Annual Report 2006 – 2007
Health and Community Services Complaints Commissioner

HCSCC Identification

2006/2007

Health and Community Services Complaints Commissioner
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28 September 2007

The Honourable John Hill MP
Minister for Health
CitiCentre Building
11 Hindmarsh Square
ADELAIDE SA 5000

Dear Minister

In accordance with the requirements of Section 16(1) of the *Health and Community Services Complaints Act 2004* I have pleasure in presenting the 2006-07 Annual Report of the Health and Community Services Complaints Commissioner.

Yours faithfully

Leena Sudano
Health and Community Services Complaints Commissioner

FROM THE COMMISSIONER

In our second year HCSCC has continued to focus on improving the safety and quality of health and community services in South Australia. This approach was also a feature of my new child protection complaints role.

Skilled, committed people work hard to provide good services, but we must and can do more to make services more accessible, safer and better—especially for those in greatest need.

A complaint can be characterised by the following:

- feelings of grief, resentment and not uncommonly, anger
- the need for information and explanation—What happened? Why did it happen?
- a desire to blame someone, to find fault
- a loss of trust in the service provider.

For many people this toxic cocktail is also compounded by:

- a fear of recrimination and powerlessness leading to under voicing—at best only 5% of people speak up about an incident
- a lack of information about how to complain
- a sense of futility—there's no point, it won't do any good, nothing will change
- defensiveness, closed ranks, delays and getting the run around from service providers.

The motivation to complain is most often to try to make sure the same thing doesn't happen again to someone else. As well as ensuring that an individual grievance is addressed, this means that HCSCC must hold service providers to account for action to reduce the likelihood of recurrence. Where the causes of the incident extend beyond the individual service user, or service provider, HCSCC can make recommendations and influence effective responses to address systemic problems.

I challenge all service providers to see good complaints handling as one way to improve the safety and quality of their services.

Experience versus generally accepted standards

The key question the Act requires me to answer is has the action, or inaction, of the service provider been reasonable and appropriate in the circumstances? I consider this question once all the relevant information has been collected from the person who complained, the service providers involved and HCSCC research.

The range of factors I am required to consider when answering this question are described in section 85 of the Act. A key consideration is whether the provider's action, or inaction, met the generally accepted standard expected in the circumstances.

HCSCC's experience has been that in the majority of complaints, the provider's action or inaction has been reasonable and appropriate based on the generally accepted standards. In these complaints there is often a gap between the person's experience and the service provider's action or inaction, rather than a failure to meet standards. This often happens because the underlying cause is systemic.

Systemic issues are issues that occur repeatedly that are not solely attributable to an individual service user or service provider. They are often the result of the customary ways things are done, or features of an organisational or professional culture, less commonly due to policies or guidelines. Systemic issues are sometimes due to a lack of resources—funds, facilities, drugs or staff. This makes it difficult to hold individual or organisational service providers to account for systemic shortcomings.

A recurrent systemic issue at the heart of many HCSCC complaints is the failure of service providers, particularly doctors and nurses, to recognise the right of a person to participate actively in their health, well being or welfare. This includes the right to good information to enable informed decision making, with the involvement of their family if this is their preference.

Historical and professional paternalism, however well intentioned, combined with defensiveness or the misapplication of privacy considerations, is out of step with the expectations of an increasing majority of citizens. It is also contrary to evidence that active participation in decision making about care and services results in a better service experience, better outcomes and lower costs. Too few service providers pay sufficient attention to the *experience* of people when a complaint occurs. They resort to defending themselves by relying on their adherence to standards. The challenge for all service providers is to work with service users, their families and staff to close the gap between the experience of a service and the service standards.

Looking towards 2007-08

In HCSCC's third year I will be focusing on several key areas to enable me to better meet my obligations under the Act.

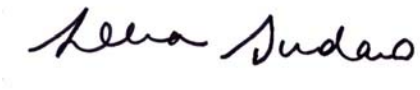
These include

1. obtaining resources to extend outreach and to improve HCSCC services for people with special needs, in particular Aboriginal people - section 9 (2) - (3)

2. participating in the development of a national charter of patient rights - Part 3

3. publishing reports about complaint trends - section 3(d)

4. holding service providers to account for timely responses and action following complaints to reduce the likelihood of the same thing happening again - sections 3 (a), 3 (e) and 76.



Leena Sudano
Health and Community Services Complaints Commissioner

ROLE OF THE COMMISSIONER

The Health and Community Services Complaints Commissioner (HCSCC) was established by the *Health and Community Services Complaints Act 2004* (the Act).

Under section 3 of the Act, HCSCC aims:

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; and

b) to provide effective alternative dispute resolution mechanisms for users and providers of health or community services to resolve complaints; and

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; and

d) to provide a scheme that can be used to monitor trends in complaints concerning health or community services; and

e) to identify, investigate and report on systemic issues concerning the delivery of health or community services.

The Commissioner is an independent statutory officer who helps people to resolve complaints about health and community services. This includes complaints about public, private and non-government services. Service users, their families and carers, and service providers can all use HCSCC to get information, advice and help to resolve complaints. HCSCC encourages direct resolution in the first instance and provides assistance when a direct approach to the service provider is either unreasonable or has not succeeded.

Functions and powers of the Commissioner

Section 9 of the Act sets out the Commissioner's functions and powers.

(1) The Commissioner has the following functions:

(a) to prepare and regularly review the Charter of Health and Community Services Rights under Part 3; and

(b) to identify and review issues arising out of complaints and to make recommendations for improving health and community

services and preserving and increasing the rights of people who use those services; and

(c) to review and identify the cause of complaints and to—

(i) recommend ways to remove, resolve or minimise those causes; and

(ii) detect and review trends in the delivery of health or community services; and

(d) to provide information, education and advice in relation to—

(i) the Charter; and

(ii) health and community service rights and responsibilities; and

(iii) procedures for resolving complaints; and

(iv) other matters (if any) determined to be appropriate by the Commissioner; and

(e) to receive, assess and resolve complaints; and

(f) to encourage and assist health and community service users to resolve complaints directly with health and community service providers; and

(g) to assist health and community service providers to develop or improve procedures to resolve complaints; and

(h) to inquire into and report on any matter relating to health or community services on the Commissioner's own motion or at the request of the Minister; and

(i) to advise, and report to, the Minister on any matter relating to health or community services or the administration or operation of this Act; and

(j) to provide information, advice and reports to registration authorities and to work with registration authorities to develop or improve procedures relating to the assessment and investigation of complaints and grievances; and

(k) to maintain links with—

(i) health and community service providers; and

(ii) organisations that have an interest in the provision of health or community services; and

(iii) organisations that represent the interests of the users of health or community services; and

(l) to consult and cooperate with other agencies and authorities that are involved in protecting interests and rights of members of the community in the area of the provision of health or community services, including—

(i) the State Ombudsman; and

(ii) the Human Rights and Equal Opportunity Commission of the Commonwealth; and

(m) to perform other functions conferred on the Commissioner by or under this or any other Act.

(2) The Commissioner must, in providing information and advice, and in the assessment and consideration of any complaint, take into account, to such extent as may be appropriate, the position of persons within special needs groups.

