Annual Report 2009-10

Health and Community Services

Complaints Commissioner

HCSCC Identification

2009-10

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Hon John Hill MP
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Dear Minister

Health and Community Services Complaints Commissioner
Fifth Annual Report 2009-10

In accordance with the requirements of section 16 (1) of the *Health and Community Services Complaints Act 2004* I am pleased to provide you with my 2009-10 Annual Report.

Yours sincerely

Leena Sudano
Health and Community Services Complaints Commissioner

CONTENTS AT A GLANCE

CONTENTS

1. ABOUT HCSCC

The office of the Health and Community Services Complaints Commissioner, HCSCC, is an independent statutory office established by the *Health and Community Services Complaints Act 2004* (the Act). HCSCC opened on 4 October 2005.

HCSCC provides free information and assistance to resolve complaints about public, private and non-government health and community services, including child protection services.

HCSCC encourages direct resolution with the service provider first. HCSCC may assist when direct resolution with the service provider is either unreasonable or has not succeeded. HCSCC also investigates serious complaints about issues of public interest or safety.

Section 3 of the Act requires HCSCC:

(a) to improve the quality and safety of health and community services in South Australia through the provision of a fair and independent means for the assessment, conciliation, investigation and resolution of complaints
(b) to provide effective alternative dispute resolution mechanisms for users and providers of health, or community services to resolve complaints
(c) to promote the development and application of principles and practices of the highest standard in the handling of complaints concerning health, or community services
(d) to provide a scheme which can be used to monitor trends in complaints concerning health, or community services
(e) to identify, investigate and report on systemic issues concerning the delivery of health, or community services.

HCSCC has a statutory relationship with 10 health professional Registration Boards and also maintains links with:

- regional health and community services providers
- organisations which represent the interests of services users and carers, including people with special needs.

HCSCC Vision

A complaint is an opportunity to:

- get information about what happened
- redress individual grievance and harm
- act to minimise serious harm happening again to others.

HCSCC Values

HCSCC upholds the following values:

- independence
- impartiality
- integrity
- accessibility
- providing a voice for people with concerns about services
- excellence in customer service
- team work
- professionalism
- responsiveness to criticism about our performance.

2. COMMISSIONER'S FOREWORD

As I write this foreword HCSCC is once again preoccupied with securing sufficient core funding to meet the responsibilities conferred by the South Australian Parliament through the *Health and Community Services Complaints Act* 2004 (the H&CSC Act).

This is not unique to HCSCC. Many independent statutory complaints agencies find it difficult to secure adequate funding to meet their legislated functions. In particular, those functions that would minimise escalated complaints by enabling them to be dealt with locally, fairly and quickly. Especially concerns and complaints arising from the experience of people who are vulnerable or disadvantaged, people who don't speak up, are hard to reach, and who are most likely to be missing out.

At the heart of the problem lies the issue of how complaints are understood and how they are valued, particularly when they are about essential public and non government services.

When essential services are struggling to meet the gap between increasing demand and less capacity, and feeling assailed by unrealistic expectations of their services, complaints may seem to be inevitable, largely insoluble and of little or no value.

It may be asked: what's the value of complaints under these circumstances?

Historically most statutory complaints agencies have been established because citizen's rights were breached, or were at high risk of being breached. Examples include institutional abuse, fraud, corruption, unlawful discrimination, privacy infringement, dangerous goods or services and lack of fairness in decision making.

In areas like health, disability and child protection services, statutory complaints agencies have often been established in response to high profile incidents that have harmed vulnerable people. These reactive foundations overshadow the positive potential of a healthy rights and complaints culture.

The messy, emotionally charged business of complaints handling is hard to measure in economic terms. Yet governments spend millions on inquiries after things have gone wrong. Many health, disability and child protection services could tell you the cost of defending legal claims, but would be unable to tell you the cost of complaints. This also means that the cost benefits of preventing or reducing complaints, and of improving complaints management, remain invisible. Likewise the benefit of complaint lessons when used to minimise a recurrence of harm or loss remain invisible.

For those who recognise the individual and public value of good quality, independent complaints agencies it is timely to ask some questions about how we sustain adequate funding for this work. For example:

- Should the service providers complained about fund or contribute to funding independent statutory complaints agencies, a model used in many industry complaints schemes, for example: the Private Health Insurance Ombudsman and the Financial Services Ombudsman?

- What about a citizens rights levy? We value emergency services and the Murray River, but what about the right to information, to respect, to comment, to fair decision making?

- Should we try to determine a cost per person to adequately fund all statutory complaints agencies and to think imaginatively about combining the knowledge, skills and experience among South Australia's small and diverse statutory complaints offices?

Meanwhile, emerging evidence in health services demonstrates that if people's basic rights to access and use services are met, significant benefits flow. In particular, benefits in timely and appropriate use of services, self management and better treatment outcomes.

Progressive community services, including those needed by people living with a disability or vulnerable families and children, understand that enabling people's rights to access services, freedom from abuse, quality services, respect, information, participation, privacy and comment, make for safety, quality and success.

The challenge for the forthcoming HCSCC Charter of Health and Community Services Rights will be to spur these benefits.

3. FIFTH YEAR HIGHLIGHTS

3.1 *Ever felt like complaining?* Aboriginal and Torres Strait Islander Outreach Project

HCSCC released the *Ever felt like complaining?* Aboriginal and Torres Strait Islander Outreach Project report in December 2009, at Tandanya. HCSCC also released a report summary, community information flyer and an HCSCC preliminary action plan in response to the project recommendations.

From January - June 2010, half of Complaint Resolution Officer Christine Egan's time was allocated for work towards the project recommendations, in particular, awareness raising among diverse Aboriginal communities. HCSCC will release a pamphlet and poster to support this work in early 2010-11.

Increased contacts to the Enquiry Service and an increase in the number of complaints lodged with HCSCC have occurred since this project. Further details are reported in the Complaints Resolution Section of this report. The project report, HCSCC action plan and progress reports are available at www.hcscc.sa.gov.au - What's new.

3.2 Health & Community Services Complaints Act 2004 section 88 Review

The Minister for Health tabled the report of the independent statutory review of the H&CSC Act, and the government's response to the report recommendations, in the South Australian Parliament on 3 March 2009.

Significant progress has been made towards the majority of the 32 recommendations. Most of the outstanding work in response to the recommendations will be completed during 2010-11. For full details please refer to Appendix 1: Recommendations requiring action arising from the section 88 review of the H&CSC Act.

The outstanding areas requiring action are:

- Recommendation 2b. That the Government consider the establishment of a consumer advocacy scheme as a mechanism to support the access of consumers, families and carers (not currently covered by existing schemes in the aged, disability and mental health sectors) to complaint services.
- Recommendation 3. That the Government consider the establishment of a Community Visitor Scheme in line with those operating in other States.
- Recommendation 10. That the Government promote all of its complaint resolution services, commencing at the point of service delivery of Government and Government-funded health and community services. These campaigns should highlight the importance of resolving complaints where and when they arise, utilising in the first instance complaint resolution mechanisms available at the service delivery level.
- Recommendation 12. That the HCSCC introduces a regular training schedule with service providers to build their capability to resolve complaints, improve their complaint handling processes and outline their obligations to the HCSCC in the investigation of complaints.

The SA Health commissioned operational review, to assist in determining core funding to enable HCSCC to meet its obligations under the H&CSC Act, was undertaken between February and May 2010.

In addition to other extensive information to support HCSCC's claim for additional resources, HCSCC developed the following comparison table which was provided to the reviewers.

Australian Health Complaints Commissioners (HCEs)
Cost per head Table January 2010

Information obtained from published 2008-09 annual reports and additional information provided on request by HCEs.

State/Territory	Population 2006 Census	HCE budget 2008\09	Cost per person	Other
ACT	323,327	3,098,000[1]	**9.58**	Health, Disability, Older People & Community Services Commissioner; Children & Young People Commissioner; Human Rights Commissioner Includes investigations about health professionals and health records privacy complaints
TAS	476,481	1,385,000[2]	**2.91**	Ombudsman/Health Complaints Commissioner
NT	190,999	462,755[3]	**2.42**	Ombudsman/Health & Community Services Complaints Commissioner
QLD	3,904,532	8,900,000[4]	**2.28**	Includes standard setting & compliance monitoring
NSW	6,549,177	11,014,000[5]	**1.68**	Includes investigation & prosecution of registered health professionals
WA	1,959,088	1,817,539[6]	**0.92**	Includes disability services
SA	1,514,337	1,126,300[7]	**0.74**	Health & Community Services Commissioner, includes community, disability & child protection services
VIC	4,932,422	2,320,146[8]	**0.47**	Includes Health Records Act 2001

The operational review report was provided to HCSCC on 25 May 2010. HCSCC's response to the recommendations will be discussed with the Minister for Health during 2010-11. The outcome of these discussions will be included in the HCSCC 2010-11 annual report.

[1] ACT Human Rights Commission budget apportionment for Human Rights Commissioner and anti-discrimination jurisdiction estimated at 50%
[2] TAS Ombudsman 2008-09 income total (excluding revenue from energy entities), no apportionment for HCSCC jurisdiction available
[3] Significant additional resources provided by the NT Ombudsman. Combined NT Ombudsman and NT HCSCC budget 2009-10 $ 2,490,000 with HCSCC share $ 592,000 2009-10 HCSCC, cost per head $ 3.09
[4] QLD HQCC budget no apportionment for health services complaints jurisdiction available
[5] Net cost of services
[6] WA OHR budget no apportionment for disability services jurisdiction available
[7] SA HCSCC no apportionment for health, disability, community or child protection services jurisdictions available
[8] VIC OHSC budget no apportionment for health records jurisdiction available

3.3 SA Parliament - Economic and Finance Committee

HCSCC provided further information about the funding shortfall to meet statutory obligations in the fourth annual submission to the Committee in November 2009.

HCSCC drew to the Committee's attention to some progress since the 2008 submission, in particular specific purpose funding from SA Health to enable:

- the statutory Charter of Health and Community Services Rights (HCSCC Charter) to be developed (non recurrent funding)
- the statutory Health and Community Services Advisory Council to be established
- the temporary employment of an additional Complaint Resolution Officer in 2009-10 pending the outcome of the operational review.

HCSCC highlighted:

- a 20% increase in Enquiry Service contacts and in complaints during 2008-09
- efficiencies to improve the utilisation of existing resources with limited impact on services to the public: ceasing the office manager position, renting under used office space and tight spending control on consumables
- the lack of funding to enable systematic outreach to people with special needs, in particular people with a disability
- the lack of funding to enable adequate formal investigations about systemic issues
- forthcoming amendments to the H&CSC Act that are likely to increase workload, including measures to enable HCSCC to deal more effectively with complaints about bogus and unregistered health practitioners
- other budget pressures due to recommendations arising from the section 88 review of the H&CSC Act, including improving the HCSCC complaints database; providing a training program; awareness raising about HCSCC and the HCSCC Charter, once endorsed by the SA Parliament
- the forthcoming new national health professional regulation law that will increase HCSCC workload.

HCSCC noted that these issues would be raised in 2010 during the operational review to determine sustainable core funding for HCSCC.

3.4 National Health Professional Regulation and Accreditation

In mid-June 2009 major draft legislation, the *Health Practitioner Regulation National Law 2009*, was released for public consultation. This new law created a single national registration and accreditation system from 1 July 2010 for the following health professionals: doctors, chiropractors, dentists, nurses and midwives, optometrists, osteopaths, pharmacists, physiotherapists, podiatrists and psychologists.

From 1 July 2012, the scheme will also include practitioners in Aboriginal and Torres Strait Islander health, Chinese medicine and medical radiation.

The key concerns for HCSCC and interstate statutory health complaints agencies (HCEs) about the new scheme were:

- lack of clarity about the relationships between national and state health professional registration authorities, the Australian Health Practitioner Regulation Agency (AHPRA) - the new national agency and HCEs
- ensuring responsiveness, timeliness, transparency and accountability for complaint management about individual registered, or formerly registered, health professionals by health professional registration authorities and AHPRA

- a national complaints register accessible to HCEs and health professional registration authorities to improve public protection
- ensuring the new arrangements eliminate other barriers which have prevented different complaints agencies, in different states/territories, from sharing information about complaints pending against a registered, or formerly registered, health professional, or adverse findings, or restrictions to practice placed on a registered, or formerly registered, health professional
- a diminished role for HCEs in resolving complaints collaboratively with health professional registration authorities.

The consultation process for the final version of the legislation was completed in spring 2009. On 3 November 2009, the Queensland Parliament assented to the overarching law for the new arrangements, the *Health Practitioner Regulation National Law Act* 2009 (Act B).

Part of the new law, Part 8 Health, performance and conduct, deals with complaints and notifications about individual nationally registered health professionals. It is principally Part 8 that overlaps with the jurisdiction of HCEs.

In April 2010 the HCEs initiated discussions with AHPRA. In May 2010 the HCEs and AHPRA commenced drafting a Memorandum of Understanding (MOU) covering their respective roles, responsibilities, information sharing and referrals for complaints and notifications about individual nationally registered health professionals.

Legislation to incorporate the provisions of Act B into South Australian law, the *Health Practitioner Regulation National Law Act (South Australia) 2010*, was passed on 29 June 2010.

Updates about the implementation of the new scheme for complaints and notifications about individual nationally registered health professionals will be available at www.hcscc.sa.gov.au - What's new during 2010-11.

3.5 Serious Complaints and Vulnerable Clients

During 2007-08 several serious complaints involving vulnerable adults that were handled poorly prompted HCSCC inquiries about complaints management and reporting in services funded by government departments.

A wide variety of non-government health and community organisations (NGOs) are governed by a common contract. HCSCC advocated improvements in the common contract to ensure that serious complaints are managed swiftly and effectively. The Department of Families and Communities (DFC) and SA Health agreed in principle to this improvement. However NGO concerns resulted in the negotiated feedback and complaints clause falling short of the protections HCSCC sought.

In April 2009, the Commonwealth Ombudsman published Fact Sheet 6 'Complaint handling: Outsourcing', available at http://www.ombudsman.gov.au/docs/fact-sheets/onlineFactSheet6_outsourcing.pdf, which clearly explains the obligations of government agencies contracting with NGOs.

HCSCC lacked capacity to progress negotiations with DFC, SA Health and the South Australian Council of Social Service, the peak body representing the majority of the NGOs, to strengthen complaint handling for vulnerable clients through the common contract during 2009-10.

3.6 SA Parliament Social Development Committee Inquiry 30th Report Bogus, Unregistered and Deregistered Health Practitioners

The Social Development Committee Inquiry into bogus, unregistered and deregistered health practitioners (the SDC Inquiry) started in February 2008. HCSCC provided submissions to the SDC Inquiry in March and November 2008.

HCSCC advocated the adoption of the NSW model of a statutory Code of Conduct for unregistered service providers and associated HCSCC enforcement powers. This would enable HCSCC to direct an unregistered practitioner to stop practices which do not meet Code of Conduct requirements and to warn the public. The NSW changes came into force in August 2008. Information about the NSW Code is available at http://www.hccc.nsw.gov.au/Information/Information-for-Unregistered-Practitioners/default.aspx

On 16 June 2009, the SDC Inquiry report was tabled in the SA Parliament. The report is available at http://www.parliament.sa.gov.au/Committees/Pages/Committees.aspx?CTId=5&CId=182

The SA government's response to the SDC report in September 2009 substantially endorsed the SDC recommendations, including the changes HCSCC advocated to strengthen the H&CSC Act.

