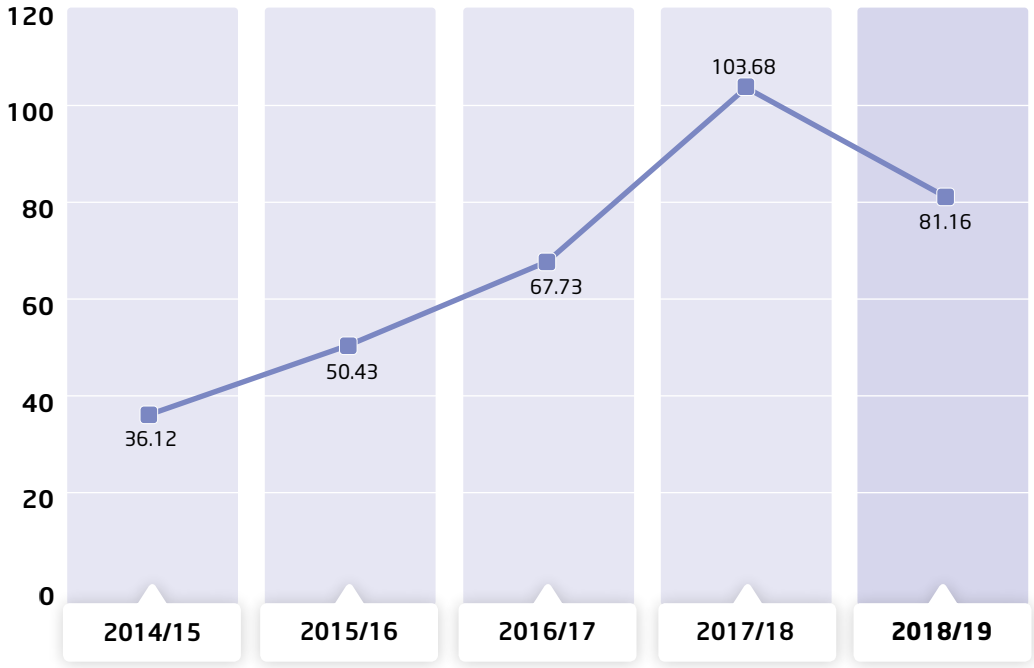
Figure 5: Time taken to finalise complaints (average days) 2015/16 - 2018/19 [1]

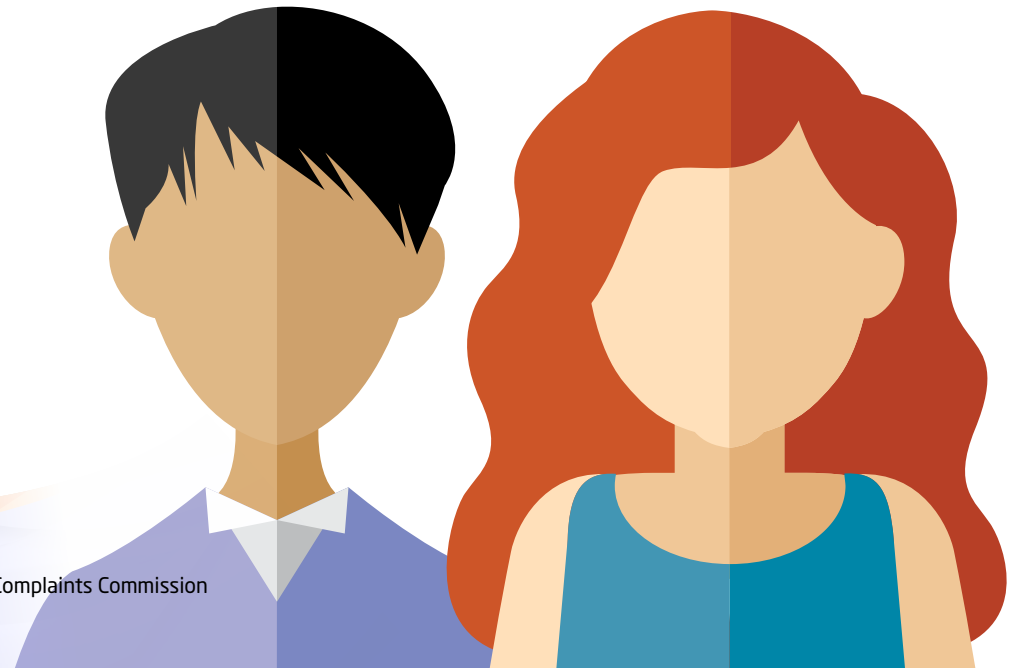


1 2016/17 was reported incorrectly in 2016/17 and 2017/18 as 99 days (AHPRA data was excluded). Timeframes for closing complaints refers to complaints received by HCSCC and notifications in HCSCC jurisdiction received by AHPRA.

Similarly, in 2018/19 64% complaints were assessed within 60 days as required by section 27(1) of the Act. This fell well below the Commission's KPI of 80%, but was an improvement on the previous year. Despite this improvement, ***Figure 6*** below demonstrates an increasing trend in the time taken to assess complaints. This reflects the gap between resourcing and workload.

Figure 6: Time taken to assess complaints (average days) 2014/15 - 2018/19





The case study below details the factors which can impinge on timeliness. They include complexities in the complaint itself and complexities which arise during the assessment of a complaint (for example, in the case study below, the need to address issues about a registered provider not pertinent at the outset). There are often delays over Christmas when organisations (including the Commission) are short staffed. Aboriginal Legal Aid organisations prefer to speak to their clients face to face, and it is not unusual to wait for months for a response from the complainant as many communities are only visited every three months. As long as the Commission is informed, there is no issue with providing an extension for this purpose. Finally, in the case below, there were further delays as this complaint seemed suitable for conciliation. The complainant was however seeking nominal damages, and the Commission was waiting for definitive information from the Department of Health as to whether it was prepared to discuss compensation or the reasons for its refusal at a conciliation conference.

Case Example 6 - 418 days in assessment

Case example 2 details a complaint from Brian about attempts to transfer him to hospital via NT Correctional Services and Prison Health. This matter was in assessment for 418 days.

Two responses were required from the Department of Health because the first response could not be used to assess the complaint due to errors, which were later acknowledged. In addition to the 28 days routinely given for a provider to respond to a complaint, DoH required an additional total 127 days for its two responses. A further 22-day delay occurred while waiting to hear whether DoH would agree to a discussion of the complainant's request for nominal damages. In addition to the delays in responses from DoH, there were delays of 144 days waiting for a response from the Legal Aid service. The Commission was responsible for a further 77 days delay, including 55 days to prepare the assessment report and the Commissioner to make a decision.

Commissioner's decision

Section 27 of the *Health and Community Services Complaints Act*, requires the Commissioner to make one of four decisions after assessing a complaint. The Commissioner can refer a matter to conciliation, refer a registered provider to a National Registration Board, take no further action under section 30 of the Act or investigate the complaint. If a matter is not suitable for conciliation and if there is no registered provider (or if a complaint about a registered provider was referred to AHPRA for assessment during weekly consultation), the Commissioner is left with two options; refer the matter to investigation or take no further action. A matter is referred to investigation only if it meets requirements set out in section 48 of the Act; that is if there appears to be a significant issue of public health or safety or public interest; or a significant question as to the practices and procedures of a service provider. Investigations are resource intensive, and for this reason, a very small proportion of matters are managed this way.

The Commissioner consistently decides to take no further action with approximately 60% of complaint issues. In 2018/19, the Commissioner decided to take no further action with 77% of complaint issues[2], compared with the 69% recorded in 2017/18. There are two primary reasons for this increase. Firstly, fewer matters (and hence fewer issues) are referred to conciliation primarily due to the Department of Health's policy of not conciliating matters involving compensation. When this is no longer an option, the Commissioner's decision-making is limited which results in a greater proportion of no further action decisions. Secondly, the focus on complaints resolution has led to more matters being closed because they are resolved. In 2018/19, 36% of matters closed with no further action were closed because they were resolved, compared with 29% in 2017/18.

Table 4: Reasons for closure - Issues closed 2017/18 - 2018/19

Reason for closure	2017/18	2018/19
Conciliation complete	44	20
Dealt with by Board	117	118
Investigation complete	31	16
Referred to Board	72	25
No further action	333	220
Referred to other entity	5	5
Total	**602**	**404**

2 Calculated after removing 118 issues from AHPRA Notifications dealt with by the relevant Board and not assessed by Commission.

Table 5 below demonstrates that while the number of complaint issues resolved in 2017/18 was consistent with the previous year, the proportion of issues resolved in relation to all issues closed increased.

Table 5: Reason for no further action - Issues closed 2017/18 - 2018/19

Reason for no further action	2017/18	2018/19
No basis for complaint /Out of Jurisdiction	20	15
Complaint over 2 years old	2	1
Failure to reasonably resolve with provider	1	2
Further investigation unnecessary and/or unjustified	164	77
Complaint lacks substance		3
Frivolous/vexatious		
Complaint is resolved	97	80
Complaint determined by a court, tribunal or board	4	3
Civil proceedings commenced		
Required information not received	14	17
Complaint has been withdrawn	31	22
Total	**333**	**220**

Case examples – complaint outcomes

Case Example 7 – Complaint referred back for direct resolution

Frank was transferred to a major acute hospital for treatment not available in his local hospital. Despite being transferred as a patient, he was made to wait for some time in the Emergency Department (ED). He complained about the way one of the nurses spoke to him while he was in ED, as well as the fact that he was in a lot of pain. A complaint was sent to the Patient Advocate and to the Commission at the same time.

The Commission contacted Frank who agreed to give the hospital the opportunity to resolve the complaint directly with him. It was further agreed that the Commission would keep the complaint open to monitor it.

The hospital contacted Frank and talked to him about the specific issues in his complaint. Relevant senior staff contacted Frank about his complaint, including the ward manager and the pharmacist.

Frank told the Commission that he was really happy with progress resolving his complaint, but there were two issues that had not been fully addressed. Commission staff emailed the hospital and later Frank advised that his complaint was fully resolved.

The Commission has found that a service provider is unlikely to resolve a complaint unless one of its staff speaks to the person with the complaint in order to know exactly what the complaint is about. Once the issues are clear, they can be addressed systematically. The Commission will continue to monitor some complaints referred back for direct resolution until it is satisfied that service providers routinely speak to the person with the complaint to clarify the complaint.

