Health and Community Services
COMPLAINTS COMMISSION

Annual Report
2014-2015

DRIVING improvement

Seventeenth Annual Report (2014/15)

The Honourable John Elferink 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 2015.

Yours sincerely

Stephen Dunham
Commissioner

30 September 2015

The HCSCC

The Health and Community Services Complaints Commission (HCSCC) was established in 1998 with the passage of the *Health and Community Services Complaints Act*. The HCSCC initially sat with the Ombudsman's Office, with the Ombudsman also holding the statutory position of Commissioner. Since 2010 the HCSCC has been a stand-alone entity with an independent Commissioner. Lisa Coffey was appointed the inaugural Commissioner, having been appointed in August 2010. Ms Coffey's term expired on 6 June 2015. Mr Stephen Dunham was appointed Commissioner for a 5 year term by his Honour the Administrator on 11 June 2015. This is the seventeenth annual report of the HCSCC and the fifth since its establishment as a separate office.

The HCSCC 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 *Health and Community Services Complaints 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.

To achieve these aims, the Commissioner's powers and functions include:

- Making enquiries into any complaints;
- Encouraging and assisting users and providers to resolve complaints directly;
- Conciliation and investigation of complaints;
- Suggesting ways of improving services and promoting rights and responsibilities;
- Reviewing and identifying the causes of complaints;
- Providing information, advice and reports to Boards, service users, the Minister and the Legislative Assembly; and
- Consulting with providers, organisations and users of health and community services.

Glossary

AHPRA	Australian Health Practitioner Regulation Agency
AMSANT	Aboriginal Medical Services Alliance Northern Territory
ATSI	Aboriginal and Torres Strait Islander
CALD	Culturally and Linguistically Diverse
COAG	Council of Australian Governments
CVP	Community Visitor Program
ED	Emergency Department
GP	General Practitioner / General Practice
HCE	Health Complaints Entity
HCSCC	Health and Community Services Complaints Commission
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
NICU	Neonatal Intensive Care Unit
NTMS	Northern Territory Mental Health Service

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Message from the Commissioner

I am pleased to present the Northern Territory Health and Community Services Complaints Commission (HCSCC) Annual Report for 2014/15. Ms Coffey's term as Commissioner covers almost the entirety of the year in review, with my appointment occurring three weeks prior to the end of the financial year. I give credit to Ms Coffey's stewardship and strong leadership of the Commission since its establishment as an independent standalone entity in 2010.

Ms Coffey has left the commission on a sound footing and deserves acknowledgement for

- Bringing clarity to decision-making processes in the HCSCC, including setting out a basis for factors to be considered in all HCSCC decision-making. Along with a commitment to hearing and considering alternate views, this has ensured robustness to decision making in the HCSCC.
- Focusing on ensuring that organisations are assisted and encouraged to develop competent practices to handle complaints independent of the Commission.
- Increasing the proportion of complaints being resolved, at enquiry stage, in assessment and in conciliation. Our historical data shows a gradual increase in the number of matters resolved, particularly by conciliation with the largest number of conciliations being conducted in the HCSCC at a record 12 matters conciliated in 2014/15 (10 of which were resolved or partially resolved). As at 30 June 2015, a further 8 matters were still in conciliation.
- Enlisting the assistance of Aboriginal legal aid organisations and advocacy groups to increase the proportion of complaints being received from areas outside Darwin, including the proportion of complaints being received from Aboriginal Territorians. Over 50% of open complaints at the year's end involve a person of ATSI background.
- Productive engagement with the disability sector, with a major investigation recently completed. The Commission worked collaboratively with those Government, consumer groups and not for profit groups involved in the Barkly Region trial for the proposed National Disability Insurance Scheme.
- A strong commitment to ensuring the staff of the Commission is well trained, enthused and experienced to deal with the important and sensitive matters which are investigated and resolved in complaints handling.

A number of policies and procedures were in the early stages of analysis and/or implementation during the 2014-15 year and many of these will come to fruition during the next reporting year. Notable among these are:

Resolve

A new system for the recording and monitoring complaints was introduced in late 2014. The out-dated *ProActive* system was replaced with *Resolve* – a system that was chosen centrally for roll out to all independent offices and is now also used by:

- Anti-Discrimination Commission
- Children's Commission

- Community Justice Centre
- Community Visitor Program
- Consumer Affairs
- Office of the Information Commission and Public Interest Disclosure

The Commission was intimately involved in the development and design of the new system and modifications continue with system improvements up to the present time to ensure that it fully meets the Commission's needs.

The changeover of systems has presented some difficulties with comparing data between the two financial years which is compounded by some changes to statistical categories and data handling. While every effort has been made to ensure accurate comparability of data sets between this and previous annual reports, some minor discrepancies are evident and these have been identified by footnote.

Review of the *Health and Community Services Commission Act*

The Act currently contains a provision that it be reviewed within two years of its 1998 commencement and every 5 years thereafter. Despite significant unfinalised consultation and analysis undertaken circa 2002, this provision has yet to be met and work will commence during the next financial year to undertake the necessary processes with a view to providing comprehensive options to Government late 2016. Some piecemeal amendments may warrant consideration outside of this comprehensive review subject to Government priorities. One such amendment may relate to the decisions over the last two years by Australian Health Ministers regarding a national code of conduct for health care workers or "unregistered providers".

Unregistered providers

At the COAG Health Council meeting of 17 April 2015, Health Ministers released the *Final Report: A National Code of Conduct for Health Care Workers* and agreed that jurisdictions should examine the implementation of the code regulation regime, how it should apply and implications for each jurisdiction. They further agreed to the development of a common web portal and a nationally consistent suite of explanatory materials to support the National Code and for this work to be led by the Australian Health Complaints Commissioners.

The continuing development of this national approach will be the subject of work and collaboration with interstate Commissions over the next year.

Australian Health Regulation Registration Agency AHPRA

Following a (yet to be released) report for Health Ministers by Dr Kim Snowball which reviewed the National Registration and Accreditation Scheme for Health Professions, Commissioners for Health Complaints Entities (HCEs) decided at their February 2015 meeting to commence a trial in Western Australia, Victoria and the Northern Territory. This trial involves higher levels of shared information and collaboration regarding complaints and notifications to the HCEs and AHPRA. The three month trial will conclude in September 2015 and it is too early to identify the outcomes and experience of jurisdictions at this stage.

Nevertheless, I can report significant goodwill between the Commission and AHPRA staff in the Northern Territory, particularly Jill Huck the NT Manager and Inta Tumuls the Director Notifications NT in regard to this trial. There is also a high level of interest in the trial among all other jurisdictions.

Community engagement

The active engagement with groups representing and advocating for people in the health, disability and senior sectors continues to be a focus of the Commission and an ambitious forward program of regional visits and representation at community events has been instituted.

Development of internal systems for organisations

A major objective of the *Health and Community Services Complaints Act* (at section 3(a)(ii)) is to encourage and assist users and providers to resolve complaints directly with each other.

Work is underway with resources, including training modules, template letters and a handbook to assist organisations to develop and improve internal systems to handle complaints. This material is in final drafts and will be available during the next year to focus on this critical legislative obligation with one expected outcome being a diminution in complaints from some high volume areas such as the Prison Health Service. The complaint statistics will be examined in detail to identify those organisations which indicate problems with internal complaints handling processes in addition to high volume areas.

Prison data

The workload emanating from the Prison Health Service, and particularly the Darwin based prisons at the now closed Berrimah and the new Darwin Correctional Centre at Holtze is substantial and is on an unsustainable growth trajectory (see Table 3). With the vast proportion of these complaints substantiated and seemingly quickly resolved, work will commence early in the new financial year to further analyse this trend with a view to instituting more effective complaint handling processes.

System Improvement

A further major objective of the *Health and Community Services Complaints Act* (at section 3(a)(iii)) is to establish systems that lead to improvements in health services and community services and enables users and providers to contribute to the review and improvement of health services and community services. Two major reports have been undertaken:

- **Disability report**
- **Discharge summaries**

Survey monkey

The Commission regularly invites feedback, including anonymously on its handling of complaints, processes and legislative base. This valuable information indicates that there is a high level of satisfaction with our work and this has been reported annually in this and previous reports. It is acknowledged however that the data from those choosing to report on their experiences with the Commission is limited by the small sample size. The Commission will investigate alternative methods of garnering this critical data and has commenced work on utilising the on line “Survey Monkey” as one such alternative

As will be seen throughout this report, this year has been a busy one for the HCSCC. There has been a slight decrease in the number of complaints and enquiries received in this office, but the most remarkable statistic is the trend evident from last year, being the significant increase in complaints closed, accompanied by improved timelines.

As reported last year, the Commission is working to assist providers to deal directly with complainants to resolve concerns with minimal involvement from the HCSCC. The emphasis on assisting service providers to ensure they develop fair and robust means of dealing with their clients remains a priority.

The resolution focus continues to encourage parties to engage in conciliation to discuss and resolve complaints. This is an option that parties are increasingly willing to consider and one that meets the aims of the Act in terms of resolution, improvement and promotion of rights.

Significant work with the disability sector has occurred preparing services for the roll-out of the NDIS. The Commission visited Tennant Creek on a number of occasions and continues to work to promote the need to have systems in place that safeguard rights of people with disabilities, now and in the future. In addition to an independent complaints mechanism such as the HCSCC, one of the most important safeguards is a robust internal complaint handling system that people are able to use without fear, confident that they will be able to have their say in how their services are delivered. The HCSCC is proud to have delivered training on National Standards in this area 2013/14 and developed a best practice system that will be the subject of consultation in the year ahead.

In terms of disability safeguards, as has been reported in past reports, urgent reform is still required to the Northern Territory Guardianship system. The Northern Territory is the only Australian jurisdiction without an independent guardian/advocate, a protection that is particularly important in remote NT with the advent of the NDIS.

Finally, I would like to sincerely thank my team at the HCSCC for their hard work and commitment in 2014/15. In particular I wish to acknowledge the generous welcome and effort to quickly induct me as the new Commissioner.

