Health and Community Services
COMPLAINTS COMMISSION

Annual Report

2012-2013

DRIVING
improvement

Health and Community Services
COMPLAINTS COMMISSION

Fifteenth Annual Report 2012/13

The Honourable Robyn Lambley 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 2013.

Yours sincerely

Lisa Coffey
Commissioner

14 October 2013

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FROM THE COMMISSIONER

2012/13 was the Health and Community Services Complaints Commission's (HCSCC) third full year of operation as a stand-alone independent office. As this report demonstrates, it was a busy year with an increase in the more serious matters handled, complaints from a wider range of areas in the NT, and more matters resolved through conciliation processes.

Complaints and Resolution

One of the most interesting aspects of our work this year was the increase in complaints, as opposed to enquiries which we deal with informally. The overall numbers of matters coming to the HCSCC remained relatively stable, but our efforts were increasingly focused at the more serious end of the complaint spectrum. This shift is good news for us as we are aiming to move out of the lower level complaints management and instead focus our energy on assisting service providers to resolve these matters without us. This will allow us to concentrate on matters that require assessment, and possibly conciliation or investigation.

We continue work to assist providers with this direct resolution however by providing input into their complaint handling procedures, having conversations about practical concerns providers face in dealing with complaints, and delivering training and tips on how to resolve complaints. We are also sharing more stories of complaint resolution in this report as providers have been telling us that these practical examples are very useful in breaking down misconceptions about how the HCSCC works and giving ideas of how complaints could be resolved in other contexts.

Even with the increase in more formal complaints, we have remained involved in informal resolution in many matters over the year. To help us to measure the effectiveness and long term sustainability of outcomes from this informal process, we have developed a new survey tool for complainants and providers. We will look forward to reporting on outcomes of this survey in the next year.

Outcomes Monitoring

At the other end of the spectrum, this year we have met our aim to more effectively monitor the implementation of outcomes from complaints, investigations and conciliations with the development of a monitoring process and register. There is no formal requirement for the HCSCC to monitor the implementation of recommendations made after investigation or the outcomes of conciliations, however we believe that this follow-through is essential to ensure we really are driving improvement through our processes.

Where parties have committed to implement a recommendation or agreed to monitoring of conciliated outcomes, the HCSCC will seek regular updates on progress against these commitments, closing the file once all have been completed. This process should not only ensure that change is made, but also allow us to test the effectiveness of our recommendations and allow for flexibility in implementation if and when appropriate.

Details of the numbers and types of matters monitored can be found later in the report.

Disability

2012/13 was an exciting year in disability services in the NT with the announcement of a National Disability Insurance Scheme (NDIS) / DisabilityCare launch site in the Barkly region. I joined National Disability Services on a road trip to Alice Springs and Tennant Creek in March to talk about NDIS, what it is, and what it means in remote NT. For participants in the

Barkly launch of NDIS, complaints will continue to be able to be made to the HCSCC about disability services provided under the scheme.

Key to the success of the full NDIS is the development of a robust oversight and complaints mechanism that allows for flexible resolution of complaints, while at the same time ensuring that systemic issues can be identified and addressed. With other Disability Services Commissioners around Australia, the HCSCC has identified a number of key qualities that an effective safeguard must have. Included in this are independent oversight, consisting of bodies with complaint handling and investigative powers as well as monitoring and review functions; safeguards to prevent and effectively respond to abuse, neglect and exploitation, including requirements for critical incident reporting and oversight of the use of restrictive interventions; community visitors at residential care services; effective public guardian and/or advocate functions; and advisory councils that represent people with a disability. Many of these safeguards could be implemented through strengthening and expanding existing oversight mechanisms in the NT.

In addition to these developments, the HCSCC has completed an important investigation into disability services provided in a remote community. The investigation detailed a number of systemic failures in service delivery, dating back to 2006. As the findings relate to a matter that is now six years old, in 2013/14 the HCSCC will undertake an audit of a sample of current services in remote communities in a bid to understand whether similar issues continue to exist. It is hoped that the findings of the initial investigation and the audit process will be valuable in informing development of the NDIS in remote NT and improving the quality of remote disability services generally.

Thanks

I record my thanks to the great team at the HCSCC for their hard work this year, and in particular to my new Deputy Judy Clisby. This year has had a variety of challenges unique to small offices, but our expertise has continued to grow, along with our commitment to learning. I am very proud of the work that we do and the way that we do it.

I speak every year about the courage required to both make a complaint as a service user, and to engage constructively in the complaint process as a service provider. That courage was evident in 2012/13 as in other years and as usual I thank all who have been involved in our processes.

This year I would also like to thank another group who are essential to our work – the expert professionals that we rely on for advice and guidance in our management of many of the more technical complaints. These experts and advisors are external to our office and are called upon to assist me in decision making about what action should be taken in relation to a complaint. We utilise their experience to identify “red flags” or issues of potential concern; and seek expert reports in investigations to allow for peer based assessment of practitioner and/or organisational conduct. Many of these practitioners that we rely on assist us without charge. I hope that they find the work interesting. Their efforts are highly valued and essential to our process.

As I said at the beginning of this section, it is the third year of independent operations for the HCSCC. Three years in, I believe that the HCSCC’s visibility has increased across all of the areas of our jurisdiction, as has our expertise, and our effectiveness in resolution, improvement and promotion of rights. We continue to work to build solid stakeholder relationships and improve our own service. In short I am confident that the quality of the service we provide has improved, and with our new plan to come into play in 2013/14, that improvement will continue.

Lisa Coffey
Commissioner

PERFORMANCE OVERVIEW FOR 2012/13

Key performance outcomes for 2012/13 period:

- Complaints increased by 28% (129 compared with 101 in 2011/12).
- Enquiries decreased by 14% (down to 393 from previous high of 458).
- The number of complaints closed increased by 23%, while the average time taken to finalise a complaint remained relatively stable at 138 days.
- Average time taken to assess a complaint was 80 days, with only 44% of complaints assessed within the legislated 60 days, down from 50% in the previous year.
- Average time to finalise an enquiry met the benchmark of 10 days.
- 26% of complaints came from outside major NT urban areas.
- There was a slight increase in complaints about disability and aged services, and a more significant increase (21 to 30) in number of enquiries about disability complaints.
- Ten complaints were resolved via conciliation, up from five in the previous year.
- Four investigations were completed.
- The HCSCC is monitoring implementation of recommendations and agreed outcomes in 17 matters, and has signed off on 31 outcomes from two matters in the reporting period. 68 individual outcomes will be carried over for monitoring in 2013/14.

This snapshot of the HCSCC's activities in 2012/13 demonstrates that the matters dealt with were of higher levels of seriousness and complexity (handled as complaints rather than enquiries). Despite a slight improvement in the time taken to finalise complaints, this increased complexity is likely to be reflected in the longer average periods required for assessment of complaints. This timeliness will be a focus for improvement in the coming year.

Efforts to promote resolution and encourage complaints from remote communities and in the area of disability are leading to incremental improvements in these numbers each year.

ABOUT US

Administrative Arrangements

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

Vision

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

Mission

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

Values

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

Objectives

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

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

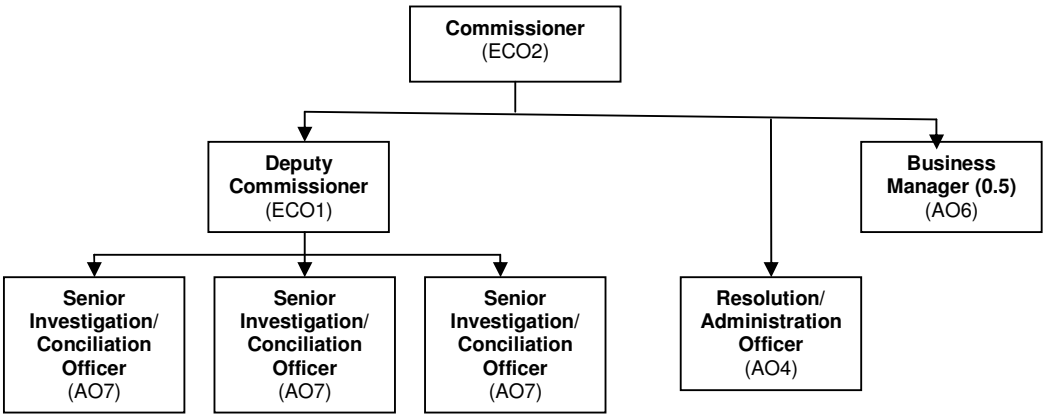
Powers and Functions

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

(a) to inquire into and report on any matter relating to health services or community services on receiving a complaint or on a reference from the Minister or the Legislative Assembly;
(b) to encourage and assist users and providers to resolve complaints directly with each other;
(c) to conciliate and investigate complaints;
(d) to record all complaints received by the Commissioner or shown on returns supplied by providers and to maintain a central register of those complaints;
(e) to suggest ways of improving health services and community services and promoting community and health rights and responsibilities;
(f) to review and identify the causes of complaints and to —
    (i) suggest ways to remove, resolve and minimise those causes;
    (ii) suggest ways of improving policies and procedures; and
    (iii) detect and review trends in the delivery of health services and community services;
(g) to consider, promote and recommend ways to improve the health and community services complaints system;
(h) to assist providers to develop procedures to effectively resolve complaints;
(i) to provide information, education and advice in relation to —
    (i) this Act;
    (ii) the Code; and
    (iii) the procedures for resolving complaints;
(j) to provide information, advice and reports to —
    (i) the Boards;
    (ii) the purchasers of community services or health services;
    (iii) the Minister; and
    (iv) the Legislative Assembly;
(k) to collect, and publish at regular intervals, information concerning the operation of this Act;
(l) to consult with —
    (i) providers;
    (ii) organisations that have an interest in the provision of health services and community services; and
    (iii) organisations that represent the interests of users;
(m) to consider action taken by providers where complaints are found to be justified;
(n) to ensure, as far as practicable, that persons who wish to make a complaint are able to do so; and
(o) to consult and co-operate with any public authority that has a function to protect the rights of individuals in the Territory consistent with the Commissioner's functions under this Act.