The case examples below depict the types of complaints received by the Commission, and the actions taken in response to them.

Case example 8 is a matter which was resolved in assessment when the Commissioner organised a meeting between the person making a complaint and the service provider.

Resolving a complaint requires goodwill on the part of the complainant and service provider. The complaint in ***Case Example 9*** was initially referred back for direct resolution after initial consultation with AHPRA. It was not resolved, and because the complaint involved a registered provider, once it returned to the Commission, section 68 of the Act required that the Commission consult with AHPRA to determine the agency best suited to manage the complaint. The matter was referred to AHPRA as it concerned the clinical practice of the provider.

Case Example 8 - Explanation resolved complaint in assessment

Gina contacted the Commission after her brother Jorge died in hospital. Gina (who was her brother's next of kin) had been visiting him and thought he was getting better, however when she went to the hospital to pick him up to take him home, he was very sick. He died a few days later. Gina's first language is not English, and she did not understand what had happened.

The staff member who managed this complaint was a nurse who had been seconded from the Top End Health Service to work with the Commission. She reviewed the medical record, and could see that Jorge had been very sick from the time he was admitted to hospital. The problem was that Gina did not understand this, because no-one had spoken to her with an interpreter present. The Commission organised a meeting with a senior doctor, an interpreter and a nurse from the ward. Gina agreed that her complaint was resolved when she understood what was wrong with Jorge and why it was that he was so sick.

Case Example 9 - Referred to Dental Board

Spencer complained about his orthodontist who charged him a large sum of money for dental work. He complained to the Commission when he found out that the work had to be re-done and that this would cost him a large sum of money. Spencer hoped that his complaint would lead to an apology and a refund from the orthodontist.

The Commission consulted with the Australian Health Practitioner Regulation Agency (AHPRA) to decide which agency was better suited to handle the complaint. While the complaint was about clinical practice, it was unlikely that Spencer would achieve the outcome he sought through the AHPRA process, and it was agreed that the complaint would stay with the Commission for an attempt to resolve it. It was also agreed that the Commission would consult with AHPRA again in future if the complaint was not resolved or if major clinical concerns were raised during the Commission's assessment of the complaint.

Resolution may have involved an explanation of what happened and the reasons for a second orthodontist assessing that Spencer would need new dental work. However, the response indicated that there would be no attempt to resolve the matter. As it would be unlikely that resolution could be achieved, the complaint was referred to AHPRA for assessment of clinical practice.

Case examples 8 and ***10*** show what can happen when a person whose first language is not English experiences serious health issues and an interpreter is not used. In 2018/19, the Commission closed an investigation into the use of interpreters as it potentially duplicated the findings of an investigation conducted by the NT Ombudsman[3]. The Commission will remain vigilant about this issue.

Case Example 10 - Interpreter not used

Mohammed is from an overseas country, and has lived and worked in Australia for over 10 years. He had complex and high risk surgery with several weeks in hospital to recover. Mohammed expected that he would be much better after the surgery but this is not what happened. He complained to the Commission that something had gone wrong during the operation and the doctors had not told him what had happened. He said the doctors had given him wrong information before the operation and he had not consented to what they had undertaken. He also said that the aftercare had not helped him at all.

In the assessment of the complaint, it became apparent that there were no problems with the medical care Mohammed received. While the operation had not led to significant improvement of his pre-existing condition, it had prevented further deterioration. This was not an unexpected outcome. It also showed that Mohammed's expectations of the surgery had been unrealistic.

When speaking to Mohammed, the Commission noted from the start that while Mohammed speaks English reasonably well in every-day life and gets by in his workplace, more complex topics are hard for him to understand or express in English. Commission staff used interpreters during face-to-face meetings and phone conversations.

It became clear that Mohammed had not understood many of the details the treatment teams had discussed with him before and after his operation and when he was receiving further treatment. He did not understand the consent papers he had signed. This happened because health service staff overestimated Mohammed's English skills. Mohammed himself had never used an interpreter before and did not think that he needed one. After using an interpreter with Commission though, he realised that it was very useful and he could participate more fully in the conversations.

This issue was discussed with the service and the service made great efforts to ensure that Mohammed would understand the explanation they were giving in their response to the complaint. The written response was in plain English and easy to understand. It explained the details of Mohammed's complex treatment well and cleared up misunderstandings which had happened because no interpreter had been used during his stay in the hospital. They also offered a meeting in which the consultants explained through an interpreter what had happened and answered questions that Mohammed still had.

3 http://www.ombudsman.nt.gov.au/sites/default/files/downloads/interpreter_services_investigation_report.pdf

When writing to the health service to advise of the decision to take no further action with Mohammed's complaint, the Commissioner commented on the impact of the service's failure to use an interpreter. Excerpts from the Commissioner's comments are below:

In August 2018, the NT Ombudsman published a report (the Ombudsman's report) on *"Strangers in their own land. The use of Aboriginal Interpreters by NT public authorities"*. It states (p.14) that many of the findings are transferable to other Territorians requiring interpreters. Many of the difficulties Mohammed experienced are described in this report.

In its response, the service stated that none of its staff thought that Mohammed needed an interpreter; that clinicians make judgements based on a range of factors, which include the patient's prior medical knowledge, presence of support persons and educational level. However, I remain unconvinced that the decision not to work with an interpreter was appropriate and reflected Mohammed's English proficiency accurately.

The Ombudsman's report lists obtaining consent for medical procedures as one of the situations, in which "there is an indisputable requirement for an interpreter" (p.3). Furthermore, services must guard against the overestimation of English proficiency. Amongst the frequently occurring circumstances leading to this are clients overstating their proficiency, often due to an eagerness to please the officers and not wanting to be seen as poorly educated or unintelligent (p.4).

In the Commission's discussions with Mohammed assisted by an interpreter, it became apparent that this was the case for him. He comes from a cultural background in which authorities are highly respected.

The Ombudsman's report further states that officers frequently overestimate a client's proficiency when they are able to have a reasonable conversation with them about basic content. "However, when faced with unfamiliar and complex situations the client may find they are out of their depth without this becoming immediately apparent to the officer." (p.4).

I have no doubt that this was the case in staff's interactions with Mohammed. Because he has been in Australia for many years, he generally appears confident and readily engages in conversation, it is easy to overestimate his proficiency. When discussing complex matters with him it is apparent that his understanding and capacity to express himself are very limited. At the time of his admission, Mohammed had no experience using an interpreter and was not aware of their value.

The Ombudsman's report states, "the fundamental obligation to ensure effective communication rests with the agency." (p.5).

The need for an interpreter was only identified at the end of Mohammed's admission. Mohammed repeatedly drew conclusions about his health based on incomplete or incorrectly understood information. A person who does not fully understand the language spoken to them cannot 'know what they don't know'. For a long time during the assessment of the complaint, Mohammed remained adamant that he was given incorrect information about his operation, that the operation undertaken was the wrong one and he had not consented to it. It was only later that he realised that he obviously did not understand everything that was said to him. This was a difficult realisation.

Consult weekly with AHPRA

Section 68 of the Act states that if the Commission receives a complaint about someone classified as one of the health professions which comprise registered providers, the Commissioner must notify the relevant Board as soon as practicable after the complaint is received. Similarly, section 150(1) of the *Health Practitioner Regulation National Law Act 2009* (National Law) provides that if the subject matter of a notification received by AHPRA falls within the jurisdiction of the local health complaints entity, the National Board must notify the health complaints entity accordingly.

The requirements of these two pieces of legislation are met through weekly consultation meetings between the Deputy Commissioner of the Commission and the Director of Notifications at AHPRA. At these meetings, a joint decision is made regarding the agency best suited to manage complaints and notifications about registered providers.

As a result of these consultations, the Commission referred complaints about registered providers to the relevant Board for assessment of 25 issues raised in 17 complaints in 2018/19.

Notifications received by AHPRA may be also be referred to the Commission for management. In 2018/19, this occurred on seven occasions when the complaint was about low risk behaviour and the outcomes sought could be better achieved in the Commission's jurisdiction. ***Case example 11*** below is typical of a number of matters managed by the Commission.

Case Example 11 - AHPRA notifications referred to the Commission

Jackson contacted AHPRA complaining that he had made an on-line booking to see his GP. He had several health issues he wished to discuss during that appointment, however when he arrived, the GP said that she could only attend to two of those issues due to the time available to her. The complaint was resolved with an apology and an explanation. The GP practice also changed its on-line booking system to enable patients to book a long consultation.

Conciliations

One option available to the Commission to assist parties resolve complaints is conciliation. Conciliation is a form of alternative 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. Its purpose is to act as an alternative to medico-legal processes, often resulting in explanations 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 2018/19, eight conciliations were closed, seven of which were resolved during conciliation. The number of matters being resolved via conciliation is likely to remain static as the Department of Health is not willing to discuss compensation at conciliation and will only manage matters where compensation is sought as an outcome (including those which will never result in payment) through legal processes. Accordingly, the Commission refers any complainant who is seeking compensation as an outcome of their complaint for legal advice from the outset.

Case Example 12 - Complaint resolved at conciliation

Larry went to a remote health clinic after an episode of reduced consciousness at home. A nurse took a history and sought input from an on-call doctor and then referred Larry to the local hospital for follow up and review. The doctor who reviewed Larry at the hospital recommended cancellation of his driver's licence based partly on the nurse's records which Larry said were inaccurate. Larry also complained that the hospital did not arrange a review by a specialist even though the doctor said she would arrange this.

In its initial response to the complaint, the service provided explanations about a range of matters, including the basis of the diagnosis which led to the loss of Larry's licence. The service apologised for not arranging for the specialist review and explained that this was being followed up. Larry indicated that there were a range of aspects of the complaint which he did not think had been adequately addressed, so with agreement of the parties, the matter was referred to conciliation.

Larry described his experiences to service management in a conciliation conference. Detailed discussion took place relating to a range of aspects of service provision. Larry was satisfied that his concerns were taken on board by the service and it was agreed that the complaint was resolved.

Investigations

Four investigations completed in 2018/19

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. 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 and the Commission 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.

In 2018/19, the Commission finalised four investigations. By the time this Annual Report is finalised, four further investigations will have been completed, two are in draft form and five others are well underway to completion.

Case example 13 details an investigation into rights issues for people with mental illness who are being held involuntarily and who are subject to Tribunal Hearing.