Stephen Dunham

Commissioner

Performance Overview for 2014/15

Some of the key performance outcomes and achievements for 2014/15 are set out below. More detail on all of these can be found later in this report.

Timelines Improved

- The proportion of complaints closed within 180 days was 84% in 2014/15, compared with 74% the previous year (benchmark is 80%);
- The average time taken to finalise complaints is slightly lower than in previous years, at 132 days, compared with 142.08 in 2013/14;
- There has been significant improvement in the average time taken to finalise enquiries. At 6.6 days, this is less than half the average time taken last year.

Increased Number of Complaints Finalised

- More complaints were closed in 2014/15 (229) than were received (198);
- The number of complaints closed per annum is gradually increasing, and in 2014/15 there were almost three times as many complaints finalised as in 2010/11.

Improved Reporting - *Resolve* Database

The *Resolve* database was implemented from October 2014; resulting in:

- Review of HCSCC workflows;
- Development of a Manual to describe how HCSCC complaint processes are recorded on the new database;
- Review of performance reporting for the HCSCC and improved search and reporting capability.

Resolution Focus

- Development and implementation of a project plan to improve the proportion of complaints resolved by the HCSCC;
- Continuing increase in matters dealt with through conciliation;
- Consultation with government and non government organisations to inform the development of training in complaints handling;
- Tasking a private provider to develop a training program.

Table 1: Key Deliverables 2013/14 – 2014/15

Key Deliverables	2013/14	2014/15
Enquiries and complaints received	667	**608**
Enquiries and complaints closed	598	**618**
Complaints resolved within 180 days	74%	**84%**

Resolution of Complaints

How We Assist to Resolve Complaints

Anyone can approach the HCSCC to discuss a complaint or possible complaint about a health, disability, or aged service. We will give you advice about who can complain; what you can complain about; what to do if a complaint is made about you; and assist you to resolve your complaint.

The most informal way of dealing with complaints is through our **enquiry**, or informal complaint, system. The aim of the enquiry system is to assist parties to resolve their concerns in the most timely and informal way possible. Not all complaints can be dealt with informally but in many cases we are able to assist the service user to raise their concerns directly with the service provider without further involvement from us. In other cases, we may make contact with the provider and facilitate the resolution in that way.

If a concern cannot be resolved via our enquiry system, we will deal with it via our **complaint** system. This is a more formal process in which we will gather information that may assist to resolve the complaint, and ultimately decide whether further action is necessary in relation to the concerns raised. In many cases the answers to relevant questions or outcomes that the person making the complaint wants can be obtained during this initial process and no further action is required.

If further, more formal action needs to be taken to resolve a complaint because it raises important questions of health or safety, the HCSCC may decide to conduct a formal **investigation**. An investigation is a longer process during which the HCSCC may call witnesses and seize information. Findings are made at the end of an investigation and a formal report prepared.

Another option for the HCSCC is **conciliation**. Conciliation is a form of alternate dispute resolution in which parties come together to discuss the issues of complaint in a confidential environment, with the aim of settling the dispute. It is a voluntary, flexible process in which parties are encouraged to discuss issues frankly and openly. It can be used as an alternative to medico-legal processes, or a forum for communication resulting often in explanations being provided to parties, along with apologies where appropriate. In some cases agreements reached through conciliation can lead to improvements in services.

If the HCSCC decides that it is not the best body to deal with a complaint, it may **refer** it to another complaint handling organisation, such as Consumer Affairs or the Information Commissioner.

The HCSCC may also decide to refer complaints about Registered Practitioners (such as doctors, nurses, dentists and physiotherapists) to the relevant **Registration Board**. The decision to refer is made in consultation with the Board concerned, which is notified about every complaint concerning registered members of their profession.

New Complaints Database

The HCSCC, along with other independent offices in the Department of the Attorney-General and Justice, transitioned to the *Resolve* complaints handling database in 2014/15. This comprised working with staff from *Resolve* to set out the steps in the HCSCC complaints handling process and design a purpose built database, with transition commencing in October 2014.

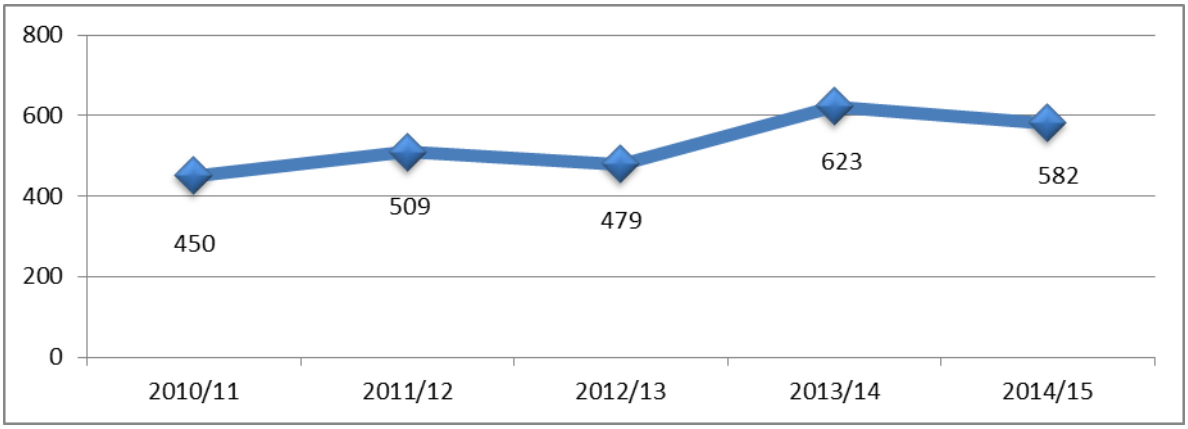
Some reporting will change due to the changeover to the *Resolve* complaints system, with these changes referenced in the performance reporting in the next section of this report.

New Approaches 2014/15

A total of 410 enquiries and 198 complaints were received during 2014/15. As 26[1] enquiries became complaints, the number of people who approached the HCSCC with concerns about services in 2014/15 was 582.

The comparison of approaches over the past five financial years demonstrates a slight decrease in approaches compared with 2013/14, however over time there is an increasing trend in the number of approaches to the HCSCC.

Figure 1: Approaches 2010/11 – 2014/15



In the past, if a complaint involved more than one organisational provider, it would be recorded as more than one complaint - the *Resolve* database has design features which enable the recording of multiple providers on each complaint, with complaint issues recorded against each provider. While the number of complaint issues recorded and assessed should remain consistent from year to year, the number of actual complaints recorded in 2014/15 (198) is slightly lower.

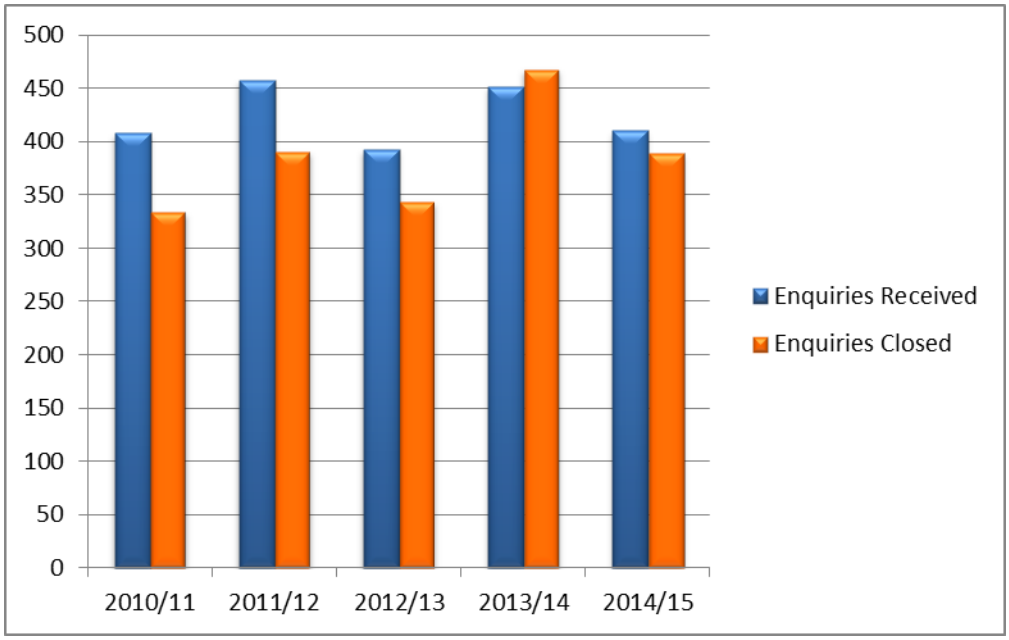
[1] This compares with an average 42 enquiries moved to complaints over the previous three years. In 2014/15 this was counted manually due to the changeover to *Resolve*.

Enquiries / Informal Complaints

The scope for early, informal resolution of complaints is a priority of the Commission to assist parties to resolve concerns about services as quickly as possible.

In 2014/15, we dealt with 410 enquiries.

Figure 2: Enquiries Received and Enquiries Closed 2010/11 – 2014/15



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

Public providers accounted for 77% of the enquiries received 2014/15, in line with an increasing trend over the past two years of a higher proportion of enquiries about the public system. The high and increasing proportion of enquiries received about the Prison Health Service (see Table 3) may account for this trend.

Table 2: Providers Subject of Enquiries 2010/11 – 2014/15

Providers	2010/11	2011/12	2012/13	2013/14	2014/15
Private	178	232	198	163	95
Public	230	226	195	289	315
Total	**408**	**458**	**393**	**452**	**410**

Prisoner Enquiries

Prisoners at Darwin and Alice Springs Correctional Centres are able to contact the HCSCC to raise concerns about services via a dedicated, secure phone line. The majority of the issues raised by prisoners are referred back to the Prison Health Service (PHS) to be resolved in accordance with agreed protocols.

154 enquiries (38%) of all enquiries received by the Commission related to Prison Health Services. This reflects the increasing number (and proportion) of enquiries received from prisoners.