During 2009-10 HCSCC provided quarterly reports to the SDC about progress in dealing with complaints about unregistered health practitioners. HCSCC also reported progress towards implementing the SDC Inquiry report recommendations linked to HCSCC.

Changes to the H&CSC Act, similar to those applying in NSW, are anticipated in 2010-11. HCSCC will provide a final report to the SDC once these amendments come into effect.

Consultation about a national approach to the regulation of bogus and unregistered health practitioners is anticipated in 2010-11.

3.7 Mental Health Act 2009

The new *Mental Health Act 2009* (the MH Act) will come into effect on 1 July 2010. HCSCC awaits details about the Community Visitors Scheme (CVS) under the Act. The CVS is an important new safeguard for people with a mental illness. Based on interstate schemes, a CVS has the potential to nip in the bud problems with standards of care and to prevent them escalating into complaints.

HCSCC will monitor the impact of the MH Act on complaints about mental health services during 2010-11.

HCSCC will be keen to see if provisions to strengthen care planning, information to mental health service users and appropriate carer involvement bear fruit. HCSCC will also be keen to see it the reasons for detention are provided to the service user and/or their substitute or legally appointed decision maker and are recorded in the case notes.

3.8 Advance Care Planning and Directives

Since 2001, a review of advance directives has been advocated. Advanced directives include several ways in which people can document their wishes about how they want aspects of their life managed and decisions made on their behalf, if they become unable to speak for themselves. This can include health care and treatment decisions.

Advanced directives fall into a number of categories:

- they can be legal documents, or policy documents eg Organ Donor Register, Do Not Resuscitate Orders, a good palliative care plan made with the agreement of a person, or their family; a Statement of Choices under the Respecting Patient Choices Program, or a Ulysses Agreement made by a person with a mental illness
- they can set out personal instructions, or appoint a proxy decision maker eg a medical agent
- they can allow for financial, lifestyle, or health care arrangements.

There are three SA laws which have different advanced directives. Research has found that this is too complex for consumers, carers, health service providers and lawyers to understand. As a result, advance directives are not used effectively, leaving families and clinicians without clarity for end of life decision making. This can result in distressing, unwanted and expensive medical interventions.

In 2006-07 the SA Advanced Directives Review started. It included an issues paper and extensive public consultation. In 2007-08 the Review Committee developed recommendations in two stages to provide to the Attorney-General:

1. the law and policy changes needed to support effective advanced directives
2. the implementation of advanced directives, including a public and health service provider education campaign.

In May 2009, HCSCC issued a media release 'End of life decision making', available at http://www.hcscc.sa.gov.au/cgi-bin/wf.pl?pid=QxMBr&mode=cd&file=../html/documents//02_what's%20new

During 2009-10 HCSCC continued to receive anecdotal reports and complaints relevant to advanced care planning and directives. These have involved:

- lack of or poor advance care planning with people who have a chronic or terminal condition and their family/carers
- non-compliance with advance care plans and directives
- lack of clarity about advance directives causing distress and difficulty for families and clinicians during end of life decision making, or when a person with a serious mental illness is not well enough to make treatment decisions for themselves.

In October 2009, the Attorney-General released the SA Advanced Directives Review Committee's recommendations. In response the Minister for Health endorsed the development of a South Australian Framework for End-of-Life Decision-Making. In November 2009 SA Health established an End-of-Life Decision-Making Project to develop the framework. HCSCC is a member of the Expert Reference Group for this project.

Along with other standards, for example the Good Medical Practice: A Code of Conduct for Doctors in Australia July 2009 section 3.12 End of life care, available at http://www.medicalboard.gov.au/Codes-and-Guidelines.aspx this project has the potential to improve advance care planning and the promotion of advance care directives.

In June 2010, HCSCC secured $ 70 000 once-off funding from SA Health for a collaborative pilot project, in conjunction with the Council for the Ageing SA (COTA SA) and the Health Consumers Alliance SA (HCA), to promote advance care planning and directives in the community.

The pilot project will build on work started by the Central Northern Adelaide Health Service - The Queen Elizabeth Hospital - Western Adelaide GP Network's Respecting Patient Choices in the Community project. The project will develop, pilot and evaluate the delivery of a peer education module to enable selected COTA SA Peer Educators, in conjunction with local health service providers, to provide information to people over 65 years of age, their carers and advocates about:

1. advanced care planning and directives for end of life care
2. their rights under the Australian Charter of Healthcare Rights and how to realise them in the context of advanced care planning and directives for end of life care
3. how to speak up if their advanced care plan or directive for end of life care is not respected.

3.9 Commission of Inquiry into the Abuse of Children in State Care - Mullighan Inquiry recommendations - Act amendments

On 16 June 2009, the *Children's Protection (Implementation of Report Recommendations) Amendment Bill 2009* was introduced to the SA Parliament. HCSCC supported provisions to enable HCSCC to accept a complaint directly from a child about services and about circumstances arising since May 2004 (the date of release of the Layton report) while they were in the care of the state. These provisions, under section 24(b) H&CSC Act, commenced on 31 December 2009.

3.10 Health and Community Services Complaints Act 2004 - Part 3 Charter of Health and Community Services Rights

HCSCC received $45,356 once-off funding from SA Health to develop the Part 3 Charter of Health and Community Services Rights (the HCSCC Charter). Lisa Firth, Senior Project Officer commenced a six month fixed term contract on 6 April 2010 to develop the HCSCC Charter.

A Project Reference Group was established comprised of the Commissioner, Leena Sudano; the Executive Director, Health Consumers Alliance SA, Stephanie Miller; the Director Safety and Quality, SA Health, Michele McKinnon; the Executive Director, South Australian Council of Social Services, Ross Womersley and Senior Project Officer, HCSCC, Lisa Firth.

The key stages of the project to 30 June 2010 involved initial research and project planning. Before developing the draft HCSCC Charter, the content of relevant local, national and international charters or codes was reviewed. Due to the complexity and diversity of HCSCC's jurisdiction, key stakeholder groups, service providers and strategic documents were identified across the public, private and non-government health and community services. This information was used to develop an extensive stakeholder contact list in preparation for consultation during July - August 2010.

An HCSCC Charter Consultation Report and a proposed Charter of Health and Community Services Rights will be provided to the Minister for Health by 1 October 2010. In accordance with the Commissioner's obligations under section 9(1)(d)(i), HCSCC will seek additional resources to provide information, education and advice about the HCSCC Charter, in particular to people with special needs (section 9(2) - (3)).

Further information about the HCSCC Charter of Health and Community Services Rights is available at: http://www.hcscc.sa.gov.au/cgi-bin/wf.pl?pid=tCSK0&mode=cd&file=../html/documents//31_hcscc%20charter%20of%20rights

3.11 The year ahead

In 2010-11 HCSCC will aim to:

- use lean thinking methodology to improve HCSCC complaint resolution processes (section 3(c))
- establish a new complaints management database to improve the management and reporting of HCSCC complaints (section 3(d))
- improve reporting about the impact and outcomes of HCSCC work beyond individual complaints (sections 3(e) and 9(1)(b)-(c))
- secure funding to enable systematic outreach to people with disabilities and people from Aboriginal and Torres Strait Islander backgrounds, their carers and advocates (section 9(2)-(3))
- provide fee-for-service training in complaints management to major service providers to improve complaints handling at the point of service (sections 3 (c) and 9(1)(g))
- promote the HCSCC Charter of Health and Community Services Rights (Part 3)
- establish the HCSCC Health and Community Services Council (Part 8)

- use new powers conferred by the anticipated H&CSC Act Amendment Bill to strengthen the management of HCSCC complaints about unregistered service providers
- review all HCSCC communications, including the HCSCC website
- continue to strengthen engagement with stakeholders in the non government and private sectors (section 9(1)(k)).
- promote understanding about the HCSCC and AHPRA statutory relationship for complaints and notifications about individual nationally registered health practitioners (section 9(1)(j) and Part 7).

4. COMPLAINT RESOLUTION SERVICE

4.1 Enquiry Service

The Enquiry Service offers information and advice about complaints, including guidance about how HCSCC can assist people within the scope of the Act.

If HCSCC cannot deal with a matter within the scope of the Act, every effort is made to refer the person to another appropriate service.

When a complaint is within the scope of the Act, the Enquiry Service will assist the person:

- to make their complaint directly to the service provider - see direct resolution below, or
- to provide enough information to HCSCC for the Commissioner to decide what action to take on their complaint.

The Enquiry Service is staffed Monday to Friday from 9 am to 5 pm and is accessible by:

- telephone 8226 8666, toll free for SA country callers on a landline 1800 232 007
- email from www.hcscc.sa.gov.au
- facsimile 8226 8620
- letter to PO Box 199 Rundle Mall SA 5000.

The HCSCC Enquiry Service is staffed by two full-time Information and Assessment Officers. An Administrative Assistant and an Enquiry Service Co-ordinator provide day-to-day support and backup.

The aim of the HCSCC Enquiry Service is to:

- ensure a high level of service in response to enquiries and new complaints, or;
- provide guidance to service providers seeking assistance to resolve complaints.

HCSCC Telephone Enquiry Service June 2010 snapshot

From 1 June 2010 to 30 June 2010, a period of 21 working days, the HCSCC Enquiry Service manually recorded the number of telephone calls dealt with by the two Information and Assessment Officers.

During this period the HCSCC Enquiry Service dealt with 343 telephone calls, an average of 16 calls each working day comprised of:

- 181 new telephone contacts and
- 162 follow up calls.

The Information and Assessment Officers also enter all new complaints on the data base, send out complaint forms, receive and process new written complaints, manage administrative processes for consultations and referrals between HCSCC and the health professional registration Boards, and assist the Complaint Resolution Officers with aspects of their allocated complaint files.

4.2 Direct resolution

HCSCC encourages people to resolve their complaint directly with the service provider. Callers to the HCSCC Enquiry Service receive information and advice about how they may be able to resolve their complaint by bringing their concerns to the attention of the service provider.

An updated A *guide for consumers* HCSCC brochure and information on the HCSCC website also provide step-by-step guidance about how to make a complaint directly to the service provider. Further assistance is provided to people who need help to resolve their complaint directly. For example, if it would be unreasonable to expect the person to approach the service provider, if a person has tried to resolve a complaint directly but this has not worked, or if a complaint is serious enough to warrant HCSCC attention in the public interest.

4.3 Facilitated direct resolution

Many larger government agencies including public hospitals, the SA Dental Service, the South Australian Ambulance Service and Families SA, have designated complaint officers. HCSCC regularly refers people directly to these complaint officers to facilitate a complaint being lodged and followed up by the service provider directly. HCSCC has generally found these complaint officers committed and skilled in dealing with complaints.

Special needs

If a person has special needs, HCSCC provides individually tailored assistance to ensure that their complaint is lodged directly with the service provider.

A common example is that HCSCC will not require a complaint to be provided in writing if a person has impaired literacy. HCSCC obtains details of the complaint verbally and, with the person's permission, lodges the complaint on their behalf.

How people respond to HCSCC encouragement to try direct resolution

"I didn't know who to complain to at the hospital about this problem but now that you have given me the name and contact details of someone who can deal with it I am happy to give it a try."

"My neighbour told me to ring HCSCC first but it makes sense to see if the provider can sort this out."

"I don't need to use the service again so although I don't want to talk to the person who was rude to me, I am happy to put it in writing - I think they should know how I felt."

What people say to contact HCSCC after their attempt to raise their complaints directly has failed

"I tried to bring up my concerns with the provider but I was too worried about repercussions. I need their care and don't want my services to stop."

"I telephoned them (the provider) three weeks ago and nobody rang back."

"I don't agree with the information sent to me in response to my complaint. I think it contains inaccuracies and I feel fobbed off."

4.4 HCSCC complaints

As reported in previous annual reports, the HCSCC complaints management system, Proactive, is outdated and inadequate for internal management and external reporting.

The HCSCC operational review was completed in May 2010. The operational review findings included that:

1. the quality of data within HCSCC is poor and incomplete impacting on the HCSCC's ability to effectively report, monitor trends and make informed decisions, and

2. the current HCSCC complaints IT system is inadequate, outdated and ineffective.

As a result, the complaint resolution service information below is the best available given the current system, but should be regarded as incomplete.

HCSCC complaints 2009-10

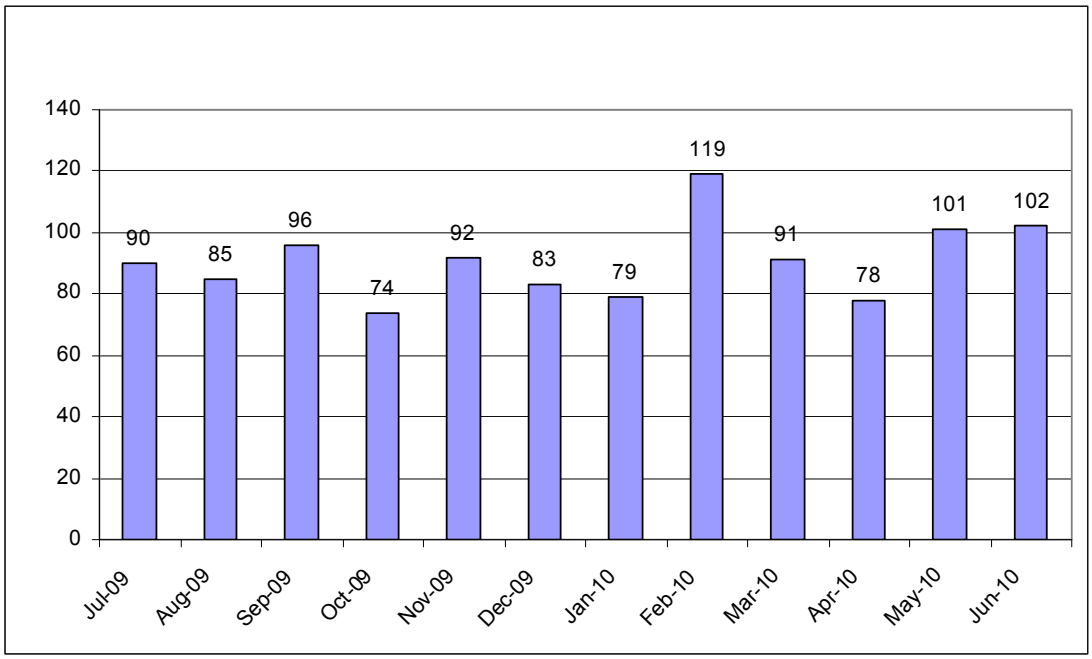
On 30 June 2009 there were 177 open complaint files carried forward to 2009-2010.

Between 1 June 2009 and 30 June 2010, HCSCC received 1090 new complaints. This represents a 31 % increase in complaints compared to 2008-2009 (832).

Of 1090 new complaints received, 308 were referred to the service provider to attempt direct resolution.