(3) For the purposes of subsection (2), *special needs groups* are particular classes of persons who, because of the nature of the classes to which they belong, may suffer disadvantage in the provision of services unless their needs are recognised.

(4) The Commissioner must, in acting under this Act, give particular attention to the position of volunteers and to their value in providing health and community services within the community and should not unnecessarily involve them in proceedings under this Act.

Part 3 Charter of Health and Community Services Rights

One of HCSCC 's responsibilities is to develop a Charter of Health and Community Service Rights.

The Charter principles are set out in Section 22 of the Act.

These principles include the entitlement of a person to:

- participate effectively in decisions about their health and welfare
- take an active role in health care decisions about health or community services being provided to them
- be provided with appropriate health and community services that take into account their background and any requirements relevant to ensuring they receive such services

- have access to a complaints procedure
- reasonable access to records about their health or other personal information.

Due to resource constraints the development of the statutory Charter has not yet started.

In the meantime, documents available from service providers and the HCSCC website, provide guidance about service user rights and responsibilities:

- as a consumer of public health services—*Your rights and responsibilities—a charter for SA public health system consumers*

- as a private patient in a public or private hospital—*Private patients' hospital charter*.

The Charter principles are also used by HCSCC as a standard against which the actions of service providers can be assessed.

During autumn 2007 the Australian Commission on Safety and Quality in Health Care (the Commission) decided to include the development of a national patient charter in its 2007-08 work plan. In June 2007 the Australian Health Ministers Advisory Council (AHMAC) endorsed the Commission's work plan, including the development a national patient charter. HCSCC will participate in the Commission's consultation process to develop the charter during 2007-08. In June 2008 AHMAC will consider the national patient charter for adoption.

HCSCC is likely to propose to the Minister for Health that the national charter be approved for adoption in South Australia, in accordance with section 23 of the Act. If this occurs, only the development of a charter of community services rights will remain outstanding.

SECOND YEAR HIGHLIGHTS

Commencing the child protection complaints jurisdiction

From July 2006 HCSCC accepted complaints about child protection services. During 2006-07 links were established with major child protection service providers, peak bodies, support groups and advocacy bodies. A total of 93 child protection complaints, including 7 that were transferred from the State Ombudsman, were received.

Developing a 2-year plan for 2006-08

After 12 months of complaints handling experience and the development of relationships with a broad cross section of service providers and representative bodies, HCSCC set priorities for 2006-08.

Through the 2-year plan, HCSCC will work with service providers, service users and consumer and carer advocacy groups to:

- develop and improve complaints handling procedures
- encourage and facilitate access to a complaints process for service users
- maintain a focus on safety and quality
- ensure services are culturally respectful and meet special needs.

The details about the HCSCC 2-year plan are included in the section, Strategic Framework.

Safer Conversations pilot project

The *Safer Conversations* pilot project was initiated by HCSCC to meet the lack of training for registered nurses and midwives to enable them to handle complaints effectively and to constructively confront unsafe practice among colleagues. The pilot project was partly funded by the South Australian Department of Health.

Training provided to nurses and midwives during the *Safer Conversations* pilot aimed to:

- increase their confidence and skills to respond effectively to consumer and carer complaints
- enable participants to raise concerns about the behaviour of colleagues that places the safety and quality of patient care at risk.

Safer Conversations bulletins are available on the HCSCC website at www.hcscc.sa.gov.au

A final evaluation report will be available in late November 2007.

At the beginning they say 'This is going to be a life changing event. After you have done this it will change your life,' and being a cynic you're thinking, 'Yeah, yeah.' It actually did.
- Participant

Achieving a landmark of 1600 complaints

In June 2007 recorded complaints reached 1600. This number represents people who have received a service from HCSCC, in addition to initial advice and information or referral to another agency.

Restructuring the Complaint Resolution Service

The initial Complaint Resolution Service staffing of 6 Complaint Resolution Officers was based on the assumption that high skill at the first service contact would promote effective and prompt complaint resolution. In addition to managing a complaint case load and project work, each Complaint Resolution Officer was rostered to provide the Enquiry Service.

Analysis of the Enquiry Service contacts in spring 2006 showed that 50% of contacts were outside HCSCC jurisdiction. As a result the Complaint Resolution Service was restructured to introduce the position of Information and Assessment Officer. Under the new structure the Information and Assessment Officer provides at least 90% of the HCSCC Enquiry Service and a range of other support functions to the Complaint Resolution Service. Complaints that progress beyond initial contact with the Enquiry Service are now allocated to a Complaint Resolution Officer for further assessment and resolution.

Reviewing data collection and reporting needs

The Information and Reporting Project commenced in February 2007 to improve internal and external reporting of the HCSCC Complaint Resolution Service. The first stage of the project involved a complete review of HCSCC's complaints data collection needs and reporting requirements. During 2007-08 the HCSCC case management system will be modified and upgraded to enable reports to be produced from the database.

All statistical reports on HCSCC services are currently produced manually. This has limited the information available for HCSCC publications, including the Annual Report.

Spreading the word

In October 2006 the Commissioner engaged a media consultant to help get more information about HCSCC out to the public.

During the reporting period media releases were distributed to:

- warn people about quacks—people who promise miracle cures
- encourage people to speak up about problems with health and community services
- advise of the Commissioner's visits to the Riverland and Whyalla.

The Commissioner gave 5 radio interviews and provided information in a telephone interview for a national television program.

Comments were also provided for 4 newspaper articles, 2 in Adelaide and 2 in regional areas.

Contributing to national safety and quality work

The Commissioner participated in a number of national committees and working parties focusing on improving the safety and quality of health services nationally.

The Commissioner's involvement in safety and quality in health care included:

- the National Open Disclosure Pilot Project SA Steering Committee
- the Australian Commission for Safety and Quality in Health Care—Review of Health Care Service Accreditation Standards
- the Clinical Practice Improvement Program—Central Northern Adelaide Health Services (CNAHS); CNAHS Mental Health Services and Southern Adelaide Health Service
- Root Cause Analysis training workshops for public health services
- Australian and New Zealand Health Complaints Commissioners' meetings.

STRATEGIC FRAMEWORK

The HCSCC 2-year plan 2006-08 was developed by asking the questions:

- What do we want to achieve by 2012?
- What do we specifically want to achieve over the next 2 years?
- How will we achieve it?
- How will we measure our progress and success?

To gain an understanding of the wider context in which HCSCC operates, information was gathered from a range of external agencies in the health and community services sector.

This information was considered together with HCSCC's obligations under the Act, the requirements of *Australian Standard, Customer Satisfaction—Guidelines for complaints handling in organisations, AS ISO 10002—2006*, knowledge gleaned from similar statutory authorities interstate and the potential implications of the South Australian Commission of Inquiry (Children in State Care).

Our study of the external environment alongside the requirements of the Act highlighted the need for HCSCC to take a leadership role in the following areas:

- capacity building to better equip both service providers and service users to resolve complaints
- increasing awareness of and meeting special needs among service users
- maintaining a focus on safety and quality
- identifying standards.

In keeping with this leadership role we identified strategies that would use HCSCC's finite resources to achieve wide ranging and sustainable results. This will involve identifying opportunities to work together with health and community service providers and peak bodies to build on their existing or planned work and provide training, information and advice.