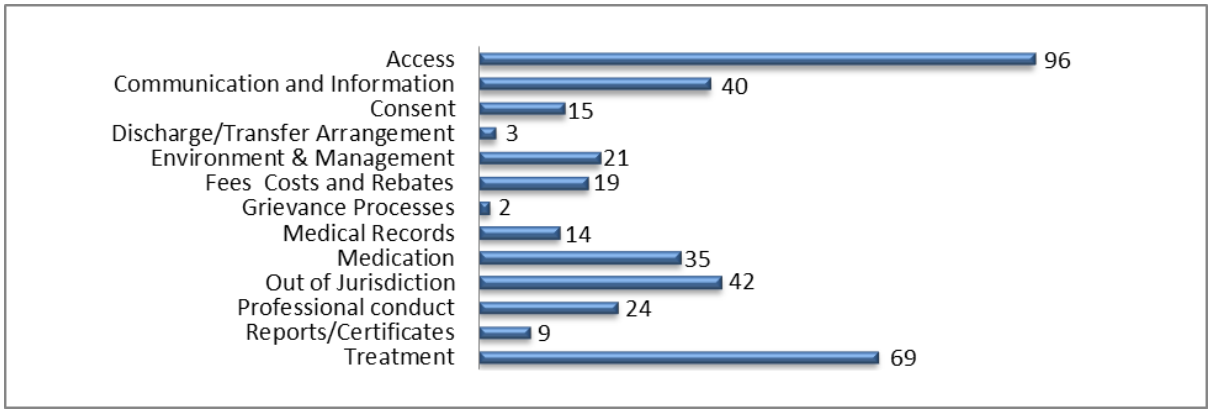
Table 3: Number and Proportion Enquiries about PHS 2012/13 – 2014/15

Year	Number	Proportion of all Enquiries
2012/13	89	23%
2013/14	146	32%
2014/15	**154**	**38%**

Issues & Outcomes from Enquiries

As with previous years, the most common issues raised and dealt through our enquiry process were access to services, standard of treatment and communication. Forty two enquiries were considered and found to be out of jurisdiction.

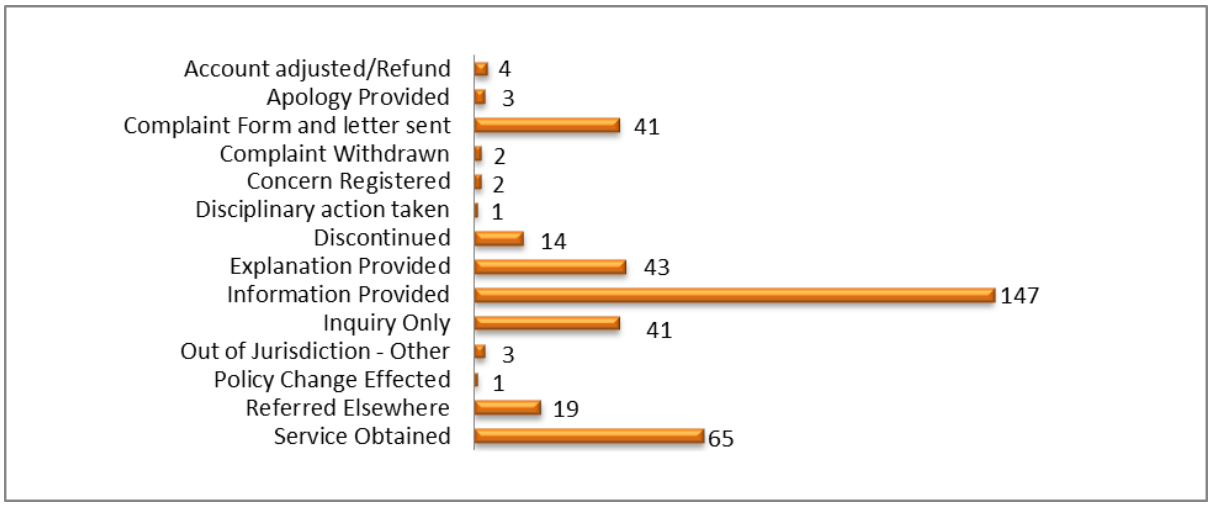
Figure 3: Issues Raised in Enquiries Closed 2014/15[2]



One hundred and forty seven enquiries (38%) were closed after the enquirer was provided with information from the HCSCC and a further 43 (10%) received an explanation related to their concern. In 65 cases (17%) a service was obtained following involvement by the HCSCC.

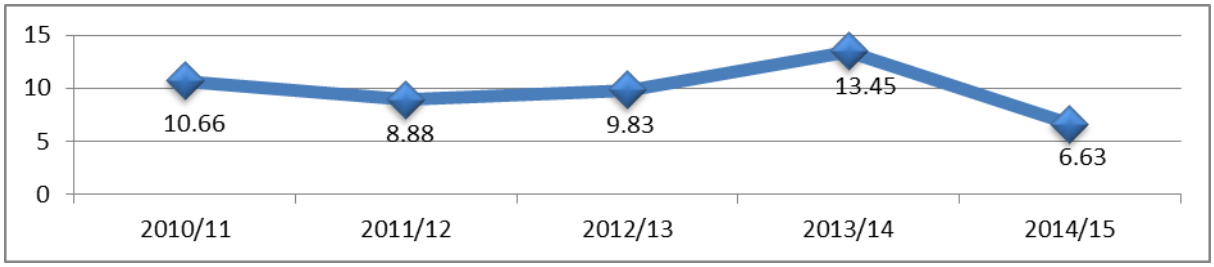
[2] Only one issue is counted for each enquiry in 2014/15 due to the limitations of the *Proactive* Database. This understates the workload of enquiries, and from 2015/16 all issues managed in enquiries will be counted.

Figure 4: Outcome of Enquiries Closed 2014/15[3]



As seen in Figure 5 below, there has been a significant decrease in the average time taken to finalise enquiries, from 13.45 days in 2013/14 to 6.6 days in 2014/15.

Figure 5: Time Taken to Finalise Enquiries (Days) 2014/15



The benchmark set for finalisation of enquiries is 10 days. There are a number of factors which may have contributed to the decrease in average time taken to finalise an enquiry. Firstly, for the first time, the Resolution Officer for the HCSCC has managed nearly all enquiries and it is likely that this focus has allowed for enquiries to be dealt with in a more timely manner; secondly fewer enquiries were received in 2014/15 than the previous year; and finally, there has been an active policy of speaking to people making an enquiry about how they might try to resolve their enquiry directly with the service provider.

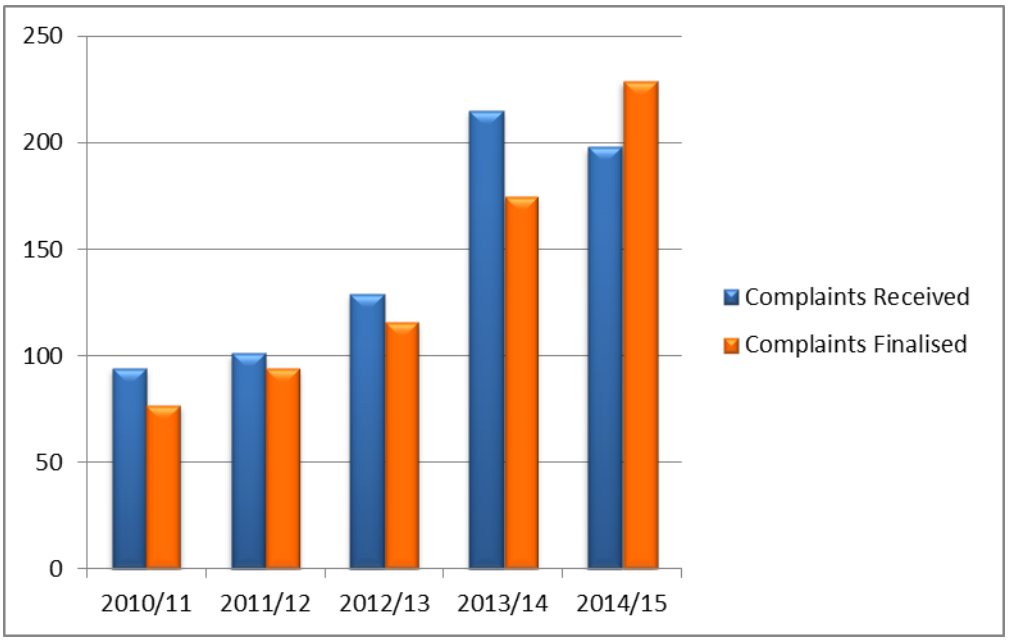
Figure 8 demonstrates the effectiveness of the Resolution Officer role with enquiries emanating from Prison Health Services (38%) of all enquiries translating to only 2% of all complaints.

[3] Two new outcomes were introduced from 1 October 2014: "Complaint Form Sent" and "Inforrmation Provided". The numbers for these categories apply only for 9 months of the year, ie from 1 October 2014 – June 30 2015.

Complaints

One hundred and ninety eight (198) new complaints were received in 2014/15.

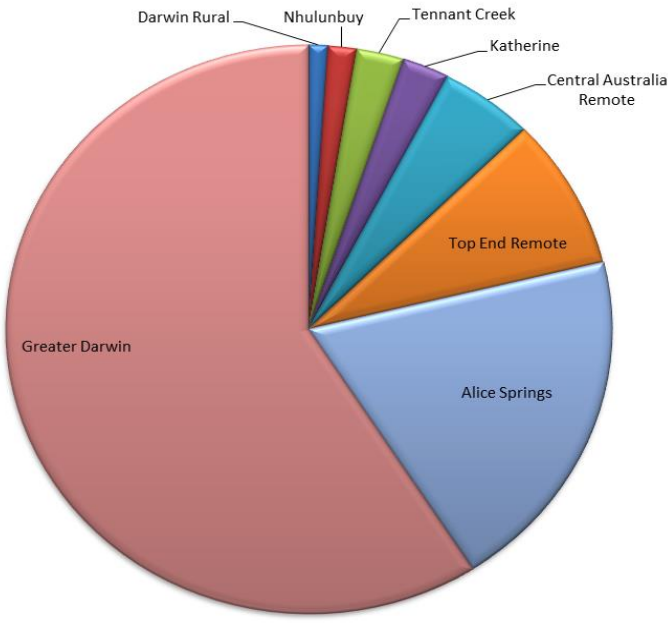
Figure 6: Complaints Received and Finalised 2010/11 – 2014/15



Location of Services Complained About

With the changeover to Resolve, the Commissioner decided to record location of service rather than location of complainant. This is reported for the first time in 2014/15.