Organisational Structure

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



Human Resources

At 30 June 2013 the HCSCC had 5.5 full time equivalent staff, compared with our full staffing complement of 6.5, with one staff member on extended leave from February 2013. The HCSCC shares a Business Manager (AO6) with the Office of the Children's Commissioner.

Table 1: Staffing Profile as at 30 June 2013

Position Level	Male	Female	Total
Commissioner (ECO2)	0	1	1
Deputy Commissioner (ECO1)	0	1	1
Administrative Officer 7 (AO7)	0	2	2
Administrative Officer 6 (AO6)	0.5	0	0.5
Administrative Officer 4 (AO4)	0	1	1
Total	**0.5**	**5**	**5.5**

Performance Measures

The HCSCC's performance for 2012/13 is measured through a set of agreed parameters as set out below. These performance measures are intended to present an overview of the operations of the HCSCC over the 12 month period. More detail on performance can be found throughout in this report.

Table 2: Key Deliverables 2011/12 – 2012/13

Key Deliverables	2011/12	2012/13
Enquiries & complaints received	559	522
Enquiries & complaints closed	485	460
Complaints resolved within 180 days of receipt	78%	80%

RESOLUTION OF COMPLAINTS

The Process

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

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

Enquiries

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

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

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

Complaints

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

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

Australian Health Practitioner Regulation Agency (AHPRA)

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

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

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

Referral

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

No Further Action

The Commissioner can decide to take no further action on a complaint at any time. Under the Act no further action may be taken for various reasons, including when a complaint has been resolved, lacks substance, or is over two years old. The Commissioner may determine to take no further action if she is of the view that the complainant has failed without good reason to make a reasonable effort to resolve the complaint. And finally, at times the Commissioner will take no further action in relation to a complaint if she forms the view that there is nothing to be gained by further investigation of the complaint. That is, all of the questions raised by the complaint have been answered, all the outcomes sought have been achieved or are unlikely to be achieved, or the nature of the complaint simply does not justify the use of further time or resources.

It is important to note that even though a decision might be made that there is nothing further to be gained from further investigation, this does not mean that the complaint itself was not justified. Nor does it mean that nothing is gained from the complaint. Often the fact of a complaint is enough to encourage providers to reflect on and change practice so that the experience of one service user is not repeated.

Conciliation

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

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

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

Investigation

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

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

New Approaches 2012/13

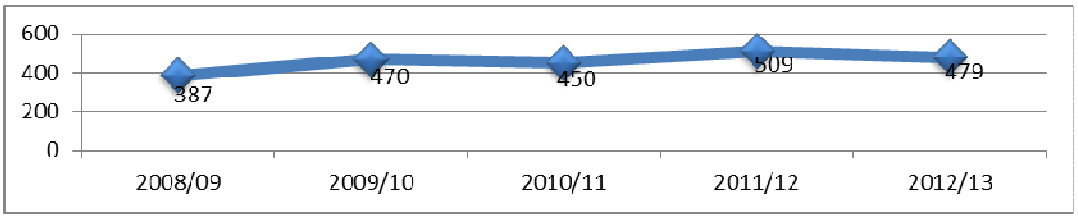
To put the process outlined above in perspective, a total of 393 enquiries and 129 complaints were received during 2012/13. As 43 enquiries became complaints, the net approaches made to the HCSCC were 479.

Explanation Regarding Approaches

Approaches registered as an enquiry	393
LESS enquiries moved to a complaint	43
Net enquiries received	350
Approaches registered as a complaint	86
PLUS enquiries moved to a complaint	43
Total complaints received	129
Total approaches for 2012/13	479

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

Figure 1: Approaches



Of all the approaches made to the HCSCC in 2012/13:

- 54% were female and 45% male;
- 69% were made by phone;
- 51% related to private providers and 49% to public providers.

Website

Anyone can access the HCSCC through our website at www.hcscc.nt.gov.au. By logging onto the site people can access our complaint form, information (including the latest Annual Report and brochures), and our legislation or ask questions without the need to formally contact the HCSCC. The number of visits to our website over the past year is set out below.

Table 3: Website Access 2010/11 – 2012/13

Year	2010/11	2011/12	2012/13
Total Visits	2017[1]	3157	2956

15% of complaints were received electronically in 2012/13 (compared with 13% in 2011/12 and 6% in 2010/11).

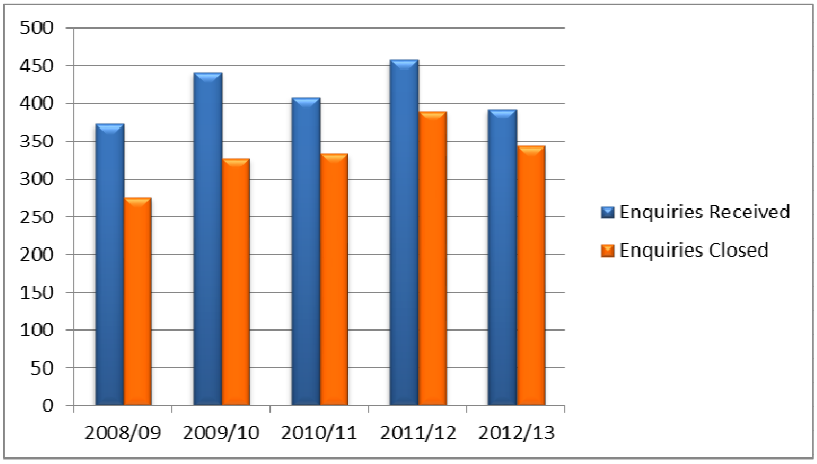
[1] There were no figures available for a number of months and therefore this number is unreliable.

Enquiries

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

In 2012/13, 393 enquiries were received, a decrease from a high of 458 in 2011/12. This decrease in enquiries was offset by an increase in complaints detailed later in the report. It is pleasing to note that the ratio of enquiries opened to closed has continued to narrow over the past three years (88% in 2012/13, compared with 85% in 2011/12 and 74% in 2008/09).

Figure 2: Enquiries Received and Enquiries Closed 2008/09 - 2012/13



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

Table 4 provides a breakdown of the types of provider subject to enquiries during the reporting year. Public providers accounted for 50% of the enquiries received, 36% of which were public hospitals and Corrections medical services 44%.

Table 4: Providers Subject of Enquiries 2008/09 – 2012/13

	2008/09	2009/10	2010/11	2011/12	2012/13
Private	173	173	178	232	198
Public	202	268	230	226	195
Total	**375**	**441**	**408**	**458**	**393**

PRISONER ENQUIRIES

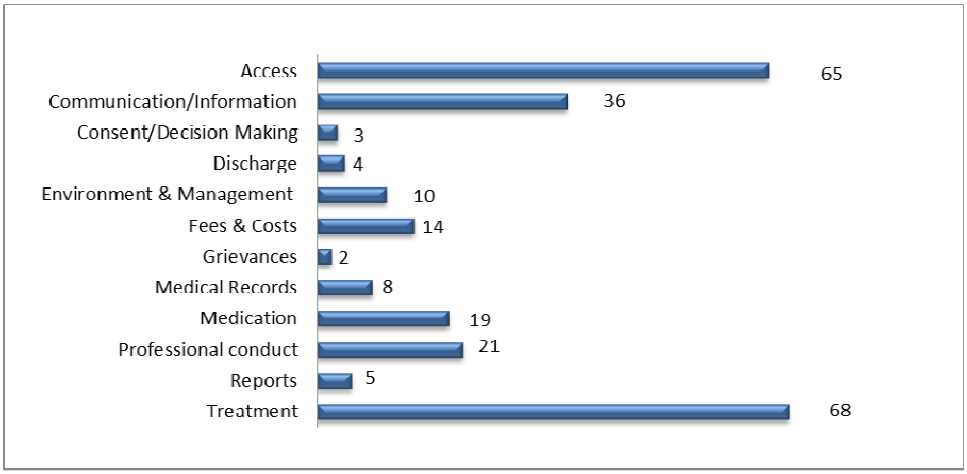
Prisoners are able to contact the HCSCC to raise concerns about services via a dedicated, secure phone line. The majority of the issues raised by prisoners are referred back to Corrections Medical Service to be resolved in accordance with agreed protocols. Of 89 prisoner approaches to the HCSCC, 96% were resolved as enquiries. The balance were dealt with through a formal complaint process.

Responsibility for Corrections Medical Services changed from International SOS to Remote Health (DoH) in 2012. This does not appear to have made a substantive difference to the number of enquiries received from prisoners about health services in prison.

ISSUES RAISED IN ENQUIRIES

Issues raised in enquiries are recorded and as Figure 3 indicates, issues associated with the standard of treatment, accessing services and communication were of most concern. These three issues are the most commonly raised in enquiries year to year.

Figure 3: Issues Raised in Enquiries Closed 2012/13

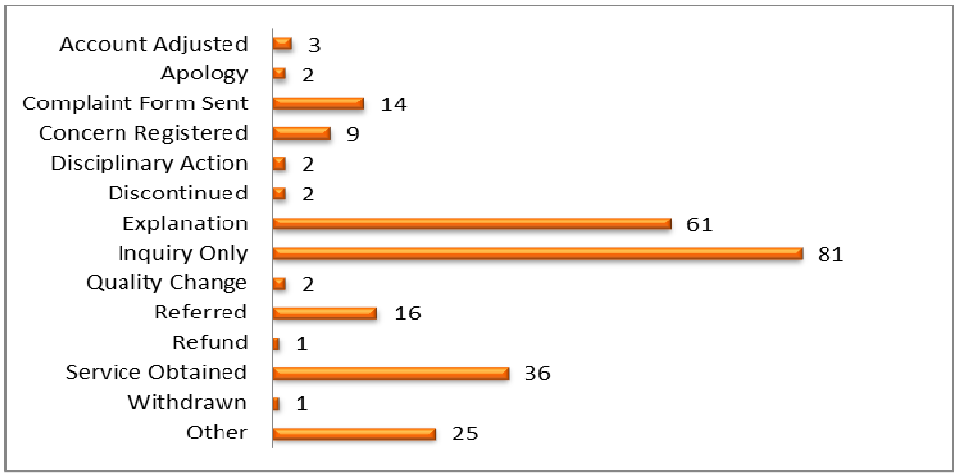


OUTCOMES OF ISSUES RAISED IN ENQUIRIES CLOSED

In 2012/13, 81 (32%) of all enquiries involved people contacting the HCSCC to seek advice about a matter, with no further action needed by HCSCC staff. 61 (24%) enquiries resulted in the person receiving an explanation related to their concern.

