3 MARCH 2011

HCSCC INTERIM RESPONSE
TO
ZED OPERATIONAL REVIEW
RECOMMENDATIONS & FINDINGS

HCSCC RESPONSE TO THE RECOMMENDATIONS OF THE OPERATIONAL REVIEW 2010

The Zed recommendations and comment appear below in black text.

The HCSCC interim response to the recommendations appears below in blue text.

1. Maintain existing level of funding for HCSCC

It is recommended that the recurrent funding base for HCSCC of $1.25m per annum be maintained at existing levels. The review indicated that the current funding base is appropriate to deliver the functions legislated under the Act.

HCSCC does not support this recommendation.

2. Redesign the structure to address functional gaps

It is recommended that the HCSCC redesign its organisational structure to facilitate the delivery of core functional responsibilities as legislated under the Act.

This will enable HCSCC to provide greater emphasis on core functions, including:

- capacity building (i.e. training and education for service providers and service users)
- systemic trends analysis
- reporting (i.e. monthly reporting, Annual Reporting)
- relationship management with stakeholders, including non-government sector, private sector, public sector and people with special needs
- support to the Health and Community Services Advisory Council.

In addition, it is further recommended that the HCSCC develops a model to gain access to expert opinion (i.e. clinical, legal, discipline specific) to support complaints management.

In developing the proposed model, consideration has been given to the level of FTE requirements. It is proposed that the model could be delivered within the current 12.5 FTE base allocation. In particular, core services could be provided with 11.0 FTE, with the remaining 1.5 FTE funding allocated for the use of external expert opinion.

On receipt of the Zed operational review report HCSCC recommenced a review of roles, responsibilities, tasks and functions started in 2009, in anticipation of:

- the Act amendments, including the proposed Code and powers to deal with unregistered service providers
- 1 July 2010 commencement of the *Health Practitioner Regulation National Law Act* 2009
- the Part 3 Charter of Health and Community Services Rights (HCSCC Charter)
- the Part 8 Health and Community Services Advisory Council
- the 2010 - 2012 work plan.

Key staff absences and the state budget savings initiative proposal have stalled the completion of this review and forward planning.

On an interim basis HCSCC has deferred recruitment to replace a Complaint Resolution Officer, who relocated to Alice Springs in March 2010. Instead, the contract of the Senior Policy Officer, HCSCC Charter has been extended until 1 October 2011, to utilise her project and business management skills to address many of the operational review recommendations.

This work includes:

- detailed preparation for the enactment of the HCSCC Charter
- detailed planning for systematic disability outreach
- an external communications review
- the development of a training and capacity building program on a fee for service basis.

HCSCC does not support the Zed proposed approach to seeking expert opinions.

HCSCC has an informal arrangement with several Health Complaints Entities (HCEs) [1] with clinical staff, or who employ clinicians on a sessional basis, to provide independent opinions. These HCEs provide this service to HCSCC free of charge.

HCSCC also obtains independent opinions when necessary, however hourly rates for such opinions range from $200-450 an hour. Typically an independent opinion with a written report costs $1500-1800. HCSCC's budget for independent opinions, $5000 a year, constrains the number of paid opinions that can be obtained.

Since 1 July 2010 new HCSCC - Australian Health Practitioner Health Regulation Agency (AHPRA) arrangements have enabled HCSCC to obtain clinical opinions from AHPRA clinical advisors. AHPRA provides this service free of charge. This arrangement did not exist at the time of the operational review.

In addition, the Commissioner is a former registered nurse and midwife. The AHPRA SA Director of Notifications is a former medical practitioner and public hospital administrator. This combined experience is drawn on extensively during all steps in the HCSCC - AHPRA consultation and referral process.

During the period of the operational review and subsequently HCSCC has continued to investigate options to replace the complaints management IT system, including Resolve and the SA Health DATIX system.

3. Redistribute resource effort to priority functional areas

It is recommended that the current resource effort is reviewed and redistributed to facilitate the delivery of the proposed organisational model outlined in Recommendation 2 above.