Figure 7: Location of Services 2014/15



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

In 2014/15, of the 121 complaints made directly to the HCSCC, 55% of complainants approached the HCSCC by electronic means (34% by email and 21% by the HCSCC website), 20% complaints were received by mail and 12% in person. The remaining complaints were referred to the HCSCC (5%) or taken by phone and/or in writing (8%)[4].

Seventy seven (39%) of complaints originated with the relevant Practitioner Registration Board and were the subject of consultation between HCSCC and AHPRA.

What Services are Complained About?

In the past, the HCSCC has reported the providers subject to complaint as one provider per complaint. This practice means that the number of providers is under-represented, as any one complaint file may involve numerous providers, including organisational providers (for example the Department of Health) and individual providers (for example medical practitioners).

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. So for example, Allan lodges a complaint about organisational provider Busy Hospital Inc. In this complaint, Allan alleges that

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

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

In 2014/15, there were a total 258 providers involved in the 198 complaints managed by the HCSCC. 173 (67%) involved public providers and 85 (33%) private.

Figure 8 gives a breakdown of public sector complaints organised into two sections; organisational provider types and individual provider types. Forty percent of all public sector complaints were about hospitals, with medical practitioners receiving the highest number of complaints about individual practitioners (27% of all public sector complaints) followed by nurses and midwives (20%) and dentists (4%).

Figure 9 shows that in the private sector, the highest number of complaints about organisations were about services offered by Aboriginal Health Services (12% of all private sector complaints), and again, medical practitioners were subject to the greatest number of private sector complaints (25%), followed by Nurses and Midwives (12%) and Psychologists (9%).

[4] Complaints in writing are not counted after *Resolve* was implemented from 1 October 2014, so this number applies only to complaints received between 1 July 2014 – 30 September 2014. Only the *method* used to convey the complaint to the HCSCC is counted now, rather than the *form* of the complaint.

Figure 8: Public Providers 2014/15

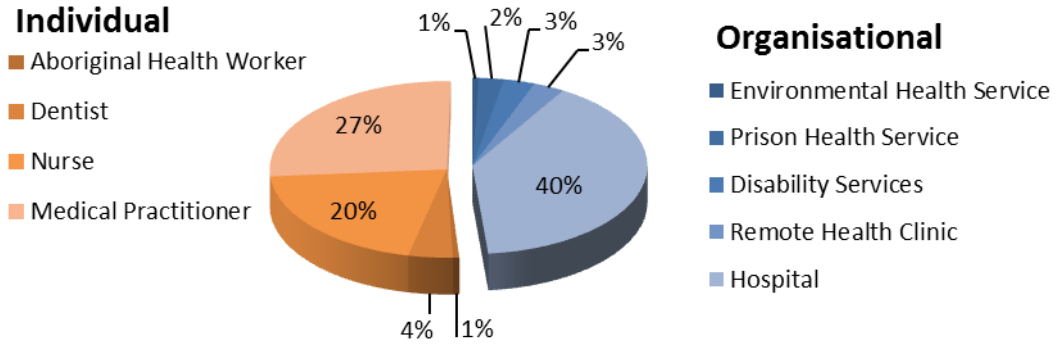
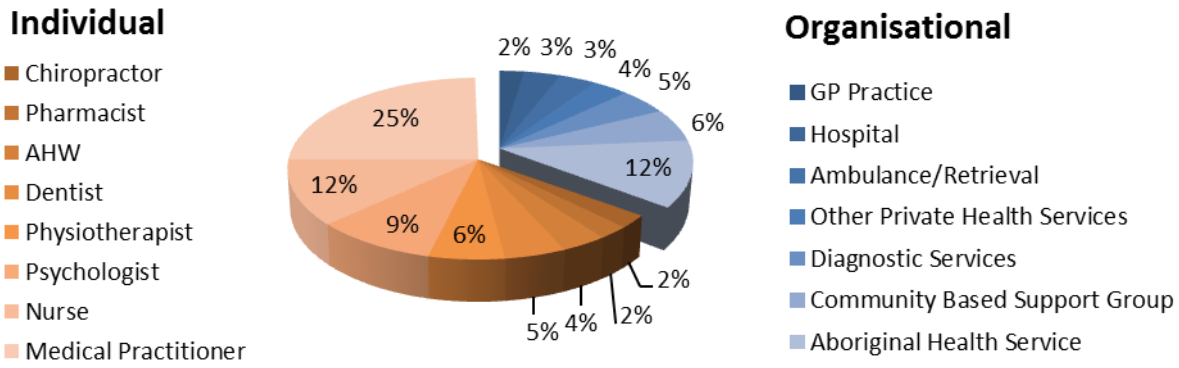


Figure 9: Private Providers 2014/15



A further breakdown of complaints about services for aged people, mental health services and services for people with a disability is set out in Table 4. As can be seen from the table, the number of formal complaints about aged and disability services is slowly increasing. This increase may be attributed to increased activity by the Commission to the promotion of rights within this demographic over recent years.

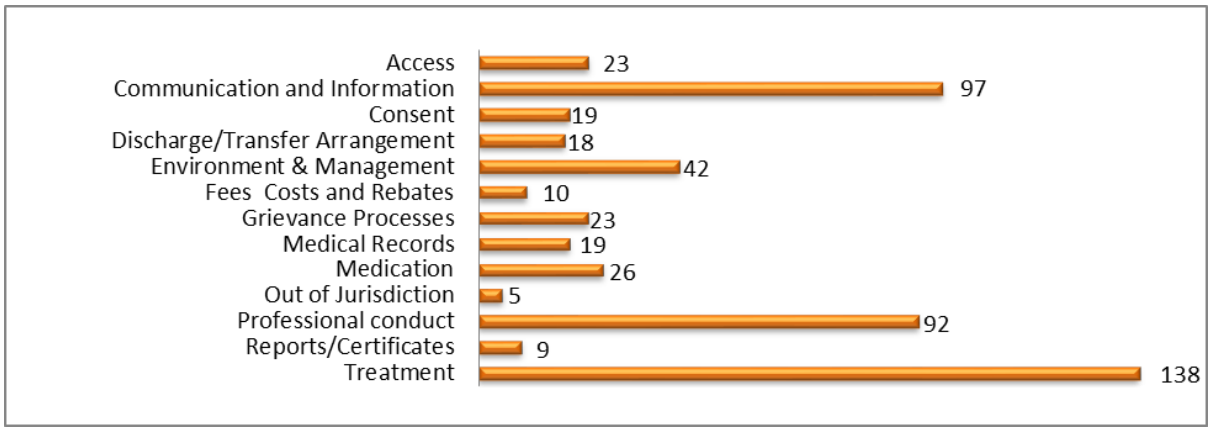
Table 4: Aged and Disability Services Complaints 2011/12 – 2014/15[5]

Provider Type	2011/12	2012/13	2013/14	2014/15
Disability Services	4	6	8	**9**
Mental Health Services	1	1	14	**18**
Aged Services	1	1	1	**1**
Total	**6**	**8**	**23**	**28**

What Issues are Complained About?

Each issue described in each complaint received by the HCSCC is recorded for reporting purposes, with some complaints raising more than one issue. Issue categories are used consistently across Australia to allow for comparison.

Figure 10: Issues Raised in Complaints Closed 2014/15



In 2014/15 issues were recorded against all complaints received by HCSCC, 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.

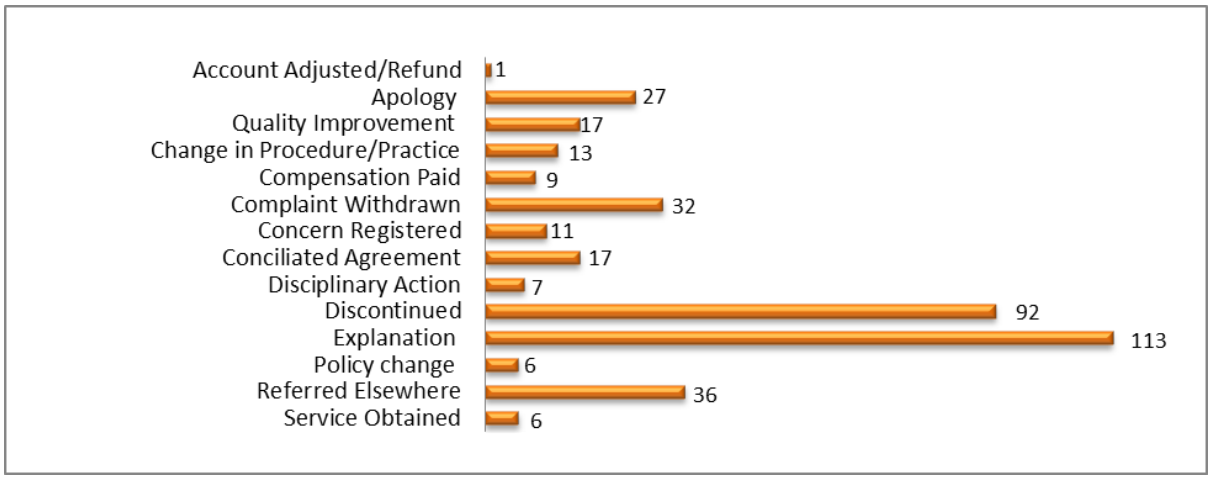
A further breakdown of each of the categories of complaint issue and a comparison with previous years can be found at Appendix 1.

[5] *Resolve* has a search category that will enable accurate differentiation between complaints about disability services and complaints about mental health. The figures in Table 4 are a best estimate based on a manual review of the data.

Outcomes of Issues Complained About

When complaints are finalised the outcome of each issue identified in the complaint is recorded.