Within HCSCC it will involve modelling best practice complaints handling and improving data management and reporting systems. This will enable HCSCC to identify and monitor systemic issues and require service providers to take action on recommendations for improvement.

The HCSCC vision:

'I took the complaint resolution officer's advice and it worked' – service user

A complaint will be an opportunity to:

- participate
- redress grievance and harm

- improve safety and quality
- hold to account to prevent recurrence.

The HCSCC mission:

To inspire a shared vision of complaints handling as a means to improve the safety and quality of health and community services in South Australia.

Objective 1

To enable effective participation in the direct resolution of complaints

HCSCC encourages people to resolve complaints directly with the service provider. Information and advice is available to complainants and service providers on the HCSCC website and support is provided through the Complaint Resolution Service.

HCSCC produces information and resources for service users, carers and service providers in simple language that is easy to understand.

During the reporting period, 3 information sheets were produced—*About the HCSCC, Child Protection Complaints* and *Getting your health records.* These information sheets were distributed at presentations and made available at conferences, for example the National Foster Carers Conference and the Nursing and Midwifery Symposium. They are also available on the HCSCC website at www.hcscc.sa.gov.au.

Two HCSCC brochures—*A guide for consumers* and *A guide for providers* are provided to individuals and agencies free, on request. *A guide for consumers* offers advice to service users on how to resolve complaints directly with a service provider and includes information about when to contact HCSCC. *A guide for providers* gives service providers an overview of how to handle complaints and how HCSCC may become involved.

The HCSCC website is a major source of information, education and advice for service users and service providers. The website sets out information about the Commissioner's role, step-by-step guidance about how to make or respond to a complaint and the HCSCC service standards. A 'what's new' section contains updates about recent HCSCC publications and activities.

Website resources include better practice guidelines, links to other useful sites and the Act. Web users can lodge complaints online and contact HCSCC by email.

HCSCC produces a regular newsletter, *BUZZ,* to keep people informed about services, staff, priorities and activities. As at 30 June 2007 *BUZZ* had an electronic subscription base of 687 individuals and organisations.

Demand for HCSCC resources

Visitors to HCSCC website	6178
A guide for consumers—brochures supplied	10330
A guide for service providers—brochures supplied	3082

Case study

Gwen, in her 80s, went to a physiotherapist for help with a pain in her leg. She advised the physiotherapist of an existing back problem, although this did not affect her ability to walk. She was an active person who still looked after herself in her own home.

At a later visit the physiotherapist asked Gwen to straddle the treatment table. She struggled to do this at the time. Gwen's complaint was that, as a result of the treatment, she could not walk without considerable pain and difficulty for some months afterwards.

After receiving information and advice from a Complaint Resolution Officer, Gwen said she felt confident to contact the physiotherapist directly to resolve her complaint. She did not require further assistance from HCSCC.

Further assistance may be provided where direct resolution has not been successful or where a direct approach would not be reasonable. This is sometimes the case where there has been a major breakdown in communication or if a person has special needs. Where possible, HCSCC encourages complainants and service providers to actively participate in the complaint resolution process.

Case study

Jenny was the foster carer of a young person with difficult behaviour. After the foster placement had been stopped by Families SA, Jenny had a number of complaints about how she had been treated in her role as carer. She also disagreed with some of the information that had been recorded about her on the Families SA file.

In addition to having her concerns addressed, Jenny wanted to maintain contact with the young person. In spite of considerable effort by both Jenny and Families SA no resolution had been reached.

After considering information and relevant documents provided by Families SA HCSCC negotiated with Jenny and Families SA to explore possible options. An HCSCC Complaint Resolution Officer facilitated a meeting between Jenny and Families SA to discuss options and future plans. At the meeting, Jenny's complaints were resolved and arrangements were made for future contact with the young person. Jenny and Families SA agreed to deal directly with each other regarding any future issues.

One aim of the complaint resolution process is to restore the complainant's confidence in a service provider. This is particularly important where a complainant needs to use the service again.

Case study

Jim was placed in an induced coma for over a week after minor surgery that he had been told would only involve an overnight stay in hospital. Following his discharge he experienced muscle wasting, hallucinations and difficulty communicating and walking.

Jim asked the hospital for an explanation about what had happened to him and wanted to know whether he had experienced an allergic reaction to the anaesthetic used to induce the coma. He was not satisfied with the initial response from the hospital and was anxious about further planned surgery.

HCSCC arranged a meeting between senior hospital staff and Jim. At the meeting Jim's questions were answered and he was given explanations about what had happened to him. After the meeting, the hospital's Patient Adviser arranged further medical appointments to assist Jim with his recovery and restore his confidence to continue using the service.

Objective 2

To improve the safety and quality of health and community services

The Information and Reporting Project commenced in February 2007 as a priority initiative of the HCSCC 2-year plan to improve the safety and quality of services. The project aims to develop:

- a strategy to identify, monitor and report systemic issues arising from complaints
- a process to record HCSCC recommendations, monitoring and reporting service provider responses.

Complain to make things better

In order to achieve these aims the project has involved a review of the information HCSCC needs to record on its case management system and how to produce key reports.

The next stage of the project will involve implementing changes identified in the review process.

Improving the safety and quality of health and community services is a priority of the HCSCC Complaint Resolution Service.

In resolving an individual complaint HCSCC encourages the service provider to review practices and procedures that contributed to the complaint. By using complaints as an opportunity to make improvements, service providers can make services safer and better. Improvements also reduce the likelihood of the same thing happening to someone else.

Case study

Megan, aged 13, was taken to a remote health service by her mother who was seven and a half months pregnant. The doctor who saw Megan diagnosed appendicitis and said she would have to go to a larger regional hospital for treatment. Megan's mother could not arrange immediate transport and went back to the hospital saying they would have to catch a bus the following day. The doctor verbally abused her.

Megan and her mother remained at the hospital until the following morning when Megan became too ill to travel by bus. The doctor then arranged for her to be taken to the regional hospital by the Royal Flying Doctor Service.

As a result of the complaint to HCSCC, Megan and her mother received apologies from the doctor and the health service. The doctor was keen to ensure the same situation did not happen again and made changes. The service has now identified patient transport options and made staff aware of procedures to determine transport priorities and choices for patients. Communication within the service has also been improved to ensure that significant issues are brought to the attention of senior staff for prompt action.

For some people, making a complaint can't change what has happened. They want to raise the issue in the hope that the same thing won't happen to someone else.

Case study

Grace, aged 80, was admitted to a country hospital after she broke her thigh bone. She was transferred to a metropolitan hospital for surgery then returned to the country hospital for rehabilitation. After a brief stay at the country hospital she was transferred to a nursing home. Grace died 12 days later from a blood clot on her lungs.

Grace's family complained about a lack of consultation about the arrangements that were made for her and a lack of care and respect in the nursing home. They were also concerned about delays in getting help when Grace was dying.

An HCSCC Complaint Resolution Officer worked extensively with Grace's family, the hospital and the nursing home to identify all of the issues and prepare for a facilitated meeting. At the meeting, staff from the hospital and the nursing home acknowledged the family's grief. The CEO of the hospital apologised for how the service had let them down. He told the family that a detailed investigation, called a root cause analysis, had been done and major changes were being made as a result of the complaint.