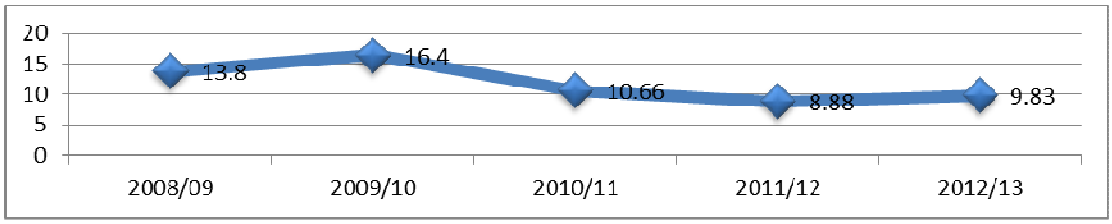
The outcome of our resolution work with enquiries is detailed in Figure 4 below.

Figure 4: Outcome of Issues Raised in Enquiries Closed 2012/13



As seen in Figure 5 below, the average time taken to finalise enquiries has increased during the reporting period, from just under 9 days to just under 10 days.

Figure 5: Time Taken to Finalise Enquiries (Days) 2012/13



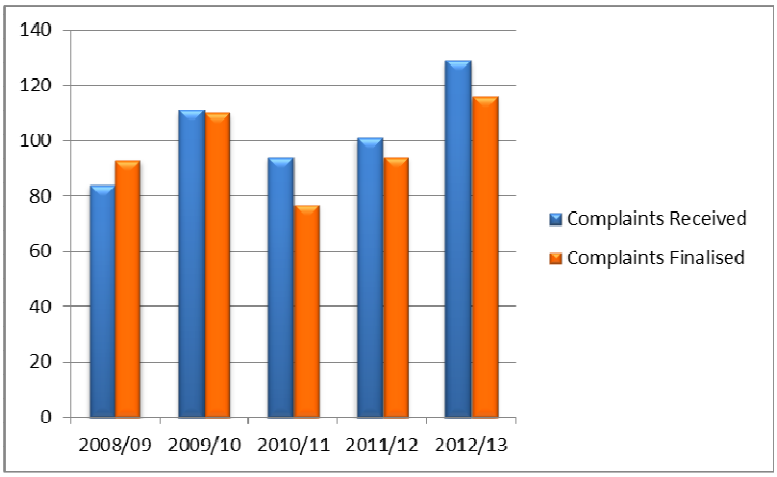
The benchmark set for finalisation of enquiries is 10 days, with significant improvements in the timeliness of enquiries achieved in the past three years.

Complaints

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

In 2012/13, staff of the HCSCC handled 199 complaints, 70 of which were already open at the beginning of the financial year. 129 new complaints were received in 2012/13, a significant increase on previous years.

Figure 6: Complaints Received and Finalised 2008/09 – 20012/13



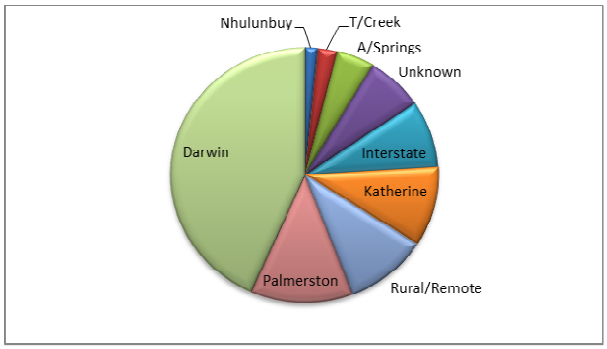
WHO COMPLAINS & HOW?

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

Of the complaints with residential details recorded in 2012/13, 47% came from Darwin, 13% from Palmerston, 15% from remote NT (including Tennant Creek), 11% from Katherine, 9% from interstate and 5% from Alice Springs.

In 2012/13 there was a significant increase in complaints from outside the two main urban centres, with 26% of complaints coming from other areas of the NT. This is up from 13% in 2011/12.

Figure 7: Geographic Source of Complaints 2012/13



Where the complaint is made by phone the complainant is asked to confirm it in writing. Where a complainant is unable to confirm a complaint in writing themselves, the HCSCC will reduce it to writing and provide a copy to the complainant as required under the Act.

In 2012/13, 23% of complainants approached the HCSCC by phone, 3% in person and 14% in writing. 15% of all complaints were received electronically. AHPRA notifications made up 29% of complaints. The remaining complaints were referred to the HCSCC by a legal practitioner (12%), a Registration Board (3%) or the Community Visitor Program (1%).

WHAT SERVICES ARE COMPLAINED ABOUT?

Table 5 provides a breakdown of providers, both individual and institutional, subject to complaints during the reporting year. The numbers of complaints against public and private providers were relatively even for the reporting period.

Table 5: Providers Subject to Complaints 2008/09 – 2012/13

	2008/09	2009/10	2010/11	2011/12	2012/13
Private	41	49	47	61	67
Public	43	62	47	40	62
Total	**84**	**111**	**94**	**101**	**129**

Figure 8 gives a breakdown of public sector complaints, with Acute Services (Public Hospitals) the most commonly complained about (31%), followed by individual Medical Practitioners (27%) and Nurses and Midwives (24%).

Figure 9 shows that Medical Practitioners were subject to the greatest number of complaints in the private sector (37%), followed by Aboriginal Health Services (12%) and Dental Services (10% up from 3% in 2011/12). Complaints against Nurses and Midwives in the private sector dropped to 1%, down from 16% in 2011/12.

Figure 8: Public Providers

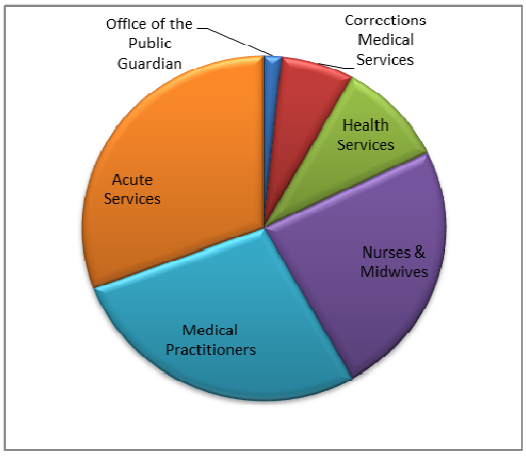
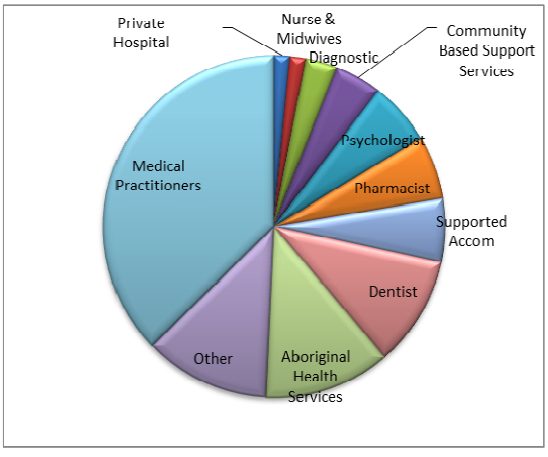


Figure 9: Private Providers



A further breakdown of complaints about services for aged people and services for people with a disability is set out in Table 6 below. As can be seen from the table, the numbers of complaints about aged and disability services are slowly increasing. This is reflected in

enquiries about disability services, which were up to 30 in 2012/13; an increase from 21 the year before.

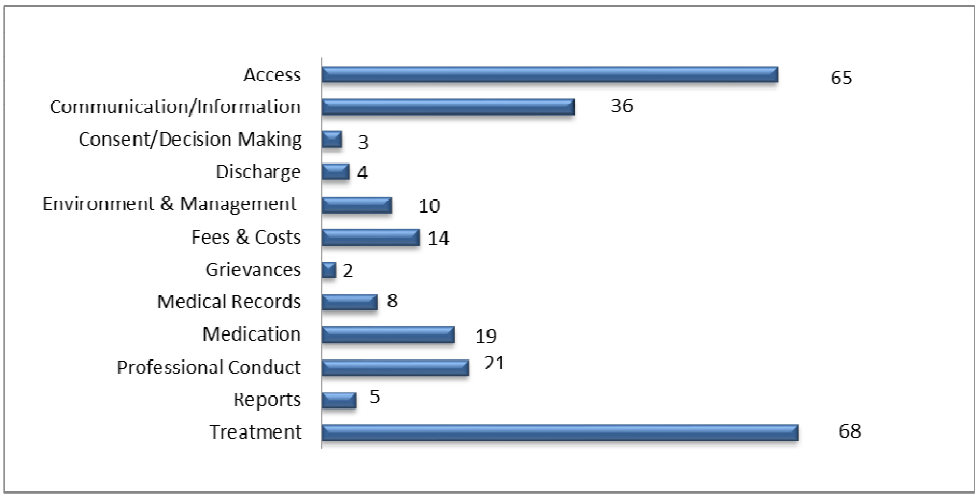
Table 6: Aged and Disability Services Complaints 2010/11 – 2012/13

Provider Type	2010/11	2011/12	2012/13
Hostel/Supported Accommodation	0	1	3
Nursing Homes	0	1	1
Aged and Disability services (public)	2	1	2
Mental Health Services (public)	3	1	1
Community Based Support - Disability	0	2	1
Total	**5**	**6**	**8**

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 2012/13



In 2012/13 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.