Case Example 13 - Access to reports before the Mental Health Review Tribunal

The Mental Health and Related Services Act (MHRSA) requires that the Mental Health Review Tribunal (the Tribunal) review the detention of a person held involuntarily in a mental health facility within two weeks of that detention taking place. If the service wishes to extend the period of involuntary detention, the psychiatrist must prepare a report for the Tribunal, which sets out the request and the reason for it.

The MHRSA also requires that except in certain circumstances (such as if it poses a risk) a copy of the report is to be provided to the person being involuntarily detained. It is not clear however, who is responsible for making sure that this occurs.

The process has always been that the reports are completed by practitioners, forwarded to the Tribunal and the Tribunal then provides a copy to the lawyer who will be representing the person during the Tribunal hearing. The lawyer will then talk to the client. The Commission was informed that it is not unusual for the client not to be aware that there will be a hearing, nor to be aware of the reasons for that hearing. It is often the case that clients will not know of the orders, or the length of the orders being sought by the treating team.

In response to the draft investigation report, the mental health service has agreed to recommendations which require the service to provide a copy of reports prepared for the Tribunal to the person prior to the hearing and to discuss the report and its contents with clients. These recommendations will be monitored throughout 2019/20.

In 2018/19, the Commission also finalised two investigations involving allegations that a disability support worker had assaulted a client. The first of these (***case example 14***) was a major piece of work, which commenced in 2017/18 and involved comprehensive review of the service provided to six individual clients. It resulted in 22 recommendations which are being monitored by the Commission.

Case Example 14 - Investigation of disability service provider

After assessing a complaint which alleged that a person with a disability had been abused by a staff member, the Commissioner also decided to investigate the quality of planning; the provision of supervision and support; staff training; and adequacy of incident reporting and complaints management. No findings were made in relation to the allegations of abuse on the basis that there was insufficient evidence. In relation to the remaining issues, the Commissioner stated:

"This investigation has revealed an organisation which has struggled to provide a quality service to people with disability who have compounding complex health conditions. The complexities inherent in attempting to provide a service in a remote town in the Northern Territory where there is a thin market of service providers, with a small and shifting population from which to draw staff cannot be under-estimated."

The Commissioner then set out a road map for the next twelve months to enable the service provider to achieve necessary service improvements. The Commissioner stated:

"It is highly recommended that [the service] begin by dealing with the safety and health issues that have been raised by this investigation. A risk management plan addressing all matters raised with this report must be developed and implemented urgently.

"Immediate work should include changes to the way in which the administration of medication is managed by [the service], with training or refresher training being provided to all staff members. A health folder should be developed for each participant that contains all documentation related to health, including charts that assist in the management of health requirements, for example seizure record charts and fluid intake. In addition, policies, procedures and practices that relate to health and medication should be reviewed. Once this is complete, [the service] should focus on ensuring that a health plan is developed for each participant in consultation with health practitioners, guardians and significant others. This health plan will form part of the sub-plans for each participant's person-centred plan once they are in place.

"Deficiencies in planning lie at the heart of the complaints, which led to this investigation. Each plan should be reviewed over the next twelve months using a revised template and planning process. Participants, their families and guardians must be genuine partners in the development of the person-centred plan. The goals in the person-centred plan should generate plans to assist participants achieve their goals, learn independent living skills and engage with work, family and community.

"Competent review of progress achieving the goals set out in the plan, along with a review of the effectiveness of strategies designed to achieve those goals will mean that the person-centred plan can act as a platform for the next NDIS plan review.

"[The service's] induction introduces the concept of person-centred practice. It may be helpful to augment the online training with on-site training as this lies at the core of good practice. Further training in a person-centred approach should result in workers attempting to see the world from the view of the participants with whom they are working. This approach, along with enhanced cultural competency training, should lead to a change in practice so that, for example, interpreters are used routinely and participants engage in cultural activities with their community.

"Finally, [the service] must work with guardians to improve communication. No agreement can legally be made with a participant under guardianship, and guardians must urgently be provided with copies of the Service Agreements, and processes put in place so that the guardian is genuinely involved in the development of participant plans."

Person-centred complaints management in practice

When closing a complaint, the Commission surveys all parties (with the exception of DoH, TEHS and CAHS) to the complaint by post or email. In 2018/19, responses were received from 19 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.

Survey outcomes consistently demonstrate a high-level complainant and provider satisfaction with interactions with Commission staff. This was irrespective of satisfaction with the outcome of the complaint.

Table 6: Survey responses 2018/19

Survey statements	Complainant	Provider
Commission staff were polite	4.72	4.21
Commission staff listened to what I had to say	4.72	3.93
Commission staff understood what I had to say	4.61	3.79
Commission staff kept me informed of the progress of the complaint	4.44	4.14
Commission staff responded promptly to my enquiries	4.28	4.29
I had a clear understanding of what I could reasonably expect from making my complaint	4.17	N/A
The Commission officer explained the complaint process so I understood the next steps	4.28	N/A
I could understand letters and emails sent by the Commission	4.39	4.43
I could understand information given over the phone	4.44	4.43
My views were taken seriously	4.17	3.93
I understand the reasons for the decision	3.61	3.71
The decisions took all available information into account	3.33	3.61
The decisions took all points of view into account	3.33	3.57
The length of time to finalise the complaint was reasonable	3.39	3.71
I am satisfied with the way the complaint was handled	3.89	3.64
I am satisfied with the outcome of the complaint	3.00	3.93
I would use the Commission's services again	4.00	3.86

As stated in previous Annual Reports, while a reasonable response rate is received to the survey, it is apparent that participants are most likely to be those people who are either very satisfied with the Commission's complaints process or very dissatisfied. This reaction to the complaints process and outcome is reflected in the cross-section of feedback from complainants and providers. Irrespective of their satisfaction with complaint outcome, those responding to the survey rate their interactions with staff as 'good' to 'very good'.

Comments received from complainants and service providers throughout the year include:

- *I was impressed by the professionalism and willingness to listen to all parties.*
- *I found that I knew very little about this complaints service when I first approached the organisation. I was given information at each and every step and phone call conversations were "backed up" by emails. This gave the opportunity for both parties to easily reach agreement on the content and the interpretation and meanings of the conversations. Time consuming, I know, but very necessary. Was very impressed.*
- *I have dealt with the Commission multiple times over the years and generally have found the Commission to be a balanced arbitor of issues raised. Whilst I have not always agreed with methodology over all I have found matters dealt with fairly and reasonably. On this occasion however, for reasons that remain unclear, I found there was an absolute bias in favour of the complainant and another service provider's evidence and a total lack of willingness to accept any of the information provided from our service as factual and truthful. The process was unreasonably drawn and the outcome, in my view, unfair.*
- *A detailed investigation should take place into the service provider as they have falsified medical documentation into the service they did not provide.*
- *My initial complaint to [...] Hospital was treated with mild contempt and the process of lodging a complaint was a joke. There are so many hoops to jump through and for most people this would be extremely intimidating. The officer who finally dealt with me was amazing. She was professional, realistic in expected outcomes and efficient.*
- *Your service is exceptional, no real scope for improvement.*
- *The Commission and Staff worked professionally and appropriately with our Indigenous client, and provided flexible timeframes to accommodate our client's logistical realities...*
- *Thanks for all your assistance through this - you've been great and informative to work with. All you've helped with and the information you have provided has been well received and appreciated.*
- *Happy to fill out survey my interactions with the HCSCC was less daunting than I had imagined due largely to the very helpful [...]. [She] was polite, professional, supportive and fair and made the whole complaint process feel like a beneficial experience I think for both parties though I can only speak for myself.*
- *I would like to thank you and your Department and the Commissioner for getting me satisfaction: a full apology from [...] Hospital. I can now put the matter to bed, hoping it won't happen to some other old veteran, such as myself.*

Policy role

National Code of Conduct for unregistered health practitioners

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 to 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. A Code regime has been implemented in Queensland, New South Wales, Victoria and South Australia.

On 30 July 2015, the Health Workforce Principal Committee agreed for Victoria to take the lead in coordinating the implementation of the aspects of the National Code regime, which require coordinated national action. These include:

- a common web portal for the National Register of prohibition orders;
- nationally consistent explanatory materials;
- a common framework for data collection and reporting;
- annual performance reporting to Ministers; and
- policy resources to assist jurisdictions implementing a code regime for the first time.

Over the last four years, the Commission has engaged with interstate health complaint entities to further this work with decisions made as to a common framework for data collection and reporting. Consultation is complete.

In 2018/19, the Commission continued to work with a Senior Policy Officer from the Department of Health on drafting instructions for changes to legislation. An issues list generated from the common framework for data collection and reporting was placed on the complaints database system on a trial basis. The Commission reviewed the list's effectiveness as a reporting mechanism, simplified, and updated it to allow for reporting once the National Code regime is implemented in the NT.

THE YEAR AHEAD: 2019/20

The team meets annually to decide on priorities for the upcoming year within the constraints of the Strategic Plan. Factors which determine priorities for the coming year include the core business of the Commission and outcomes of the Commission's performance indicators, feedback from parties to complaints managed by the Commission and the policy environment in which the Commission operates.

Improve complaints handling practice

In 2018/19, the Commission decided to improve its investigations by focussing on small, single-issue investigations. While only four investigations were finalised in 2018/19, this policy, along with a focus on ensuring investigations are completed, will mean that at least double this number will be finalised in 2019/20.

The Commission also planned to update the investigations section in the Policy and Procedures Manual in 2018/19. This was not complete, however it remains a focus for 2019/20. Two staff completed a Certificate IV in Investigations in 2018/19, and will use the skills gained through that course to update Commission policies.

There will be a continued focus on reducing the time taken to finalise complaints in 2019/20 including that parties respond to the Commission in a timely fashion. Delays in completing assessments and sending correspondence will be monitored in fortnightly file meetings and in quality assurance audits when files are closed.

In 2018/19, the delegations of Senior Investigation Officers were expanded to enable them to make a decision to take no further action in accordance with section 30 of the Act. Further changes to processes in 2019/20 will ensure that a colleague will also be responsible for undertaking quality assurance audit reviews on decisions and correspondence. This peer process should improve the consistency of decision-making between Commission staff.

Policy environment

Safeguards for people with disability

From 1 July 2019, the new Commonwealth NDIS Quality and Safeguards Commission will manage all complaints about NDIS funded services. Some functions will however remain with the Commission.