Since the complaint was made, the hospital has introduced ongoing professional development and education for staff, increased opportunities for consumer participation and adopted a case conference approach to patient discharge. Communication processes have been reviewed and barriers between the hospital and the nursing home are being removed.

Objective 3

To reduce serious incidents, in particular those involving people with special needs

Under section 9 of the Act, HCSCC must take into account people with special needs who may be disadvantaged in getting or using services unless their needs are recognised.

Though the words 'special needs' may be unacceptable to some people, this legal obligation is about making sure that people who already find it hard to get services, or to receive good, safe services are given help to voice their concerns.

While many people need help to make a complaint, HCSCC has initially prioritised 2 groups of people—Aboriginal people and people living with a severe, enduring mental illness.

Aboriginal people and people with a chronic mental illness are more likely than others to have difficulty getting appropriate health and community services. They are also more likely to receive poorer quality or less safe services.

When things go wrong they are less likely to speak up due to barriers like stereotypes, prejudice, cultural differences, language barriers, lack of information, power

imbalance and fear of recrimination. They also often lack the confidence and trust to raise their concerns because they think service providers won't listen or take action to address them.

HCSCC has established links with a wide range of key groups interested in a better deal for Aboriginal people and people who have a chronic mental illness.

Collaboration with others provides a foundation for HCSCC outreach to ensure their voices are heard and action is taken to minimise the likelihood that the same thing will happen to others.

This includes action about systemic issues—issues that keep happening.

The following case studies about Aboriginal people and their experiences of health services highlight these issues. HCSCC has made it a high priority in the next 2 years to improve our ability to work with Aboriginal people and organisations to better address these issues.

Case study

Lisa was referred to HCSCC by the Aboriginal Legal Rights Movement after she had tried unsuccessfully to resolve her complaint with a hospital consumer adviser. Lisa's 3 month old daughter has a chronic illness and was being treated in hospital for infection. After staying in the hospital for nearly a week, Lisa had left the hospital for the first time to collect personal belongings. When Lisa returned she found her baby on the floor crying after falling out of her pram. Lisa felt fobbed off by nurses when she complained. Lisa did not accept the hospital's apology, or action taken after an incident report was made and improvements identified. Although a doctor examined her baby and found no injuries, Lisa felt that the fall should not have happened. She also felt that staff had a racist attitude towards her. Lisa no longer felt confident that she could trust the hospital staff to care for her baby. HCSCC arranged a meeting with hospital staff to address Lisa's concerns and to restore her trust so that she would feel confident when she needed to use the hospital's services again. his also included making sure that an Aboriginal Liaison Officer would be contacted if Lisa or her baby were admitted.

Case study

Barbara heard about HCSCC at a public presentation. She complained to HCSCC when her efforts to get hospital cooperation so relatives could visit their dying father were frustrated, largely due to family conflict. HCSCC facilitated communication between the health care team, including the hospital social worker and consumer adviser, to ensure the visits happened.

Barbara said "Thank you for listening to my story and following up with the hospital, we can visit at any time during the day, now I feel I've been supported."

HCSCC followed up with Barbara a few days later to make sure things were OK. She told us "I think the hospital could have been more sensitive to cultural needs and talked through their concerns with the boys. Perhaps staff and doctors need to do some cultural sensitivity training." HCSCC was told that cultural sensitivity training had been provided to staff, but Barbara's experience highlights the challenge of imbedding cultural sensitivity, not just once off training sessions.

A general focus of the HCSCC Complaint Resolution Service is holding service providers to account to prevent recurrence. Complaints are an opportunity to learn from mistakes and change practices to reduce serious incidents.

Case study

Tim, a 60 year old Vietnam veteran, had a history of stomach and intestinal problems. He complained to his regular doctor at least twice about symptoms that had been bothering him. After being told not to worry about them Tim consulted another doctor who arranged tests that showed he had a malignant tumour. He received treatment and has made good progress.

Tim's complaint to the Medical Board of South Australia about his regular doctor's failure to investigate his symptoms was initially referred to HCSCC. After obtaining information, HCSCC discussed the case further with the Medical Board. It was agreed that the Medical Board would investigate the conduct and competency of the doctor.

Tim was concerned that a number of other veterans who consulted the same doctor were unhappy with services they had received.

As a result of the investigation the doctor was counselled by the Medical Board.

Tim received a written apology from the doctor and feedback from another veteran who noted improvements in the doctor's practice following the complaint.

Case study

David, in his mid 50s, was detained by a metropolitan public hospital after attempting suicide. He was discharged two weeks later, a day after making a further suicide attempt while in hospital. No plan was made to manage the risk of suicide after his discharge. The following day he took his own life.

David's family complained about his treatment and the lack of planning for his discharge from hospital.

After gathering information HCSCC facilitated a meeting between members of David's family and a senior mental health service manager. During the meeting, family members were able to express their concerns. They also received explanations about services and other improvements to support patients and families during admission to hospital and after discharge.

As a result of this and other similar complaints HCSCC is undertaking further work with service providers to ensure good practice care and follow-up for family members after suicide.

COMPLAINTS HANDLING

Overview of the Complaint Resolution Service

The HCSCC Complaint Resolution Service assists service users, their families and carers, and service providers to resolve complaints. Section 29(5) of the Act requires a person to take reasonable steps to resolve their concerns with the service provider before making a complaint to HCSCC. People contacting the Complaint Resolution Service are encouraged and assisted to try to resolve their complaint with the service provider directly.

In circumstances where it is unreasonable to expect a complainant to approach the service provider directly or where an attempt at direct resolution has been unsuccessful, HCSCC may become involved to help resolve the complaint.

HCSCC's involvement can vary from assisting a person to put their complaint in writing to the service provider through to mediation or conciliation. In assessing a complaint, HCSCC makes preliminary inquiries under section 30 of the Act as a basis for the Commissioner's decision about what action, if any, will be taken.

Enquiry Service

Service users, their families and carers, and service providers can use HCSCC's Complaint Resolution Service through the HCSCC Enquiry Service by phone, mail, fax or email.

The Enquiry Service offers information and advice about complaints including guidance on how HCSCC can assist people within the scope of the Act. When HCSCC cannot deal with a matter, every effort is made to refer the person to another appropriate service.

Even when a complaint is within jurisdiction, Section 29(5) of the Act requires the Commissioner to be satisfied that reasonable steps have been taken by the person to resolve the matter directly with the service provider before HCSCC takes any action.

When a person has agreed to attempt direct resolution with the service provider, HCSCC will follow up after 30 days to check on progress and see whether further assistance is needed.

The HCSCC Enquiry Service is staffed Monday to Thursday, from 10am to 4pm and is accessible by:

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

Contact with Enquiry Service

Single contact matters within jurisdiction	509
Information/advice provided	277
Assisted to attempt direct resolution	258
Single contact outside jurisdiction	471
Total telephone contacts	**1515**

Most matters falling outside jurisdiction did not involve a health or community service provider within the terms of section 4 of the Act, or were outside the 2 year time limit set out in section 27.

Service use by non-metropolitan residents

Single contact	100
Complaints received	51
Total	**151**

'I am really pleased you are looking into this because I think I wouldn't have received fair treatment from the service' – service user.