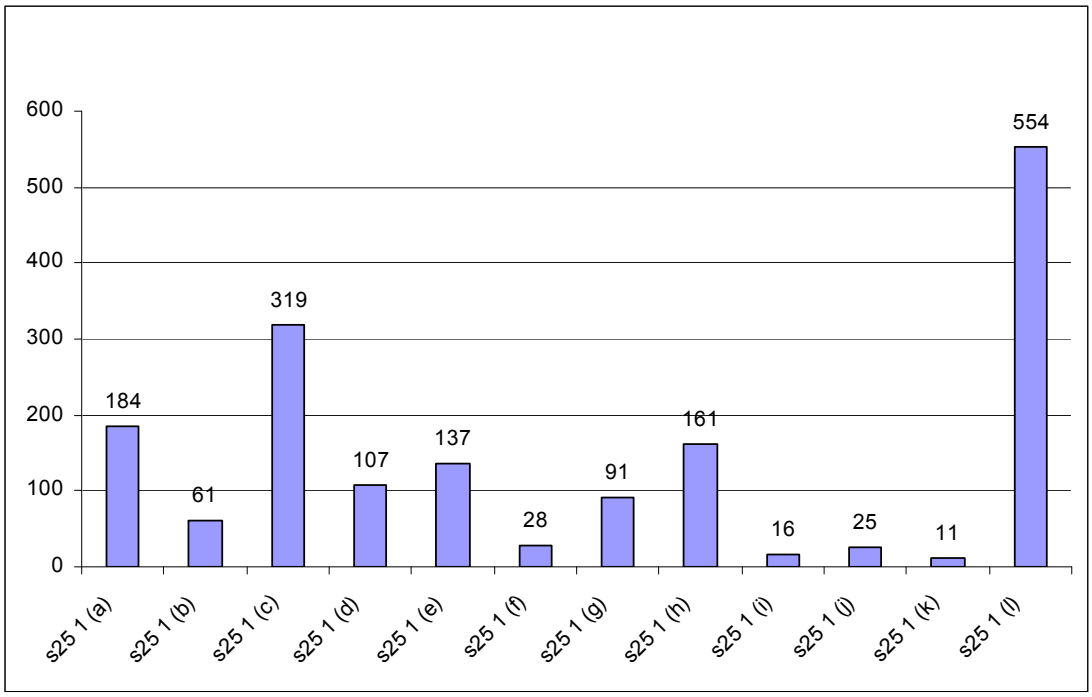
On 1 July 2010 there were 168 open complaint files carried forward to 2010-2011.

Table 1 – 2009-10
Complaints opened by month



Average new complaints per month: 90 (2008-09, 70 per month).

Table 2 – 2009-10
Grounds for complaint – section 25



Note: a single complaint may raise more than one ground:

s25 1 (a)	service not provided
s25 1 (b)	service not necessary or inappropriate
s25 1 (c)	unreasonable manner in providing service
s25 1 (d)	lacked due skill
s25 1 (e)	unprofessional manner
s25 1 (f)	failure to respect privacy or dignity of service user
s25 1 (g)	quality of information
s25 1 (h)	access to records denied or information from records not provided
s25 1 (i)	unreasonable disclosure of information
s25 1 (j)	action on complaint not taken by provider
s25 1 (k)	acted in a manner inconsistent with the Charter
s25 1 (l)	didn't meet expected standard of service delivery.