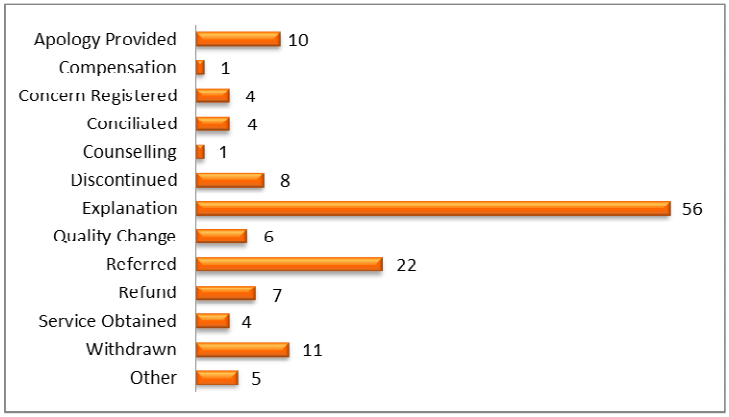
As a result of this amendment, issues associated with professional conduct have been identified as most common in 2012/13. While the top three issues remain consistent year on year (conduct, treatment and communication), most conduct matters are dealt with by the National Health Practitioner Boards.

A further breakdown of each of the categories of complaint issue and a comparison with previous years can be found at Appendix 1. Of note is the increase in the number of issues in categories such as medication, access, discharge and transfer, and grievances.

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 2012/13



The most common outcome from complaints was an explanation (40%). In 16% of cases, at least one aspect of the complaint was referred elsewhere, including to the relevant Health Practitioner Regulation Board for further consideration. The figures do not report on outcomes of Board processes, or outcomes of matters that originated with the Boards unless referred to HCSCC.

WHAT HAPPENS TO OUR COMPLAINTS?

The HCSCC finalised 126 complaints in 2012/13. As seen below, 116 complaints were closed, and a further ten were closed pending implementation of outcomes.

Table 7: Reasons for Closure: Complaints Closed 2012/13

REASONS FOR CLOSURE 2012/13	Number	Total Closed
Investigation complete	2	
Conciliation complete	5	
No further action	53	
Referred to other entity	14	
Dealt with by Board pursuant to MOU[2]	42	
Total		**116**
Closed Pending Monitoring		
Investigation	3	
Conciliation	5	
Resolved at Assessment	2	**10**
TOTAL COMPLAINTS CLOSED 12/13		**126**

[2] Matters dealt with by the National Boards following MOU consultation with HCSCC (previously considered referrals).

It is not unusual for the HCSCC to take no further action in a complaint as seen above. However this may be for a variety of reasons as noted earlier in this report.

Table 8: Reason for No Further Action Complaints Closed 2012/13

Reason for No Further Action	Number
No basis for complaint to HCSCC	2
Complaint over 2 years old	2
Failure to reasonably resolve with provider	1
Further investigation unnecessary &/or unjustified	27
Complaint lacks substance	6
Complaint is resolved	8
Complaint determined by a court, tribunal or board	2
Required information not received	1
Complaint has been withdrawn	4
TOTAL	**53**

TIME TAKEN TO FINALISE COMPLAINTS

Figure 12 shows the average time taken to finalise complaints in 2012/13 remained reasonably consistent with previous years despite the increase in complaint numbers. Again in 2012/13 the mandatory consultation between the Boards and HCSCC has added to the time taken to finalise complaints that involve a registered provider.

Figure 12: Time Taken to Finalise Complaints 2012/13 (Average Days)

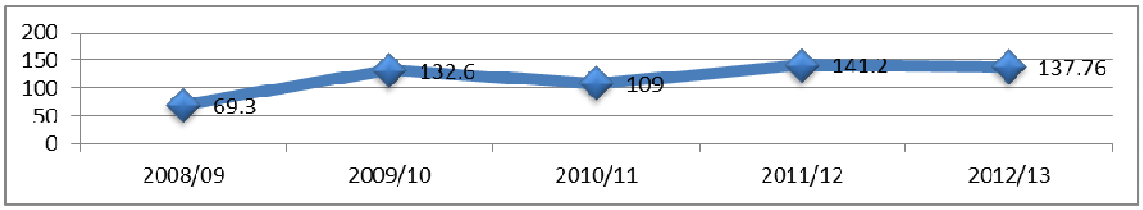
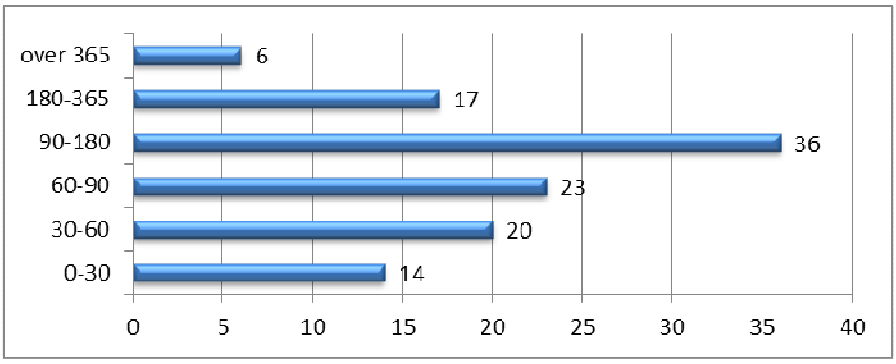


Figure 13 shows the time taken to finalise complaints when grouped over a period of time. 80% of complaints were closed within 180 days. The benchmark for closure within 180 days is 70%.

Figure 13: Time Taken to Finalise Complaints 2012/13 (Period of Time)



IMPROVING HEALTH AND COMMUNITY SERVICES

Overview

Investigations

In 2012/13 the HCSCC completed four investigations.

If investigations result in recommendations, those files will be closed but the HCSCC will continue to monitor the implementation of those agreed recommendations. Of the four investigations completed this year, three are subject to monitoring.

In addition, a further six investigations that were completed in previous years await final implementation of recommendations. Ten investigations were ongoing at the end of the reporting period.

Conciliations

In 2012/13 ten matters were resolved through formal conciliation. The outcomes from five of those matters are being monitored by the HCSCC with agreement of all parties.

Achieving Service Improvements: Monitoring

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

The HCSCC contributes to improvement of services in a number of ways at all stages of our process. One mechanism for ensuring that service improvements generated by a complaint are embedded in service delivery is to monitor implementation of formal outcomes arising from the complaint.

In 2012/13 the HCSCC monitored implementation of 99 outcomes from 19 separate complaints. Thirty-one of those outcomes were achieved and closed in the reporting period.

Service Improvements: Enquiries and Complaints

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

With this objective in mind, with the assistance of the HCSCC, parties can agree on the need for improvement in a particular area and implement change in practice, policy or procedure to effect that improvement. In many cases, this commitment to change and improvement will allow the concerns to be resolved. At the conclusion of a matter, even where no further formal action will be taken, the HCSCC may identify areas of potential improvement and make suggestions to providers of ways in which they could avoid future complaints. While

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

these are not formal recommendations under the Act, they do provide an opportunity for providers to review and improve their services, and in the process build their reputation for quality service.

Where the parties agree or request, the HCSCC can monitor the implementation of this type of outcome.

In 2012/13, the HCSCC monitored 16 outcomes from the resolution of three complaints. Two outcomes flowing from one complaint have been implemented; and the HCSCC will continue to monitor 14 outcomes from the remaining two complaints in 2013/14.

Service Improvements: Conciliation

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

In 2012/13, with the agreement of parties to the conciliations, the HCSCC monitored 25 outcomes from five separate conciliations. Six of those outcomes have already been implemented.

Service Improvements: Investigation

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

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

Recommendations now include expected completion or compliance dates, and regular reports are sought on progress towards implementation to ensure that the work of the HCSCC is relevant and effective.

In 2012/13, the HCSCC completed four investigations. Three of those investigations resulted in 18 new recommendations to be monitored. In all, 58 recommendations arising from 10 separate investigations were monitored in 2012/13.

Improvements Made: Investigation Outcomes

PATIENT TRANSFER

In 2011/12, we reported that an investigation into travel arrangements for transfer between hospitals in the NT had been completed. In our investigation, we found that the arrangements that were put in place for the transfer of the person concerned caused extreme discomfort to the patient; and that communication between providers in the lead up to the transfer was insufficient and led to a missed opportunity for a review of the patient's health and wellbeing before he was flown to another hospital.

Two recommendations arising from this aspect of the complaint were monitored in 2012/13. The first recommendation was that the hospital develop policies and procedures for inter-hospital transfers in the NT. These policies were completed in 2012/13, meaning that this recommendation has been implemented.

The second recommendation was designed to address the need for improved communication between nursing and medical staff, especially in relation to patients who were in the process of being transferred. This review has taken place and the processes are now in place to ensure effective communication occurs at a senior and ward level. The new processes include Director of Medical and Clinical Services (DMCS) attending weekly bed management and discharge planning meetings with senior nurses; and the Director of Retrieval services or a delegate having formal responsibility for establishing priorities for transfer and discussions with the medical and nursing staff involved. Implementation of this recommendation is also now complete and the file will be closed.

WOMEN'S DECISION MAKING ABOUT BIRTH

A woman complained about her experiences in the NT when having her first baby. She said she had asked about an elective Caesarean Section (CS) during her first appointment at the antenatal clinic but was counselled against it. She eventually agreed to a vaginal delivery.

Following a long and difficult labour during which she experienced some medical problems, an instrumental delivery was necessary. The baby also experienced some complications that the woman felt were connected with the birth process. She complained that if a CS had been performed as she wished, these problems would not have occurred.

The HCSCC did not engage in the debate about whether women should be able to elect to give birth by CS but rather investigated the quality of medical care through pregnancy and birth. The investigation showed that the medical care provided was in accordance with standard care guidelines.

The HCSCC found however that the issue underlying this complaint was the lack of effective communication between the woman and the service providers from her first contact with antenatal services, throughout her pregnancy and up until birth.

From the practitioners' perspective, the birth was likely to be a low-risk, meaning that CS was unlikely to be necessary. From the woman's perspective, she had been told previously that it was likely that she would need a CS as a result of her history of other medical issues. While she did agree to vaginal delivery, she felt pressured to do so and did not feel that her concerns were properly heard.