Service provider types involved in complaints

Aged care	23
Community services	65
Health—public	311
Health—private	137
Health—non-government	5
Individual registered health service provider	74
Individual unregistered service provider	4

The most common issue complained about was treatment, followed by access to services and communication.

Issues complained about

Access to services	98
Communication	73
Consent	6
Privacy/discrimination	9
Professional conduct	55
Treatment	305
Unable to resolve with service provider	21
Other	70

NOTE: A complaint may involve more than one issue

Complaints accepted by HCSCC

If an attempt at direct resolution with a service provider has been unsuccessful, or it is not reasonable to expect a person to try, for example, where the person has special needs, HCSCC will manage the complaint. HCSCC also manages complaints involving a significant issue of public safety, interest or importance.

To assess what action should be taken, HCSCC gathers information about the complaint by making preliminary inquiries under section 30 of the Act. This can involve the exchange of written information and inspection of files held by the service provider that are relevant to the complaint. It may also include facilitated meetings to:

- reach a better understanding of what happened
- improve the relationship between the complainant and the service provider
- discuss changes that could be made to minimise the likelihood of the same thing happening again.

During 2006-07 HCSCC commenced preliminary inquiries into 251 new complaints. This was in addition to work already underway on complaints received in the previous year.

The case studies set out in this report have been drawn from complaints finalised in 2006-07.

When assessing the allegations raised by a complaint, the Commissioner must consider a range of factors to determine whether or not the service provider has acted reasonably. This involves looking into the circumstances surrounding the complaint, including the response of the service provider when the issue was first raised by the service user, their family or carer.

In deciding what is reasonable, the Commissioner must take into account the Charter principles set out under section 22 of the Act. These principles include the right of a service user to:

- effective participation and an active role
- have their individual background and requirements taken into account
- get access to records
- have access to a complaints process.

An assessment of whether the actions are reasonable will also be based on the generally accepted standard that could be expected of a service provider. The Commissioner must also take into account the resources that are available to the provider. This requirement is set out in section 85 of the Act.

Determining what is reasonable and appropriate can be difficult. Across health and community services a wide range of standards exists. These include: legal standards, national standards, evidence-based practice guidelines, various accreditation standards, as well as departmental, professional association and local policies and guidelines. In some areas, standards don’t exist or are not formalised, especially among non-government service providers. Where there are no standards HCSCC looks at standards for similar services as a guide to what is reasonable and appropriate.

The Commissioner must act independently, impartially and in the public interest in resolving complaints. This responsibility influences the complaint resolution process and the outcome. The outcome must also address any issue of significant public safety, interest or importance.

Successful complaint resolution usually involves a range of actions to respond to the specific issue raised to restore the complainant's confidence in the service provider and to address any wider systems issues to reduce the likelihood of the problem recurring.

The outcome of a complaint may include one or more of the following:

- information and explanation
- an apology
- change to practice or policy
- access to service
- confidence and trust restored
- commencement of other proceedings.

Some complainants come to HCSCC seeking outcomes that are inconsistent with the focus and requirements of the Act. In many cases their anger and anxiety have resulted from a combination of the original incident and their experience in trying to raise their concerns with the service provider. Managing the expectations of complainants therefore presents a major challenge for HCSCC. Complaint Resolution Officers explain the role and powers of the Commissioner to complainants at the beginning of the complaint resolution process. However, some complainants remain dissatisfied with the options available under the Act.

Section 33 decisions to take no further action

At any stage in the process of assessing a complaint the Commissioner may decide to take no further action based on the grounds set out in section 33 of the Act. This may occur for a variety of reasons including the resolution of the complaint, referral to another body or a finding that the service provider has met all, some or none of the relevant standards in providing the service and handling the complaint.

In response to feedback gained through the 2006 HCSCC Service Evaluation, Complaint Resolution Officers now contact people by telephone to explain the Commissioner's decision to take no further action on a complaint. This decision, and the reason for it, is then confirmed in writing.

All communication about a decision of the Commissioner includes information about the right to seek a review by the State Ombudsman, along with the Ombudsman's contact details.

Child protection complaints jurisdiction

In the first 12 months of the child protection complaints jurisdiction, 93 complaints were received. This included 7 that were transferred from the State Ombudsman.

Seventy three percent of the 93 child protection complaints came from family members. Parents made up 60% of complainants, followed by grandparents (14%) and other relatives (8%).

Two thirds of complaints came from people in the metropolitan area.

All but one complaint involved services provided by Families SA.

This was to be expected as Families SA is the statutory child protection agency in South Australia with primary responsibility for child protection.

Most people complained about more than one issue.

The top 3 issues raised were:

- delays in case management decisions
- care arrangements
- access arrangements.

Parents complaining to HCSCC most commonly wanted their children returned to them. Almost as common was a request to have their child's care arrangements or access schedule changed.

Under the Act, HCSCC can take no action on a complaint about a decision of a court. The return of children to their parents, once the Youth Court had made an order placing them in care, is not within HCSCC's scope. In these situations it was often helpful for Families SA to explain decisions that had been made, and to give parents an opportunity to be involved in case planning.

During the first 12 months of the child protection complaints service, HCSCC has found Families SA staff in general:

- committed to responding to complaints
- willing to learn from experience
- receptive to making appropriate changes.

To minimise duplication in child protection complaints, HCSCC has worked closely with the Guardian for Children and Young People to ensure appropriate referrals and establish procedures in line with the different roles of each office. The Guardian acts as an advocate for children and young people in the care of the Minister for Families and Communities, while the Commissioner must act independently, impartially and in

the public interest in carrying out her functions. The Guardian can complain to HCSCC on behalf of a child in the care of the Minister.

Assistance to service providers

Health and community service providers can complain to HCSCC where a service they provided was necessary because of the actions or inaction of another service provider.

HCSCC also has a role in assisting service providers to develop or improve procedures to resolve complaints. During the reporting period a few service providers sought information, advice and training about best practice complaints handling.

'I need to know I've done everything I can do and it's good to have you there to check with. Thanks for your help.' – service provider

In addition to using the resources on the website, service providers contacted HCSCC for advice and guidance about a particular complaint or complaints handling generally.

Bogus, unregistered or deregistered health practitioners

Since October 2005, HCSCC has dealt with 3 lengthy complaints involving the families of a person with terminal cancer, who consulted an unregulated health provider during the late phase of their illness. All 3 were offered the hope of a miracle cure involving unorthodox regimes or treatments. All 3 were required to pay large amounts of money up front. After the person died, without any benefit, the family members were unsuccessful in obtaining a partial refund. In addition to feeling ripped off financially, the family members wanted action taken to prevent these providers duping other vulnerable terminally ill people.

In response to publicity, representation from local members of parliament and HCSCC reports, the South Australian Parliament Social Development Committee (SDC) has determined to conduct an inquiry into bogus, unregistered or deregistered health practitioners.

The SDC inquiry will start in 2008. HCSCC will provide a submission to the inquiry based on these complaints and information from other states about ways to regulate these practitioners to protect the public.