Table 3 – 2009-10
Issues complained about – health

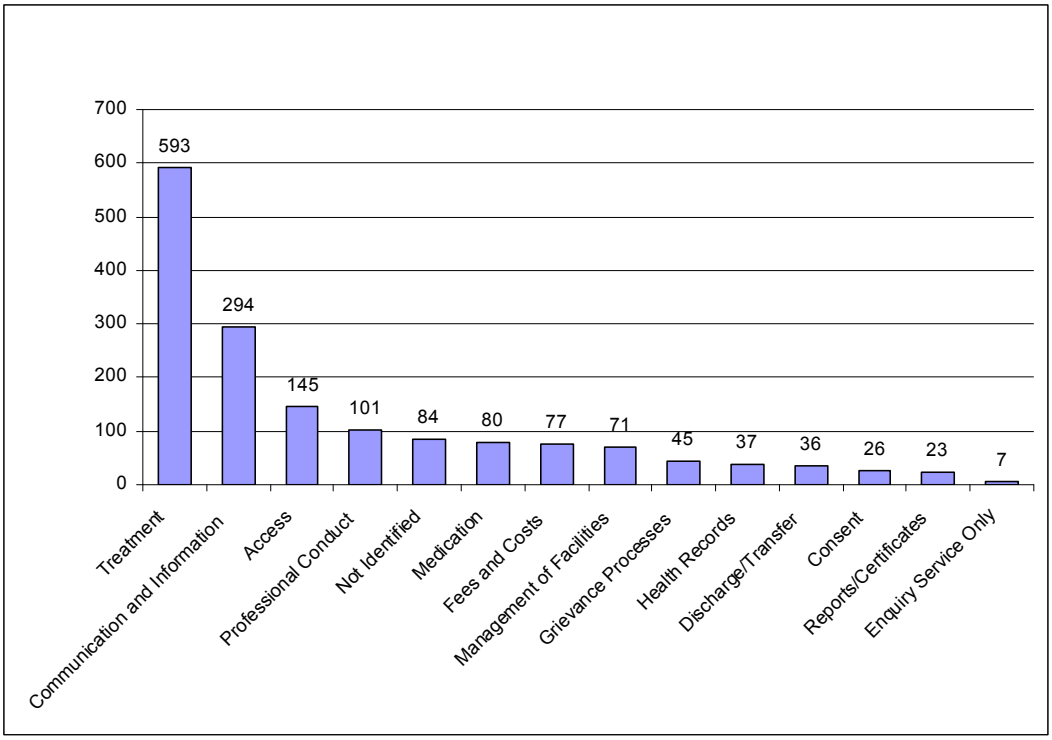


Table 4 – 2009-10
Issues complained about – community services

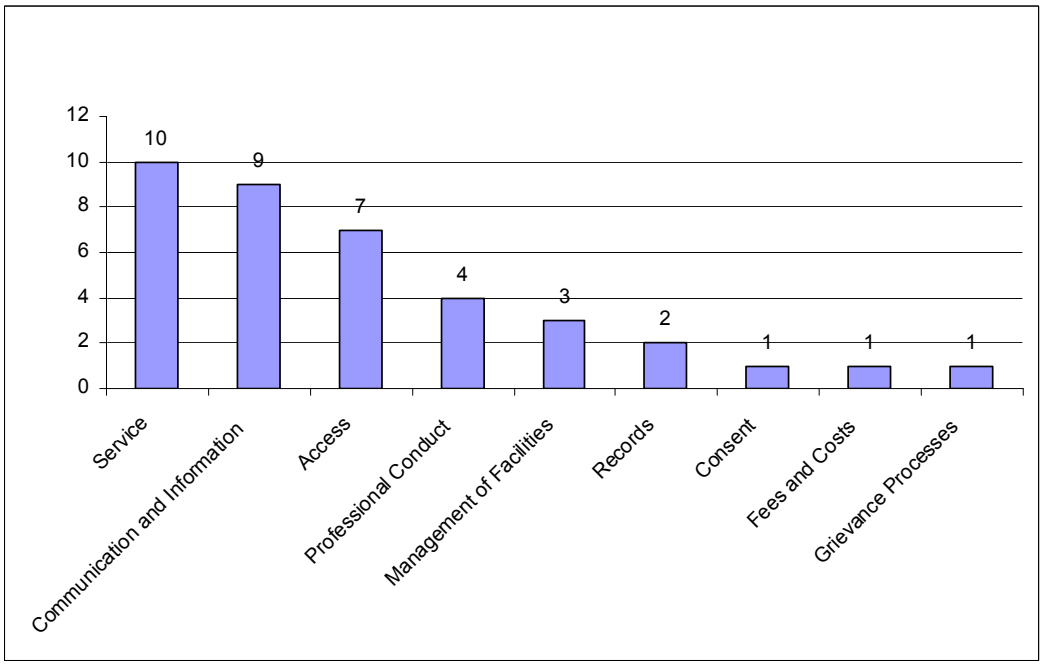


Table 5 – 2009-10
Issues complained about – child protection

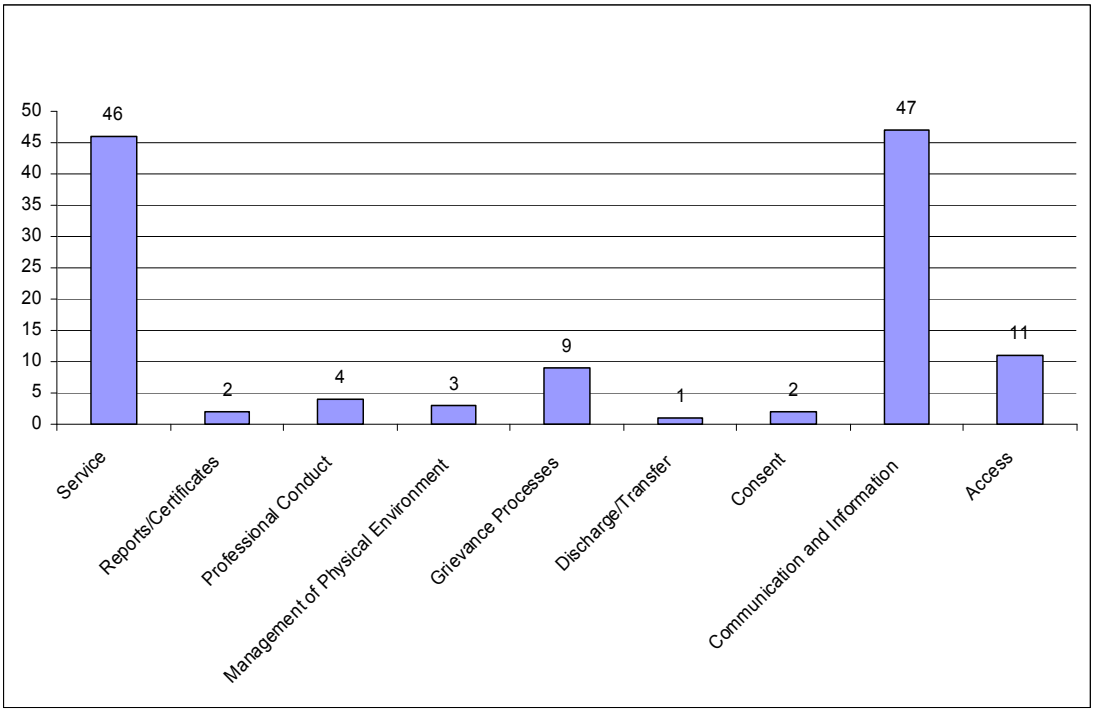


Table 6 – 2009-10
Mode of contact with HCSCC

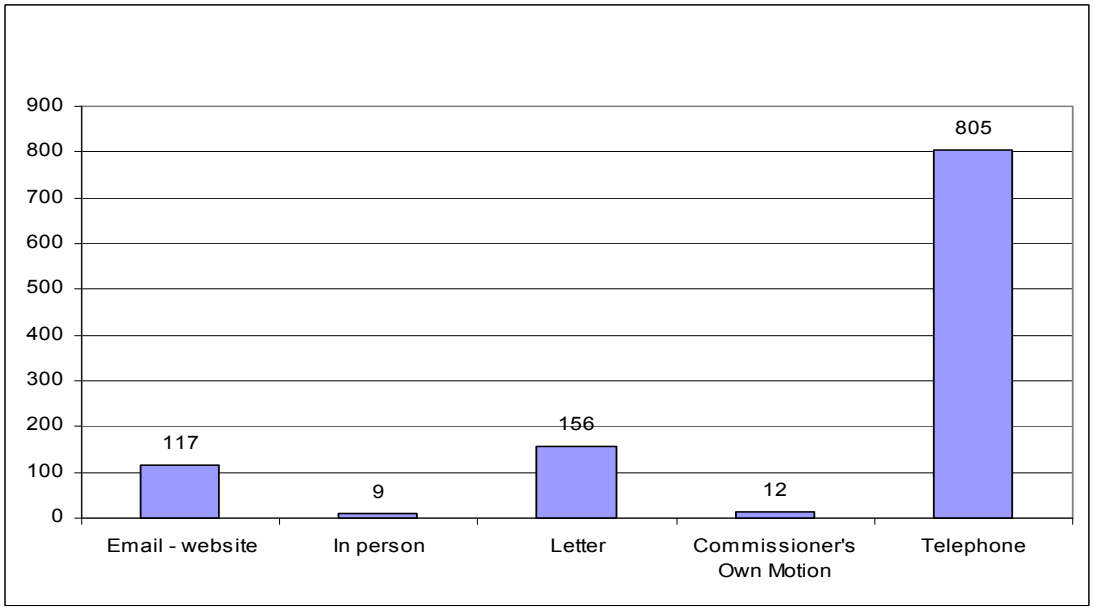


Table 7 – 2009-10
Location of service provider

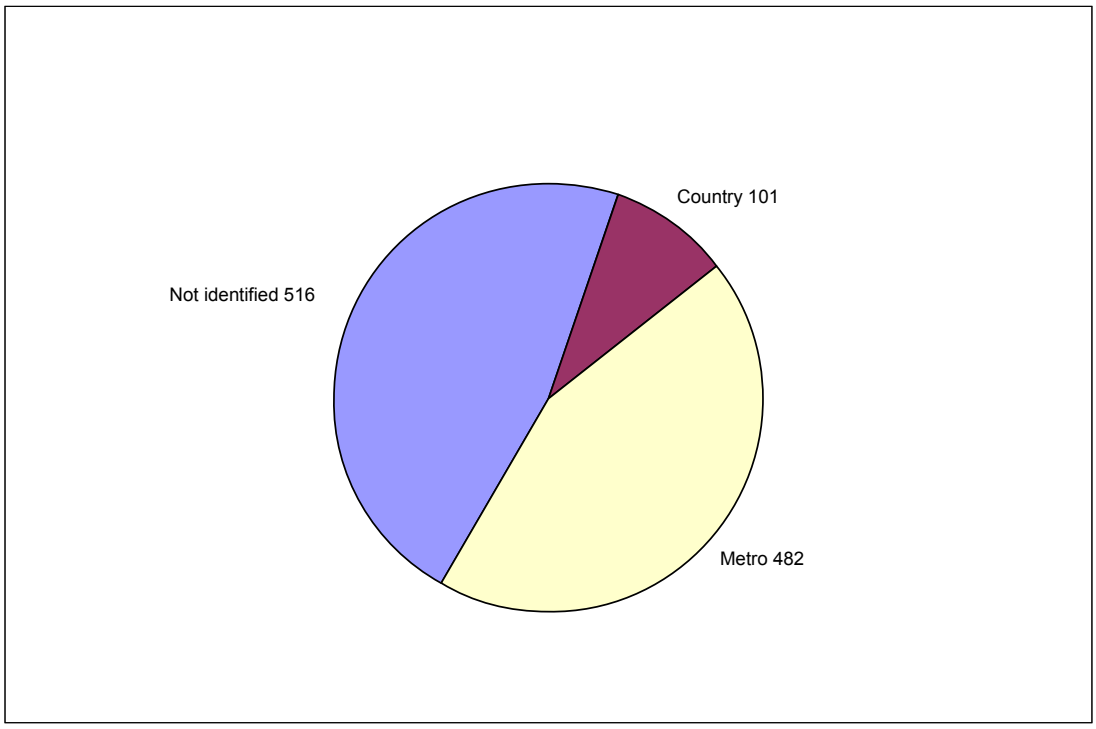


Table 8 – 2009-10
Residential location of person contacting HCSCC

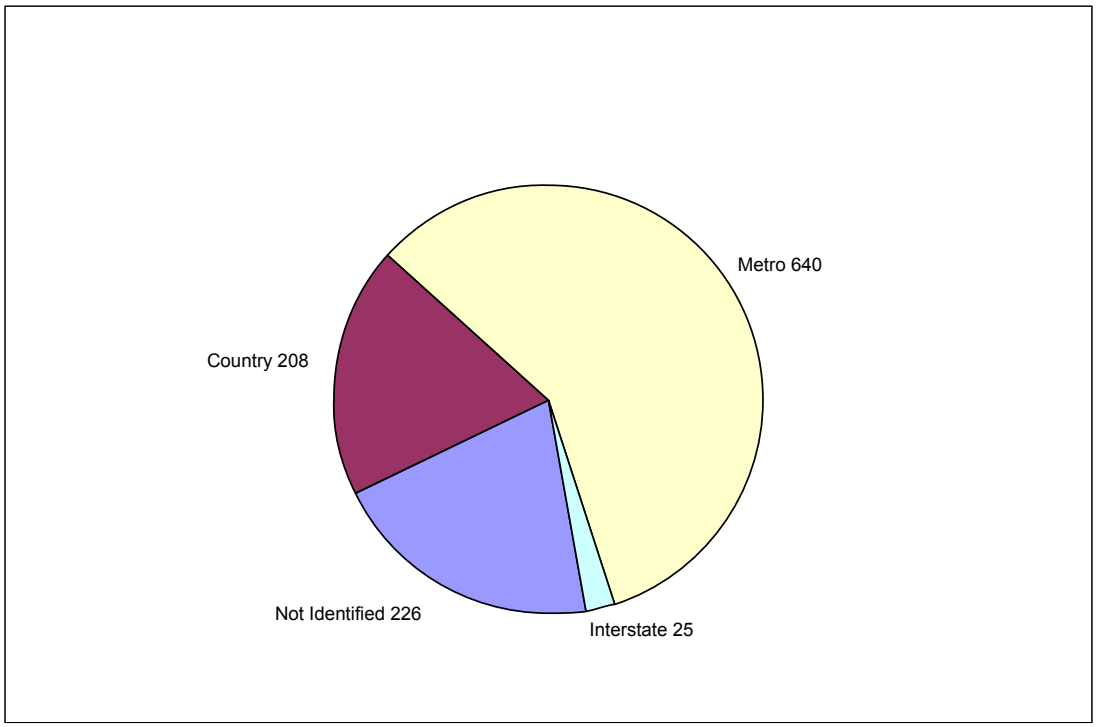


Table 9 – 2009-10
Role of contact person

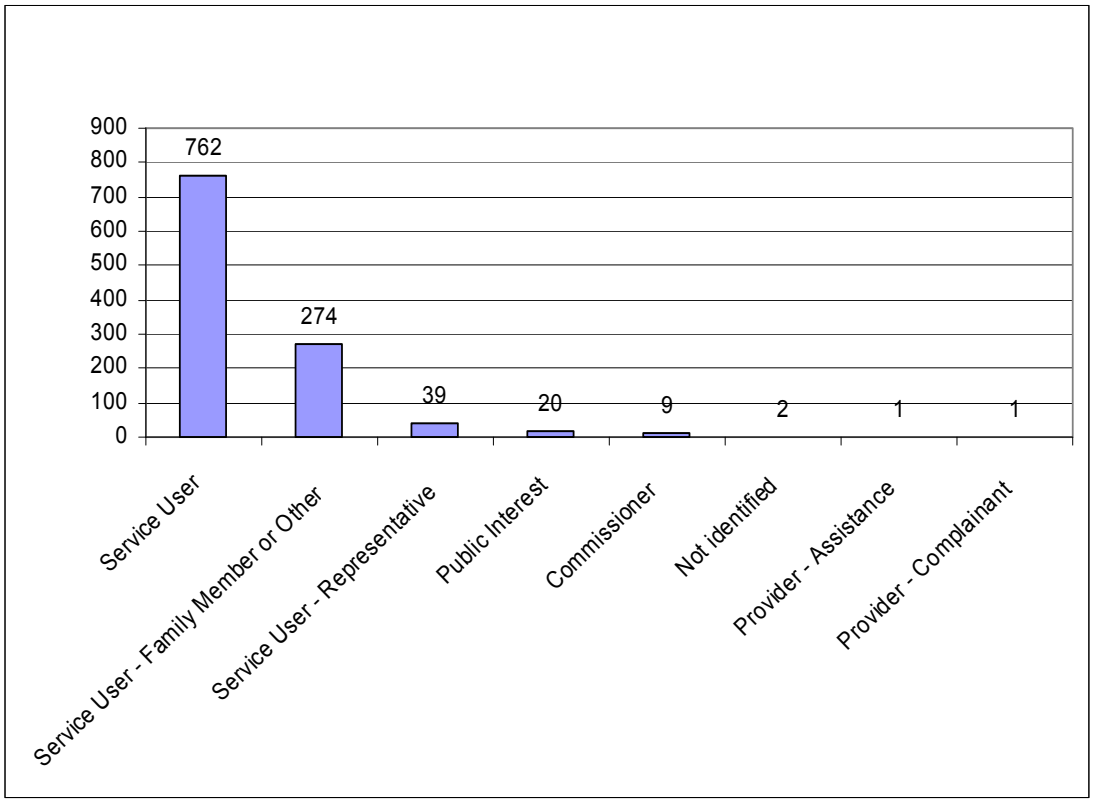


Table 10 – 2009-10
Gender of contact person

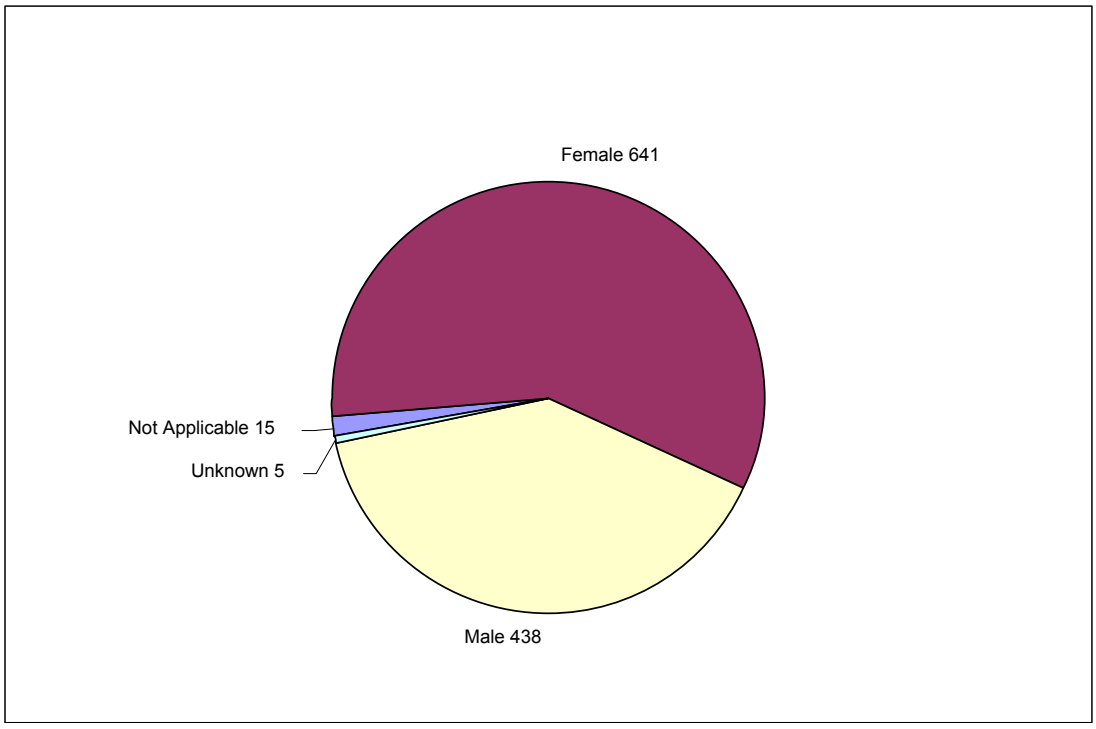
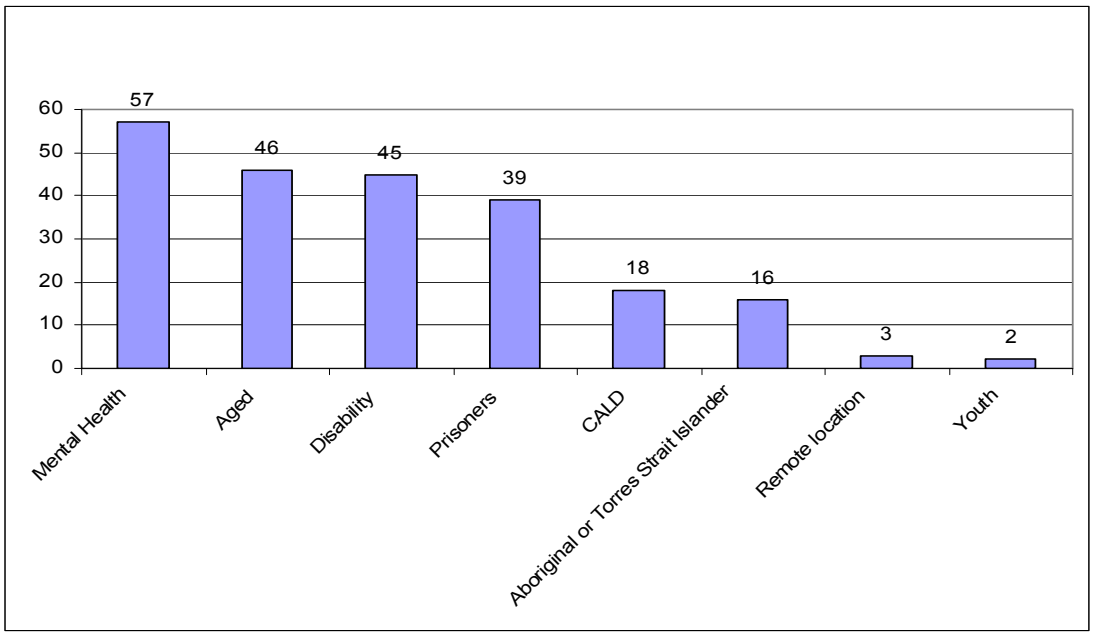


Table 11 – 2009-10
Contact from people with special needs



HCSCC complaint handling performance standards include:

- 80% closed within 26 weeks
- 95% closed within one year
- no files open more than two years
- <1% of complaints reviewed by the SA Ombudsman.

Of all new complaints received in 2009-10:

- 73.74% were closed within 21 days
- 23.95% were closed within 22-44 days
- 2.31% were open more than 45 days
- 2 systemic files have been open more than two years
- 8 (<1%) of complaints were reviewed by the SA Ombudsman.

4.5 Complaints by, or on behalf of, Aboriginal people

In 2009, HCSCC conducted an outreach project with Aboriginal and Torres Strait Islanders in South Australia (SA) called *Ever Felt Like Complaining?*

HCSCC consulted with SA Aboriginal community members and workers in SA Aboriginal and mainstream health and community services. Information about the project and updates are available at www.hcscc.sa.gov.au

Since this project, a number of Aboriginal people made direct contact with HCSCC to talk about how they or members of their family had been treated when they used health and community services. Twenty three complaints resulted from these contacts (2008-09, 12 complaints).

The following are examples of complaints made about mainstream health service providers.

Mental health services

Mary, an elderly Aboriginal woman, rang HCSCC to complain about lack of cultural sensitivity by a mainstream mental health service when providing services to her 30 year old son, Thomas. Mary complained that the allocation of a female doctor failed to take into consideration her son's cultural background. Mary said that her son was uncomfortable talking to a female doctor and preferred to have his mental health services provided by a male. Mary also complained that requests to the doctor for a support letter to enable her son to obtain his own accommodation had been refused.

Mary claimed that when she spoke with the doctor about her son's health and housing needs she was ignored, she felt the doctor's attitude and manner towards her was disrespectful. HCSCC wrote to the service provider seeking a review of Mary's complaint. HCSCC requested that Mary be provided with a written response that outlined the action that would be taken to address her complaint.

The service provider advised HCSCC that Thomas had been allocated a male doctor for his ongoing care and treatment and that a letter of support had been provided for independent housing.

Mary contacted HCSCC advising that her complaint had been resolved to her satisfaction. She was thankful for HCSCC assistance to communicate her concerns to the service provider in a way that improved services to her son.

Rural health service

HCSCC was contacted by Ellen about a pharmacy in a small rural town. Ellen said she wanted to complain on her own behalf, as well as for other members from the local Aboriginal community. Ellen alleged that when Aboriginal people went to the pharmacy they were treated rudely and spoken down to by staff. She said this made her angry and upset.

She also said the Aboriginal community did not want to use the pharmacy for their medical needs but felt they had little choice as the only alternative service was located in another town, a distance of two to three hours away.

Ellen requested that HCSCC not identify her, or the other Aboriginal complainants, to the service provider for fear of being victimised. HCSCC considered the request and determined it was reasonable to protect the complainants' identity under these circumstances.

HCSCC wrote to the service provider and requested a response to the issues raised by Ellen. In the response the service provider stated that they prided themselves on providing a high level of service to all members of the community and took such complaints seriously. The service provider told HCSCC that as a result of receiving the complaint, they would review their policies, procedures and systems for the delivery of services and complaints handling.

HCSCC contacted Ellen to see if she was satisfied with the outcome of her complaint. Ellen stated that there had been a marked improvement in the services to her, and the Aboriginal community by the pharmacy. She was happy that the issues had been resolved satisfactorily.

Ellen also told HCSCC that if she had any further concerns about the service provider she now had the confidence to resolve her concerns directly with the pharmacy.

4.6 Other complaint case studies

Behaviour management *Code Black*

Hayden complained to HCSCC saying he had been assaulted, forcibly restrained and injected by staff at a general hospital. He had tried to sort the matter out with the hospital but was not happy with their response.

HCSCC asked the hospital for a response to Hayden's complaint. The hospital responded that Hayden had woken in a confused state and could have become aggressive to staff. A *Code Black* had been called. *Code Black* refers to how the hospital deals with risk, or potential risk, to staff from aggressive patients and others. The hospital said that 6 staff (the usual number) had been involved in restraining Hayden and that he was given medication, not an injection, to calm him down.

The hospital said they understood that, even though they believed the *Code Black* was needed, it would have been overwhelming for Hayden. The hospital provided HCSCC with Hayden's case notes.

HCSCC found that the response from the hospital was not good enough because:

- the record keeping was not as good as it should have been
- it was not clear what the hospital had done to try to help Hayden calm down before calling the *Code Black*
- it was not clear that the *Code Black* was really needed
- no-one explained to Hayden afterwards what had happened and why.

HCSCC decided that these shortcomings needed follow up but by looking into the general issue, rather than just Hayden's complaint.

HCSCC is continuing to work with the health service to make improvements including:

- making sure that *Code Blacks* are only called when really needed and everything else has been tried
- making sure that staff talk with patients after a *Code Black*
- making sure that hospitals have a plan to try to reduce the number of *Code Blacks*
- making sure that, when one hospital or area does good work, or makes improvements in reducing *Code Blacks*, that this is shared with others so that eventually all services get better.

Cause of death on death certificate

Evelyn contacted HCSCC because she wanted her husband's death certificate changed. Her husband's cause of death had been stated as Parkinson's disease. Evelyn explained that although her husband had Parkinson's like symptoms, he had died of Alzheimer's disease. The mistake had resulted in the rejection of Evelyn's application to the Veteran's Affairs Board for a widow's pension.

Evelyn had two other concerns. Her husband had received medication for Parkinson's even though he didn't have this disease. She was also concerned that other family members would be misinformed if they read the death certificate.