Firstly, all complaints received prior to 1 July 2019 will be finalised by this office. As at 30 June 2019, this comprised one significant complaint potentially involving unethical behaviour by a service provider. The Commissioner has decided to progress this matter to investigation. Outstanding matters also include an investigation, which will be finalised in the first quarter of 2019/20, and monitoring recommendations from two other investigations completed in 2018/19.

Secondly, any complaint about a matter, which occurred prior to 1 July 2019, will fall within the jurisdiction of this office. The time limit for matters, which the Commission can assess, is two years. It is conceivable (but not likely) that the Commission will continue to receive, complaints about NDIS funded services for the next two years.

Finally, any complaint about a disability service not funded by the NDIS will remain with the Commission. This includes services funded by agencies other than the NDIS (for example, some services being provided by Office of Disability, and others funded through Motor Vehicle Accident Compensation) as well as mainstream services that do not attract NDIS funding.

Despite this office's continued role, the key agency in Disability Complaints will be the NDIS Quality and Safeguards Commission. This organisation has extensive compliance and monitoring powers, and the interaction between its complaints and compliance arms should result in safer quality services for people with disabilities living in the NT. The Commissioner has already commenced regular meetings with the Director, NT Office and has established relationships at a national level. These will continue throughout 2019/20.

In addition, the Commission will continue to be represented on the Zero Tolerance Reference Group and will contribute to policy regarding the institution of disability advocacy services until funding for this is exhausted. The 'Talk Up!' message will remain a prominent focus for the Commission in 2019/20.

National Code of conduct for unregistered health practitioners

The National Code of conduct is operational in Queensland, New South Wales, Victoria and South Australia. Legislation has passed in the Australian Capital Territory and Tasmania. Legislative change to enable implementation of the regime has not yet been passed in Western Australia or the Northern Territory.

The Commission has worked with the Department of Health to plan how the new Code regime will be implemented via its legislation and this work is ongoing.

Chapter 3: Promote Capacity and Improve Systems

ACHIEVEMENTS 2018/19

Coaching

When approached with a complaint, the Commissioner will always determine whether the service user has made a reasonable attempt to resolve that complaint first. If not, the service user will be asked to try to resolve their complaint directly with the service provider. The Commission's experience is that people who contact the Commission with a complaint are often quite happy to try to resolve their complaint this way, but do not do so because they don't quite know how to go about it. Commission staff will coach service users in how to go about making a complaint.

Coaching is also provided to service providers at enquiry stage to assist with direct resolution of matters and when a complaint is being assessed with a view to skills learned being adaptable to future complaints. Case example 16 below is an example of coaching provided to a service user to help her resolve her complaint directly with the service provider.

Case Example 15 - Complaint resolved at conciliation

Jo, who lives independently in an Aged Care facility, had a urine test. Instead of posting the results to her, the pathology lab addressed the results to the attention of the Care Manager of the Aged Care Centre. Further, her results were placed in her mail box, and not in an envelope. Jo wrote to the Pathology service, but did not get a response. The officer at the Commission discussed with Jo how she might progress this, providing information about who she could phone and what she might say. A week later, Jo emailed the Commission saying she had done so and that her complaint was resolved.

Disability focus

The Commission has been less involved in community engagement activities throughout 2018/19 due to the increasing workload. The Commission has also lost the services of the staff member seconded from TEHS, and this has resulted in increased workload for remaining staff.

Commission staff have attended a few seminars held in 2018/19. They have also participated in the 'Zero Tolerance to Abuse and Neglect' program hosted by NDS along with the Disability Advocacy group hosted by NDS with funding from NDIS Sector Development grants.

At a policy level, the Commission has commented on proposals for the Office of the Senior Practitioner, which will be responsible for authorising restrictive practices, which must be set out in participants' Positive Behaviour Support Plans. In addition, the Commission contributed to the consultation on the *Restrictive Practices Bill*, which was subsequently passed.

Launch of TALK UP Videos

In its 2017/18 Annual Report, the Commission reported on the outcomes of the "TALK UP!" project, funded by an NDIS sector development grant. The Talk Up video, a major outcome of the project, uses a catchy rap to give information about how to go about making a complaint. It is available in English and Kriol, with a spoken section in five other Aboriginal languages.

The Minister, the Honourable Natasha Fyles MLA, launched the video at Parliament House on 27 September 2018. As can be seen from the photo, the launch was well attended by people from the disability sector. The Office of Disability provided much valued assistance with the launch, including liaising with the Minister's office; liaising with disability service providers; and providing expertise to assist with logistics on the day.

Talk Up! video launch at Parliament House on 27 September 2018.

Lisa Tiernan, who works for the Commission, made a speech in which she described her understanding of what a complaint is and how to make a complaint. Liz Keith, a senior investigation/conciliation officer worked with Lisa to write her speech. All Commission staff were with Lisa as she practised her speech several times prior to the big day. Lisa is to be congratulated on the quality of the speech that she gave before a large audience.

Bintang Daly, Administration/Resolutions Officer with the Commission, coordinated the Commission's activities for the launch including IT and was a significant contributor to its success.

Darwin's sign language choir, the Sing Song Signers performed the Talk Up song in sign language for the audience. Their involvement, aided by Rachael Kroes who teaches and leads this wonderful group of performers, was appreciated.

Lisa Tiernan giving her speech.

The Sing Song Signers language choir.

PossABILITIES Expo

Henbury School hosts an "expo" every year. The expo's purpose is to make information available to people with disability and their families, friends and guardians about disability services in the NT. These services include the Health and Community Services Complaints Commission, which plays a role in quality disability services and which promotes the rights of people receiving disability services. Commissioner Stephen Dunham is a regular attendee at the Expo and can be seen in the photo at the Expo in March 2019.

The 2019 PossABILITIES Expo at Henbury School.

Accessibility to the Commission

Table 7 below details the number of complaints received about disability services, mental health services and aged care services over the past three years. Contacts about aged services are consistently low because the Aged Care Complaints Commissioner is responsible for almost all complaints about aged care services.

The data in ***Table 8*** below demonstrates that the benefits of community engagement work undertaken in 2016/17 flowed through to 2018/19 where the number of enquiries about disability services remained very similar. This number should reduce in 2019/20 now that the NDIS Quality and Safeguards Commission is responsible for managing complaints from participants who received services from NDIS funded service providers.

Table 7: Aged and disability services complaints 2015/16 - 2018/19

Provider type	2015/16	2016/17	2017/18	2018/19
Disability services	4	8	4	8
Mental health services	3	15	16	16
Aged services	3	6	2	0
Total	**10**	**29**	**22**	**24**

Table 8: Aged and disability services enquiries 2015/16 - 2018/19

Provider type	2015/16	2016/17	2017/18	2018/19
Disability services	11	11	40	37
Mental health services	12	31	60	44
Aged services	10	7	19	9
Total	**33**	**49**	**119**	**90**

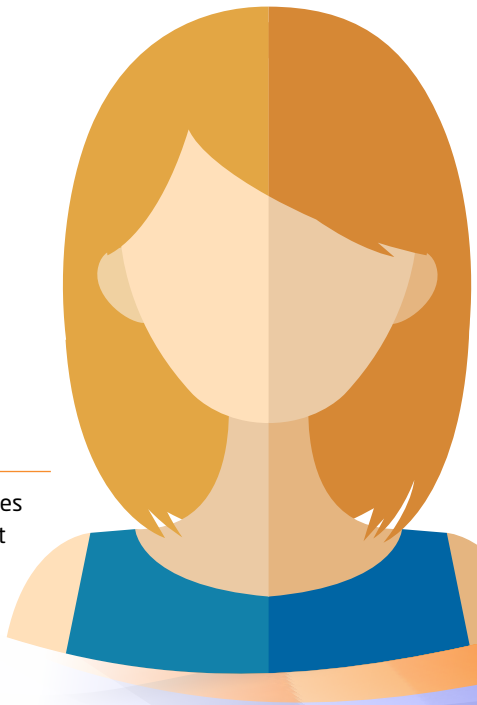
Prison Primary Health Care Service (PPHCS)

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 2018/19, 226 enquiries (including 22 enquiries about the health care service at ASCC) were received, raising 268 separate issues. Seventy enquiries comprising 87 issues were referred back to the PPHCS for direct resolution.

Table 9 below details the number of contacts from prisoners. With the return enquiries removed prisoner enquiries as a proportion of enquiries managed by the HCSCC has diminished over time and now stabilised. TEHS has now instituted a number of mechanisms to improve its complaint handling, including a nurse managing feedback from prisoners and talking to them about their issues. This should lead to a further reduction in contacts from prisoners.

Table 9: Number and proportion of enquiries about PPHCS 2013/14 - 2018/19

Year	Number[4]	Proportion of all enquiries
2013/14	146	32%
2014/15	154	38%
2015/16	149	34%
2016/17	205	36%
2017/18	137	22%
2018/19	**156**	**22%**



4 Refers to net enquiries received from PPHCS. In 2018/19, 226 enquiries were received. Of these, 70 were referred back to the PPHCS for direct resolution and subsequently contacted the HCSCC regarding the same issue. Number of PPHCS enquiries is 156 (226 - 70).

Prescribed provider reports

Providers prescribed in Schedule 7 of the Health and Community Services Complaints Regulations (the Regulations), in accordance with section 99 of the Act, are required to provide details of complaints received during the financial year. Prescribed providers for this purpose as set out in Schedule 7 of the Regulations are:

- Anyinginyi Congress Aboriginal Corporation
- Central Australian Aboriginal Congress Incorporated
- Danila Dilba Biluru Butji Binnilutlum Medical Service Aboriginal Corporation
- Miwatj Health Aboriginal Corporation
- Northern Territory Health Services
- Wurli Wurlinjang Aboriginal Health Service
- Darwin Private Hospital Pty. Ltd.

Important organisations missing from this list include the Katherine West Health Board and Sunrise Health Service. The names of organisations included in the list of prescribed providers needs updating. Northern Territory Health Services, for example, should be included as three separate entities: the Department of Health, Top End Health Service and Central Australia Health Service.

Returns for all prescribed providers were received for the 2018/19 financial year. It is difficult to collate what the complaints were about as prescribed providers have different systems for categorising data. It is therefore possible only to report on complaints received.