In particular, focus should be given to the following areas:

- reduce current administrative effort from approximately 2.8 FTE to 2.0 FTE (as depicted in the business management functional stream of the proposed organisational structure in Recommendation 2 of this report)
- reduce current complaints resolution effort from 6.7 FTE to 5.0 FTE (including management positions).

The available resource effort should be redistributed to priority functional areas within the new model.

Please refer to HCSCC's response at 2. above.

[1] Health Quality and Complaints Commission QLD; Health Services Commissioner VIC; Health and Disability Services Complaints Office WA

4. Replace existing HCSCC complaints IT system

It is recommended that the HCSCC replaces the existing complaints IT system. It is further recommended that the HCSCC consider leveraging from the current tender process that SA Health is undertaking to implement one common complaints and incident management system across the public health system.

This would also enable the use of a common system across the public sector which would greatly facilitate the ability to collect, analyse and report on complaints management data (i.e. systemic trends analysis). In addition, the replacement of the system will reduce current costs and enable the redirection of current labour intensive administrative effort towards priority functions of the HCSCC.

Please refer to HCSCC's response at 2. above.

5. Increase accessibility of HCSCC services

It is recommended that the HCSCC gives consideration to increase accessibility to HCSCC services for users through:

- extending hours of enquiry services to 5 days per week
- increased use of personal contact for initial enquiries, rather than re-directing service user to a message bank
- increased opportunities for face-to-face contact for service users.

Current volumes (i.e. average of 3 new complaints per day) indicate that there is capacity within existing resources to meet this need.

Since May 2010 the HCSCC Enquiry Service has been provided Monday to Friday 9am to 5pm. Two Information and Assessment Officers provide this service to minimise the use of message bank, however use of message bank is unavoidable at times. All contacts are returned within 2 working days, the majority on the same day.

In anticipation of the Act amendments and the HCSCC Charter two key activities were planned in spring 2010:

- lean process improvement workshop
- improvement workshops facilitated by the former NZ Deputy Health and Disability Commissioner, Rae Lamb, based on NZ experience with a statutory Code of Health and Disability Rights.

These were deferred due to:

- delays with the Act amendments
- the Minister for Health's pending response to the HCSCC Charter
- the state budget savings initiative
- key staff absences and
- the relocation of Rae Lamb to Australia, to the position of Aged Care Commissioner.

The lean process improvement workshop took place on 25 February 2011. The workshops facilitated by Rae Lamb have been rescheduled to 12-13 April 2011.

6. Develop a formal communication plan

It is recommended that the HCSCC establishes a formal communication plan to guide engagement and interaction with key stakeholders at a strategic and operational level.

The communication plan should include (but not be limited to) the following:

- a set of communication principles for the HCSCC
- a defined list of stakeholders
- communication approach for each stakeholder

- format\medium to be used for communication with each stakeholder
- frequency of communication for each stakeholder
- defined roles and responsibilities for HCSCC staff regarding communication with stakeholders.

Please refer to HCSCC response at 2. above.

A draft formal communication plan has been substantially completed. Several new communication initiatives are underway, for example: an Aboriginal Speak Up poster and pamphlet with a detachable business card with HCSCC contact details [2] ; two special Issues of *Buzz*, one with a disability focus [3] and the other an Aboriginal focus [4] ; a Braille HCSCC contact card and the development of an HCSCC Charter Champions network. [5]

The timetable for substantial elements of the plan is linked to the enactment of the HCSCC Charter and Act amendments.

7. Establish formal success criteria for HCSCC

It is recommended that the HCSCC defines and documents a formal set of success criteria (internal and external) to be used for monitoring, assessing and reporting on HCSCC performance and outcomes.

In developing the success criteria, consideration should be given to:

- achievement of obligations under the Act
- development of internal key performance indicators for HCSCC functional streams within the proposed organisational structure (i.e. capacity building, business management and complaints management)
- development of key performance indicators for HCSCC staff.