Evelyn told HCSCC that she had approached the doctor who had signed the death certificate. He told her that the death certificate could not be changed, but had given her a statement to explain the mistake. He suggested to Evelyn that his statement be stored with the death certificate. Evelyn then appealed the rejection of her application for a widow's pension.

To address Evelyn's concern that her husband may have been harmed by receiving medication for Parkinson's disease, HCSCC was able to confirm that the medication was appropriate to treat his Parkinson's like symptoms.

HCSCC also found out that it was possible to amend a death certificate through the Births Deaths and Marriages Office with the Office of Consumer and Business Affairs. The process required documents to be provided by the doctor. HCSCC provided this information to the doctor and to Evelyn. The doctor agreed to help Evelyn have her husband's death certificate corrected.

Disability services and informal mediation

Gary heard about HCSCC on talk back radio and called the radio station to talk to the Commissioner about his complaint. He was given the information he needed to make a complaint to HCSCC about his disability services.

Gary has a rare disease that is making it harder and harder for him to absorb food. With the help of disability workers, Gary can get the nutrition he needs through a tube and live on his own. Gary works part time and uses a wheelchair.

Gary had a number of complaints about the services he needs. In the past, he'd made formal complaints but nothing had changed. Gary was very frustrated and he didn't think that making a complaint to HCSCC would make any difference.

Gary complained that his carers were not turning up and not calling him to let him know. This often made him late for work. He also complained that the workers were not trained and didn't know how to do the tube feeds properly. He was losing strength and the ability to do things himself. Gary also complained that when he contacted the service on the weekend he was asked to leave a message and nobody got back to him before Monday, even when he really needed help straight away. When he complained about these problems, nobody returned his calls or they left him waiting on the line. He felt like the service didn't treat him with respect, take him seriously or understand that he depended on the service.

HCSCC organised two meetings, a month apart, for Gary and his parents to talk directly to the service managers about Gary's problems. Meeting face to face gave Gary a chance to talk about what he thought would make things better. It also gave his parents a chance to talk about the problems they had seen Gary experience.

During the meetings everyone agreed on changes that would make things better for Gary. The service apologised to Gary for the difficulties he had had in the past and assured him that they would listen to him in the future. A new link was set up between the service and Gary's parents so that communication about what was happening to Gary was improved. Gary said that services had improved between the first and second meeting. He also said that he noticed that when his carers seemed to care about working with him, he cared more about keeping them informed.

Gary said that making a complaint to HCSCC seemed to have made a real difference but he would wait and see. Six months later, HCSCC checked with Gary. He said he was having a much better time with his carers, the services were better and he had no complaints.

Early dementia, stroke, transfer to city and discharge information to family members

Josie, her mother Jean and her step father Bob, live nearby each other in two country towns. Bob has early dementia. Bob was admitted to a large regional hospital and was transferred by flying doctor to a major city hospital after a week. He was admitted to the stroke unit. Josie and Jean rang the city hospital regularly to find out how Bob was going.

Eleven days after Bob had been admitted to the unit, Josie rang the unit and was told that they had never admitted Bruce to the unit. Josie questioned this and the nurse asked another nurse, who confirmed it.

Josie, alarmed by this information, drove 40 kms to the regional airport, thinking that Bob may have been sent home on the plane and was “sitting out there”. Bob was not at the regional airport.

Josie rang the city hospital again and asked to speak to Admissions. Admissions told her that Bob had been discharged 3 days before. They also told her that he had been readmitted the next day with a broken nose and discharged the same day. Josie and Jean were now extremely alarmed. It was winter, Bob had no jumper and only had $20 in his pocket. They were worried that he was wandering the city streets and in harm's way.

Josie rang the regional police to report Bob as a Missing Person. She also rang Bob’s brother, Kevin, who lived in a country town closer to the city, to let him know.

Josie was told later that the regional police rang the city hospital about Bob’s whereabouts and "got the same answers" as Josie. Josie checked the on-line Missing Persons sites to see if Bob was listed.

The next morning Kevin rang the city hospital and spoke to a nurse in the stroke unit. This nurse remembered Bob and said that he had been transferred to the city hospital’s residential unit, where people from country areas await upcoming surgery. Kevin rang Josie, who then rang the city hospital to double check. She then rang the regional police to let them know that Bob had been found.

Josie told HCSCC that the police officer who was investigating the Missing Person report was extremely cross that so much police time and resources had been wasted because of wrong information from the city hospital and had urged Josie to complain to HCSCC.

Josie, Jean and their families said they had undergone a lot of stress. Josie had a larger than usual telephone bill and had to outlay money for petrol to get to the regional airport. She estimated that her out of pocket expenses were $60. Josie and Jean sought a full apology for themselves and the regional police. Josie also wanted reimbursement for her out of pocket expenses.

HCSCC referred Josie’s complaint to the city hospital Consumer Advisor, asked that it be investigated and that HCSCC be given a copy of the letter to Josie in response to the issues.

The city hospital said that they had relied on Bob to let his family know where he was. They acknowledged that in Bob’s circumstances, hospital staff should have contacted Bob’s family to let them know about his discharge plan. The city hospital stated that is would use Josie’s complaint as a reminder to all staff of the importance of informing families about discharge plans. The city hospital apologised to Josie, Jean and the police. They also reimbursed Josie $60 for her out of pocket expenses.

Pregnancy care and care after early pregnancy loss

Jack complained to HCSCC on behalf of his wife, Jill. Jill had attended a hospital for an early pregnancy ultrasound scan. The scan was abandoned when her baby was identified as too young to enable the required measurements to be taken. No report about this was sent to Jill's GP.

When Jill returned for the same scan several weeks later, she was told that the scan showed that her baby was dead. Jill did not receive any support when this information was given to her.

After the first HCSCC letter, the hospital recognised the need for a report of the 11 and 18 week ultrasound scans to go to the GP, even if the full procedure had not been completed. The hospital also acknowledged that they had not provided support to Jill when she was told that her baby had died.

As a result of this complaint the hospital introduced new policies:

All under age 11 and 18 week ultrasound scan reports will be sent to the GP, the service user will be bulk billed and asked to obtain a GP referral for a later scan at the clinically appropriate time.

Women having an ultrasound scan in pregnancy will be encouraged to bring a support person with them. The support person will, with the woman's permission, be invited to be present during the scan. Support will also be provided by a trained medical imaging staff member. If there is bad news as a result of the scan, the support person and the trained staff member will stay with the woman to provide support while the results are discussed.

Fee for non attendance

Eric received a $ 20 bill from a doctor's surgery for non-attendance. Although he had previously attended the surgery, Eric did not believe he had made the appointment that he had been billed for not attending. When he checked the contact details for the surgery on the internet, Eric also found that they had a policy stating that $10 would be charged for non-attendance. The surgery also had information about HCSCC that was incorrect.

Eric rang the HCSCC Enquiry Service and explained his complaint. HCSCC obtained Eric's permission to speak to the surgery directly to understand his complaint better.

The Practice Manager told HCSCC that they had a clear record of the date and time the call was received requesting Eric's appointment. The Practice Manager offered to waive the fee 'in good faith'. The Practice Manager also agreed to correct the information on their website about the charge for non attendance and HCSCC.

HCSCC thanked the Practice Manager for her constructive approach to resolving the complaint. The Practice Manager said she appreciated the way HCSCC had contacted her and talked through the complaint.

HCSCC contacted Eric and explained the fee waiver and website information corrections. Eric wasn't happy. He felt the waiver by the Practice Manager insinuated that the surgery was being gracious, whereas Eric didn't believe he, or anyone else, had made the appointment on his behalf.

Eric wanted to take his complaint further. HCSCC explained to Eric that, given the fee would not be charged and the website information had been corrected, HCSCC would not take any further action.

Impaired decision making capacity and aged care in hospital

HCSCC received a complaint from the family of an elderly blind woman, Mrs M, who had been admitted to hospital. Her GP wanted the hospital to investigate Mrs M's growing confusion. After running some tests, the hospital assessed Mrs M as okay to go home and organised some home help services for her. The family complained that the hospital didn't properly assess Mrs M and that it was not safe for her to return home on her own.

HCSCC met with the hospital to find out how they had assessed Mrs M. HCSCC also wanted to understand what was done to assist people like Mrs M who might not be capable of making a decision about their own care. The hospital explained their assessment process. The hospital emphasised that they have to protect a person's right to make their own decisions, as well as to protect those who aren't able to do so. The hospital explained why they had decided that Mrs M was able to make her own decisions.

Mrs M's family asked the Guardianship Board to decide if Mrs M could look after herself. Mrs M was also assessed by the Aged Care Assessment Team (ACAT). The Guardianship Board appointed Mrs M's family as her guardians. ACAT recommended that Mrs M live in supported residential care so Mrs M moved into a nursing home.

HCSCC was about to close the complaint when Mrs M's family asked HCSCC to consider it further. Although Mrs M was now safe, her family still thought the hospital had made a mistake in assessing her as fit to make her own decisions and to live independently, they were afraid it could happen to somebody else. They wanted to know how Mrs M could have been assessed by the hospital as capable and then, just three weeks later, be assessed by the Guardianship Board and ACAT as entirely unable to look after herself.

HCSCC decided to review if the hospital's process for assessing people like Mrs M was adequate or needed improvement.

HCSCC looked at a lot of information about Mrs M and best practice assessment processes to determine if a person has the mental capacity to make their own decisions. HCSCC considered information from the Guardianship Board, ACAT, a senior medical officer and other experts.

HCSCC found that the different assessments are done for different purposes. This means that they could not be compared. HCSCC found that at each step, each service provider had met the expected standards. No one had done a bad assessment or done an assessment incorrectly.

The main problem HCSCC identified was that no one had taken responsibility for Mrs M's overall care. Only Mrs M's family could see the whole picture, including the gaps between the different assessments and services.

As a result of recurrent complaints on behalf of people over 75 years with fluctuating decision making capacity and chronic illness, HCSCC raised this systemic issue with SA Health.

As a result, the Statewide Clinical Network for Older People has set up a Care of the Older Person in Hospitals working group to improve the assessment, care, discharge and advanced care planning, including family/carer involvement, for people over 75.

Urine testing

Colin had a health assessment as part of a job application. He was required to undergo a urine drug test. The result was positive for methyl amphetamine and / or benzodiazepines. Colin was upset and went to his GP who also tested his urine and sent his sample to a different laboratory for testing. The results were negative.

Colin complained that the first testing procedure was flawed. He claimed that the container used to collect his urine had been used by others before him and had not been sterilised before he used it. Colin's job application had failed and he believed that this was due to the positive urine drug test.

HCSCC asked the first clinic to respond to Colin's concerns. HCSCC also asked for information about their testing procedures and safeguards.

The clinic provided a detailed response. The response demonstrated that the clinic's testing procedures and safeguards met the generally accepted standards. The response was exemplary. The clinic explained the reasons that preliminary results are positive and the need for confirmation testing after an initial positive result. The clinic also explained that Colin's initial urine test had been sent to another laboratory for confirmation testing. The confirmation test results were negative.

HCSCC determined to take no further action on Colin's complaint and sent a copy of the clinic's response to him. HCSCC also rang Colin to explain HCSCC's decision. Colin was unhappy despite the explanation from HCSCC and from the clinic. He remained convinced that his initial positive urine drug test happened because the clinic's procedure was flawed.

Delayed hospital discharge, bathroom modifications and contractor standards

A complaint was lodged with HCSCC by Rose on behalf of her husband, Peter. Peter was in hospital having rehabilitation for his medical condition.

To enable Peter's discharge home, Rose applied and was approved to receive a government service to renovate the bathroom to allow wheelchair access. Halfway through the modification work Rose and Peter raised their dissatisfaction about the quality work done by the contractor. They alleged that the renovations failed to meet the relevant Australian standards for access and mobility.

Rose claimed that her attempts, over several months, to resolve concerns about the standard of the renovations with the lead agency were not successful. This had resulted in an unreasonable delay in Peter's discharge from hospital and Peter incurring a large hospital fee which was not covered by their health insurance.

HCSCC wrote to the service provider detailing Rose's complaint. In response the service provider agreed to review their internal procedures for monitoring contractual arrangements for home modifications to ensure that the relevant codes, standards and the agency's disability policies are met.

The service provider also agreed that their complaints process had not been followed and would be improved, including by ensuring that all staff would undergo training in complaints handling.

HCSCC conducted an informal mediation with Rose, Peter and the service provider to resolve the outstanding concerns about the bathroom renovation and the unexpected hospital fee. Rose and Peter's complaint was resolved by the service provider agreeing to rectify all the outstanding bathroom modification issues and to negotiate on their behalf to have the hospital fee waived. Peter was successfully discharged home to a safe, accessible bathroom and the hospital fees were waived.

4.7 Conciliation

The conciliation process provides an opportunity for complainants and service providers to talk to each other about a complaint and how it might be resolved. With the assistance of an HCSCC appointed conciliator, in an environment which promotes good communication, the parties have the opportunity to speak frankly about their concerns and if they can, reach an agreement that satisfactorily resolves the complaint for everyone.

This year HCSCC managed at least 12 complaints where the complainant was seeking financial compensation as a result of preventable harm. HCSCC offered to conciliate these complaints under Part 5 of the Act. As conciliation is a voluntary process and there is no statutory obligation for the parties to participate, only four complaints commenced the conciliation process. Of these four complaints, three were finalised to the satisfaction of the parties involved, while the fourth is close to being finalised.

Although the numbers of complaints that reach conciliation under Part 5 of the Act are low, the good results are encouraging and HCSCC will continue to promote conciliation as a successful way to resolve complaints.

Angiogram bleed and conciliation

Marilyn was admitted as a day patient to a metropolitan hospital for an angiogram. Marilyn told HCSCC that before she was discharged she complained of severe pain. She said that the hospital had failed to investigate this. Marilyn's pain increased over the next few days so Marilyn went to the hospital's Emergency Department. She was diagnosed with a type of bleeding that is a known complication of an angiogram. The bleeding had resulted in a large internal bruise. Marilyn received treatment and spent several weeks recovering. Marilyn had just started a new job and did not have sick leave so she didn't have an income while she recovered.

Marilyn had complained to the hospital before contacting HCSCC. She had requested compensation for an amount that matched her loss of income while she recovered. The hospital acknowledged Marilyn's dissatisfaction but refused compensation. The hospital described the bleed as a known complication that was difficult to detect immediately after an angiogram. The hospital also stated that Marilyn's reports of pain had preceded the angiogram and that she had been properly assessed before discharge.

As the complaint involved a registered doctor, HCSCC consulted the Medical Board of South Australia (MBSA). The MBSA declined to investigate the complaint.

HCSCC obtained a clinical opinion from an interstate independent health complaints office. While this confirmed that the bleed was a known complication of an angiogram, flaws in the hospital's procedures were identified. The flaws included a poorly worded consent form and poor clinical record keeping.

Marilyn and the hospital accepted HCSCC's offer of conciliation to resolve the complaint. The hospital requested the conciliation process without a face to face meeting. Marilyn agreed. HCSCC conducted the conciliation between the hospital and Marilyn by exchanging documents and through separate meetings. Marilyn accepted the hospital's offer of financial compensation made through HCSCC. The amount offered was less than, but close to, the amount Marilyn had requested.

HCSCC also requested a response from the hospital to the flaws identified in the clinical opinion. The hospital acknowledged the shortcomings and outlined steps that had been taken to address them.