Part 6 Investigations

Suicide and serious self harm

In 2005-06 I reported that I was investigating the circumstances surrounding the suicide of Mr Darcy Smith, on referral from the former Minister for Health, the Hon. Lea Stevens. During my inquiries into this complaint, 5 other complaints following a suicide and 1 complaint following serious self harm, it became clear that there would be a public interest benefit in investigating these 7 cases together. This enabled their common features and the systemic failures to be more clearly identified. It will also provide a firmer basis for recommendations to prevent recurrence.

The common features included:

- gaps in information exchanged between different service providers that contributed to a less than comprehensive assessment of the risk of suicide or serious self harm
- poor communication between professionals looking after the physical health of a person and professionals looking after their mental health
- the involvement of many different service providers but no single provider with responsibility for ensuring the comprehensive assessment and care of the person, or communication with their next of kin
- poor quality care planning and documentation, including suicide/self harm risk assessment and crisis management planning
- management of patient medication between and across different treating professionals, including between public and private services
- inadequate information and services to support GPs caring for people with severe mental illness in the community
- poor communication with family members after discharge and after suicide or serious self harm, leaving families to cope with grief and guilt compounded by unanswered questions.

My investigation of most of these cases was complicated due to the involvement of the Coroner. It was also constrained as the findings and recommendations of confidential internal investigations by the service providers could not, by law, be given to me, the staff involved, the families or the Coroner. A report about this cluster of cases and my recommendations will be published in 2007-08.

In 2006-07 I also commenced quarterly meetings with the Executive Directors for Mental Health in Central Northern and Southern Adelaide Health Services; the South Australian Director for Mental Health and the Minister for Mental Health and Substance Abuse. The focus of these meetings was to monitor action to address the shortcomings identified in HCSCC complaints. These meetings also served to monitor the impact of mental health reforms designed to improve the safety and quality of public mental health services.

Influenza death - country health service

In 2005-06 I reported that I was investigating the circumstances surrounding the sudden death of a healthy 29 year old, with a history of mild asthma, in a sub regional country hospital. As this complaint mainly concerned his medical assessment and treatment, the matter was referred to the Medical Board, in accordance with Part 7 of the Act. The Medical Board's investigation, that included an independent medical specialist opinion, found that the diagnosis and management fell within the accepted standards for a rural GP. The Medical Board concluded that this death from influenza occurred in circumstances that were extreme and uncommon.

In addition to the Medical Board's investigation, I identified several systemic features—features beyond the responsibility of the individual rural GP - that either contributed to shortcomings in the timeliness and treatment provided in this instance, or that if left unaddressed could potentially lead to similar tragedies in country health services.

These features included:

- access to chest x ray and x ray reports
- access to blood tests and the timeliness of results to the GP
- clinical guidelines when flu-like symptoms persist beyond 5 days, including prescribing antibiotics
- availability of ambulance services for transfer or retrieval
- rural Registered Nurses scope of practice
- training and accreditation in emergency resuscitation for rural GPs and nurses
- serious incident investigation and reporting in country health services
- access to an adequate complaints process in country health services.

As part of my research, I sought to identify applicable standards for these features in country health services, as a basis for making recommendations for improvement to Country Health SA. Work to progress these issues with Country Health SA started in 2006-07 and will continue throughout 2007-08.

Bowel perforation complaints

During 2006-07 HCSCC received 5 complaints about bowel perforations in people over 72 years of age. Four occurred during, or after, colonoscopy and one occurred during a barium enema. As with the suicide and self harm complaints, I grouped these 5 cases to identify any common or systemic features. My findings and recommendations arising from these cases will be reported in 2007-08.

KEY RELATIONSHIPS

Part 7 Relationships with registration authorities

The Commissioner established information sharing and referral protocols with each of the 10 health professional registration authorities during 2005-06. These arrangements exist to ensure that complaints are dealt with by the appropriate body.

Registration authorities generally deal with complaints about the competence or professional conduct of an individual registered service provider that may give rise to disciplinary proceedings. Complaints of a less serious nature, and those that extend beyond an individual health service provider's conduct, are usually dealt with by HCSCC.

During 2006-07 the Commissioner has built on the relationships established in 2005-06. HCSCC has implemented an effective recording system to enable prompt discussion and appropriate information exchange, and regularly consults registration authorities on complaints received about individual registered service providers. The Medical Board of South Australia (the Medical Board) receives monthly information updates and all other registration authorities will receive quarterly updates from 1 July 2007.

Complaints sometimes involve a registered service provider and another service provider. In this situation the Commissioner can split a complaint into two or more complaints. The relevant registration authority then considers the complaint about the individual registered service provider and HCSCC deals with aspects of the complaint involving the other service provider. A complaint may also be split so that the individual conduct of a registered service provider can be dealt with separate from any systemic aspects of the complaint.

On 22 September 2006 HCSCC presented a submission in response to the South Australian Parliament Statutory Authorities Review Committee (SARC) Inquiry into the Medical Board. SARC's final report about its inquiry into the Medical Board is expected during 2007-08.

In July 2006 the Council of Australian Governments (COAG) agreed to establish new national health professional registration arrangements to take effect from 1 July 2008. COAG also agreed to establish new national health professional accreditation arrangements from this date.

These announcements were made in ignorance of the existence of independent statutory health complaints bodies in each state and territory, many of which like HCSCC, have a legal relationship with state or territory health professional registration authorities. In South Australia these legal relationships are set out in Part 7 of the Act.

The COAG consultation papers issued in September and November 2006 did little to clarify the impact of the proposed arrangements on state or territory statutory health complaints bodies. The proposals cut across the Part 7 obligations and arrangements established between HCSCC and 8 of the 10 health professional registration

authorities in South Australia. Along with interstate counterparts, HCSCC has raised concerns about the proposed arrangements with the COAG Health Working Group. The HCSCC submission, March 2007, remains unanswered as at 30 June 2007.

The impact of these arrangements on Part 7 relationships between HCSCC and 8 South Australian health professional registration authorities may become clearer during 2007-08.

Case study

Nick complained to HCSCC about the circumstances surrounding his wife's death in a private hospital where three doctors were involved in her care. The Commissioner decided to split the complaint.

The conduct of the doctors was referred to the Medical Board and HCSCC inquired into the actions of the hospital.

The Medical Board conducted a thorough investigation and concluded that there were no grounds to take disciplinary action against the doctors. One doctor received informal counselling. He was advised to learn from the case by modifying his future practice when assessing and managing risks associated with the type of surgery performed.

The hospital introduced good practice policies for recording and investigating deaths, like the one in this case, to minimise the risk of recurrence. The hospital also noted the need to be diligent in recording and reporting concerns about patients to senior medical staff to ensure better outcomes.

Links with service providers and representative bodies

HCSCC has established good working relationships with other complaints handlers and investigation agencies. This includes individual complaints handlers and designated units within service provider agencies.

So that service users know how to pursue a complaint and who to contact, HCSCC has established information and referral arrangements and protocols with relevant agencies. This approach also helps to ensure that service providers do not receive inquiries about an incident from several different bodies.

During 2006-07 HCSCC developed a protocol with the Second Story Youth Health Service to establish a pilot outreach service for young people.

In addition, written protocols exist between HCSCC and the following agencies:

- Department of Health
- Department for Families and Communities
- Central Northern Adelaide Health Service—Prison Health Service.