Table 10: Complaints received by prescribed providers 2018/19

Provider type	Number of complaints received 2018/19
Anyinginyi Health Aboriginal Corporation	**3**
Central Australian Aboriginal Congress	**44**
Central Australia Health Service	**275**
Danila Dilba Health Service	**17**
Darwin Private Hospital	**67**
Department of Health	**6**
Miwatj	**12**
Top End Health Service	**836**
Wurli Wurlinjang Aboriginal Health Service	**4**

THE YEAR AHEAD 2019/20

Maintain work with disability sector

In the coming year, the Commission will work with the NDIS Quality and Safeguards Commission to ensure that its complaint function transitions in a way that ensures that complaint services are maintained for people with a disability receiving services funded through the NDIS. It will retain its focus on trying to increase participation from the disability sector in the complaints processes, either by direct resolution or by access to a complaints body, ensuring that that will be 'no wrong door' and that any person contacting the Commission will be referred to the agency best able to manage the complaint.

Improve 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 that includes the latest Annual Report and brochures, complaints handling training, the Guide to Complaints Resolution and our legislation.

There are three major imperatives for updating the Commission's website and this will be a focus over the next two financial years. Firstly, it requires a full review of all information and secondly, it does not meet NT Government website requirements. This situation must be urgently addressed. Into the future, the Commission must be able to display information about any NT and interstate prohibition orders for unregistered health service providers, and the website will need to be updated to incorporate this function.

Update Information available on the website

Results of the survey sent to parties to complaints indicate that complainants and providers are often not satisfied with the outcome of their complaints. This may be the case for a number of reasons, including expectations about the outcomes of complaints as well as not really understanding the reasons behind the Commissioner's decisions. The HCSCC intended to update information regarding the reasons for the Commissioner's decisions in 2018/19. This was not achieved and remains on the Business Plan for 2019/20. In addition, the Commission plans to update information about all the Commission's functions, including conciliation handouts to ensure they are accurate and user friendly. In addition, information sheets will be prepared and outcome letters reviewed to ensure that reasons for decisions can be better understood.

Resolving complaints requires some skill and willingness by all parties, service providers and service users. As stated earlier in this report, Commission staff, when referring a complainant back to resolve their complaint at point of service, will when possible provide coaching to assist this process. Coaching addresses the best person to contact with their issue and how to prepare for this contact (for example, being clear about the complaint and what they hope to achieve from it). Similarly, service providers can contact the Commission for advice on how to manage existing or potential complaints.

There is already helpful information on the Commission's website to assist parties when they are making a complaint or responding to complaints. The Commission plans to review and update this information in 2019/20 as the website is updated.

Table 11: Website access 2014/15 - 2018/19

	2014/15	2015/16	2016/17	2017/18	2018/19
Total visits	4056	6185	6853	5072	**6155**

Chapter 4: Governance and 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 DoH entities) are informed in writing of the right to have the conduct of the complaint reviewed by the HCSCC Review Committee established under Section 78 of the Act.

Review Committee positions expired in March/April 2019. Ms Karyn Cook, Provider Representative and Ms Kiah Hanson, User Representative did not seek re-appointment. Their service during the three years of their appointment is acknowledged.

At 30 June 2019, the HCSCC Review Committee comprised:

Mr Andrew George
Chairperson

Dr Joanne Seiler
Provider Representative

Ms Susan Burns
Provider Representative

Mr Robert Kendrick
User Representative

Mr Mark Coffey
User Representative

There were no requests for a review in 2018/19.

ACHIEVEMENTS 2018/19

Evaluate the clinical position

An officer from TEHS was seconded to the Commission from February 2017 in what was to be an ongoing arrangement. The seconded officer would return to TEHS so that expertise gained through working in the Commission could be brought back to TEHS. Ms Robynne Lower was selected as the first person seconded, adding valuable clinical expertise to the complaints handling team until she resigned in February 2019.

The effectiveness of the clinical position role was evaluated using primarily qualitative methods, interviewing Ms Lower, the TEHS Consumer Feedback Coordinator, the Commissioner and a staff member of the Commission. The Deputy Commissioner also conducted a focus group with the Commission's complaints management team. Qualitative data was supplemented by quantitative date collected via the complaints database maintained by the Commission.

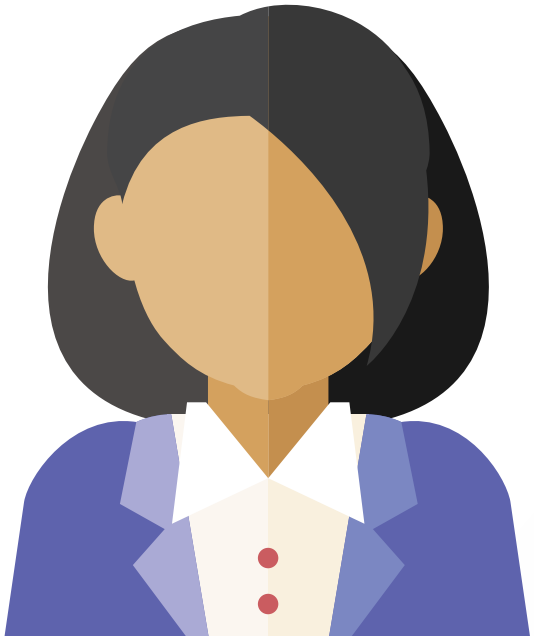
The evaluation found that the aims of the project, while clear to the Commissioner, his staff and Ms Lower were not equally clear to TEHS. The implementation of the project was ad hoc in that there was no pathway for the TEHS staff member involved in the project back to TEHS. As a result, the Commission was the major beneficiary of the project, gaining an additional staff member with a range of skills relevant to the role and adding a clinical focus to the Commission. TEHS received benefit via matters being resolved at a lower level due to the clinical knowledge available within the team, and improved Commission staff understanding of the experience of individual providers named in a complaint. It was recommended that the project continue, but before proceeding, project goals should be clearly agreed between TEHS and the Commission. Planning should ensure from the outset an evaluation framework, a clear

strategy in line with project goals to ensure that TEHS and the Commission benefit equally from the project and a pathway back to TEHS for the incumbent on completion of the rotation in the Commission.

The Commission is a paper free office

Complaints management at the Commission has been paper free since 1 July 2016. The Commission had planned to be entirely paper free from 1 July 2018, however given the workload of the Commission, along with delays in finalising the Business Classification Scheme for TRIM, this initiative was deferred.

The Commission has now achieved its goal of being entirely paper-free. All documentation received by the Commission has been categorised and classified according to the NT Government's Business Classification Scheme and related disposal schedules. Training in the use of HP Records Management has now been provided to all staff, with further training planned on an 'as needs' basis. In 2019/20, existing hardcopy files will be either stored or disposed of according to the type of file involved and business rules will be developed for naming and storing of all documentation. The Commission is grateful to the Records Management Team in the Department of the Attorney General and Justice for their help and their availability to answer questions and provide much needed advice along the way.



THE YEAR AHEAD 2019/20

KPIs are meaningful

The Commission's KPIs used for Estimates have been amended. The original intention was that the number of complaints and enquiries closed during a given period would be reported as a number and proportion of complaints and enquiries received during that period. In 2018/19, the KPI would be reported as:

Number of complaints and enquiries closed and as a proportion of complaints and enquiries received 2018/19: 909 (98%).

The intention was that this measure would detail work completed during the period, along with a measure of how the Commission is managing its workload. Unfortunately, this has been altered to read: Complaints and enquiries closed 98%. This is a meaningless measure, which the Commission has been trying to amend with little success.

The Commission remains a learning organisation

The Commission offers a quality service by ensuring that staff are properly trained, that they provide a consistent service that is courteous and empathetic to all parties.

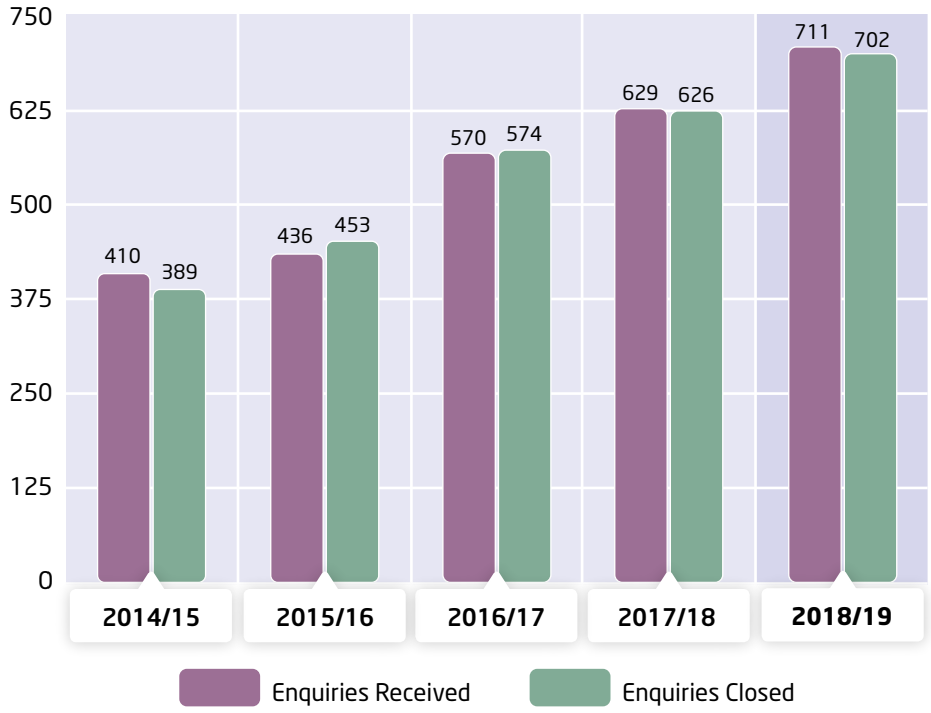
In 2019/20, all staff will benefit from a performance evaluation review which will set work goals for 2019/20 as well as identifying development needs and the training to be provided. In addition, Friday afternoons are set aside for professional development, which includes monthly meetings to evaluate performance, to learn from each other and to invite speakers to the Commission for mutual professional development opportunities.

Appendix 1: Performance

Enquiries/informal complaints

In 2018/19, the Commission received 711 enquiries and closed 702. This is the highest number of enquiries received and closed in the Commission's history.