4.8 Investigations

During 2009-10, HCSCC undertook work on 18 Part 6 Investigations under the H&CSC Act.

Thirteen arose from systemic issues identified in individual complaints initially dealt with as Preliminary inquiries under section 30. Once HCSCC had finalised the individual complaint, a Part 6 Investigation was commenced to address the systemic issues.

Three investigations concerned unregistered health service providers. There were serious concerns about their conduct with clients and the type of services provided. Due to a lack of corroborating information, HCSCC had to end these investigations. HCSCC has put the providers on notice that they need to comply with the same standards as the NSW Code of Practice for Unregistered Health Providers.

These matters were included in the third HCSCC report to the SA Parliamentary Social Development Committee, following their Inquiry into bogus, unregistered and deregistered health practitioners.

One investigation involves the safeguarding of vulnerable people who receive disability services.

Other investigations include the following issues:

- safe medication dispensing to people in prison
- assessment of mental capacity in acute hospital settings
- use of *Code Blacks* including chemical and physical restraints in general hospitals
- end of life care planning
- open disclosure after a patient safety incident
- equity between state and federal aged care services
- best practice pressure ulcer prevention and management
- protocol for community acquired pneumonia assessment and treatment
- best practice services in country areas for people who present after an alleged sexual assault
- mental heath services taking into account the physical health needs of clients
- insulin management of people admitted to hospital
- access to rehabilitation services in country areas.

4.9 Relationship between HCSCC and registration authorities

Until 30 June 2010, the established constructive HCSCC relationships with the 10 SA health professional registration authorities (the Boards) under Part 7 of the H&CSC Act were maintained through regular telephone consultation and meetings.

Appropriate information sharing was ensured through regular reports from the Boards and through automatic consultation by HCSCC with the relevant board when a complaint was received about an individual registered service provider.

As predicted in HCSCC's 2008-09 Annual Report, the Part 7 statutory relationship with the boards and the section 77 reports will be impacted by the *Health Practitioner Regulation National Law Act* 2009 from 1 July 2010. This means that 10 health professions will be regulated by a nationally consistent law from 1 July 2010.

The Australian Health Practitioners Regulation Agency (AHPRA) is the new national agency responsible for the registration, accreditation and notifications about individual health practitioners in Australia. AHPRA acts on behalf of the 10 national registration Boards. Information about AHPRA and the 10 national registration Boards is available at www.ahpra.gov.au

From 1 July 2010, HCSCC will consult and exchange information with AHPRA SA about notifications and complaints involving individual nationally registered health practitioners working in South Australia.

HCSCC will continue to consult with the Occupational Therapy Board of SA about complaints involving occupational therapists. From 1 July 2012, they will join the national law, along with Chinese medicine, medical radiation and Aboriginal and Torres Strait Islander health practitioners.

Part 8 of the new national law will require AHPRA and HCSCC to notify each other as soon as practicable, and to consult each other about the management of any matter they receive concerning the health, performance or conduct of an individual nationally registered health practitioner, including students.

HCSCC and AHPRA SA have worked to establish new processes and systems to meet the new legal requirements. Along with counterparts in each state and territory, HCSCC and AHPRA SA have developed a written document that describes their legal obligations to each other and how they will meet them. This document, a Memorandum of Understanding (MOU), will be available at www.hcscc.sa.gov.au from November 2010.

From 1 July 2010 HCSCC and AHPRA SA plan to exchange information about notifications and complaints and to meet fortnightly to consult about their management. A first quarterly report about HCSCC and AHPRA SA notifications and consultation under the new laws will be available at www.hcscc.sa.gov.au - What's new in spring 2010.

HCSCC and AHPRA SA will collect information and report on the following:

- the number of HCSCC to AHPRA SA and AHPRA SA to HCSCC notifications and consultations
- the proposed HCSCC action before AHPRA SA consultation
- the HCSCC and AHPRA SA agreed action after consultation
- any disagreements about action to be taken
- the number of referrals by HCSCC to AHPRA SA and AHPRA SA to HCSCC
- the outcome of HCSCC to AHPRA SA and AHPRA SA to HCSCC referrals.

4.10 Improvement monitoring register

One of HCSCC's statutory objectives is to improve the safety and quality of health and community services through complaint resolution.

HCSCC assists service users and service providers to identify ways of improving services arising from complaints. The improvements may be specific to an individual to ensure that they get a better service in the future. The improvements may also be needed because many people are affected by a shortcoming and would benefit from improvements.

As a result of a complaint to HCSCC, a service provider will often identify what improvements need to be made for an individual or by changes to policies and practices.

Communicating the improvements to the person who made the complaint is an essential component of effective complaint resolution. Many people come to HCSCC saying they don't want others to go through what happened to them. Seeing the changes made to a service as a result of their complaint is essential for many people to move on with their lives.

If the service provider is not able to identify the improvements that are needed, HCSCC may seek independent advice about what the best practice is for the issue in question. HCSCC then makes recommendations to the service provider based on this advice. Most service providers engage positively with HCSCC to work towards service improvement.

As well as identifying the improvements needed, HCSCC asks service providers to report on the progress and completion of the planned improvement activities. Some service improvements occur over an extended period of time due to other priorities and lack of resources.

Some examples of service improvements that HCSCC has monitored during the year include:

1. for individuals who complained to HCSCC:

- Community service - arranged for appropriately skilled staff to provide service, created team approach, developed communication plan.
- Mental health service - clinical review arranged and new care plan created.

2. Systemic improvements as a result of individual complaints to HCSCC:

- Mental health service - complaints discussed at weekly team meetings to ensure staff skilled and supported to respond appropriately to complaints, staff given training on how to write appropriate letter to clients.
- Hospital cardiology department - new consent form developed to ensure patients fully aware of procedures and risks.
- State aged care services - plans in place to ensure that state aged care services are of the equivalent standard to those covered by Federal government legislation.
- Hospital - new policy and practice to manage pregnancy scans
- Hospitals - plan to update and educate staff about changes to administration of new types of insulin.

4.11 State Ombudsman reviews

Section 86 (c) of the H&CSC Act enables people to request that the State Ombudsman reviews HCSCC decisions and actions. HCSCC advises complainants of this right at various times during the course of a complaint to HCSCC.

The Ombudsman does not have to advise HCSCC if a complaint has been made about HCSCC. HCSCC only becomes aware that a review has been sought if the Ombudsman requests information from HCSCC. This information may include an informal overview of HCSCC actions and decision, copies of the entire HCSCC complaint file or interviews with HCSCC staff.

In 2009-10 the Ombudsman informed HCSCC that eight requests for review had been received about HCSCC actions or decisions. The Ombudsman advised HCSCC that five of the eight complaints had been closed with the Ombudsman finding that HCSCC had acted reasonably. HCSCC awaits the Ombudsman findings about the remaining three reviews.

4.12 HCSCC service evaluation

Complainant feedback

HCSCC routinely seeks feedback from a sample of complainants about their experience of HCSCC by using a service evaluation survey.

In response to 72 survey forms sent to complainants, 24 responses (33%) were received.

Of the 24 responses received:

- 87% found HCSCC staff courteous and to be good listeners
- 72% were satisfied with how HCSCC dealt with their complaint
- 69% would recommend HCSCC to their family and friends.

In response to the question 'In the end, did you get want you needed?'

- 25% responded yes
- 33% responded partly
- 43% responded no.

One third were dissatisfied with the time it took for HCSCC to address their complaint. Timeliness is always a challenge because HCSCC must obtain information or a response from a service provider. Procedural fairness requires that reasonable time must be given to the provider to respond. Service providers often requested additional time to respond, which lengthened the process.

Service provider feedback

HCSCC sought feedback from service providers who had been the subject of a complaint between April and June 2010.

In response to 52 survey forms sent to service providers, 23 responses (44%) were received.

Of the 23 responses received:

- 22 said that HCSCC clearly explained what the complaint was about and what information the service provided need to give HCSCC
- 23 said they knew who to contact at HCSCC about the progress of the complaint
- 20 said they found HCSCC staff helpful and courteous (2 did not answer this question)
- 23 said HCSCC acted impartially and objectively
- 16 said they'd rate HCSCC overall quality of work as excellent.

Service evaluation - comments

"I cannot say how pleased I am with HCSCC".

"I am just disgusted, not at your service but the set up by the hospital and staff, thanks for what has been done".

"I wasn't sure what to expect. I was pleasantly surprised by the workers knowledge and enthusiasm".

"Go a bit harder on the part of the people like myself who really do need help and are helpless because they are in jail and the system can be very unfair at times".

Six of the 22 complainants commented that HCSCC lacks the appropriate legislative power to properly investigate their complaints.

4.13 HCSCC assistance to service providers

HCSCC is contacted informally by a range of service providers seeking assistance with issues they are facing in providing services or complaints resolution.

The majority of requests from service providers concerned three areas:

1. Managing unreasonable behaviour by a service user

Service providers sought assistance to manage situations where:

- the service provider believed a service user was being unreasonable in their behaviour towards staff, or their expectations of the services that should be provided.
- the service provider was having difficulty with a service user who was not satisfied about the outcome of the service provider's complaints process.

In providing assistance to service providers HCSCC addresses:

- procedural fairness
- safety for clients and staff
- reasonable complaints processes
- reasonable limit setting on complainants
- review options if unable to resolve complaints at point of service, including referral to HCSCC.

2. Managing and reporting alleged assaults – physical and sexual

HCSCC was contacted by service providers about allegations, or suspicions of abuse against service users within services and in domestic settings.

HCSCC ensured that proper internal and external reporting processes had been commenced, that support was provided to the clients and their carers, that actions had been taken to prevent recurrence and that an appropriate investigation was underway with plans to report the progress and outcome to HCSCC.

For matters outside HCSCC jurisdiction, HCSCC encouraged providers to notify the relevant authorities, including SA Police and Office of the Public Advocate.

3. Service user eligibility to complain to HCSCC

This included situations where a service user may not have been satisfied with the outcome of a complaint they had made direct to the service provider, or where interested parties such as lawyers or advocates were seeking information on someone's behalf.

5. EXTERNAL RELATIONSHIPS AND COMMUNICATION

5.1 Health Consumers Alliance SA

HCSCC met regularly with the Health Consumers Alliance SA (HCA) Executive Director, Stephanie Miller and Chair, Tony Lawson. HCSCC contributions to the HCA quarterly newsletter this year focussed on:

- the Australian Charter of Healthcare Rights and the development of the HCSCC Charter of Health and Community Services Rights
- progress with action following the section 88 review of the Act, in particular the proposed consumer advocacy scheme and the establishment of the Health and Community Services Advisory Council
- the HCSCC Aboriginal and Torres Strait Islander outreach project
- advanced care planning and directives.

HCSCC's ability to collaborate formally with HCA to build the capacity of consumers to raise and resolve complaints was constrained by lack of HCSCC resources.

5.2 Carers SA

HCSCC met regularly with the Carers SA Chief Executive Officer, Rosemary Warmington. HCSCC was promoted throughout Carers SA networks, including stalls, events and Carers SA general and mental health newsletters. HCSCC newsletter contributions covered:

- the right of carers to complain
- carer fears about retribution if they complain
- family carer authority to complain to HCSCC on behalf of a person being cared for.

HCSCC's ability to collaborate formally with Carers SA to build the capacity of carers to raise and resolve complaints was constrained by lack of HCSCC resources.

5.3 SA Health

5.3.1 SA Health - Chief Executive Liaison Committee

HCSCC met twice with the SA Health Chief Executive, Dr Tony Sherbon. Issues raised by HCSCC included:

- action arising from the section 88 review of the H&CSC Act, including amendments
- complaints management and reporting by non government organisations contracted by SA Health to provide services, particularly complaints about abuse
- progress with the SA Cancer Services Review action plan
- delayed discharge from hospital for some people with disabilities
- assessment and treatment of older people in hospital, including advanced care planning and directives
- HCSCC Aboriginal outreach project, SA Health Aboriginal cultural respect and patient experience reporting
- access to mental health assessments for children and young people under guardianship
- regulation of bogus and unregistered practitioners
- implementation of the national registration scheme for health professionals.

5.3.2 SA Health - Safety and Quality Unit

HCSCC met three times with the Executive Director Public Health and Clinical Coordination, Dr Stephen Christley and the Director, Safety and Quality, Michele McKinnon. The issues discussed included:

- review of consent policy and practice
- clinical incident management policy
- open disclosure standard implementation
- pressure area prevention and management guidelines
- SA Health services complaints management and reporting
- medical credentialing and performance
- concerns and complaints about doctors
- the Australian Charter of Healthcare Rights
- SA Patient Safety Survey action plan
- patient identification guidelines
- SA Health consumer advisor network
- SA Health patient experience surveys - findings, reporting and action plans.

5.3.3 SA Health - Mental Health Unit

HCSCC met once with the Director, Mental Health Operations, Derek Wright and the Chief Psychiatrist, Dr Margaret Honeyman to monitor the progress of the *Stepping Up* mental health reforms and to deal with serious, recurrent or emerging issues arising from HCSCC complaints about mental health services.

Issues considered included:

- interstate transfer of people detained under the *Mental Health Act*
- new *Mental Health Act* implementation, including the community visitor scheme
- Victorian mental health complaints review
- restraint and seclusion - practice and reporting
- mental health safety and quality plan
- physical health assessment and treatment for people with mental illness
- safeguarding people with mental illness from abuse.

5.3.4 SA Health - Country Health SA

Country Health SA made further progress in improving their complaints management and reporting. This included:

- successfully completing a pilot project to improve complaints management
- engaging HCSCC to provide a workshop about recognising and responding effectively to complainants whose behaviour is unreasonably persistent
- providing HCSCC with quarterly complaints reports.

5.4 Department of Families and Communities

5.4.1 Department of Families and Communities - Chief Executive

HCSCC met with three times with the Department of Families and Communities (DFC) Chief Executive, Joslene Mazel. Issues raised by HCSCC included:

- systematising DFC complaints management; policy, practice, reporting and action to minimise recurrence, in particular serious complaints involving Disability SA services:

- complaints management and reporting by non government organisations contracted by DFC to provide services, particularly complaints about abuse
- monitoring improvements arising from Families SA complaints
- progress with the Commonwealth State and Territory Disability Services Funding Agreement and state funding to increase disability services
- action to minimise recurrence after Coronial findings about a medication error within a DFC funded NGO
- HCSCC Aboriginal outreach project
- DFC Special Investigations Unit revised procedures for the management of care concerns
- safeguarding vulnerable clients from sexual and physical abuse, particularly people with a disability
- agreeing DFC - HCSCC complaints management under the Act.

5.4.2 Department of Families and Communities - Families SA

HCSCC met twice with the Executive Director, Families SA, David Waterford. Issues raised by HCSCC included:

- Families SA management of serious complaints
- recommendations and progress following the DFC internal investigation of circumstances surrounding child neglect in two families
- monitoring progress with systemic improvements arising from HCSCC complaints about Families SA
- Families SA gap analysis and action plan - systemic issues identified in Victorian Ombudsman 2009 annual report
- improving the appropriate and safe use of physical restraint arising from the report by the Guardian for Children and Young People in November 2009.

5.4.3 Department of Families and Communities - Disability SA

Due to an increase in complaints by, or on behalf of people with a disability during 2008-09, HCSCC initiated regular meetings with Disability SA in early 2009. HCSCC met twice with the Executive Director, Disability SA, Lynn Young in 2009-10. Issues raised by HCSCC included:

- safeguarding vulnerable clients - sexual and physical safety - policy, monitoring, training, reporting, incident and complaint review, action to improve after incidents and complaints
- strengthening complaints handling within services
- improving complaints reporting, including reporting serious complaints to HCSCC as agreed
- good practice complaints handing guidelines and resources produced by the Victorian Disability Services Commissioner.