In April 2007, the Commonwealth Government announced the establishment of a new complaints scheme for Commonwealth funded aged care services, the Aged Care Complaints Investigation Scheme (ACCIS). HCSCC will finalise a protocol with ACCIS in 2007-08.

Presentations and briefings

The Commissioner met quarterly to provide briefings to the Minister for Health and the Minister for Mental Health and Substance Abuse. The Commissioner also met with the Minister for Families and Communities in May 2007 to brief him about child protection complaints.

Quarterly briefings were also provided to the Chief Executives—Department of Health and Department for Families and Communities.

To promote understanding of the scheme under the Act and foster effective working relationships, HCSCC also presented information to a wide range of peak bodies in various forums.

Examples include:

- Families SA operational directors
- South Australian private hospital directors of nursing
- members of state parliament and state electoral office staff
- Australian Medical Association executive
- Child Death and Serious Injury Review Committee
- Aboriginal Legal Rights Movement
- Government Reform Commission
- Federation of Natural and Traditional Therapists
- Australian Association of Social Workers, South Australian Branch
- Multicultural Communities Council of South Australia.

A total of 58 presentations were made during 2006-07.

STANDARDS

Australian standards for complaints handling

The *Australian Standard, Customer Satisfaction—Guidelines for complaints handling in organisations, AS ISO 10002—2006* came into operation in April 2006. This international standard provides guidance on how to design and implement an effective and efficient complaints handling process.

During 2006 HCSCC procedures for dealing with complaints were reviewed against the requirements of the new international standard.

AS ISO 10002—2006 was also used to guide the development of the HCSCC policy and procedure for dealing with complaints about our services.

HCSCC service standards

The HCSCC service standards include commitments to:

- listen to people's concerns
- treat people with courtesy
- work cooperatively with all parties to explore options to resolve issues
- make appropriate referrals
- provide independent, impartial and honest advice
- regularly monitor standards.

'Thank you for the manner in which the situation was handled.' – service provider

The standards also require all services to be accessible, timely and respectful of people's privacy. In particular, HCSCC is committed to ensuring that people with disabilities or other special needs are enabled and assisted to use the Complaint Resolution Service.

A complete list of the service standards is set out on the website at www.hcscc.sa.gov.au

Measuring HCSCC performance

The creation of the new role of Information and Assessment Officer in November 2006 has allowed HCSCC to deal with more matters at first contact through the Enquiry Service. Information and advice are often all people need to resolve their complaint directly with the service provider.

Enabling participation in direct resolution has resulted in the complaints handled by Complaint Resolution Officers becoming more complex, and cases are taking longer to resolve.

The current HCSCC performance measures require:

- acknowledgement of all complaints within 2 working days of receipt
- a named staff member to follow up within 10 working days to discuss options and next steps
- resolution of child protection complaints within 12 weeks
- resolution of all other complaints within 6 weeks or, where this is not possible, keeping all parties informed about progress.

HCSCC aims to meet these performance measures for 80% of all complaints.

While HCSCC continues to aim to provide timely service, the 6 and 12 week performance measures for the resolution of complaints are currently under review.

Service Evaluation

The 2006-07 service evaluation included randomly selected complainants and service providers who had dealt with the Complaint Resolution Service during the year.

Of the 71 survey forms sent out, 42 completed forms were returned to HCSCC, 24 from complainants and 18 from service providers.

Both survey groups were asked 11 common questions considered relevant to the nature of their interaction with HCSCC. Complainants were asked a further 10 questions and service providers were asked 2 additional questions.

The 8 core questions selected by the South Australian Government from the Canadian Customer Measurement Tool were used in the survey form for complainants. Only 3 of the core questions were considered suitable for inclusion in the survey form for service providers.

Overall, service providers were more satisfied with HCSCC services than complainants.

Almost three quarters of all respondents found that HCSCC staff members were:

- courteous
- good listeners
- knowledgeable and competent.

'Thank you so much for following up for me. It gets so hard sometimes and I appreciate your help.'– representative of service user

More than half of all respondents agreed:

- they were treated fairly
- the Commissioner's final decision was easy to understand

- they were satisfied with the overall quality of service delivery.

The most notable feature of the responses from complainants was that 71% said they did not get what they needed and a further 17% said they only got part of what they needed. This was not surprising as many complainants see HCSCC as an extension of their complaint about a service provider, rather than an independent, impartial reviewer. Although complainants are given information about the Commissioner's powers and role, they often have expectations that cannot be met. In spite of this, 54% said they would recommend HCSCC to friends, colleagues and family.

A large majority of service providers were satisfied with all aspects of the Complaint Resolution Service. Of the service providers who responded, 28% had dealt with HCSCC more than 10 times.

During 2006-07 HCSCC used information from the 2005-06 survey to make several service improvements including:

- keeping people informed of progress with their complaint every 21 days or more often if required
- phoning complainants before sending a letter advising them of the Commissioner's decision to take no further action
- re-writing all standard letters to make them easier to read.

While the number of responses from complainants does not make it possible to draw reliable conclusions, it is noteworthy that 63% of respondents agreed that information in letters was easy to understand, compared to 27% in 2005-06. Agreement that the Commissioner's final decision was easy to understand rose to 50% from 32% in the previous year.

Service provider standards for complaints handling

An important part of HCSCC's work is promoting best practice complaints handling. Where a complaint reveals that a service provider does not have an appropriate complaints handling process, HCSCC works with the provider to achieve this as part of the resolution of the complaint.

Case study

Brendan applied to a community service for assistance with housing and other support services. The worker began to visit Brendan outside work hours and approached him one night for sex. Brendan agreed because he didn't want to lose the worker's support or his access to services. The worker then advised Brendan that he was HIV positive and asked him to sign a letter saying they were friends who were not in a client/counsellor relationship.

As a result of his complaint to HCSCC, Brendan received an apology from the service and was offered counselling. Another client of the service felt confident to make a similar complaint about the same worker who was then dismissed from the service.

HCSCC worked with the service to improve policies and procedures dealing with complaints handling and a code of conduct for staff and volunteers. The service has agreed to provide complaints handling training to its workers and has been referred to the Service Excellence Program, a continuous improvement program for community service organisations.

HCSCC has encouraged all health service providers to adopt the *Better Practice Guidelines on Complaints Management for Health Care Services* developed by the Australian Council for Safety and Quality in Health Care Services in July 2004. HCSCC has also encouraged these service providers to audit their policy and practice using the audit tool set out in the *Better Practice Guidelines Complaints Handbook*, pages 55-58.

In 2005-06 public health services completed their first audit against the guidelines as part of their health service agreement obligations. The 3 main regional public health services, Children Youth and Women's Health Service, Central Northern Adelaide Health Service and Southern Adelaide Health Service, developed a 2006-07 action plan to improve their complaints handling to meet the *Better Practice Guidelines.* HCSCC reviewed the May 2006 progress report for each of the 3 regional services. All services identified gaps between their existing approach and the *Better Practice Guidelines* and planned action to close the gaps. This exercise will be continued in 2007-08.

Country Health SA completed their first audit against the guidelines in 2006-07. Their report and action plan for improvement will be reviewed by HCSCC in 2007-08.

Community service providers funded through the Department for Families and Communities are encouraged to adopt the Service Excellence Framework, SEII, which provides a best practice process for complaints handling. During 2006-07 the South Australian Council for Social Service Inc. has also delivered SEII training and support to smaller community service agencies.