Figure 7: Enquiries received and closed 2014/15 - 2018/19



Although the majority of enquiries do not become formal complaints, they represent a substantial proportion of the Commission's workload.

Public providers accounted for 73% of the providers about whom enquiries were received in 2018/19, roughly equivalent to the proportion in previous years.

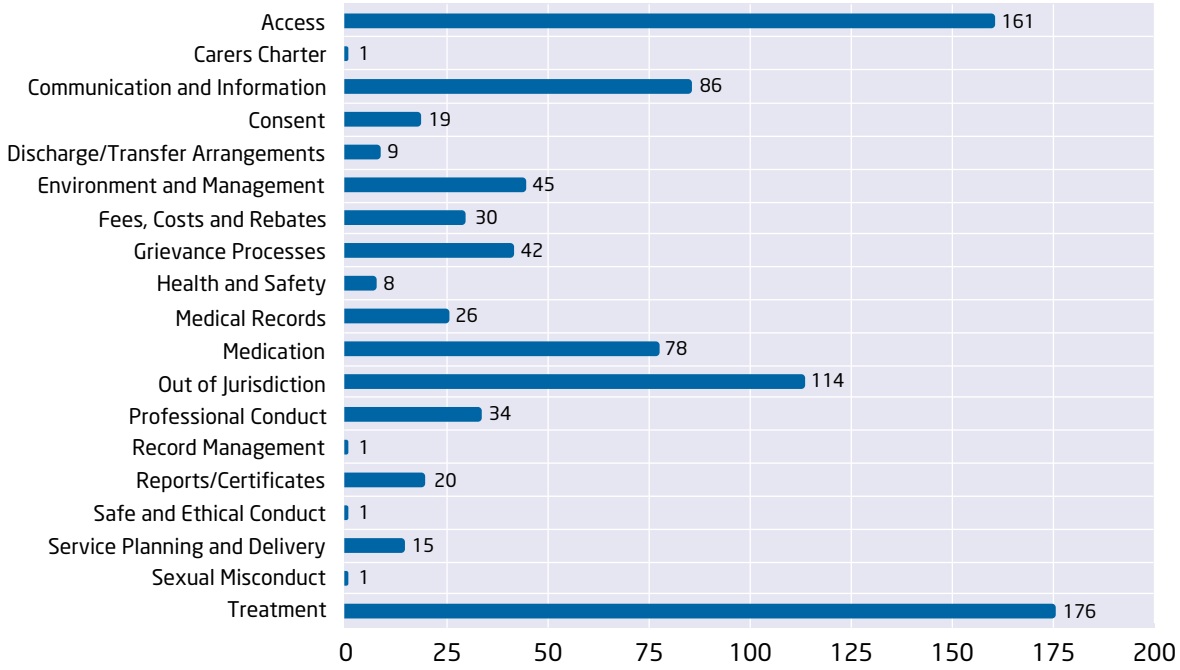
Table 12: Providers subject of enquiries 2014/15 - 2018/19

Providers	2014/15	2015/16	2016/17	2017/18	2018/19
Private	95	75	131	184	208
Public	315	381	464	495	559
Total	**410**	**456**	**595**	**679**	**767**

Issues raised in enquiries

Often more than one issue is raised per enquiry, 867 issues were dealt with when assisting with the 711 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. One hundred and fourteen (114) issues were out of jurisdiction. Out of jurisdiction enquiries include contacts from prisoners where it is assessed that primary responsibility lies with NTCS rather than health (in which case the enquirer is referred to the Ombudsman), and enquiries about environmental health issues and people seeking general information. The Commission has a 'no wrong door' policy, and ensures that every enquiry receives some consideration, ensuring that the caller is provided with the information needed.

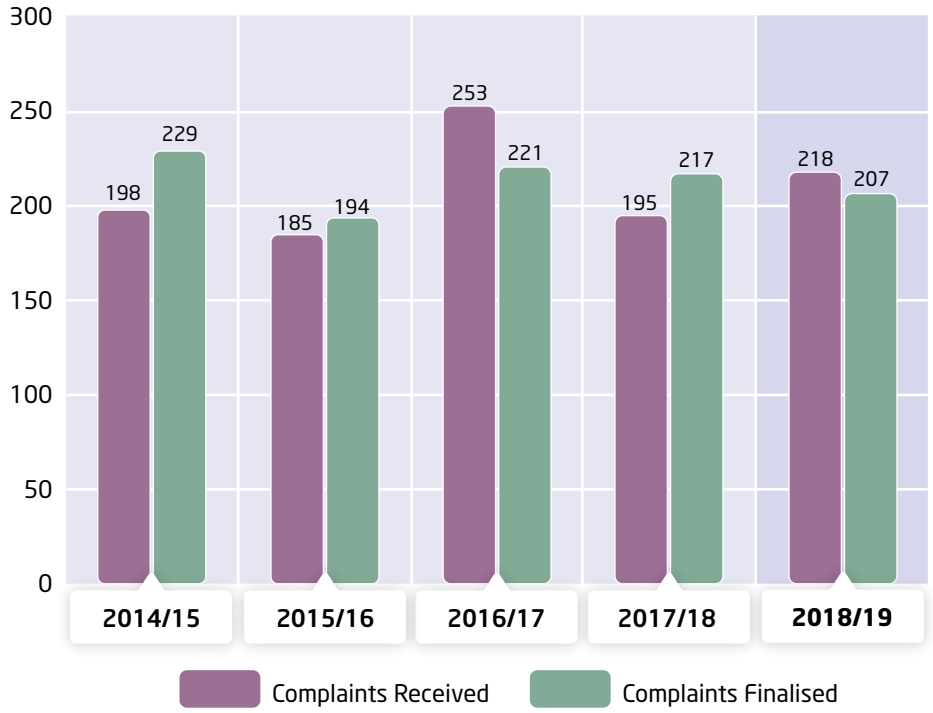
Figure 8: Issues raised in enquiries closed 2018/19



Complaints

Two hundred and eighteen (218) new complaints were received in 2018/19, representing a 12% increase on the number received in the previous year. As can be seen from Figure 6 below, the number of complaints handled by the Commission has remained relatively static since 2015/16. This should be viewed in the context of a significant increase in the number of matters handled by the Commission year on year (929 in 2018/19 compared with 621 in 2015/16; an increase of 50%). In 2018/19, 207 complaints were finalised.

Figure 9: Complaints received and closed 2015/16 - 2018/19



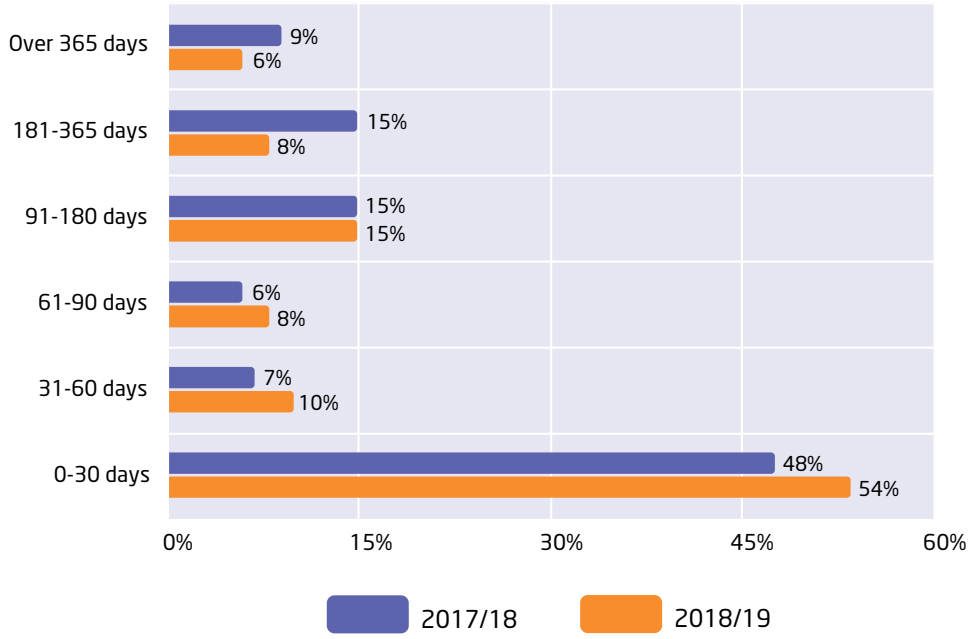
Time taken to finalise complaints

The average time taken to finalise complaints[5] (where complaints include complaints received by the Commission and notifications received by AHPRA subject to consultation with Commission) decreased from an average 131 days in 2017/18 to 108 days in 2018/19. This decrease may be due to fewer long-standing matters such as investigations being completed, and so may not be significant.

The Commission has focussed on improving timelines for complaints resolved in assessment. There has been some success in 2018/19 as demonstrated in the figure below. Internal factors, which include Commission resources influence timelines. External factors include timeliness of providers responding to complaints, the ability to contact complainants easily (i.e. some live remotely and others may be travelling).

5 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.

Figure 10: Percentage complaints closed and timeframes 2017/18 and 2018/19

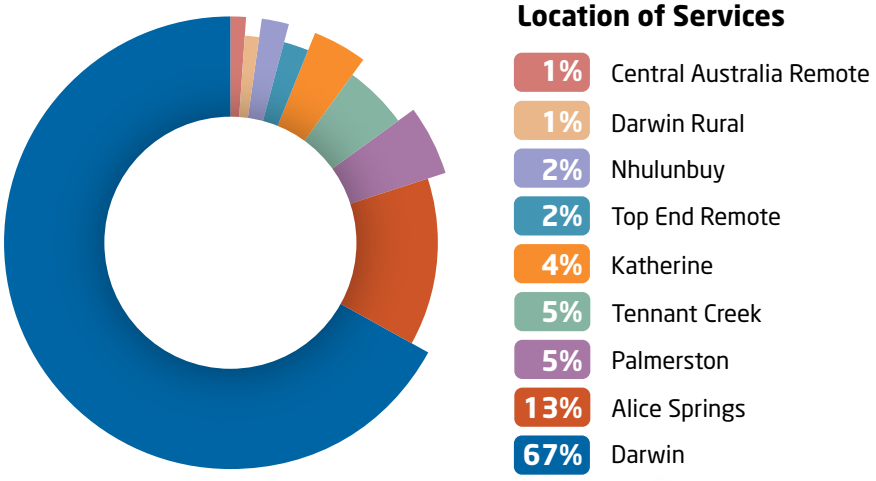


In 2018/19, 87% of complaints were closed within 180 days. The benchmark for closure within 180 days is 80%.