5.5 Minister for Health and Minister for Mental Health and Substance Abuse

HCSCC met twice with Minister John Hill. Issues raised by HCSCC included:

- the continuing trend of increasing numbers and complexity of complaints about health, disability and other community services
- the continuing impact of lack of advocacy services and a community visitors scheme on the capacity of vulnerable people to raise and resolve complaints directly with service providers
- HCSCC funding constraints impacting systematic outreach and training

- progress with H&CSC Act amendments to regulate bogus, unregistered and deregistered providers
- progress with amendments arising from the section 88 review of the H&CSC Act, including linked to the HCSCC Charter and Council
- expediting the release of the Advance Care Directives Review reports by the Attorney-General
- delayed discharge of people with a disability from hospital due to lack of funding for disability services
- SA Cancer Services Review
- HCSCC Aboriginal outreach project
- the national health professional regulation reforms and the potential implications for HCSCC relationships with health professional registration authorities
- proposed HCSCC - COTA SA - HCA pilot project to promote advanced care planning and directives in the community.

Separate to these meetings, the Minister formally sought information about HCSCC complaints reporting. HCSCC drew the Minister's attention to information, including previous annual reports, about the inadequacy of the HCSCC complaints management database for public reporting. HCSCC also raised these inadequacies during the SA Health commissioned HCSCC operational review.

5.6 Minister for Families and Communities and Minister for Disability

HCSCC met three times with Minister Jennifer Rankine. Issues raised by HCSCC included:

- DFC complaints management policy, practice, reporting and action to minimise recurrence, in particular serious complaints involving Disability SA
- complaints management and reporting by non government organisations contracted by DFC to provide services, particularly complaints about abuse
- funding to increase disability services
- HCSCC Aboriginal outreach project
- DFC Special Investigations Unit procedures for the management of care concerns
- Victorian Ombudsman 2009 report - systemic issues arising in Families SA complaints
- response to the Guardian for Children and Young People's report about improving the appropriate and safe use of physical restraint
- safeguarding vulnerable clients from sexual and physical abuse, particularly people with a disability.

5.7 South Australian Parliament MPs

MPs infrequently refer complaints directly to HCSCC. Once the H&CSC Act amendments and the HCSCC Charter of Health and Community Services Rights have been finalised, HCSCC will arrange further briefings for MPs and their staff in 2010-11.

5.8 The Public Advocate

HCSCC met twice with the Public Advocate, Dr John Brayley. The issues discussed included:

- not for resuscitation orders
- safeguarding vulnerable people from sexual and physical abuse
- Mental Health Act 2009 Community Visitor scheme
- HCSCC Charter of Health and Community Services Rights.

HCSCC and the Public Advocate met with the SA Police Sexual Crime Investigation Branch about improving police investigation of allegations of sexual abuse of people with a disability.

5.9 Australian Commission for Safety and Quality in Healthcare

HCSCC engagement with the Australian Commission for Safety and Quality in Healthcare included the following issues:

- Australian Charter of Healthcare Rights
- draft National Safety and Quality in Healthcare Standards
- Australian Bureau of Statistics patient experience survey.

5.10 Australasian Health Complaints Commissioners'

HCSCC participated in the meetings of the Australasian Health Complaints Commissioners' (AHCCs) in October 2009 and April 2010. Issues considered by the AHCCs included:

- commonwealth aged care complaints and trends
- national health system reform
- AHCC engagement with Aboriginal and Torres Strait Islander peoples
- legal aspects of open disclosure
- regulation of unregistered health practitioners
- complaints management under the new national health practitioners registration scheme
- AHCC - Australian Competition and Consumer Commission overlap - information sharing and complaint referrals.

The highlights of these meetings included:

- presentations by Professor Michael Ward, Commissioner, Queensland Health Quality and Complaints Commission and Dr David Studdert, University of Melbourne, about their retrospective analyses of complaints about doctors to identify factors indicating that a complaint should be escalated to a higher level of action

- a presentation by the Australian Bureau of Statistics (ABS) about the ABS national patient experience survey 2009, including questions relevant to rights under the Australian Charter of Healthcare Rights and complaints to AHCCs.

5.11 Private Health Service Providers

Arising from HCSCC's submission to the Royal College of General Practitioners (RACGP) about the draft 4th edition Standards for General Practices, the RACGP has agreed to collaborate with HCSCC, and counterparts in each state and territory, to develop a fact sheet to support:

- the practice information for patients and
- the patient feedback

requirements in the standards. This work will start in 2010-11 once the RACGP standards have been endorsed.

HCSCC requested meetings with key private health service providers, including bodies representing general practitioners, medical specialists, private hospitals and other private service provider peak bodies.

HCSCC will meet with the AMA SA Branch; the St Andrews Hospital Chief Executive Officer; the Australian Private Hospitals Association SA Branch Executive; the ACHA group hospitals; the Calvary group hospitals; General Practice SA and the Royal College of GPs, in early 2010-11.

5.12 Others

5.12.1 Victorian Disability Services Commissioner

HCSCC continued to network with the Victorian Disability Services Commissioner (VDSC). On 19 April 2010, HCSCC hosted meetings with the VDSC and various stakeholders including Disability SA senior staff, the Julia Farr Association, the Ministerial Disability Advisory Council Chair and HCSCC complaints resolution staff.

In 2010-11 HCSCC will participate in a VDSC research project about statutory conciliation, in particular approaches to enable the participation of people with a disability in conciliation.

5.12.2 Ministerial Disability Advisory Council

HCSCC met with and provided information to the Ministerial Disability Advisory Council to assist their work to improve safeguards for people with a disability from physical and sexual abuse.

5.12.3 South Australian Council of Social Service

HCSCC held an introductory meeting with the new South Australian Council of Social Service (SACOSS) Executive Director, Ross Womersley and SACOSS Health Policy Group Chair, Marj Ellis. Issues discussed included:

- HCSCC Part 3 Charter project - SACOSS sector representative
- NGO contracted services - DFC and SA Health master contract and service agreements safeguarding vulnerable clients and serious complaints
- joint HCSCC - SACOSS NGO sector capacity building workshops subject to operational review outcome
- HCSCC Aboriginal outreach project.

HCSCC also attended the SACOSS Child Health and Well Being event April 2010.

5.13 Media

HCSCC issued media releases and/or responded to media contacts about the following issues:

- HCSCC's fourth annual report
- unregistered health practitioners
- unregistered counsellors
- overseas trained health professionals - English language proficiency standards and complaints
- new national health professional registration scheme, including mandatory notification requirements
- access to medical records
- teeth whitening
- A&E waiting times
- HCSCC Aboriginal outreach project
- safeguarding people with disabilities from abuse.

5.14 Demand for HCSCC resources and speakers

HCSCCC provided 10,477 consumer brochures and 1,063 provider brochures to various individuals and organisations during 2009-10.

A revised HCSCC *Guide for consumers* pamphlet was distributed widely with a fridge magnet promoting the HCSCC Enquiry Service.

HCSCC also promoted the Enquiry Service at forums and events including: health and community service conferences; Carers Week, Mental Health Week, NAIDOC Week, Aboriginal Youth Expo, Disability and Ageing Expo and the International Day of the Older Person.

There were 251,939 visits to the HCSCC website, on average 20,994 per month, a 40% increase compared to 2008-09.

The most popular documents downloaded from the website were:

- ACSQHC Better Practice Guidelines Complaints Handbook
- HCSCC Annual Reports 2005-06 and 2007-08
- Safer Conversations Training Information Sheet
- ACSQHC Better Practice Guidelines on Complaints Management for Healthcare Services
- HCSCC *Buzz* Newsletter November 2009
- *Ever Felt Like Complaining?* Report
- *Ever Felt Like Complaining?* Stakeholder flyer
- Development of the HCSCC Charter of Health and Community Services Rights.

5.15 HCSCC external presentations

From 1 July 2009 – 30 June 2010 HCSCC provided presentations to the following audiences:

- Central Northern Adelaide Health Service – improving management of unreasonably persistent complainant behaviour
- Office of the State Ombudsman
- Office of the Public Trustee
- National Aborigines and Islanders Day Observance Committee
- Health Consumers Alliance Inc. of SA Board
- University of South Australia – School of Psychology, Social Work and Social Policy
- Flinders University of South Australia – Graduate Entry Medical Students Year 1
- Red Shield Companions Club
- Uniting Care Wesley Port Pirie
- Supported Residential Faculties Advisory Committee
- Office of the Public Advocate
- Carers SA
- Flinders University of South Australia – School of Nursing – Infection Control
- Country Health SA – improving management of unreasonably persistent complainant behaviour
- University of Adelaide – Clinical Leadership Programme
- Uniting Care Wesley Adelaide
- Onkaparinga City Council
- Children's Centre Leaders Day
- Southern Adelaide Health Service Consumer Advisory Council
- Anglicare SA
- Northern Carers Network Group
- Aboriginal Health Council of South Australia Inc. – Accreditation training workshop
- Aboriginal Health Council of South Australia Inc. – Board
- Country Health SA – Aboriginal Patient Pathway Officers
- Avant medico – legal forum
- SA Aboriginal Advisory Council
- Mission Australia
- Port Lincoln Aboriginal Aged Care – Council of Elders
- University of Adelaide – 6th year medical students.

6. FUNDING AND EXPENDITURE

HCSCC is funded from the state budget. HCSCC financial transactions are included in the financial statements of SA Health. HCSCC transactions are audited by the Auditor-General, along with those of SA Health.

A summary of 2009-10 funding and expenditure is provided below.

Recurrent base as at 1/7/09	$1 232 000
Commissioner Remuneration Tribunal increase	$10 000
Enterprise Bargaining supplementation	$14 300
HCSCC Charter of Health & Community Services Rights Project Officer	$22 700[9]
Funding from SA Health Chief Executive	$100 000[10]
Health & Community Services Advisory Council	$ 30 000[11]
Revised annual budget as at 30/6/10	**$1 409 000**

Summary of revenue and expenditure

Accommodation cost recovery	$(7 709)
Total revenue	**$(7 709)**

Salaries & wages	$1 124 341
Goods & services	$262 937
Total expenses	**$1 387 278**
Net operating result	**-$569**

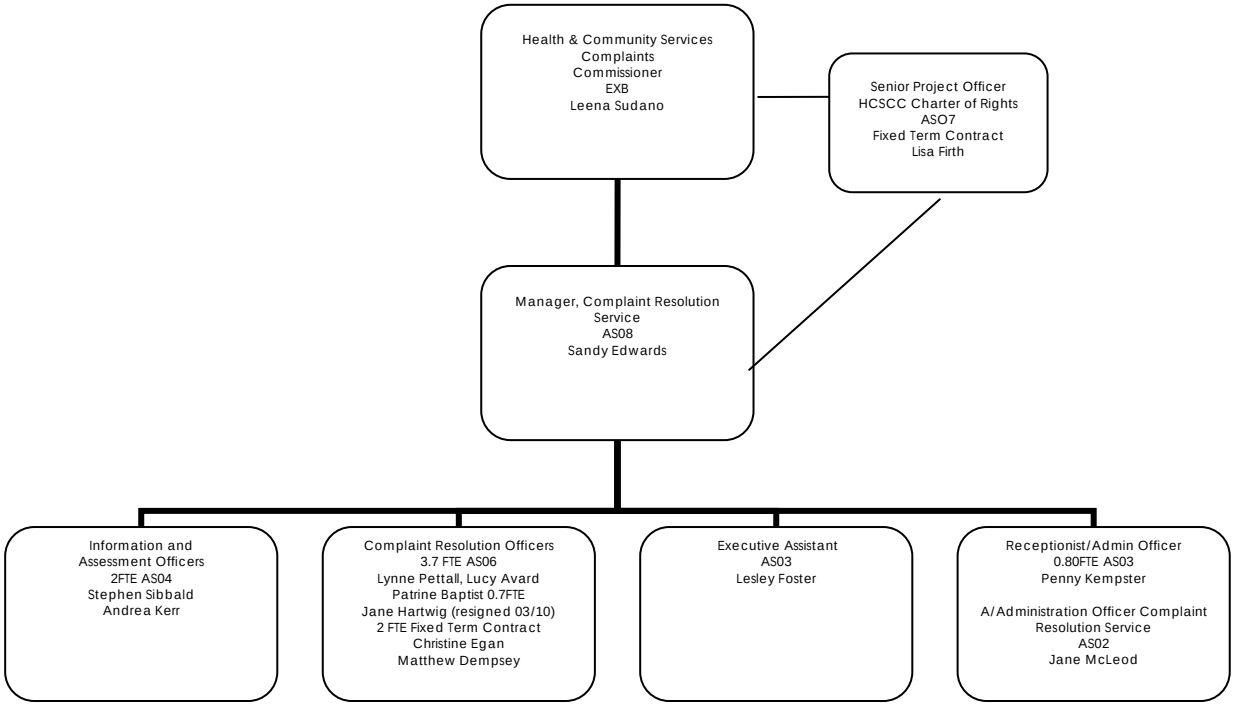
Account payment performance 2009-10

	Number of accounts paid	Percentage of accounts paid (by number)	Value in $A of accounts paid	Percentage of accounts paid (by value)
Paid by due date	408	55.14%	$184,349.71	72.93%
Late but < 30 days	237	32.03%	$58,189.16	23.02%
> 30 days due date	95	12.84%	$10,245.78	4.05%
Total	**740**	**100.00%**	**$252,784.65**	**100.00%**

[9] Non recurrent.
[10] One-off pending outcome of operational review.
[11] Not expended due to delays with Council member and deputy member appointments.

7. HUMAN RESOURCES

HCSCC organisational chart 2009-10



Employment

During 2009-10, three people left HCSCC and four were recruited. All vacancies were advertised through the Notice of Vacancies and two vacancies were also advertised in the external press.

Employee numbers, gender and status

Total number of employees		
Persons	13	
FTEs	11.75	
Gender	**% Persons**	**% FTEs**
Male	15%	17%
Female	85%	83%
Number of persons during the 2009-10 financial year		
Separated from the agency		3
Recruited to the agency		4
Number of Persons as at 30-06-10		
Leave without Pay		0

Number of employees by salary bracket

Salary Bracket	Male	Female	Total
$0 - $47 999		2	2
$40 000 - $60 999	1	2	3
$61 000 - $78 199	1	4	5
$78 200 - $98 499		2	2
$98 500 +		1	1
Total	**2**	**11**	**13**

The Health and Community Services Complaints Commissioner is appointed on an untenured 7 year contract until 31 March 2012.

Status of employees in current position by FTE

FTE	Ongoing	Short-Term Contract	Long-Term Contract	Other (Casual)	Total
Male	1.00	1.00			2.00
Female	7.50	2.25			9.75
Total	**8.50**	**3.25**			**11.75**

Status of employees in current position by persons

Persons	Ongoing	Short-Term Contract	Long-Term Contract	Other (Casual)	Total
Male	1	1			2
Female	8	3			11
Total	**9**	**4**			**13**

Executives by gender, classification and status

	Ongoing		Contract Tenured		Contract Untenured		Other (Casual)		Total	
Classification	M	F	M	F	M	F	M	F	M	F
Commissioner						1				
Total						**1**				

Leave management
Average days leave per full time equivalent employee

Leave type	2007-08	2008-09	2009-10
Sick Leave	7.25	8.06	9.73
Family Carers Leave	1.91	2.19	1.25
Miscellaneous Special Leave	0.96	1.14	0.50

Workforce Diversity

HCSCC has 11 female and two male staff. One staff member is Aboriginal: Ngarrindjeri-Ramindjeri; Gurindji.