The investigation found that the woman and her partner were not fully involved in decision making during the pregnancy.

As a result of the investigation, the HCSCC recommended that the Department of Health develop processes to ensure that pregnant women are actively engaged in discussions about birth from first contact with the antenatal clinic. These discussions should centre on the woman's birth preferences, with information to be provided at her first contact with the service, and available for discussion and enquiries throughout pregnancy. Birth preferences will formally recorded in the later stages of that pregnancy.

The recommendation has been accepted and implementation will be monitored by the HCSCC in 2013/14.

QUALITY OF CARE IN DISABILITY SUPPORTED ACCOMMODATION

The HCSCC received a complaint about one aspect of services provided to a young man who was living in 24 hour supported accommodation for people with a disability. The issues that gave rise to the complaint were able to be resolved between the parties. During the course of the assessment process however, a number of additional concerns came to light regarding appropriateness of staff training, accessibility of policies, quality controls, frequency of care planning and incident reporting systems.

The Commissioner determined that these issues warranted investigation as they appeared to raise significant questions about safety and wellbeing of clients and the overall practices of the provider.

A systems based investigation was undertaken with a great deal of cooperation from the provider concerned. Through the investigation a number of issues were identified, including difficulties in recruitment and retention of staff, and other challenges associated with operating in the NT.

The investigation found that there were deficiencies in a number of the areas outlined above. The investigation also found that the organisation was already working proactively to address many of these deficiencies.

Sixteen recommendations were made at the conclusion of the investigation, including commitment to minimum training levels for staff, mandatory induction processes prior to commencement in new workplaces, improvement of transparency in reporting against key criteria, regular auditing of person centred planning, and establishment of a client reference group to assist with planning and eventually recruitment.

The investigation revealed that more robust critical incident reporting was also required, along with clearer pathways for reporting. This was identified as an issue that was likely to be relevant to other organisations in the Northern Territory and accordingly the concerns around reporting were brought to the attention of the funding body.

The organisation engaged actively with HCSCC during the investigation with a view to improving the quality of their service and has developed a comprehensive plan to implement the recommendations. The HCSCC will now monitor progress against those recommendations.

Investigations in 2013/14

The 2011/12 annual report detailed a number of investigations that were expected to be finalised during 2012/13. Unfortunately due to staffing shortages and other factors, these reports have not been completed. At the time of publication, draft reports on electronic prescriptions in remote communities, the admission of a patient to a mental health facility and the care of two patients with rheumatic heart disease are in the process of being finalised.

Other investigations into the use of interpreters in acute settings and best practice grievance procedures in community health are ongoing and now expected to be completed in 2013/14.

In addition, the HCSCC is currently undertaking investigations into the following issues:

DISCHARGE SUMMARIES

As noted in the list of issues that arose in complaints in the reporting period (see Appendix 1), the HCSCC has become increasingly aware of concerns relating to transfer of information between service providers at the time of discharge and through discharge summaries in particular. As a result of the increased incidence of this type of complaint, an investigation will be conducted in 2013/14 that will focus on identifying any systems-based deficiencies in current processes, and making recommendation for improvement in this area if required.

HIGH RISK PREGNANCY

An investigation into management and supervision of childbirth in situations where there are increased risk factors present is currently underway. This systems-based investigation will focus on staffing arrangements, supervision, processes for escalation of concerns, and open disclosure.

GUARDIANSHIP

An investigation into the interaction between guardians, aged care and acute health services will progress in 2013/14. The focus of the investigation will be on information sharing and ways in which communication can be improved to ensure that the needs and rights of the individual subject to guardianship are met and protected.

DISABILITY SERVICES IN REMOTE COMMUNITIES

In 2012/13 the HCSCC completed a long overdue report into the service provided to a woman with intellectual and physical disabilities in a remote NT community. The investigation considered services provided by a number of organisations and found that there were a number of systemic failings that led to detrimental outcomes for the woman concerned. The systemic issues identified related to failures in coordination between different service providers, inadequacy of planning for individual clients, and the absence of adequate and effective safeguards to ensure safety of vulnerable clients. Questions were also raised about the adequacy of the actual services provided to the woman.

The incidents that gave rise to these findings occurred over a period of time up until 2006. As a result the Commissioner has determined that a further investigation is required to ascertain the relevance of these findings in current times.

An audit of services provided to remote area disability clients in a number of different remote communities will be conducted in the coming year, with a view to establishing whether the same issues identified in the investigation report continue to exist. Following this audit a decision will be made as to what further level of investigation and/or recommendations are required.

It is anticipated that an overview of the findings of the investigation and the audit will be published once the next stage is complete.

PROMOTING RIGHTS

The third main objective of the HCSCC, as set out in section 3 of the Act, is the promotion of the rights of users of health and community services, and encouragement of awareness of rights and responsibilities of both service users and providers.

The HCSCC works to achieve this objective in a number of ways, including through involvement in policy discussion at both Territory and national level, community education activities, delivery of training on subjects such as resolution of complaints, and development of new information brochures. Details of some of the work undertaken in 2012/13 is set out below.

National & Territory Perspectives

As in previous years, the Commissioner and Deputy Commissioner participated in meetings with their counterparts around Australia.

The Health Commissioners met twice in the reporting period, in Brisbane in November 2012 and Adelaide in April 2013. Some of the matters discussed at those meetings included:

- Open Disclosure National Framework & Report
- Complaints processes generally
- Review of MOU between Health Complaints Entities/AHPRA
- Review of Victorian health complaints legislation
- SA Aboriginal Health Project
- Development of conciliation standards (including through a meeting with the Mediator Standards Board)
- Three year review of the National Law
- Unregistered Health Practitioners Project
- Issues of cognitive capacity and representation in aged care complaints

In addition Health Complaints Entities from around Australia signed an MOU with the Australian Competition and Consumer Commission (ACCC) to assist in cooperation in matters of mutual interest.

The Disability Commissioners met in Canberra in October 2012 and in Adelaide in April 2013. Unsurprisingly, much of the discussion at these meetings centred on the National Disability Insurance Scheme (NDIS).

A number of guests attended these meetings, including:

- Jeff Harmer, Chair NDIS Advisory Group and Ken Baker, CEO NDS, to discuss NDIS oversight, scheme design and concerns
- David Bowen, CEO NDIS Launch Transition Agency to outline the work of the agency and explore opportunities for cooperation
- Senator Jan McLucas, Parliamentary Secretary for Disability and Carers to provide an overview of NDIS set up and discuss issues including need for data evaluation
- David Heckendorf to discuss his paper entitled “Sexuality, human rights and services for people with disabilities” and the template policy on Disability, Relationships and Sexuality
- Damian Griffis, Executive Officer, and Gail Rankine, Chair, First People’s Disability Network to present their ten point plan for implementation of NDIS in Aboriginal and Torres Strait Island communities.

Following the meeting in Adelaide, Disability Commissioners also agreed on a list of the minimum national safeguards that should be part of the NDIS. These are outlined in the introduction to this report.

The Deputy Commissioner and complaints managers from around Australia meet annually to exchange information, develop improved processes and procedures, and increase awareness of current and emerging issues. The meeting was held in Canberra in April 2013, and topics covered included:

- Working with AHPRA
- Employer involvement and awareness of complaints and notifications – how to ensure systems issues do not get lost
- Safety and pathology/radiology recall systems
- National data-set – standardised reporting of complaints and issues.
- Open Disclosure and Root Cause Analyses
- Training

In addition to participating in these meetings, the HCSCC was involved in discussions on a number of legislative and policy reforms including:

- Advance Care Directives
- Development of legislation for Optional Protocol to the Convention Against Torture.

Disability Services

The previous HCSCC annual report outlined our strategy for increasing engagement with the disability sector in the NT. That strategy involved increasing the HCSCC's knowledge and expertise; accessibility and recognition; and engagement with providers.

The strategy was implemented in 2012/13 and as a result we have seen a small improvement in the number of approaches to the HCSCC regarding disability issues, with complaints up from 6 to 8, and enquiries from 21 to 30.

Disability Awareness Week

In September 2012 the HCSCC, along with the Community Visitor Program, Information Commissioner, Anti-Discrimination Commissioner, Carer's NT and Darwin Community Legal Service hosted a forum as part of Darwin City Council's Disability Awareness Week. The forum, entitled "Know Your Rights" presented an opportunity for disability service users, carers and others to discuss the types of issues that come up in everyday life, impediments to realisation of rights, and hear from the various organisations about what they can make a complaint about and how. The forum was well received and another one is planned for Disability Awareness Week 2013.

NDIS Information Sessions

With thanks to National Disability Services NT, in 2012/13 the HCSCC presented at a number of forums around the Territory held to talk about the NDIS. The forums in Alice Springs, Tennant Creek, Katherine and Darwin were a great opportunity for service providers to find out more about different aspects of the NDIS. For the HCSCC it was a great experience that put us in contact with more disability providers and gave us the opportunity to promote the work that we do now, and discuss the importance of similar safeguards and complaints systems in the future NDIS.

Health Services

As discussed earlier in this report, the HCSCC is committed to working closely with health service providers to ensure that they understand the HCSCC's role and the focus on resolution and improving services.

Complaint Resolution Training and Information

One of the primary initiatives undertaken during 2012/13 was the development and delivery of training sessions on "Dealing with Complaints". These training sessions are designed to assist staff in health services to deal with some of the lower level complaints as soon as they arise, by providing tips for resolution and working through practical examples of complaints that have, have not or should have resolved.

More work will be done in 2013/14 to refine the training and develop accompanying materials to assist in resolution at a local level.

Health Services

During the course of 2012/13 officers from the HCSCC met and delivered information sessions to representatives from a number of Aboriginal Controlled Health Services. We aim to do more of this work in 2012/13.

The Commissioner met with staff and had tours of Royal Darwin Hospital, Tennant Creek Hospital, Katherine Hospital, Alice Springs Hospital and Darwin Private Hospital in the past year.