Location of services complained about

As expected, the majority of services subject to a complaint are located in the greater Darwin area (73%). There is a slight increase in complaints received about services in Alice Springs in 2017/18; however overall the number of complaints received from remote NT remains relatively constant.

Figure 11: Location of services 2018/19



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 2018/19, of the 123 complaints made directly to the Commission, 81% of complainants approached the Commission by electronic means (54% by email and 27% by the Commission website), 9% by phone and 7% were received by mail. The remaining complaints were taken in person (4%).

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, David lodges a complaint about organisational provider GP Pty Ltd. In this complaint, David alleges that:

- he waited too long in Reception;
- when he finally consulted with the GP, the doctor didn't listen to him; and
- he paid too much for a very short consultation.

This comprises three complaint issues; however, GP Pty Ltd is counted once for this complaint. On another occasion, a second person, Matt, also makes a complaint about GP Pty Ltd. A second complaint file is opened, and GP Pty Ltd is counted again.

In 2018/19, there were a total of 245 providers involved in the 218 complaints received by the Commission. Of these, 137 (56%) were public providers and 108 (44%) private.

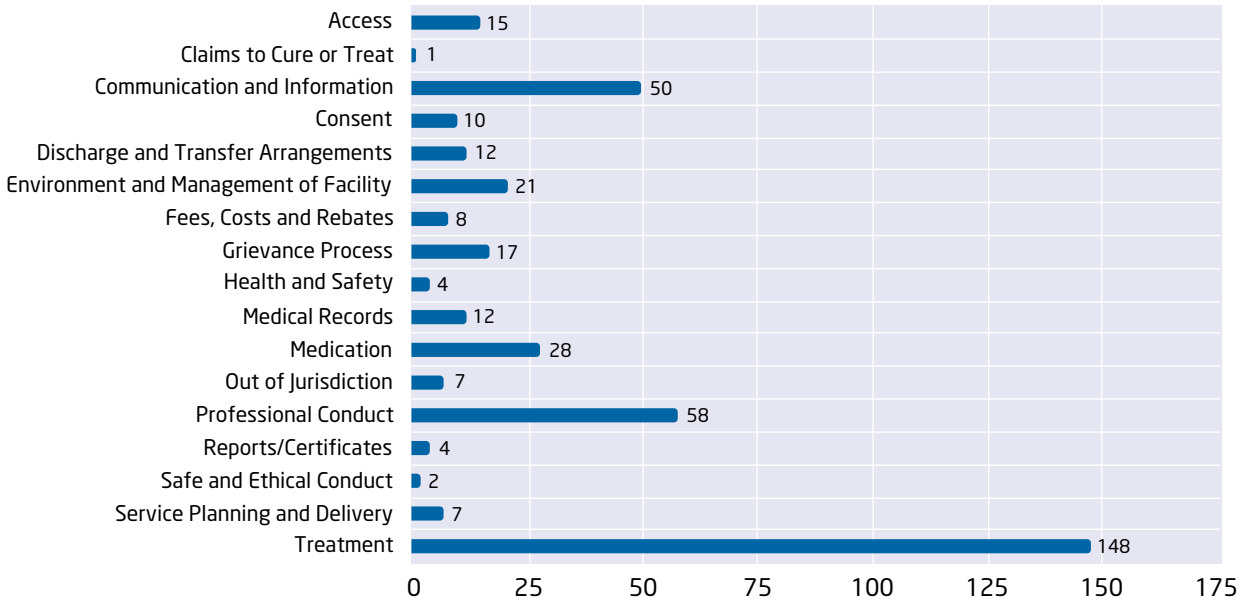
Thirty four percent (34%) of all public sector complaints were about hospitals, with doctors receiving the highest number of complaints about individual practitioners (23% of all public sector complaints) followed by nurses and midwives (17%).

In the private sector, the highest number of complaints about organisations were about services offered by a private hospital (6%) with the proportion of complaints about GP Clinics decreasing from 13% of all private sector complaints in 2017/18 to 3% in 2018/19. However, once again medical practitioners were subject to the greatest number of private sector complaints about individual practitioners (44%), followed by pharmacists, nurses and midwives (both 8%).

What issues are complained about?

Each issue described in individual complaints 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. In 2018/19, a total 404 issues were assessed.

Figure 12: Issues raised in complaints closed 2018/19



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.

A further breakdown of each of the categories of complaint issue and a comparison with previous years can be found below. The breakdown does not include the seven issues assessed as out of jurisdiction.

Table 13: Complaints about access 2014/15 - 2018/19

Access	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Access to facility	3	0	0	2	1
Access to subsidies	2	0	3	2	3
Refusal to admit or treat	7	4	4	3	5
Service availability	9	5	8	6	5
Waiting list	2	1	1	1	1
Total	**23**	**10**	**16**	**14**	**15**

Issues relating to access made up 4% of all issues raised in complaints in 2017/18. Concerns about access to services, however, comprised 23% of all enquiry issues, largely due to the high proportion of contacts from prisoner and waiting lists for outpatient appointments.

Table 14: Complaints about carers charter 2017/18 - 2018/19 (new issue category)

Carers Charter	2017/18	2018/19
Obligations to carers not met	1	0
Total	**1**	**0**

This is a new issue category, included because section 23(1)(k) of the Act specifically refers to service provider obligations to meet the expectations of the Northern Territory Carers Charter as set out in the Regulations to the *Carers Recognition Act*.

Table 15: Complaints about communication and information 2014/15- 2018/19

Communication and Information	2014/15	2015/16	2016/17	2017/18	2018/19
Attitude and manner	42	41	44	46	24
Inadequate information provided	37	31	31	29	17
Incorrect/misleading information provided	12	4	11	15	5
Special needs not accommodated	6	5	9	4	4
Total	**97**	**81**	**95**	**94**	**50**

Issues relating to communication and information made up 12% of all issues complained about. While still a sizeable proportion of reasons for complaining, the proportion is less than the 16% in 2017/18.

Table 16: Complaints about consent 2014/15 - 2018/19

Consent	2014/15	2015/16	2016/17	2017/18	2018/19
Consent not obtained or inadequate	17	21	16	19	7
Involuntary admission or treatment	1	3	4	12	0
Uninformed consent	1	4	4	4	3
Total	**19**	**28**	**24**	**35**	**10**

Issues relating to consent constituted 2% of all issues complained about in 2018/19, slightly less than in previous years.

Table 17: Complaints about discharge and transfers 2014/15 - 2018/19

Discharge and Transfers	2014/15	2015/16	2016/17	2017/18	2018/19
Delay	0	0	1	2	1
Inadequate discharge	17	9	9	11	9
Mode of transport	1	1	2	2	1
Patient not reviewed	0	0	0	0	1
Total	**18**	**10**	**12**	**15**	**12**

Three per cent of issues raised in 2018/19 related to discharge and transfer arrangements.

Table 18: Complaints about environment and management of facility 2014/15 - 2018/19

Environment and Management	2014/15	2015/16	2016/17	2017/18	2018/19
Administrative processes	16	10	19	15	6
Cleanliness/hygiene of facility	10	5	3	6	2
Physical environment of facility	7	3	5	6	4
Staffing and rostering	3	1	6	5	0
Statutory obligations/ accreditation standards not met	6	11	9	8	4
Workforce issues/staff related issues	0	0	0	0	5
Total	**42**	**30**	**42**	**40**	**21**

Complaints in this category relate to administration rather than the care/treatment component of the service. These issues made up 5% of all issues raised in complaints, decreasing from 9% in 2016/17.

Table 19: Complaints about fees, costs and rebates 2014/15 - 2018/19

Fees, Costs and Rebates	2014/15	2015/16	2016/17	2017/18	2018/19
Billing practices	9	11	6	6	7
Cost of treatment	0	0	1	2	0
Financial consent	1	0	1	4	1
Total	**10**	**11**	**8**	**12**	**8**

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

Table 20: Complaints about grievance procedures 2014/15 - 2018/19

Greivance	2014/15	2015/16	2016/17	2017/18	2018/19
Inadequate/no response to complaint	19	16	10	22	15
Information about complaint procedure not provided	2	1	2	2	1
Reprisal/retaliation as a result of complaint lodged	2	6	2	3	1
Total	**23**	**23**	**14**	**27**	**17**

Issues related to grievance procedures and complaint handling made up 4% of all issues complained about, consistent with 2018/19. Consistency in the proportion of complaints indicates that the Commission's focus on upskilling service providers has not been effective to date. This will be reviewed in Business Planning for 2019/20.

Table 21: Complaints about medical records 2014/15 - 2018/19

Medical Records	2014/15	2015/16	2016/17	2017/18	2018/19
Access to/transfer of records	7	3	5	3	4
Record keeping	7	10	7	2	8
Record management	5	1	3	6	0
Total	**19**	**14**	**15**	**11**	**12**

The medical record category includes complaints about errors and inadequacies in medical records. They accounted for 3% of all issues complained about in 2018/19. The Commission is likely to refer complaints that are only about records to the relevant information specialist: the Office of the Information Commissioner in the NT for public records, and the Australian Office of the Information Commissioner for private records (such as those held by GPs).

Table 22: Complaints about medication 2014/15 - 2018/19

Medication	2014/15	2015/16	2016/17	2017/18	2018/19
Administering medication	7	8	6	6	7
Dispensing medication	3	11	3	5	8
Prescribing medication	9	10	11	22	11
Supply/security/storage of medication	7	4	1	3	2
Total	**26**	**33**	**21**	**36**	**28**

Medication related concerns made up 7% of all issues in 2018/19. In addition, the Commission handled 78 complaints (9% of all enquiries) about medication at enquiry level. Many of these complaints were about access to prescription opiate medication. This reflects a change in policy Australia-wide which required a doctor's prescription for all products containing codeine and which had previously been available in pharmacies and supermarkets.