Figure 11: Outcomes of Issues Raised in Complaints Closed 2014/15



The most common outcome from issues closed by the HCSCC was an explanation (29%). Sixteen percent of matters were discontinued without further outcome in 2013/14, and 10% resulted in a quality improvement of some kind.

Note: These figures do not include outcomes of Board processes unless the matter was referred to the HCSCC.

What Happens to our Complaints?

The HCSCC finalised 229 complaints in 2014/15. When a complaint is received, the Senior Investigation/Conciliation Officer handling the complaint works with the complainant to work out the issues in a complaint. There may be several issues to each complaint, every one of which is individually assessed and a decision made in accordance with the HCSC Act. It is therefore possible for a single complaint with 5 issues recorded against it to result in 5 different outcomes.

In past Annual Reports, shortcomings with the *Proactive* Database meant that it was only possible to report one Commissioner decision for each complaint. With the new *Resolve* complaints database, all issues are recorded and an issue outcome and Commissioner decision against that issue recorded. From 2014/15, the HCSCC will report Commissioner decisions against complaint issues (rather than individual complaints) in order to ensure a more accurate account of decision-making.

Table 5: Reasons for Closure: Issues Closed 2014/15

Reason for closure	Number
Conciliation complete	**23**
Dealt with by Board pursuant to MOU	**168**
Investigation complete	**10**
No further action	**315**
Referred to other entity	**5**
Total	**521**

It is not unusual for the HCSCC to take no further action in relation to a complaint (see Table 5), however that may be for a variety of reasons, including the fact that a complaint has resolved through the process. In 2014/15, in addition to the 23 complaint issues resolved in conciliation, a further 86 issues were resolved in assessment. A breakdown of the reasons for no further action can be seen in Table 6.

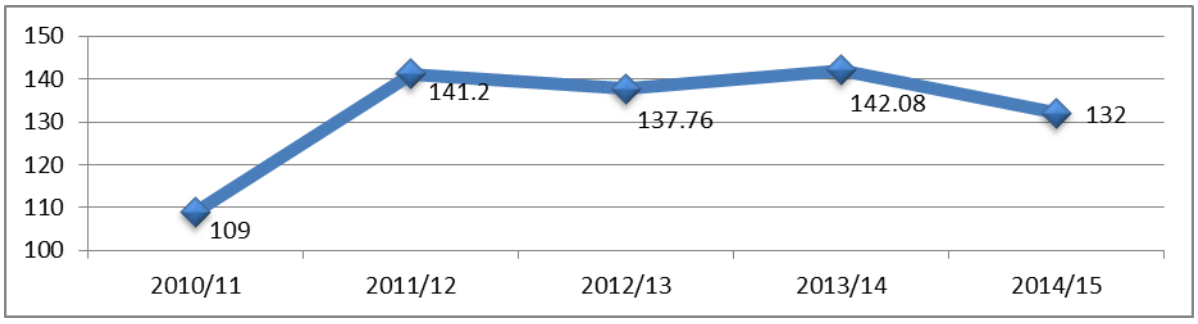
Table 6: Reason for No Further Action Issues Closed 2014/15

Reason for No Further Action	
No basis for complaint to HCSCC	15
Complaint over 2 years old	4
Failure to reasonably resolve with provider	4
Further investigation unnecessary &/or unjustified	173
Complaint lacks substance	1
Complaint is resolved	86
Complaint determined by a court, tribunal or board	1
Required information not received	7
Complaint has been withdrawn	24
Total	**315**

Time taken to Finalise Complaints

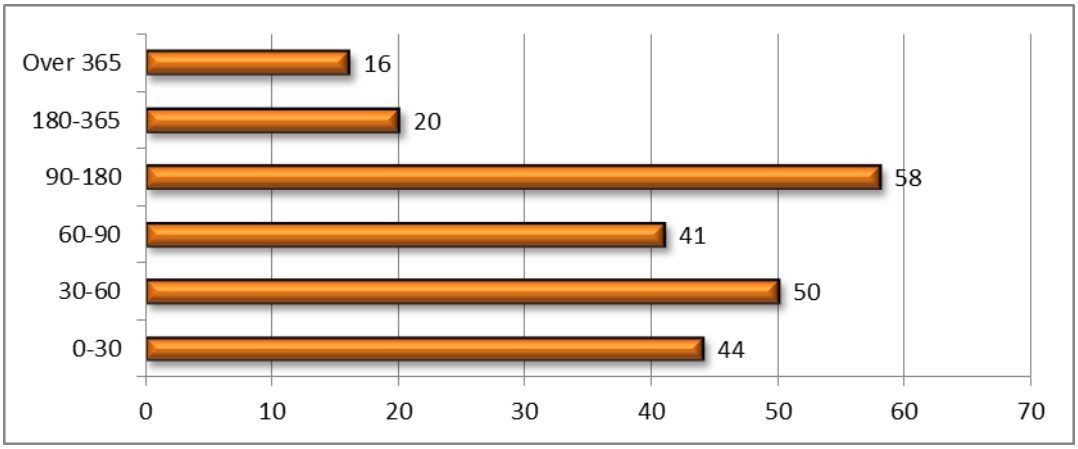
The average time taken to finalise complaints in 2014/15 remained reasonably consistent with previous years despite the increasing trend in complaint numbers. Again in 2014/15 the mandatory consultation between the Boards and HCSCC has added to the time taken to finalise complaints that involve a registered provider. It is envisaged that the change in the AHPRA consultation process will mean that complaints can be finalised more quickly.

Figure 12: Time Taken to Finalise Complaints 2014/15 (Average Days)



In 2014/15 84% of complaints were closed within 180 days. The benchmark for closure within 180 days is 80%.

Figure 13: Time Taken to Finalise Complaints 2014/15 (Total Days)



Website

Anyone can access the HCSCC through our website at www.hcscc.nt.gov.au. Our site has links to our complaint form, information (including the latest Annual Report and brochures), and our legislation, and aims to allow people to find answers to questions without the need to contact the HCSCC directly. The number of visits to our website over the past year is set out below.

Table 7: Website Access 2011/12 – 2014/15

Year	2011/12	2012/13	2013/14	2014/15
Total Visits	3157	2956	3802	4056

Twenty one percent (21%) of complaints were received from the website in 2014/15, compared with 15% in 2013/14.

Investigations

The Commissioner may decide to investigate a complaint where it is complex or raises 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 and required to advise the Commissioner of action that has been, or will be, taken to comply with the recommendation. If the Commissioner is not satisfied that appropriate steps have been taken in relation to a recommendation, the Commissioner may provide the Minister with a copy of the report and it will then be tabled in the Legislative Assembly.

Where recommendations are accepted and action plans put in place to address them, the HCSCC regularly monitors implementation of the recommendations to ensure that undertakings are met and improvements made.

Four investigations were completed in 2014/15, some of which are detailed below. Forty two recommendations were made as a result of these investigations.

Overview of Investigations

Discharge Summaries

Several complaints were received by the HCSCC about problems with discharge summaries from acute hospitals in the NT, including problems with their timeliness, problems with the correct identification of recipients of discharge summaries and poor quality information contained in them. As a consequence, the Commissioner determined to investigate what appeared to be a systemic problem with the transfer of critical health information from the acute hospital setting to the primary care setting.

Evidence for the investigation was drawn from a variety of sources, including internal Department of Health (DoH) reports, RiskMan incident reports and interviews with staff. The primary source of data was a survey circulated in April and May 2014 to all GP practices, remote health clinics and community care clinics in the NT. One hundred and twenty two completed responses were received, 57% from Allied Health Professionals, 22% from General Practitioners and 21% from Health Centre Managers and Practice Managers.

Eighty five percent of survey participants reported that in the previous twelve months there had been an occasion when they had not received a discharge summary for a patient. Fifty two percent of participants reported that this happened often, with reasons including time constraints, incorrect identification of the primary care provider or failure to identify the primary care provider at all. Interviews with hospital staff in October 2014 revealed that in the previous three months 80 pieces of correspondence had been returned, having been sent to the wrong address.

When asked the timeframe in which they normally receive discharge summaries, 37% of survey participants reported receipt within one week, 31% within two weeks and 32% longer than two weeks.

Survey participants reported that poor quality transfer of information impacts negatively on patient care, with medication incorrectly ceased, missed or not available on return to community. They reported incidents of follow up appointments not attended, primary care providers not aware of complications; and delays in management resulting in deterioration in health. There were numerous reports of breastfeeding not maintained due to lack of information and support and wellbeing also adversely affected. More extreme outcomes included the need for evacuation and re-admission to hospital. In one case, a patient was referred back to hospital for surgery that had already been performed.

It is evident that there is a problem with the preparation and dissemination of discharge summaries in the NT. The investigation showed that summaries are not commenced, not completed, dispatched but to the wrong recipients, or not to all relevant recipients. Continuity of care is broken, resources are wasted, and patients experience adverse outcomes.

Thirteen recommendations were made, addressing five areas of improvement for discharge summaries under the following headings: *Get them done, Get them right, Get them out, Send them to the right people* and *Have pathways for follow up*.

Choice and Control in Disability Services in the NT

At a national level, the focus in disability services is on people with disability exercising choice and control in the identification and planning of the services and supports they require. The Commissioner decided to investigate the way disability services are provided in the Territory in response to two complaints. The first was received from a person who requires comprehensive support to remain independent. He complained that he wanted to be the decision maker in services provided to him including annual reviews of service providers, decisions regarding the renewal of services and how his annual allocation of funding should be spent. A second complaint was received from a man also with severe physical disability who, under current NT government policy was unable to choose his service provider and make decisions about how his funding would be spent.

The investigation found that these two complainants were not fully involved in developing their own individual support plan (ISP). In comparison with equivalent policies in Western Australia which require active client involvement and ownership of their of their plan, in the NT the relevant policy does not set out in great detail how an individual can be involved, let alone drive the process.

It was also found that the Office of Disability's move away from direct funding in 2009, and continued adherence to this policy is contrary to national movements in disability services. The NT policies are based on risk mitigation concerns; whereas the National view focusses on ensuring supports are in place to ensure people with disability are empowered to and capable of taking control of their financial management. More work needs to be done to prepare and empower service providers and service users should the full NDIS roll out take place.