Mental Health

Staff from the HCSCC were involved with Mental Health Week in 2012/13, attending the launch and Mental Health Week breakfast. The HCSCC also had a stall at the Mental Health Week Expo at Charles Darwin University to spread the message about the work that we do, and delivered presentations to mental health services in Darwin.

The Commissioner and Deputy Commissioner held regular meetings with the Community Visitor Program (CVP) to discuss general matters and where appropriate referrals were made between the two services – to CVP for advocacy services, and to HCSCC for assessment and investigation.

Aged Services

In 2012/13 the HCSCC participated in the Darwin Seniors' Month forum coordinated by the Office of the Information Commissioner. The forum allowed the HCSCC to explain our role, with a focus on the aged services jurisdiction and the ability to take complaints about services provided to carers.

The HCSCC continued to work closely with the Aged Care Complaints Scheme (ACCS) in 2012/13. While the HCSCC has jurisdiction over all services for aged people in the Northern Territory, the roles and focus of the HCSCC and ACCS are different. Cooperation between the two agencies aims to ensure that there is no duplication of process but that service users have the opportunity to have matters resolved with assistance, as well as investigated from both a systems and individual provider perspective where appropriate.

Remote Services

Local Councils

The HCSCC had increased interaction with local councils in 2012/13 and recognised the potential to work more closely with councils to promote our message. Councils are a valuable source of information about communities and are often of great assistance when we need to contact individuals. Councils refer complaints to us and identify issues that may be related to complaints. They also help us with the practical side of community engagement through providing venues and contact people for meetings, conciliations and presentations.

As service providers, councils also have a direct interest in the way in which the HCSCC handles complaints and works towards resolution. We look forward to meeting with more councils in 2013/14.

Legal Services & Advocacy Organisations

The HCSCC continued to work closely with a number of legal and advocacy services in 2012/13 to ensure that clients of these services can be made aware of their right to make a complaint about health, disability or aged care services, and are able to access advocacy support throughout the process.

Legal services were the source of 12% of complaints made to the HCSCC in the past year. The majority of these complaints came from outside the Darwin/Palmerston/Alice Springs area, demonstrating the value of the connection between legal services and HCSCC in promoting the right to complain in remote NT.

Information Brochures

In 2012/13 the HCSCC produced two new brochures:

- *Got a Problem with a Health Service?* – a simple English brochure outlining when and how to contact the HCSCC

- *Do you have a Complaint about a Disability Service?* – an introduction to the HCSCC for people who use disability services and their families and carers.

We have also produced our general poster in A5 size in the hope that it will be easier for service providers to display in waiting rooms and the like.

Information brochures and posters are sent to organisations at their request. In 2012/13, 955 information brochures and 316 posters were sent to 52 separate organisations. These organisations included hospitals, private and public health services, disability services and electorate offices.

Copies of our brochures and posters can be obtained by calling or emailing the HCSCC.

PLANNING AND DEVELOPMENT

Strategic Planning 2013-2015

The new HCSCC business plan developed for 2013 – 2015 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 the key aims and initiatives that the HCSCC will work towards in the coming year are set out below.

Resolution

- Increase number of complaints resolved in the assessment stage and in conciliation
- Resolutions skills training
- Implement outcomes of the review of point of service resolution

Improvement

- Utilise the systemic issues register to assist in identification of areas of concern
- Develop training & information packages for service providers
- Improve processes for stakeholder identification and engagement
- Improve utility of prescribed provider annual reporting

Rights

- Develop and implement a strategy for engagement with remote NT
- Continue to build knowledge and engage with disability sector
- Continued engagement in development and roll out of the NDIS
- Develop and implement a strategy for engagement with users and services for aged people

Governance

- Prioritise staff training and development
- Review and improve records management
- Review internal templates and data recording

Scrutiny

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

Feedback about our performance is also obtained through provider and complainant surveys. Once a complaint is finalised, parties to the complaint are provided with a standard feedback form addressing issues under four headings, and invited to fill it in and return it. Seventeen responses were received in 2012/13, with results shown in Table 9.

Table 9: Satisfaction Survey Results

Measure	Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree
Accessibility	53%	41%	0%	6%	0%
Timeliness	35%	29%	12%	12%	12%
Fairness	41%	41%	12%	0%	6%
Independence	41%	41%	18%	0%	0%

These figures indicate that the majority of survey respondents thought the HCSCC was accessible, fair and independent and staff carried out their tasks in a professional manner. While 64% respondents thought the HCSCC completed the assessment of their complaint in a timely manner, 24% of people responding to the survey did not agree this was the case. This outcome reflects the decrease in timeliness in assessment of complaints in 2012/13.

In light of the low number of responses to the current survey, in 2012/13 the HCSCC developed a new survey that will be able to be completed electronically as well as on paper. We will also survey all parties who use our services, rather than only those who participate in more formal processes. The new survey will be rolled out in the second half of 2013/14. It is anticipated that the new format will increase the feedback received and enable the HCSCC to access more information about ways in which we might improve our service.

Review Committee

The most formal scrutiny of the HCSCC complaints processes is undertaken by the Health and Community Services Complaints Review Committee (the Review Committee) set up under Part 9 of the Act. At the conclusion of a complaint, a complainant, provider or the Commissioner may request that the Review Committee review the way in which the HCSCC dealt with the matter.

The Review Committee is established to:

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

The Review Committee is not authorised to:

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

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

REVIEWS IN 2012/13

There were two applications for review in the reporting period.

The first application sought a review of the Commissioner's decision not to exercise her discretion to accept a complaint that was lodged outside the two year complaint period. As the Review Committee does not have jurisdiction to overturn the Commissioner's decisions there was no review undertaken.

The second application for review was made by a Complainant whose complaint had been discontinued by the Commissioner as she found that investigating the matter further was unjustified and/or unnecessary. The Review Committee reviewed the conduct of the matter. At the conclusion of the review, a number of recommendations were made to the Commissioner about ways in which the complaints process might be improved. The Commissioner accepted the recommendations and changes have been implemented as a result.

Notable changes made as a result of the review include:

- **Settling of complaint:** after a complaint is received, the officer concerned will formally settle the basis for the complaint with the Complainant prior to sending it to the Provider for a response. Assessment of the matter will not commence until this step is complete. Parties will then be made aware of the end date for the assessment process.
- **Complaint:** the HCSCC will no longer use the term "allegation" in referring to the complaint. It was noted that this language was considered rather legalistic and threatening for some parties. Instead the focus will be on the "complaint" and the "basis for complaint" under the Act.
- **Witnesses:** during the assessment process, officers will seek details of any witnesses who may be able to assist the Commissioner through the complaint process. As the assessment is an interim process only, formal statements will not usually be taken at that time, but the availability of such evidence will be considered as part of the decision making process.
- **Staff absences:** parties to a complaint will be informed in advance of extended staff leave where it is likely to impact on the progress of their complaint. Standard electronic "out of office" facilities will be used and files reallocated to other officers where resources allow.
- **Timelines:** electronic reminders have been set up to ensure officers and the Deputy Commissioner are aware of approaching deadlines and benchmarks.
- **Training:** training on issues such as procedural fairness and dealing with difficult complaints will become part the ongoing training program for the HCSCC team.

CASE STUDIES

Enquiries

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

Maintaining Relationships with Disability Service Provider

Manie's mother Merry was receiving home help services from a disability provider. Manie contacted the HCSCC because she was unhappy with several aspects of this service. She said a worker, Jack had been angry and taken it out on Merry; and she also felt that Jack was interfering by telling her that she didn't keep the house clean enough and giving her tips about how to manage Merry when she became angry and upset.

The Senior Investigation Officer (SIO) suggested to Manie that the concerns may be able to be resolved informally. Manie agreed and the SIO contacted Jack to discuss the issues.

Jack became angry when told that Manie had complained and threatened to withdraw the service. The SIO talked to Jack about the fact that it can be very difficult for people to make complaints about disability services because of the long term relationships between service providers and users. They also talked about the possibility that people are scared that services will be withdrawn if a complaint is made. Jack said that he was not upset about the issues being raised, but upset that Manie didn't speak directly to him.

The SIO contacted Manie, who told us that she hadn't raised the complaint directly because she was scared of upsetting Jack. In the end, the complaint was resolved when the SIO setting up a meeting between Manie and Jack and his managers to talk about Manie's concerns and ways that complaints can be easily raised and dealt with. Manie was invited to contact the HCSCC again if she was unhappy with the outcome of the meeting.

Contracted Disability Services

Maryanne's brother was receiving 24-hour care in supported accommodation in regional NT. She phoned the HCSCC when the service provider told her they were not funded to provide a service over the weekend, and she was expected to provide care for her brother from Friday evening until after dinner on Sundays. Maryanne had understood that funding was provided for 24 hour care 7 days per week.

The HCSCC phoned the funding provider who confirmed that Maryanne was correct. This meant that Maryanne could see her brother any time, but there was no expectation that she would.

At a meeting between Maryanne, her brother, the funder and the service provider, the service provider acknowledged that they had been wrong in their interpretation of the contract. The complaint was resolved.

Interstate Financial Administration Orders and Aged Care Facilities

Jason lodged a complaint with the HCSCC on behalf of his mother Audrey who at the time was living in an aged care nursing home.

Audrey was under guardianship in the NT and subject to an interstate financial management order.

Audrey was about to move back to Queensland to live, and wanted to take her belongings with her. This move was proving difficult as whenever arrangements were made to move Audrey's clothes and other belongings, the staff member who had made those arrangements left the service and nothing was done.

The HCSCC Senior Investigation Officer (SIO) contacted the nursing home and was told that Audrey's belongings were boxed up and ready to go, but that the nursing home would not pay for the transfer interstate. This was complicated by the fact that Audrey's money was being managed by a financial management firm.

The SIO contacted the financial management firm and was told that they were trying to contact the nursing home to pay for the move, but that they had not had any success.

The SIO contacted all parties. Money held with the private firm was transferred to the Public Trustee interstate who arranged for payment for Audrey's belongings to be transferred to her new care facility. Once this had happened, the residential facility was happy to arrange for the belongings to be transferred. The matter was resolved.