HUMAN RESOURCES

Employment

During the 2006-07 financial year, 1 person was granted leave without pay, 4 people left HCSCC and 5 people were recruited.

All vacancies were advertised through the Notice of Vacancies. Of the 5 vacancies, 4 were also advertised in the external press due to the level of the position and/or the specialist skills required.

Employee numbers, gender and status

Total number of employees	
Persons	11
FTEs	10.4

Gender	% Persons	% FTEs
Male	9.19%	9.6%
Female	90.9%	91.4%

Number of Persons during the 2006/2007 financial year	
Separated from the agency	5
Recruited to the agency	4

Number of Persons at 30 June 2007	
On Leave without Pay	1

Number of positions by salary bracket

Salary Bracket	Male	Female	Total
$0 - $43,999	0	2	2
$44,000 - $56,999	1	1	2
$57,000 - $72,999	0	4	4
$73,000 - $91,999	0	2	2
$92,000 +		0	
Total	**1**	**9**	**10**

The Commissioner holds an Executive B position on an untenured 7 year contract, which started on 31 March 2005. The Commissioner has a right to further appointment for another 7 year term.

Status of employees in current position by FTE

FTE	Ongoing	Short-Term Contract	Long-Term Contract	Other (Casual)	Total
Male	0	1	0	0	1
Female	7.8	0.6	1	0	9.4
Total	**7.8**	**1.6**	**1**	**0**	**10.4**

Status of employees in current position by number of persons

Persons	Ongoing	Short-Term Contract	Long-Term Contract	Other (Casual)	Total
Male	0	1	0	0	1
Female	8	1	1	0	10
Total	**8**	**2**	**1**	**0**	**11**

Leave management

Average time taken by leave type

Average days leave taken per full time equivalent employee		
Sick Leave	Family Carer's Leave	Special Leave with Pay
7.4	1.61	0.63

Profile of workforce

HCSCC staff comprises 9 females and 1 male. None of the staff are Aboriginal.

Age profile of staff

Age Bracket	Male	Female	Total	% of Total	Workforce Benchmark
15-19					7.9
20-24					10.7
25-29					9.8
30-34		1	1	9.0	10.5
35-39	1	1	2	18.2	11.4
40-44		1	1	9.0	12.4
45-49		5	5	45.6	12.4
50-54					10.9
55-59		2	2	18.2	8.3
60-64					4.4
65+					1.3
Total	**1**	**10**	**11**	**100.0**	**100.0**

NOTE: Benchmark as at January 2006 from Australian Bureau of Statistics Supertable LM8

Voluntary flexible working arrangements

The Commissioner supports voluntary flexible working arrangements to assist staff in balancing work and family life.

Employees using voluntary flexible working arrangements

Type of arrangement	Number of employees
Purchased leave	0
Flexi-time	10
Compressed weeks	2
Part-time	2

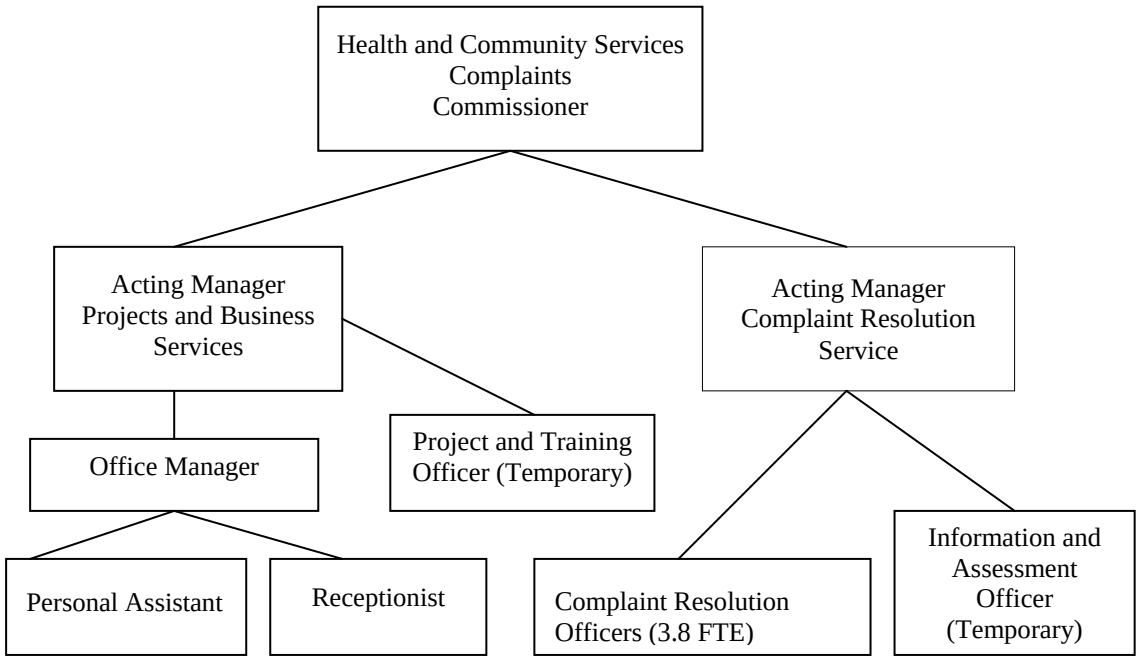
Training and Development

Percentage of training expenditure by salary range, including Commissioner and staff

Salary Bracket	Amount	% of Training Expenditure
$0 - $43,999	941.66	7.33
$44,000 - $56,999	1051.66	8.19
$57,000 - $72,999	5760.47	44.86
$73,000 - $91,999	700.83	5.46
$92,000 +	4385.66	34.16
Total	**$12,840.28**	**100%**

Organisation chart

30 June 2007



The Health and Community Services Complaints Commissioner is appointed under Part 2 of the Act.

The Commissioner is a statutory officer independent of the legislative and executive arms of government.

The Commissioner reports to Parliament by way of an annual report tabled by the Minister for Health.

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 Department of Health, Code of Fair Information Practice as far as possible.

FUNDING AND EXPENDITURE

The Health and Community Services Complaints Commissioner's financial transactions are included in the operating account of the Department of Health. As such the transactions of the Commissioner are audited by the Auditor-General along with those of the Department of Health.

The Commissioner is funded from the State budget and received some external funding this year from the Office of Nursing and Midwifery, South Australian Department of Health, towards the *Safer Conversations* Project.

A summary of 2006-07 funding and expenditure is provided below.

Sources of funding

Dept of Health—recurrent base at 1/7/06	$1,151,000
Dept of Health—Office of Nursing & Midwifery	$107,700
Enterprise Bargaining supplementation	$10,700
Revised annual budget at 30/6/07	**$1,269,400**

Summary of revenue & expenditure

Revenue from Office of the Guardian for Children & Young People - contribution to receptionist position	(11,650)
Training revenue	(90)
Total revenue	**(11,740)**

Salaries & wages	$1,012,789
Goods & services	$346,593
Total expenses	**$1,359,383**

Net operating result	$1,347,643

Variance	(78,243)

Note: Deficit due to unfunded long service leave expense of $81,106