Recommendations accepted by the Department of Health included the need to review Office of Disability policies and update them to ensure their language and focus is in line

with person-centred principles and requirements of the National Standards for Disability Services; replacing the 2009 policy preventing self-directed funding with a policy and process designed to encourage and facilitate the maximum level of autonomy possible; and finally, that the National Standards be adopted in the NT as the standard applicable to all NT service delivery.

Management of Community Mental Health Client

The client had been case managed voluntarily by mental health services for five years. She had several admissions to hospital, however once commenced on depot (regular injection) medication she remained relatively well and out of hospital. After three years without a hospital admission, the case management team decided that the client did not have schizophrenia, that instead her problems were drug related. Her medication was ceased and she was discharged from the service. The complaint which led to the investigation concerned the failure to listen to family, the ceasing of medication and discharge from the service and inadequate follow up post discharge.

The investigation demonstrated that there were systemic problems with documentation and assessment in relation to diagnosis and the decision to discharge the client from case management. These problems included assumptions being made about the client's drug and alcohol use without proper assessment; circular decision-making processes which led to a team decision to discharge without proper oversight; a failure to question the decision to discharge the client and the basis on which this decision was made; and finally a failure to consider that the client may be becoming unwell in the face of evidence that this was the case.

The Commissioner was satisfied that improvements were implemented as a result of findings from the Northern Territory Mental Health Service (NTMHS) internal investigation into the complaint; however it was recommended that a system be put in place to ensure that a Consultant Psychiatrist review any decision to discharge client who has been managed long term by a community team and that systems be put in place to ensure that conclusions drawn about the role of drugs in a person's mental health presentation are based on properly documented assessments.

Ongoing Investigations

Investigations currently underway at the HCSCC and expected to be completed in 2014/15 cover topics including:

- Access to medical services for women in prison;
- Quality of services provided by non government disability providers;
- Internal complaint systems in an acute hospital;
- Systems issues affecting the quality of health care in a remote setting;
- Guardianship; and
- Use of interpreters in hospitals.

Public Awareness & Engagement

Aside from complaint handling and resolution, other key functions of the HCSCC include promotion of the rights and responsibilities of both service users and providers, promotion of effective complaints systems, and provision of information, education and advice about the *Health and Community Services Complaints Act*, the Code and complaint resolution.

In 2014/15 the HCSCC continued to work closely with a number of different organisations, providing training, information sessions, and workshops, and delivering presentations. Our efforts included:

- participation in the Disability Awareness Week stalls;
- information sessions in a variety of legal, council, health and disability settings; and
- consultation in person and by phone with ten government and non-government health and disability organisations to aid the development of the HCSCC Complaints Resolution training.

In addition team members from the HCSCC met with a variety of organisations one-on-one to promote our services and complaints resolution generally. These organisations included prison health services, disability providers, local councils, Integrated DisAbility Action (IdA), Community Visitor Program (CVP), National Disability Insurance Agency (NDIA), Brain Injury Association, the Medical Board, AMSANT, and National Disability Services (NDS).

In addition to the face-to-face work that was undertaken by the HCSCC, we continue to distribute brochures and posters to a range of health and disability organisations in the NT.

Planning, Development and Review

Planning

The 2013 – 2015 HCSCC Strategic Plan focuses on three main objectives of the HCSCC, being resolution of complaints, improvement of services and promotion of rights, as well as the governance or internal workings of the Commission. Some of our achievements from 2014/15 are set out below:

Resolution

- Completed a project plan for increasing the rate of complaint resolution health and disability services by increasing the proportion of complaints resolved directly with providers and increasing the proportion of complaints received by the HCSCC resolved in assessment or in conciliation;
- Consulted with government and non-government organisations to develop a training package for providers to assist with resolution of complaints;
- Tasked and assisted a provider to develop the training – this will be completed 2015/16; and
- Completed further training in resolution skills.

Improvement

- Continued to use the systemic issues register to assist in identification of issues requiring investigation;
- Continued to monitor the implementation of recommendations arising from investigations, and where appropriate, outcomes from conciliations; and
- Drafted a Complaints Handling Guide for Organisations emphasising the interaction between complaints and quality improvement – to be available early 2015/16.

Rights

- Continued to work on increased engagement with remote NT; and
- Continued to work on increased engagement with other vulnerable groups and their service providers; for example people of Culturally and Linguistically Diverse (CALD) backgrounds, people with disability and people (such as prisoners) who are only able to source services from a monopoly provider.

Governance

- New electronic complaints management system (*Resolve*) implemented from October 2014;
- New assessment report format trialled and implemented; and
- In accordance with professional development plans, training in complaint handling, conciliation and investigation provided to Senior Investigation/Conciliation Officers and Resolution Officer. Staff also participated in training in Management, NT Government Business systems and cultural awareness.

Quality

The best way to know about the quality of the HCSCC service is to ask the people who use it for their opinion; that is people who make complaints, their representatives and the people who provide the services that are complained about.

All parties to a formal complaint are provided with a survey asking whether they agree with a series of statements. The survey is provided electronically to complainants and providers who provide email addresses for the HCSCC, and in paper form for those who do not have access to internet.

People responding to the survey are given five options – Strongly Disagree with the statement, Disagree, No Opinion, Agree, Strongly Agree. When measuring responses, 5 points are awarded for Strongly Agree, 4 points for Agree and so on. Statements are framed so that 5 points indicates a positive response, and 1 point (Strongly Disagree) indicates a negative response. There are four categories on the survey related to experience with staff; the complaint process (for example whether service users and service providers understood information provided by the HCSCC); the complaint outcome; and satisfaction. A score of 90% in any given category indicates a score of 4.5, 80% a score of 4, 70% a score of 3.5, 60% a score of 3.0 and so on.

2014/15 was the first full year that the survey was used, with 32 fully completed responses received; 25 from complainants and 7 from providers. The average score from participants in the survey was as follows: experience with staff 86%; the complaint process 84.6%; complaint outcome 71.4%; and overall satisfaction 74.1%. Survey participants who were unhappy with the outcome of the complaint indicated on the survey that they did not believe that their point of view was taken seriously. They also indicated that they believed the information they provided during the complaint process was considered less important than information provided by the other party.

A difficulty with the HCSCC complaints process is the need during assessment to consider whether further outcomes can be achieved from continuing with the complaint. The problem is that there are situations where even though the complaint has substance, nothing can be achieved by investigating the issue any further. The challenge for the HCSCC is to be able to communicate effectively with people making a complaint so that they understand that a no further action decision is not a negative comment about the validity of the complaint; and in some circumstances, that outcomes are achieved from the complaint, even if the Commissioner decides to take no further action.

In response to the survey question asking whether the complaint led to an improvement in service, 51% of people involved in complaints responded that it had.

In addition to surveying parties to a complaint, in 2014/15 the HCSCC surveyed parties to an enquiry, however only seven responses were received. Due to the poor response rate, the use of the survey when enquiries are closed will be reviewed in 2015/16.

People who prefer to provide feedback in writing, or who wish to provide feedback in addition to completing the survey are able to do so via a new feedback email address: hcsccfeedback@nt.gov.au. No feedback was received via this email address in 2015/16.

Case Studies

The case studies detailed below represent a cross section of the types of matters that were finalised in 2013/14. The examples have been modified to remove identifying features.

Enquiries

Apology from patient resolves dispute

Joe contacted the HCSCC stating that he had paid a consulting fee for surgery, that a review with the surgeon was cancelled, and that the surgery was also cancelled. Joe didn't know why the surgery had been cancelled, however he needed to have it, and so was concerned about the delay and the lack of information provided to him about the cancellation.

The surgeon told the HCSCC that there had been an incident during which Joe had threatened her and other clinic staff. As a consequence, the surgeon was not sure whether she wished to go ahead with the surgery. When this response was discussed with him, Joe acknowledged the incident and asked the best way to apologise. The enquiry was resolved with a written apology from Joe and a second review appointment with the surgeon.

Refund for patient after poor treatment coordination

Jane had been treated for a medical condition by the GP practice for several years. She had been referred to a specialist, however when she found out that there would be a long delay before she could see the specialist, she decided to travel interstate. Jane contacted her GP practice for an updated referral, however she was told that they could not provide the referral as Jane's GP no longer worked for the practice and she had never consulted another doctor at the Clinic. Jane was advised she would need to attend a GP at the practice for a consult and to receive an updated referral.

The HCSCC contacted Medicare and was advised that in circumstances where the referral to the specialist had not been used and the specialist was in the same practice area (for example, neurology), the new specialist could use the referral irrespective of the name of the specialist on the referral. In other words, there was no need to update the referral, and Jane could use the referral she already had.

Enquirer resolved dispute directly by contacting the service provider

Kathleen attended the Emergency Department (ED) in a remote hospital with abdominal pains and advised the doctor that she had a few drinks with dinner the night before. The Doctor diagnosed Kathleen with gastritis and gave her a referral letter to pass on to her GP.

The referral letter suggested that Kathleen was an alcoholic – a statement which she vehemently disagreed with. Any such statement on her record would potentially place her employment at risk in the event that her employer found out. Kathleen was advised to contact the hospital directly and ask for the letter to be reviewed and re-written.

She was further advised that she could contact the HCSCC if this did not resolve her complaint. The enquiry was closed when no further contact was made.

Wrong price quoted

Before making an appointment with a Physiotherapist, Jethro was given a quote for the cost of five sessions. He agreed to the price, and after he had attended and paid for his first session, the physiotherapist rang him advising that he had given him the wrong price. The new price was double the original quote.

Jethro said he would not have gone ahead with the first session if he had been given the correct price from the outset. He felt uncomfortable contacting the physiotherapist directly, and asked the HCSCC for help.

After contact with the HCSCC and discussion with the practice manager, the physiotherapist agreed to provide the service to Jethro at the cost of the original quote.

Limited access to facilities

Janice lives in supported accommodation operated by a non government disability provider. Mandy, Janice's sister and guardian, phoned the HCSCC because she did not think that Janice was getting to go out on a regular basis as was provided for in her plan.