Complaint Leads to Improved Administrative Processes

Zeta contacted the HCSCC with a complaint about lost belongings. A year ago, Zeta had stayed in a residential health facility. She had left suddenly after an argument with another resident and left her belongings, including money and her phone, at the facility.

Staff at the facility told the SIO that personal belongings are only kept for seven days, after which time they are destroyed or donated. Personal belongings are stored but not itemised when people arrive at the facility.

Zeta's belongings had probably been lost, destroyed or donated elsewhere and so her complaint was not able to be resolved fully, in that she did not get her belongings back. She was pleased to learn however that her complaint did lead to improved processes at the facility.

As a result of the complaint, the facility amended its policies, extending the time that it kept personal property to 28 days; ensuring all items would be itemised when a person was admitted and checked off when they were discharged; and implementing more transparent ways of accounting for any money that a client has with them when they are admitted.

Three attempts will now be made to contact a client once they leave the facility if they have left behind money or property.

Medical Chits and Prison Health Services

John told us that he had diabetes, that he had seen a doctor at the prison health service and that the doctor had written a medical chit allowing him to have a change in diet to help manage his diabetes. John said that the Deputy Superintendent had not approved the change in diet.

The HCSCC only has jurisdiction over the actions of the health service in this type of matter, and so we contacted the health service to confirm John's story. The HCSCC was supplied with evidence that a medical chit had been written on the advice of an Endocrinologist. The chit was not approved by the prison authorities.

An officer from the HCSCC contacted the Superintendent to discuss this issue, explaining that it was a medically informed request. The medical chit was then approved and John was able to have the special diet he needed.

Refund when Client not Advised of Cost of Service

Damian attended a physiotherapy appointment at a new practice. He had previously been getting treatment from another practice, however the physiotherapist he was seeing moved interstate.

Before attending the clinic, Damian received a letter confirming the appointment and a follow-up email. At no time was he advised how much his treatment would cost.

At the end of the consultation, Damian was given his bill and was shocked at the amount he was charged. He had not been told of the fees in advance and there was no sign in the practice to notify clients of the cost of services.

To resolve his complaint, Damian wanted the clinic to put up a sign with consultation fees on it so that clients would know in advance what it would cost them to attend the practice. He also said that any discount would help him pay his bill.

The practice said that they usually do advise their clients of costs up front, but acknowledged they hadn't done so in Damian's case. They agreed to refund the gap between his bill and the refund he would receive from his health insurance.

Resolution Takes Many Forms

Josie phoned the HCSCC because she was unhappy with the way her local health and wellbeing service set up appointments. She said she had been using the service for a long time and thought that she should not have to wait to get an appointment, or wait so long when she did attend an appointment.

Josie told the officer at the HCSCC that she just wanted her complaint to be heard. The SIO phoned the service and the appointment system was explained. It appeared reasonable, and the SIO phoned Josie to tell her what the service had said.

Despite the explanation, Josie was still very frustrated. The SIO reminded her that she had achieved the outcome she was seeking because the service was now aware that she is unhappy with them. Josie confirmed that this was a good result and said she was happy with the outcome.

Direct Resolution Works

Allan had been unhappy with his local GP surgery because he felt that staff never followed through on their promises. For example, he had been trying to contact his doctor and staff had said they would get back to him, but didn't do so. Allan said this happened the previous week, but it had happened many times in the past and he was sick of it. Allan agreed that his complaint could be managed by attempting a direct resolution with the GP clinic. He did not want to approach them himself however because the point of his complaint was that no-one ever got back to him.

The SIO phoned the practice manager, who agreed to contact Allan and then contact the HCSCC with the outcome. The practice manager later reported that the contact with Allan went well and Allan's issues had been addressed. He acknowledged that the issue arose from communication problems at the surgery. The SIO then phoned Allan who confirmed that he was happy with the outcome of his complaint. He will go directly to the practice manager should he experience any similar difficulties in future.

Contact the Patient Advocate

Trevor was unhappy with the service he was receiving from the local hospital. He was in great pain due to a long-term medical problem and wanted to be referred interstate for immediate attention.

An appointment with an interstate specialist had been made in four month's time, however Trevor thought that his problem required immediate attention. He agreed with the suggestion that the SIO attempt to resolve the complaint informally. The SIO explained that the HCSCC role is not to push appointments forward, and that every person has the right to elect to seek help interstate, however they may not be eligible for Patient Travel Assistance.

The Patient Advocate followed up with Trevor, and noted that an appointment had been made for him with the pain clinic to assist him to manage his pain. She also checked the appointment with the visiting specialist, and told Trevor that there may be an interstate referral depending on the outcome of that appointment.

Trevor was happy with the service received, and agreed that he would contact the Patient Advocate if he needed any further assistance.

Assessment

Resolved During Assessment

Geoffrey had been wearing dentures for many years. When he broke the two front teeth on his denture, he took it to the dentist for repair.

The denture was repaired but not long after, the teeth fell out again. Geoffrey took his denture back to the dentist again. It was repaired and he wasn't charged for the work. Soon afterwards, one of the teeth broke off again. This time, the dentist said he would charge Geoffrey for the cost of fixing the denture. Geoffrey decided he would not go ahead with the repair, and complained to the HCSCC.

While the complaint was still being assessed, the parties resolved the complaint between themselves. The dentist apologised to Geoffrey and the consultation fee was refunded.

No Further Action – Complaint Resolved

Phil, recently moved to a remote community, complained that he had the flu and that he had been very unwell and running a high temperature. Phil said he had asthma and often suffered an attack when he was ill with the flu. He said he tried to see a doctor at the local health centre, only to be told that the clinic closed at 11 am that day and he would not be seen until the following Monday. When he moved to the community, Phil expected that the health clinic would operate in the same way as urban GP clinics in his hometown.

During the assessment of the complaint it was found that a sign was placed on the front door of the clinic and a voice recording on the phone directed any clients needing medical assistance to Health Direct. Because he was new to the Territory however, Phil did not know what Health Direct was.

The complaint was considered resolved when changes were put in place to make sure patients were clear about how to seek further help if required when the clinic was closed. A standardised voice mail message is now used at all health centres, so that when staff are away from the clinic messages can be left about non-urgent matters. For urgent matters, callers are advised to call the medical officer on call and provided with a phone number. Callers are also told to ring 000 in case of emergency. Signage was also developed advising clients when staff are expected to return and providing the relevant phone numbers to contact if the matter is urgent.

Complaint More Than Two Years Old

Morry asked a legal service to represent him in a complaint to the HCSCC. Six years earlier, Morry's mother had died three weeks after coming home from hospital. Morry thought that his mother should not have been discharged from hospital and that staff in the hospital did not provide the high level of care she needed.

Complaints to the HCSCC must usually be made within two years of the person becoming aware of the circumstances of the complaint. If the complaint is outside that timeframe, the Commissioner will consider whether to accept the complaint, weighing up a number of factors including whether a delay lodging a complaint unfairly prejudices the respondent, any reason for delay and whether there are public interest considerations. In Morry's case, the Commissioner decided that there were insufficient grounds for accepting the complaint outside the two year time frame.

Smokers Don't Get Discounts

Cherie made an appointment with a doctor and was told she was entitled to a concession. After seeing the doctor, she complained that she had been charged full price because she was a smoker. She said the doctor was very critical of her smoking even though it was not connected with the reason for consultation. She complained to the HCSCC about the charges and the consultation. Cherie wanted her consultation fee refunded and an assurance that future patients who smoke would not be treated the same way.

Cherie and the doctor had very different stories about the consultation, with the doctor providing a different context to the conversation about smoking. Despite this the complaint was resolved when the fee was refunded, and an apology was provided for the way that Cherie felt as a result of the discussion about smoking. As a result of the complaint the doctor said he would reconsider the way he approached situations such as Cherie's and the clinic revised the concession policy so that it was more transparent.

Apology Resolves Complaint

Jean and Mike were travelling around Australia. Jean had an inoperable tumour and she had been having tests conducted at various hospitals on their travels to monitor her health. The results were given to Jean and she sent them on to her regular doctor in her home town.

Jean and Mike visited an NT hospital, explained what they needed and what they had been doing during their travels.

Jean and Mike complained that the employee they were dealing with told them, in front of all other patients in the waiting room that they were an inconvenience and it just was not possible to get a doctor to give the results to them as they were all extremely busy. Jean and Mike wanted the employee to be told to treat all people with dignity, respect and compassion.

The complaint was resolved when a Consultant telephoned Jean and Mike and apologised on behalf of the hospital. The apology was accepted and the complaint resolved.

Failure to Take Reasonable Steps to Resolve

Jacques complained that he had been given a double dose of his medication for several months while incarcerated and this had caused him to feel unwell and dizzy.

Evidence from the prison health service and Jacques' medical records indicated that at no time was he prescribed the wrong medication or higher doseage while in prison. Further evidence indicated that even if his medication had doubled, the dose would still have been well within a safe daily dosage range.

It was also evident that at any time, Jacques could have spoken to a nurse or doctor to ask about his medication and attempt to resolve this issue. He had not done so.

No further action was taken on this complaint for two reasons. The complaint was not substantiated, and Jacques had not taken reasonable steps to try to resolve the complaint before contacting the HCSCC.

Complaint Referred to the Dental Board

Maria's tooth was crowned at a cost of $2,000, however she had ongoing pain and so returned to the Dental Clinic where she saw a second dentist who told her the tooth would need to be removed. She saw a third dentist, the owner of the practice, who agreed to fix the tooth with root canal therapy at no extra charge. The practice owner did not follow through on this commitment however, and Maria contacted the HCSCC.

The HCSCC looked at a number of issues in the complaint. An independent clinical advice indicated that root canal therapy should have been considered prior to preparing the crown. Further, the clinical advisor stated that the dentist should have given a clear warning of the risks involved in the procedure, including the risk of pain afterwards. After consultation with AHPRA, the complaint was referred to the Dentistry Board for further investigation of the dentist's standard of practice.