Number of employees by age bracket and gender

Age Bracket	Male	Female	Total	% of Total	2010 Workforce Benchmark*
15-19					6.1
20-24					10.6
25-29					10.5
30-34					9.4
35-39		2	2	15	11.2
40-44	2	2	4	31	11.1
45-49		1	1	8	12.0
50-54		2	2	15	11.0
55-59		3	3	23	9.2
60-64		1	1	8	6.0
65+					2.9
Total	**2**	**11**	**13**	**100%**	**100**

**Source: Australian Bureau of Statistics Australian Demographic Statistics, 6291.0.55.001 Labour Force Status (ST LM8) by sex, age, state and marital status—employed—total from Feb78 Supertable, South Australia at May 2010*

Cultural and linguistic diversity

	Male	Female	Total	% Agency	SA Community *
Number of employees born overseas	1	6	7	54%	20.3%
Number of employees who speak language(s) other than English at home	0	0	0	0%	16.6%

**Benchmarks from ABS Publication Basic Community Profile (SA) Cat No. 2001.0,2006 census.*

Disability

Number of employees with ongoing disabilities requiring workplace adaptation			
Male	Female	Total	% of Agency
0	0	0	0%

Performance Development

HCSCC uses the SA Health Performance Development and Review Policy and resources to review performance and development for all permanent staff.

Documented review of individual performance management

Employees with….	%Total Workforce
A review within the last 12 months	75%
A review older than 12 months	10%
No review	15%

Leadership and Management Development

Training Expenditure

Training and Development	Total Cost	% of Total Salary Expenditure
Total training and development expenditure	7635.00	0.68%
Total leadership and management development expenditure	0	-

Accredited training packages by classification

Classification	Number of accredited training packages
Nil	Nil

Occupational health, safety and injury management

HCSCC occupational health, safety and injury management information is included in the SA Health annual report.

8. FREEDOM OF INFORMATION STATEMENT

Under the *Freedom of Information (Exempt Agency) Regulations 1993*, the Commissioner is exempt from the provisions of the *Freedom of Information Act 1991*. HCSCC follows the SA Health Code of Fair Information Practice as far as possible.

APPENDIX 1: Recommendations requiring action arising from the section 88 review of the H&CSC Act

Recommendation 2 2a. That the Government note that while complaints mechanisms established under the Health and Community Services Complaints Act 2004 are largely working well, some fine tuning is required to improve access by disadvantaged individuals and groups. 2b. That the Government consider the establishment of a consumer advocacy scheme as a mechanism to support the access of consumers, families and carers (not currently covered by existing schemes in the aged, disability and mental health sectors) to complaint services.	HCSCC has undertaken outreach to some special needs groups, in particular people with a disability and their family carers and Aboriginal and Torres Strait Islander communities. HCSCC telephone Enquiry Service hours increased to Mon-Fri 9am-5pm in April 2010, a 66% increase in telephone service availability. HCSCC *Guide for consumers* was simplified in June 2010. A poster and pamphlet developed for Aboriginal communities will be widely distributed in 2010-11. HCSCC sought information from 142 government contracted non-government disability service providers about how they provide information about their complaints process, and HCSCC, to their clients and their family carers or other representatives. HCSCC will review all HCSCC communications in 2010-11. Subject to resources HCSCC will aim to further improve awareness about HCSCC and access to HCSCC for people with special needs. HCSCC is not aware of any government action in response to recommendation 2b. HCSCC provided SA Health with information about the New Zealand Health and Disability Commissioner's advocacy scheme.
Recommendation 3 3a. That the Government consider the establishment of a Community Visitor Scheme in line with those operating in other States. 3b. That the most suitable administrative location of such a scheme be determined once an appropriate scope has been established.	SA Health has indicated that options for a Community Visitor Scheme linked to the H&CSC Act may be progressed in 2010-11.

Recommendation 4 4b. That any issues of potential overlap between the jurisdictions of the HCSCC and the State Ombudsman should be resolved through appropriate protocols or guidelines to avoid duplication.	HCSCC and the State Ombudsman have improved information sharing and consultation about jurisdictional overlap. HCSCC is not aware of any duplication in complaints handling in 2009-10.
Recommendation 7 7a. That the government note that the ability of the HCSCC to meaningfully monitor trends in complaints has been limited by a lack of appropriate information systems. 7b. That the HCSCC continues to improve its data collection and information provision and work closely with other service providers on improving overall data availability.	HCSCC wrote to the Minister for Health about these constraints on HCSCC complaints reporting in April and June 2010. HCSCC also provided information about these constraints and potential solutions during the operational review. HCSCC has established spreadsheets to assist HCSCC reporting about unregistered service providers; Ombudsman's reviews; improvement monitoring arising from complaints and investigations; conciliations; Aboriginal and Torres Strait islander complaints and complaint cases studies.
Recommendation 10 10a. That the Government promote all of its complaint resolution services, commencing at the point of service delivery of Government and Government-funded health and community services. These campaigns should highlight the importance of resolving complaints where and when they arise, utilising in the first instance complaint resolution mechanisms available at the service delivery level. 10b. That HCSCC services be included in the promotion of this integrated Government-funded complaints system.	HCSCC has contributed to the development of comprehensive complaints management frameworks for SA Health and Department of Families and Communities services within HCSCC's jurisdiction. HCSCC is not aware of any promotional campaign about complaint resolution services, commencing at the point of service delivery of Government and Government-funded health and community services. HCSCC has been consulted about major improvements to the information provided about feedback, including complaints and HCSCC, for a new SA Health website.

Recommendation 11 11a. That protocols\guidelines be established between the HCSCC and relevant providers, such as SA Health and the Department for Families and Communities, to detail operating principles in relation to investigations. 11b. That these protocols\guidelines focus on a practical approach to the working relationships and information requests but do not in any way undermine the independence of the HCSCC. 20c. That service providers and the HCSCC continue their efforts of building strong mutual relationships.	HCSCC finalised simplified guidelines for complaints handling under the H&CSC Act with major service providers: • SA Health - CNAHS; SAHS; CYWHS & Country Health SA • Department of Families and Communities (DFC) - Families SA; Disability SA & other DFC services within HCSCC's jurisdiction. HCSCC meets regularly with a wide range of service providers and stakeholders. HCSCC offers presentations about various aspects of the H&CSC Act and implications for services providers to all stakeholders.
Recommendation 12 12b. That the HCSCC introduces a regular training schedule with service providers to build their capability to resolve complaints, improve their complaint handling processes and outline their obligations to the HCSCC in the investigation of complaints.	Consumers, carers, health professional students, SA Health and DFC services within HCSCC jurisdiction and others continue to request HCSCC workshops and training. HCSCC has provided some *Safer Conversations* training programs and ad hoc training about recognising and managing unreasonably persistent complainant behaviour. HCSCC has been unable to establish a training schedule due to resource constraints. HCSCC plans to pilot fee-for-service training in 2010-11.
Recommendation 13 13a. That the current arrangements between the HCSCC and health profession registration boards be maintained. 13b. That the move to a national registration and accreditation scheme and any potential impact on the role of the HCSCC be closely monitored.	HCSCC collaborated with the Australian Health Practitioner Regulation Agency (AHPRA) to establish systems and processes in preparation for the new arrangements for complaints and notifications about nationally registered health professionals from 1 July 2010. This included negotiating a Memorandum of Understanding (MOU) to facilitate information exchange and referrals. HCSCC will monitor and report on the impact of the new scheme on HCSCC's role and workload.

Recommendation 14 14a. That the HCSCC establish a Charter for Health and Community Services Rights as required by the Health and Community Services Complaints Act 2004 no later than March 2009. 14b. That section 22 of the Health and Community Services Complaints Act 2004 is amended to include an additional Charter principle stating that a person should be entitled to nominate a representative to assist in resolving a complaint.	A Senior Project Officer commenced a 6 month contract in April 2010 to develop the Charter for Health and Community Services Rights. HCSCC anticipates that the Charter for Health and Community Services Rights will be endorsed by the Minister for Health and the SA Parliament in 2010-11. This was supported by the SA government. A Bill to amend the H&CSC Act to include this additional Charter principle is anticipated in 2010-11.
Recommendation 15 That following the report from the Social Development Committee's Inquiry into bogus, unregistered and deregistered health practitioners the Government consider any potential flow-on effects on the Health and Community Services Complaints Act 2004.	HCSCC provided advice to SA Health and the Minister for Health about the likely impacts of the Social Development Committee's (SDC) Inquiry into bogus, unregistered and deregistered health practitioners. HCSCC provided quarterly reports to the SDC about complaints involving unregistered practitioners and progress in response to their recommendations impacting HCSCC. HCSCC was consulted about proposed amendments to the H&CSC Act arising from the SDC recommendations. A Bill to amend the H&CSC Act to include provisions to enable HCSCC to deal more effectively with complaints about unregistered practitioners is anticipated in 2010-11.
Recommendation 16 That the Health and Community Services Complaints Act 2004 is amended to provide the HCSCC with powers to follow-up with service providers on recommendations made following an investigation and to publicly report on unreasonable non-compliance.	A Bill to amend the H&CSC Act to include this additional power is anticipated in 2010-11.
Recommendation 17 17a. That no legislative change is required to address the occasional potential for jurisdictional overlap between investigation bodies. 17b. That improved communication between all parties can be achieved through guidelines\protocols as long as the independence of the HCSCC is not compromised.	HCSCC finalised a Memorandum of Understanding (MOU) with the Aged Care Complaints Investigation Scheme (ACCIS) to facilitate information exchange and referrals. To date HCSCC has not succeeded in engaging the SA Office of Consumer and Business Affairs in improved communication.

	HCSCC has started discussions with the Australian Competition and Consumer Commission towards an MOU to facilitate information exchange and referrals in 2010-11.
Recommendation 18 That the Government note that the ability of the HCSCC to share information with complaints resolution bodies under the Aged Care Act 1997 (Commonwealth), where service providers may fall under either jurisdiction, should be clarified by either amendment to the Health and Community Services Complaints Act 2004, or a variation to regulations under the Act.	This issue was addressed through the HCSCC - ACCIS MOU for information exchange and referrals under the Aged Care Act 1997 and the H&CSC Act 2004. A Bill to amend the H&CSC Act to enable HCSCC to share information with other relevant agencies is anticipated in 2010-11.
Recommendation 21 That section 74 of the Health and Community Services Complaints Act 2004 is amended to provide for an additional ground for the HCSCC to protect the identity of a service user or complainant where issues of public safety or interest, or questions of the practice of a service provider, are raised.	A Bill to amend the H&CSC Act to enable HCSCC to protect the identity of a service user or complainant where issues of public safety or interest, or questions of the practice of a service provider, are raised is anticipated in 2010-11.
Recommendation 22 That section 76 of the Health and Community Services Complaints Act 2004 is amended to include provisions for the HCSCC to publish any return received, or a summary of information contained in a return from a prescribed provider, in such a manner that the HCSCC sees fit.	A Bill to amend the H&CSC Act to include provisions for the HCSCC to publish any return received, or a summary of information contained in a return from a prescribed provider, in such a manner that the HCSCC sees fit is anticipated in 2010-11.
Recommendation 23 That section 76(1) of the Health and Community Services Complaints Act 2004 is amended to require prescribed providers to report complaints relating to rights under the Charter provisions in their return to the HCSCC.	A Bill to amend the H&CSC Act to require prescribed providers to report complaints relating to rights under the Charter provisions in their return to the HCSCC is anticipated in 2010-11.
Recommendation 24 That the HCSCC, through the Minister for Health, establish as a matter of urgency the Health and Community Services Advisory Council as required under the Health and Community Services Complaints Act 2004, with at least one meeting taking place no later than March 2009.	The Minister for Health advised HCSCC of his appointments to the Health and Community Services Advisory Council on 25 June 2010. The Health and Community Services Advisory Council will commence in 2010-11.

Recommendation 25 That the Council focus its discussions on key strategic issues affecting complaints resolution in the health and community services sectors, such as the impact of national registration on the HCSCC and the effective implementation of the Charter of Health and Community Services Rights.	The Health and Community Services Advisory Council will commence in 2010-11. A Bill to amend the H&CSC Act to change the Health and Community Services Advisory Council functions to strategic issues is anticipated in 2010-11.
Recommendation 26 That the Government consider expanding the membership of the Health and Community Services Advisory Council to provide for meaningful consumer representation and a focus on the quality and safety of health services.	A Bill to amend the H&CSC Act to expand the Health and Community Services Advisory Council membership is anticipated in 2010-11.
Recommendation 27 That Recommendation 31 of the Children in State Care commission of Inquiry is adopted to allow all children and young people to make a complaint directly to the HCSCC. This explicit reference will enable the HCSCC to target information to this important group of vulnerable people.	The H&CSC Act has been amended to enable children and young people to make a complaint directly to the HCSCC.
Recommendation 28 That Recommendation 32 of the Children in State Care commission of Inquiry is adopted partially: 28b. That a public awareness campaign concerning the role of the HCSCC to receive complaints from people (including current and former children and young people in State care) about child protection service providers be undertaken as part of the promotion of the Government-funded complaints system.	HCSCC is not aware of any government action in response to this recommendation.
Recommendation 29 That Recommendation 33 of the Children in State Care Commission of Inquiry is adopted and that the Health and Community Services Complaints Act 2004 is amended to explicitly extend the two-year limit in the child protection jurisdiction where the complaint arises from circumstances since the launch of the Keeping them safe reform agenda in May 2004.	The H&CSC Act has been amended to extend the two-year limit in the child protection jurisdiction where the complaint arises from circumstances since the launch of the Keeping them safe reform agenda in May 2004.

Recommendation 30 That Schedule 1 of the Health and Community Services Complaints Act 2004 is updated to reflect the current titles of the relevant health profession registration Acts.	The provisions about health professional registration Acts in Schedule 1 of the Health and Community Services Complaints Act 2004 were made redundant by the Health Practitioner Regulation National Law 2009 and the Health Practitioner Regulation National Law (South Australia) effective 1 July 2010.
Recommendation 31 That the matter of confidentiality of prisoners' mail be raised by the HCSCC with the Chief Executive of the Department for Correctional Services as it is outside of the jurisdiction of this review and the legislative responsibility of the Minister for Health.	HCSCC wrote to the Minister for Correctional Services in March 2009 and requested that HCSCC be added to the list of specified persons and agencies in section 33, subsections (7) and (8) of the Correctional Services Act 1982. In May 2009 the Minister responded that that a Direction had been made by the Director, Custodial Services to all prisons, that until such time as the legislative amendment is formally made, all prisoner mail to the HCSCC is to be treated as 'privileged' mail.
Recommendation 32 32a. That the Government note the existing funding level of the HCSCC is perceived by some stakeholders as a limitation to the Health and Community Services Complaints Act 2004 achieving its full potential. 32b. That the Government consider an operational review of the HCSCC in due course to ascertain whether the funding levels are commensurate with levels of responsibility.	SA Health commissioned an operational review of HCSCC which commenced in February 2010. A final report was provided to HCSCC on 28 May 2010. HCSCC is considering the report findings and recommendations. HCSCC has requested a meeting with the Minister for Health to discuss the review recommendations.