Janice really loves her outings and looks forward to them. Mandy believes that the problem is that the staff member responsible for taking Janice out has not been at work and no action has been taken to replace her. Mandy tried to resolve her complaint directly with the agency, but had not had a response from them.

The disability agency provided a detailed response to the issue by email to the HCSCC, acknowledging the problem and actions taken to address it. This response was forwarded to Mandy who was happy with the outcome of her enquiry with the HCSCC.

Service improvement

Zac rang the HCSCC after contacting his doctor's surgery for some test results. He felt the receptionist was rude and unhelpful – he needed to know whether the test results were in so that he could request an appointment with the GP to discuss the results.

The HCSCC contacted the practice manager who stated that reception staff did not have password access to patients' records at a level at which would enable them to know whether a test had been undertaken and results received.

The management team in the practice reviewed the Royal Australian College of General Practitioner standards in relation to password access to records with a view to ensuring that staff would be able to respond to patients' calls, while at the same time protecting patient privacy.

The procedures were changed so that reception staff could advise patients whether test results had been received, but not the results of the tests.

The Practice Manager phoned Zac directly and apologised for what had happened. She thanked him for his complaint as it provided the opportunity for an improvement in the service given to patients. Zac was very satisfied with the outcome of his complaint.

Assessments

Complaint about diagnostic service - resolved

A woman took the results of a diagnostic service provided in Darwin to an interstate appointment, only to find that she had the results of a test recently conducted on her younger brother. The woman contacted the service from her interstate appointment, but was advised that the correct results could not be forwarded without management approval. As the manager was on leave at the time, the request was not followed up. After another phone call to the service, the matter was rectified.

The complaint was resolved in assessment when the service provided a letter of apology and an explanation of how the error had occurred.

Restraint of elderly person in hospital – systemic issues register

A complaint was received from a woman (with her mother's authority) about her elderly mother who seemed to deteriorate while being treated in hospital. During the admission, the mother's usual medication regime was changed, and she became progressively more confused. The daughter thought that the deterioration in her mother's condition was due to the medication change. Due to the complexity of practice issues, the complaint about the treating doctor was referred to the Medical Board for further investigation.

The daughter also complained that when she visited her mother early one morning, she found her lying in bed with her feet elevated and the bed rails up. Her mother had been unable to get out of bed and go to the toilet. The daughter was so upset by this that she discharged her mother from hospital believing that better care could be provided at home.

The hospital advised that there were significant concerns about the mother's safety due to her confusion, level of agitation and the risk of injury should she fall. The Commissioner decided to place this issue on the HCSCC's systemic issues register, and advise the hospital that the practice of elevating a patient's feet and raising bed rails constitutes restraint. This obligates the service to collaborate with families when managing delirium and associated behaviours; document the use of restraints including the use of rails and elevating feet; ensure the use of restraints is reviewed by a medical practitioner; and monitor the consequences of restraint use.

Elderly man unable to move into nursing home without GP support - resolved

A complaint was received from the guardian of Malcolm, an elderly man who had been admitted to hospital because he was no longer able to live independently at home. Some aged care facilities in the NT will not accept residents who do not have a GP willing and able to provide health care for them in the nursing home, and accordingly, it looked as if Malcolm would have to stay in hospital.

The complaint was resolved when the HCSCC contacted the Practice Principal of the practice which had been responsible for providing a GP service to the elderly man. Another GP agreed to visit Malcolm in the nursing home and he was subsequently discharged from hospital into nursing home care.

Medical Board referral of systemic issue – no further action

The Medical Board of Australia was concerned that there may be a systemic problem with the way telephone clinical advice by Medical Practitioners working for Remote Health are documented in the clinical record, particularly when the patient cannot be identified. This followed an incident where a medical practitioner gave authorisation over the phone for medication to be dispensed to a patient, and where the identity of the patient was mistaken.

The assessment looked at 3 issues derived from the referral – identification of patients; on-call consultations; and record security. In relation to the identification of patients, the department advised that the process in place for staff to identify patients in the prison setting is for the nurse to use a minimum of 3 identifiers being the name, date of birth and IJIS number. The on-call medical practitioner is also required to identify the patient and this is usually by name, date of birth and HRN but there are other identifiers that can be used. In the case referred to AHPRA, this was not done; the nurse and medical practitioner accepted the name without checking. The Commissioner determined that satisfactory processes are in place to ensure patient identity is checked, and that this situation is unlikely to recur.

Complaint about failure to refer for further treatment - resolved

Herb, an elderly gentleman who suffers from an autoimmune disease attended the Emergency Department with an eye infection. He was reviewed by an Ophthalmology Registrar who treated the infection and discharged him from hospital. Herb remained worried about his eye, and so flew interstate to see his usual Ophthalmologist who found a mass under his eyelid. Herb complained that the Registrar did not do a thorough examination. The complaint was resolved with an apology, an explanation and agreement to reimburse the cost of airfares.

Because the complaint was resolved, the HCSCC could take no further action in relation to the practice of the Ophthalmology Registrar. Accordingly, this aspect of the complaint was referred to the Medical Board for its determination.

Birth plan not followed – referred to Medical Board

A woman complained about her experience of giving birth in an NT hospital. The woman had a birth plan in place, which included a statement that she not be given an episiotomy during birth. She complained that the Consultant decided to deliver the baby using vacuum delivery without any discussion; and that an episiotomy was performed in contravention of her explicit wish. This later became infected. Prior to contacting the HCSCC, the woman had contacted the hospital with her complaint but was not happy with their response.

When assessing the complaint, it became apparent that while the Consultant was an experienced practitioner and technically skilled, she was new to Australia and new to the hospital. As a consequence, her induction had not encompassed the need to ensure consultation with the woman giving birth. The practitioner was referred to the Medical Board. No further action was taken with the remaining complaint issues after the hospital agreed to review the orientation of new medical staff, and to report the outcomes of the implementation of this review to the HCSCC.

Birth experience spoiled by poor communication

The baby's parents were understandably upset when their baby needed resuscitation at birth and was transferred to the Neonatal Intensive Care Unit (NICU). The parents were very keen to make sure that their plans for the baby were followed; including their written request that the baby not be given a dummy. The parents felt that not only were their requests ignored, but when they tried to speak to the doctor, he was dismissive and rude.

The hospital acknowledged that the dummy should not have been provided against parental wishes. While this resolved some matters, further questions were raised. A meeting was arranged between the parents and senior hospital staff to address these further questions. No further action was taken in relation to concerns about communication with the doctor, accepting that there were differences in the way this communication was experienced and remembered by each party, and that nothing could be gained by further investigation.

Multiple issues in one complaint - quality improvement

Many complaints received by the HCSCC occur because there is a breakdown in communication between patient and family and the treating team. This is more likely to lead to a complaint if the patient is very ill and the family stressed; and what might seem minor issues are not addressed quickly and sensitively. Once there is tension in the relationship, trust is more difficult to maintain and complaints are likely to increase. The complaint outlined below is about a young woman who was brought to hospital with a severe injury, and her family who were understandably worried about her and wanting to be fully informed about current and proposed treatment.

Problems from the family's perspective started when their daughter was first admitted to hospital. She was frightened and wanted her family with her. When the family asked to stay with her overnight, they were told this was not possible. Their concerns were compounded when, over the first week, they were given conflicting information by different members of the treating team about their daughter's diagnosis and proposed treatment. On review by the HCSCC, this confusion was reflected in the patient medical record. With respect to the day to day care provided to their daughter, the family were upset that food and drinks were consistently placed out of her reach, and that nothing was done when they raised this issue with nursing staff.

The hospital responded and addressed concerns about clinical handover. One outcome from this complaint is that clinical handover now takes place with the patient present and thus allows for information to be consistently provided to patient and family as well as team members. In relation to the quality of treatment provided, the family now understands that the treating team was in constant touch with an interstate team regarding how the patient's condition should best be managed. Finally, in advising the hospital of the outcome of the complaint, the HCSCC strongly suggested that the hospital's visiting and boarder policy be reviewed. The hospital was also asked to consider improvements that could be made in relation to the issues raised in the complaint, and specifically around meals and drinks to ensure that staff communicate with the patient to ensure placement of meal trays and drinks is appropriate.

Conciliations

Transfer of medical care from interstate

A man was diagnosed with cancer just prior to his transfer to the Northern Territory for work. His interstate medical team developed a treatment plan, and advised him that appropriate treatment would be available in the NT. Accordingly, the man decided he would not change his decision, and proceed to move to the NT. Initial treatment commenced quickly, however there were delays with the next stage in treatment, with NT specialists appearing to question the plan developed interstate. Eventually, the man sourced and obtained treatment outside the NT. The complaint concerned the co-ordination of treatment between the interstate and NT hospitals and delays in treatment. The complainant was also unhappy about the standard of communication between his GP and the NT hospital.

Although very ill, the man wanted to continue with his complaint to ensure that his experience was not repeated. Representatives of the NT hospital attended a conciliation conference within a few weeks of the decision to conciliate. As a result of this complaint, improvements have been made to ensure that only appropriate referrals are accepted by the hospital and that the coordination of treatment is improved.

Conciliation conducted in the prison

The prisoner had contacted the HCSCC on multiple occasions with concerns about the failure of the prison health service to provide ointments needed to manage a chronic skin condition. The ointment had been prescribed by a dermatologist, however the team at the prison ceased treatment on the grounds that long term treatment could cause harm. The prisoner was also having problems with other topical treatments which needed replenishing on a regular basis. He complained that these treatments were not routinely ordered and that he would go for long periods of time without the treatment, leading to continued deterioration in his skin condition.

The conciliation was held at the prison, attended by the prisoner and senior staff from Remote Health Services (responsible for the health service in the prison), including a senior medical practitioner. The complaint was resolved with an agreement that the treatments would be made routinely available, and that any concerns the prisoner had would be addressed by regular meetings between him and a senior practitioner from the prison health service.

Disfigurement following surgery

After discharge from a public hospital in the NT following cosmetic surgery, a woman developed infections which required several further procedures for debridement and ultimately a split skin graft. The complaint made to the HCSCC was that the woman was not provided with adequate information either before or after the surgery about what might go wrong, that the standard of care provided by the doctors was not to a reasonable standard and that medications were changed without consulting her.