Table 23: Complaints about professional conduct 2014/15 - 2018/19

Professional Conduct	2014/15	2015/16	2016/17	2017/18	2018/19
Annual declaration not complete	0	0	0	0	1
Assault	6	2	5	4	5
Boundary violation	4	4	7	1	4
Breach of condition	2	1	4	3	2
Breach of guideline/law[6]	*	*	*	12	20
Competence	53	42	42	26	13
Discriminatory conduct	2	5	2	3	2
Emergency treatment not provided	0	1	3	3	2
Financial fraud	1	3	1	4	0
Illegal practice	6	8	6	5	1
Impairment	3	1	0	0	0
Inappropriate disclosure of information	14	10	5	8	7
Misrepresentation of qualifications	0	2	2	5	1
Sexual misconduct	1	2	2	0	0
Total	**92**	**81**	**79**	**74**	**48**

Issues relating to professional conduct consistently made up 12% of all issues complained about. The majority of these matters are dealt with by the relevant Board after consultation has occurred as required by the National Law.

Table 24: Complaints about reports/certificates 2014/15 - 2018/19

Reports/Certificates	2014/15	2015/16	2016/17	2017/18	2018/19
Accuracy of report/certificate	7	6	5	6	2
Costs of reports/certificates	1	0	0	0	0
Inadequate/no consultation	1	0	0	0	0
Refusal to provide reports/ certificates	0	1	1	1	1
Report written with inadequate or no consultation	0	1	2	1	1
Timeliness of report/certificate	0	1	1	0	0
Total	**9**	**9**	**9**	**8**	**4**

6 New category 2017/18

Complaints about reports and certificates made up 1% of issues in complaints closed in 2018/19. The Commission has no jurisdiction over the process of writing, or the content of, a health status report, and these would have been referred to the relevant Board at consultation.

Table 25:Complaints about service planning and delivery 2017/18 - 2018/19 (new issue category)

Service Planning and Delivery	2017/18	2018/19
Decision making and choice	3	2
Person centred planning	1	5
Total	**4**	**7**

Seven issues related to service planning and delivery were assessed in 2018/19. This complaints category is most likely to describe complaints about disability services. Now that the NDIS Quality and Safeguards Commission has commenced operations, it is possible that this category will be less relevant to the Commission's operations.

Table 26: Complaints about treatment 2014/15 - 2018/19

Treatment	2014/15	2015/16	2016/17	2017/18	2018/19
Attendance	1	1	0	1	0
Coordination of treatment	18	5	20	25	16
Delay in treatment	11	7	16	20	12
Diagnosis	13	19	12	24	23
Excessive treatment	3	1	1	0	1
Experimental treatment[7]	*	*	*	2	0
Inadequate care[8]	*	*	*	17	16
Inadequate consultation	5	10	3	8	11
Inadequate prosthetic device[9]	*	*	*	1	0
Inadequate treatment	39	54	58	50	39
Infection control	5	4	1	2	2
No/inappropriate referral	9	7	4	10	4
Public/Private election	0	3	1	3	1
Rough and painful treatment	4	4	3	5	1
Unexpected treatment outcome/ complications	13	10	9	27	15
Withdrawal of treatment	4	1	2	4	0
Wrong/inappropriate treatment	13	8	17	17	7
Total	**138**	**134**	**147**	**216**	**148**

7 New category 2017/18

8 Ibid

9 Ibid

Issues relating to treatment constituted 36% of all issues in complaints closed in 2018/19, consistent with the 36% in 2017/18. Inadequate treatment is identified as the primary concern within this category.

Table 27: National Code of Conduct complaints 2017/18 - 2018/19 (new issue category)

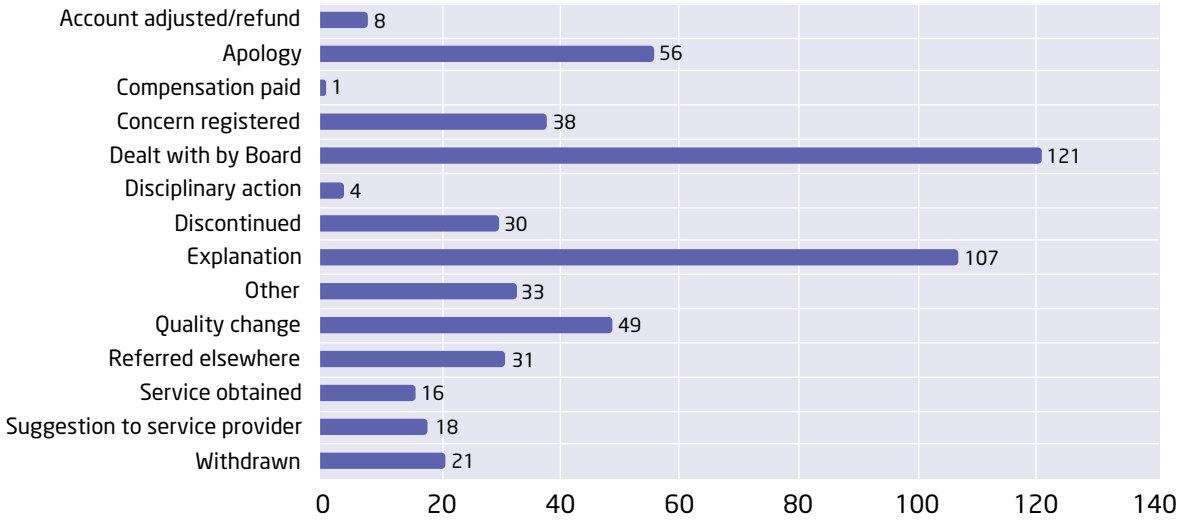
National Code of Conduct	2017/18	2018/19
Clause 1 Safe and ethical conduct – Safe and Ethical Conduct	0	2
Clause 1 Safe and ethical conduct – Treatment/Appliances	1	0
Clause 5 Adverse events – Prevent adverse events	1	0
Clause 8 Claims to cure or treat – Claim to Treat/Alleviate symptoms	0	1
Total	**2**	**3**

In 2017/18, the Commission introduced issues related to the National Code of Conduct into its issues list; firstly to trial how they would be incorporated into the Commission's reporting, and secondly so that the Commission could track the types of complaints that might be handled under provisions of the Code of Conduct. In 2018/19, only three issues were classified as Code of Conduct issues. This does not represent the number of issues which might have been handled as Code complaints had the regime been in place.

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 13: Outcomes of issues raised in complaints closed 2018/19

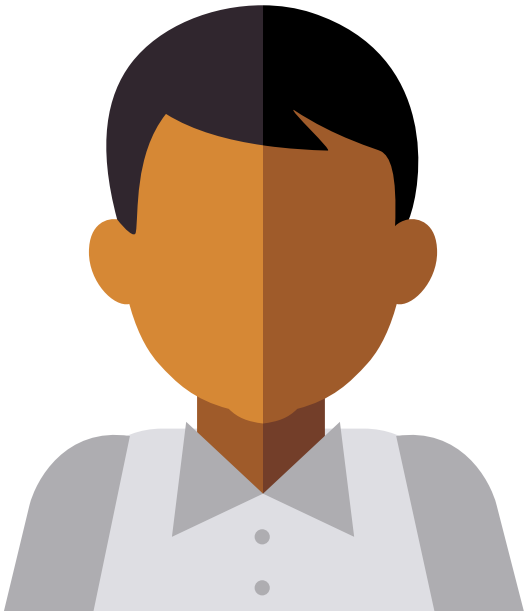


The most common outcome from issues closed by the Commission was an explanation (26%). Twelve per cent of matters resulted in a quality improvement and 6% were referred elsewhere. The Commissioner made suggestions for quality improvements under section 12(1)(e) of the Act on 18 occasions. An apology was an outcome of 14% of issues.

Appendix 2: Community Engagement Activities 2018/19

2018

Date	Organisation	Activity
18/7/18	AHPRA	Meeting with NT Manager
27/7/18	NT Carers	HCSCC Presentation
31/7/18	TEHS	Tour of Palmerston Hospital
10/8/18	Heart Foundation Health Ambassador Program	HCSCC presentation
14/8/18	Anyinginyi Health Aboriginal Corporation	Info share, provision of "talk up" resources
15/8/18	Darwin Aged & Disability Services Network	Networking and info share
18/8/18	Integrated Disability Action	"Know your rights" presentation and display
25/9/18	NDS	NT Disability Advocacy Collective
24/8/18	Reducing Abuse and Neglect in the NT Working Group - hosted by NDS	Working group meeting - showed Talk Up video
19/10/19	Project 21	Morning Tea
12/11/18	OCPE	Hands up for Inclusion
22/11/18	Darwin Mental Health and AOD Network	Network meeting of MH and AOD providers, presentation by Tristar
28/11/18	Palmerston Carers Group, MIFANT	Support group meeting, information provided on HCSCC
30/11/18	Danila Dilba-Palmerston	Provision of talk-up resources & complaints handling pamphlets - offer of future HCSCC attendance at in-services.
10/12/18	Ombudsman	Christmas Morning Tea
11/12/18	NDS	NT Disability Advocacy Collective



2019

Date	Organisation	Activity
7/12/19	PHS	Meeting
6/2/19	Mental Illness Fellowship Australia NT (MIFANT)	Meeting with mental health consumers and staff to discuss HCSCC and Talk Up
8/2/19	NDS	NT Disability Advocacy Collective
15/3/19	AGAC	Panel session Talk Up and Indigenous Engagement
18/3/19	NDIS Q & S Commission - Complaints Commissioner Miranda Bruyniks	Meeting
27/3/19	NDIS Q & S Commission	Transition arrangements
	Q&S Commission workshop	Transition arrangements
	NT Restrictive Practice Authorisation Bill w/ Robyn Westerman	
28/3/19	Independents + Q & S	Transition arrangements
4/4/19	Erma	Launch
22/5/19	NDIS Q & S Commission	Transition arrangements
23/5/19	Prison Health	Relationship/Collaboration
31/5/19	COTA Expo	Display
3/6/19	NAAJA Alice Springs	Relationship/Collaboration and questions
	Disability Advocacy Service Alice Springs	Relationship/Collaboration and questions
4/6/19	Flynn Drive Community Health Centre, Alice Springs	Relationship/Collaboration, site visit
	Meeting with complaints team CAHS	Relationship/Collaboration
	Site visit and meeting with staff of PHS ASCC	Relationship/Collaboration, site visit
	Meeting DASA Alice Springs	Discussion on complaints management processes
4/6/19	RDH Surgeons	Presentation and questions
27/6/19	Prison Health	Relationship building

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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