Immunisation Error Leads to Improved Practice

Brad complained that his two-year-old child had been given a vaccine meant for an older child. He complained about the clinic and the nurse who administered the injection.

As soon as the nurse realised that he had administered the wrong vaccination, he completed an incident form, reported the error to his supervisor, and informed Brad, inviting him to come back to the clinic to discuss the error.

Brad did go back to the clinic to discuss the error but was not satisfied with the outcome.

The HCSCC assessed the complaint. As a result of the incident the clinic had revised its practices so that vaccinations can now only be given once a doctor has given clearance. Given this outcome, no further action was taken in relation to the clinic.

While the HCSCC noted that there were no adverse outcomes for the child involved, and recognised that all appropriate steps were taken by the nurse once his error had been identified, the incident was referred to the Nursing and Midwifery Board for noting and investigation as it raised questions of practice.

Care at Home for an Elderly Man not to a Reasonable Standard

The HCSCC received a complaint from Mabel, made on behalf her brother, an elderly man who had been receiving care from an aged service provider in his own home. The complaint concerned the care and treatment provided to him by a nurse.

Mabel complained that the nurse had told her that she was consulting regularly with the local GP about the brother's care, but Mabel claimed that this was not the case. Mabel's brother's health deteriorated over time and when he was admitted to hospital, he was acutely unwell and required a long stay in hospital. Mabel thought that her brother's significant deterioration could have been avoided if the nurse had provided better care and the GP been kept informed of her brother's condition.

The complaint raised sufficient concerns about the nurse's practice for the complaint to be referred to the Nursing and Midwifery Board for investigation.

Conciliation

Explanation Resolves Complaint

A complaint was received about dental services provided in a remote community in the NT. Following the removal of two teeth, a woman developed an abscess in her mouth, and she had to be transferred to hospital where she underwent an operation.

The woman complained that the removal of the teeth had caused the abscess and the distress associated with it. She wanted an explanation of how this happened and compensation as she had missed a number of weeks of work while in hospital.

The complaint was referred to conciliation.

The conciliation was held in a regional town and dental and medical specialists from Darwin travelled to the town to meet with the woman. Independent advice from a specialist confirmed that the abscess was not caused by or related to the dental treatment as it was in a different part of the mouth. It was a coincidence that the abscess had developed soon after the dental work had been completed.

The woman did not know that this was the case, and told us that had she known that she would not have gone ahead with the complaint. The hospital acknowledged that they should have explained what they knew about the abscess more clearly at the time and used an interpreter to ensure the woman understood what had happened. They agreed that in future where possible, interpreters would be used in situations such as this.

Pain Management

A patient with a serious pre-existing medical condition attended the emergency department following a fall. The patient was admitted to hospital so that his injuries could be treated. He remained in a great deal of pain.

The HCSCC received a complaint about pain management, and the family's concern that the hospital had failed to listen to them and hear their views about ways in which the pain might be alleviated.

The complaint was referred to conciliation to allow for discussion of the pain management plan. The complaint resolved when the hospital gave an explanation of the complications of the pain management in this case and acknowledged that these complications meant that his pain was not always able to be alleviated. Through the meeting the parties identified that some staff were unclear about who was responsible for pain management and who could authorise and administer certain types of medication. Areas for improvement were identified. A new process was put in place to ensure there were clear lines of responsibility, and training was provided to relevant staff on the issues raised.

The family felt reassured that those changes would help others in the future.

Complications from Surgery

A man complained to the HCSCC after he underwent surgery at a public hospital. During the course of the surgery there were a number of complications and the man became very unwell as a result and required further surgery. He complained about the practice of the surgeon, during and after the surgery.

During the course of the assessment it became clear that the surgery had in fact been performed by a Registrar under the supervision of the specialist. The man was upset by this as he had understood that the specialist would perform the operation.

The complaint was referred to conciliation as the assessment revealed no practice issue in relation to the surgery itself. The issues dealt with in conciliation included whether it was clear that the specialist may not perform the surgery himself, and the follow-up provided to the man post-operation.

During the course of the conciliation it became clear that while the consent forms signed prior to surgery did clearly indicate that a Registrar may perform the surgery, the patient did not fully comprehend this possibility. To resolve this aspect of the complaint it was agreed that consent forms would be reviewed to ensure that this is clearly stated.

In relation to the complaint that the surgeon had not followed up with the patient following surgery, it was explained to the complainant that the surgeon no longer works at the hospital, having left shortly after the initial surgery. This explanation was accepted.

APPENDIX 1
BREAKDOWN OF COMPLAINT ISSUES

Tables 10-21 provide further breakdown of the content of each of the major issue categories. One issue was determined to be out of jurisdiction, and is not detailed in the tables below.

Table 10: Access Category

ACCESS	2010/11	2011/12	2012/13
Access to facility	0	0	1
Access to subsidies	0	0	1
Refusal to admit or treat	3	4	5
Service availability	7	1	6
Waiting list delay	1	2	3
Total	**11**	**7**	**16**

Issues relating to access made up 8% of all issues raised in complaints in 2012/13. The major issue complained about in complaints about access was service availability (38%), followed by refusal to admit or treat (31%) and waiting list delay (19%).

Table 11: Communication & Information Category

COMMUNICATION & INFORMATION	2010/11	2011/12	2012/13
Attitude and manner	18	12	20
Inadequate information provided	4	7	12
Incorrect/misleading information provided	1	1	2
Special needs not accommodated	2	0	4
Total	**25**	**20**	**38**

Issues relating to communication and information made up 19% of all issues complained about. Complaints associated with the attitude and manner of a provider continue to be the most significant communication issue (53%) followed by inadequate provision of information (32%).

Table 12: Consent Category

CONSENT	2010/11	2011/12	2012/13
Consent not obtained or inadequate	2	4	3
Involuntary admission or treatment	3	2	0
Uninformed consent	0	0	1
Total	**5**	**6**	**4**

Issues relating to consent constituted 2% of all issues complained about.

Table 13: Discharge & Transfer Arrangements Category

DISCHARGE & TRANSFERS	2010/11	2011/12	2012/13
Delay	1	0	0
Inadequate discharge	5	0	6
Patient not reviewed	1	0	1
Total	**7**	**0**	**7**

Three per cent of issues raised in 2012/13 related to discharge and transfer arrangements. There were no complaints in this category in 2011/12.

Table 14: Environment & Management of Facility Category

ENVIRONMENT & MANAGEMENT	2010/11	2011/12	2012/13
Administrative processes	2	1	4
Cleanliness/hygiene of facility	1	2	2
Physical environment of facility	0	1	0
Staffing and rostering	1	1	2
Statutory obligations/accreditation	1	1	2
Total	**5**	**6**	**10**

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.

Table 15: Fees, Cost & Rebate Issues Category

FEES, COSTS & REBATES	2010/11	2011/12	2012/13
Billing practices	3	0	1
Cost of treatment	2	1	0
Financial consent	0	0	1
Total	**5**	**1**	**2**

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

Table 16: Grievance Category

GRIEVANCE	2010/11	2011/12	2012/13
Inadequate or no response	2	2	6
Complaint information not provided	0	1	1
Reprisal/retaliation as a result of complaint lodged	0	0	2
Total	**2**	**3**	**9**

Issues of grievance and complaint handling made up 4% of all issues complained about, an increase from 2% in 2011/12 and 1% in 2010/11.

Table 17: Medical Record Category

MEDICAL RECORDS	2010/11	2011/12	2012/13
Access to/transfer of records	2	0	0
Record keeping	1	2	6
Total	**3**	**2**	**6**

The medical record category includes complaints about errors and inadequacies in medical records. They accounted for 3% of all issues complained about in 2012/13, an increase on previous years.

Table 18: Medication Category

MEDICATION	2010/11	2011/12	2012/13
Administering medication	2	2	5
Dispensing medication	2	0	4
Prescribing medication	4	6	6
Supply/security/storage of medication	1	2	2
Total	**9**	**10**	**17**

Medication related concerns made up 8% of all issues in 2012/13.

Table 19: Professional Conduct Category

PROFESSIONAL CONDUCT	2010/11	2011/12	2012/13
Assault	1	1	2
Boundary violation	1	7	4
Competence	17	21	20
Discriminatory conduct	0	0	2
Emergency treatment not provided	1	0	0
Financial fraud	1	1	0
Illegal practice	0	5	6
Impairment	0	1	3
Inappropriate disclosure of information	1	1	8
Misrepresentation of qualifications	2	0	1
Sexual misconduct	0	0	4
Total	**24**	**37**	**50**

Issues relating to professional conduct made up 25% of all issues complained about. As noted above, the majority of these matters were dealt with in conjunction with AHPRA in accordance with the consultation requirements under the National Law. The main issue complained about was the competence of a provider (40%), followed by inappropriate disclosure of information (16%) and illegal practice (12%). Where these allegations relate to the conduct of a registered provider, they are likely to be referred to the relevant National Health Practitioner Board for consideration.

Table 20: Reports/Certificates Category

REPORTS/CERTIFICATES	2010/11	2011/12	2012/13
Accuracy of report/certificate	1	0	2
Timeliness of report/certificate	1	0	0
Total	**2**	**0**	**2**

Complaints about reports and certificates made up 1% of issues in complaints closed in 2012/13. It should be noted that the HCSCC has no jurisdiction over the process of writing, or the content of, a health status report.

Table 21: Treatment Category

TREATMENT	2010/11	2011/12	2012/13
Coordination of treatment	2	3	1
Delay in treatment	3	2	1
Diagnosis	7	12	8
Excessive treatment	0	0	3
Inadequate consultation	0	1	0
Inadequate treatment	12	9	7
Infection control	0	0	2
No/inappropriate referral	1	2	4
Public/Private election	0	0	2
Rough & painful treatment	4	0	0
Unexpected treatment outcome	4	8	8
Withdrawal of treatment	2	2	3
Wrong/inappropriate treatment	5	5	2
Total	**40**	**44**	**41**

Issues relating to treatment constituted 20% of all issues in complaints closed in 2012/13. Issues associated with diagnosis and unexpected treatment outcomes/complications (20%) were the main ones identified.