The hospital representative acknowledged the adverse outcome. It was explained that it can sometimes be difficult to convey to patients what outcomes they may have and what complications there can be with surgery. Resolution was reached with these explanations and partial payment towards the cost of future surgical procedures to repair the damage.

Communication problems

An Aboriginal man contacted the HCSCC because his wife had been taken to a regional hospital where she received emergency treatment for a heart attack. She subsequently passed away. The man did not understand what happened to his wife and what caused her death. He complained to the HCSCC in the hope that he could get an explanation of his wife's medical condition, and the treatment provided to her.

The conciliation was attended by the man and his NAAJA representative, with the hospital represented by senior medical staff. An explanation was provided, and resolution reached with an agreement that the hospital would investigate whether they could provide a card to clients containing hospital contact person details for follow-up of information after critical events.

More communication problems

A woman complained about the care her mother received from the hospital when she lost a lot of weight after being prescribed medication to treat a lung condition. When the daughter tried to tell multiple doctors about her concerns, it felt like no-one was listening. Eventually, her mother stopped taking the medication and seemed to get better, however doctors later put the mother back on another medication, and she deteriorated again. Many problems with communication were raised in this complaint, including problems with communication between doctors and mother and daughter, problems with the discharge summary being sent to the incorrect GP and problems in communication between staff discharging the client and the ward treating team.

It was agreed at conciliation that the complainant would be given a letter of apology and that formal feedback would be provided to staff regarding the communication difficulties that had occurred. It was also agreed that the discharge policy would be amended to ensure that the team monitoring patients before discharge would contact the treating team in the event of any concerns about discharge.

Treatment delayed in the Emergency Department

A man who has managed his own asthma for many years attended the Emergency Department when he experienced an acute episode. He complained that it had taken too long to triage him and was unhappy about the triage category assigned to him, believing that he should have been treated more urgently. The man wrote to the hospital with his complaint, but did not receive a response.

At conciliation, an explanation of the triage system in the hospital Emergency Department was provided. Information was also provided about relevant professional development undertaken by Emergency Department staff. In relation to the failure to respond to the complaint made directly to the hospital, the complainant was advised that all complaints received by the hospital are entered in the TRIM database and responses tracked to ensure that all complaints are responded to. It was also agreed that a protocol would be placed on the man's medical record for any future attendances at the Emergency Department.

Appendix 1: Breakdown of Complaint Issues

Tables 8 - 19 provide further breakdown of the content of each of the major issue categories.

Table 8: Access Category

ACCESS	2011/12	2012/13	2013/14	2014/15
Access to facility	0	1	0	3
Access to subsidies	0	1	0	2
Refusal to admit or treat	4	5	8	7
Service availability	1	6	12	9
Waiting list delay	2	3	5	2
Total	**7**	**16**	**25**	**23**

Issues relating to access made up 4% of all issues raised in complaints in 2014/15.

Table 9: Communication & Information Category

COMMUNICATION & INFORMATION	2011/12	2012/13	2013/14	2014/15
Attitude and manner	12	20	38	42
Inadequate information provided	7	12	16	37
Incorrect/misleading information provided	1	2	4	12
Special needs not accommodated	0	4	3	6
Total	**20**	**38**	**61**	**97**

Issues relating to communication and information made up 19% of all issues complained about. This is consistent with last year's figures (18%).

Table 10: Consent Category

CONSENT	2011/12	2012/13	2013/14	2014/15
Consent not obtained or inadequate	4	3	9	17
Involuntary admission or treatment	2	0	2	1
Uninformed consent	0	1	1	1
Total	**6**	**4**	**12**	**19**

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

Table 11: Discharge & Transfer Arrangements Category

DISCHARGE & TRANSFERS	2011/12	2012/13	2013/14	2014/15
Delay	0	0	1	0
Inadequate discharge	0	6	3	17
Mode of transport	0	0	0	1
Patient not reviewed	0	1	1	0
Total	**0**	**7**	**5**	**18**

Three per cent of issues raised in 2014/15 related to discharge and transfer arrangements.

Table 12: Environment & Management of Facility Category

ENVIRONMENT & MANAGEMENT	2011/12	2012/13	2013/14	2014/15
Administrative processes	1	4	3	16
Cleanliness/hygiene of facility	2	2	0	10
Physical environment of facility	1	0	2	7
Staffing and rostering	1	2	6	3
Statutory obligations/accreditation	1	2	3	6
Total	**6**	**10**	**14**	**42**

Complaints in this category relate to administration rather than the care/treatment component of the service. These issues made up 8% of all issues raised in complaints, double that of last year.

Table 13: Fees, Cost & Rebate Issues Category

FEES, COSTS & REBATES	2011/12	2012/13	2013/14	2014/15
Billing practices	0	1	7	9
Cost of treatment	1	0	0	0
Financial consent	0	1	0	1
Total	**1**	**2**	**7**	**10**

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

Table 14: Grievance Category

GRIEVANCE	2011/12	2012/13	2013/14	2014/15
Inadequate or no response	2	6	5	19
Complaint information not provided	1	1	0	2
Reprisal/retaliation as a result of complaint lodged	0	2	0	2
Total	**3**	**9**	**5**	**23**

Issues of grievance and complaint handling made up 4% of all issues complained about, an increase from 1% last year, but consistent with previous years.

Table 15: Medical Record Category

MEDICAL RECORDS	2011/12	2012/13	2013/14	2014/15
Access to/transfer of records	0	0	2	7
Record keeping	2	6	5	7
Record Management	0	0	1	5
Total	**2**	**6**	**8**	**19**

The medical record category includes complaints about errors and inadequacies in medical records. They accounted for 4% of all issues complained about in 2014/15.

Table 16: Medication Category

MEDICATION	2011/12	2012/13	2013/14	2014/15
Administering medication	2	5	7	7
Dispensing medication	0	4	3	3
Prescribing medication	2	6	6	9
Supply/security/storage of medication	2	2	3	7
Total	**6**	**17**	**19**	**26**

Medication related concerns made up 5% of all issues in 2014/15, consistent with 2013/14.

Table 17: Professional Conduct Category

PROFESSIONAL CONDUCT	2011/12	2012/13	2013/14	2014/15
Assault	1	2	12	6
Boundary violation	7	4	5	4
Breach of Condition	0	0	2	2
Competence	21	20	60	53
Discriminatory conduct	0	2	5	2
Emergency treatment not provided	0	0	0	0
Financial fraud	5	0	1	1
Illegal practice	5	6	14	6
Impairment	1	3	1	3
Inappropriate disclosure of information	1	8	12	14
Misrepresentation of qualifications	0	1	4	0
Sexual misconduct	0	4	1	1
Total	**41**	**50**	**117**	**92**

Issues relating to professional conduct made up 18% of all issues complained about. The majority of these matters were dealt with in conjunction with AHPRA in accordance with the consultation requirements under the National Law.

Table 18: Reports/Certificates Category

REPORTS/CERTIFICATES	2011/12	2012/13	2013/14	2014/15
Accuracy of report/certificate	0	2	3	7
Cost of report/certificate	0	0	0	1
Inadequate/no consultation	0	0	1	1
Timeliness of report/certificate	0	0	0	0
Total	**0**	**2**	**4**	**9**

Complaints about reports and certificates made up 2% of issues in complaints closed in 2014/15. The HCSCC has no jurisdiction over the process of writing, or the content of, a health status report.

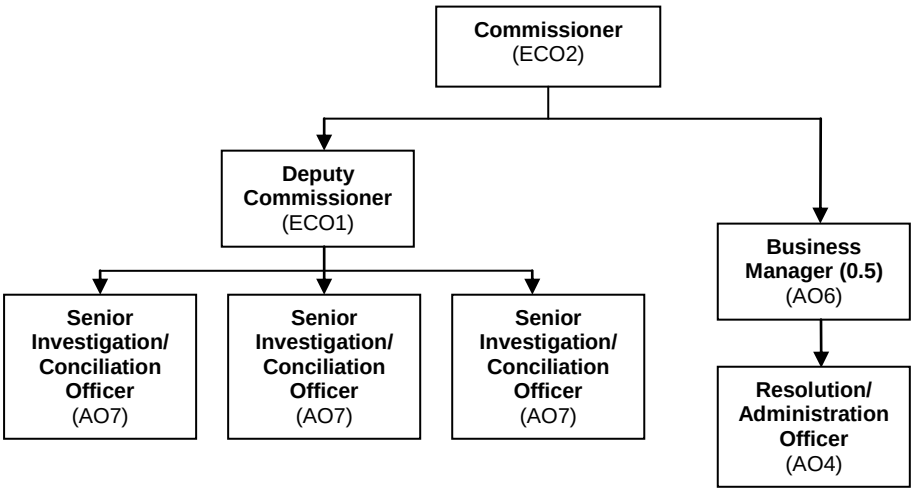
Table 19: Treatment Category

TREATMENT	2011/12	2012/13	2013/14	2014/15
Attendance	**0**	**0**	**1**	1
Coordination of treatment	3	1	11	18
Delay in treatment	2	1	9	11
Diagnosis	12	8	12	13
Excessive treatment	0	3	0	3
Inadequate consultation	1	0	4	5
Inadequate treatment	9	7	17	39
Infection control	0	2	2	5
No/inappropriate referral	2	4	0	9
Public/Private election	0	2	0	
Rough & painful treatment	0	0	1	4
Unexpected treatment outcome	8	8	4	13
Withdrawal of treatment	2	3	1	4
Wrong/inappropriate treatment	5	2	9	13
Total	**44**	**41**	**71**	**138**

Issues relating to treatment constituted 26% of all issues in complaints closed in 2014/15, higher than in 2013/14 (20%). Inadequate treatment is identified as the primary concern within this category.

Appendix 2: Organisation

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



The HCSCC has 6.5 full time equivalent staff. The HCSCC shares a Business Manager (AO6) with the Office of the Children's Commissioner.

Table 20: Staffing Profile as at 30 June 2015

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

Vision

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

Mission

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

Our Values

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

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