HCSCC started a review of key performance indicators and potential success criteria in spring 2010. This included a review based on

- discussions with HCEs
- review of HCE 2009-10 Annual Reports
- discussions with other statutory complaints agencies
- review of 2009-10 Annual Reports of other statutory complaints agencies
- review of HCSCC service evaluation - complainant and service provider feedback.

Key staff absences and the state budget savings initiative proposal have stalled the completion of this review.

8. Establish formal staffing strategy

It is recommended that the HCSCC establishes a formal staffing strategy to support the delivery of HCSCC core roles and responsibilities.

This would include:

- development of a succession planning model which would facilitate knowledge sharing between HCSCC staff and reduce reliance on key individuals

[2] Released 1 October 2010
[3] Released 2 February 2011
[4] To be released autumn 2011
[5] Canvassed with Health and Community Services Advisory Council December 2010 - January 2011

- revision of existing job and person specifications to reflect the proposed new organisational model
- identification of key skills sets and competencies required to deliver functional priorities under the proposed new organisational model
- assessment of current skills sets and competencies against requirements
- development of a formal training and education programme to up skill HCSCC staff
- consideration of a rota system between HCSCC staff and patient advisors from SA public hospitals to facilitate improved understanding of complaints management within health for both parties. This may be impacted by potential statutory and conflict of interest barriers. However, given the potential benefits, further consideration should be given.

Key staff absences and the state budget savings initiative proposal have stalled the completion of this work.

9. Implement formal planning processes

It is recommended that the HCSCC implements formal planning processes, with particular focus on:

- Long term strategic planning (3 - 5 years) to identify medium to long terms objectives, strategies and priorities to guide HCSCC's effort
- Development of an annual work programme linked to the annual financial process and underpinning the long term strategic vision of HCSCC

Key staff absences and the state budget savings initiative proposal have stalled the completion of this work.

10. Develop a transition plan

- an approach to facilitate the transfer from the current environment to the future organisational model, including activities, milestones, assignment of responsibilities and timeframes
- prioritisation of areas for transition with consideration of inter-dependencies
- incorporation of a risk management strategy during transition to ensure the business of HCSCC is not impacted
- development of a communication strategy to manage the expectations of HCSCC staff and key stakeholders during transition.

Key staff absences and the state budget savings initiative proposal have stalled the completion of this work.

HCSCC RESPONSE TO THE FINDINGS OF THE OPERATIONAL REVIEW 2010

The Zed Business Management (Zed) findings are set out below in black text.

The HCSCC response to Zed's findings is set out below in blue.

HCSCC summary response to the findings

1. Zed only partially understood the workflow and business processes associated with HCSCC as an independent statutory complaints agency, including administrative effort and the wider context within which HCSCC operates as a second resort agency.

2. Comparisons with other jurisdictions are flawed due to factors outside HCSCC and Zed's control e.g. non uniform laws and descriptions of the work of statutory complaints agencies in different jurisdictions.

3. HCSCC has reported many of the shortcomings that Zed identified as findings since 2005-2006.

4. HCSCC's poor quality enquiry and complaints reporting, largely due to an inadequate IT system, has been a major constraint on Zed's ability to understand the nature and extent of HCSCC's workload accurately.

5. Zed's methodology excluded substantial HCSCC work undertaken on functions other than complaints resolution.

6. HCSCC is in establishment phase, as such comparisons with fully established statutory complaints agencies, while direction pointing, should not be considered definitive.

7. HCSCC, like other small statutory complaints agencies, struggles with professional business management due to poor economy of scale.

HCSCC detailed response to the findings

FUNCTIONS

The following findings relate to the functions and associated workload activities which underpin the obligations of the HCSCC under the Act.

1. Low level of Effort on Some Prescribed Functions under the Act

- reporting and trends analysis - s(1)c(i-iv) – 0.2FTE
- increase awareness – s(1)d(i-iv) – 0.6 FTE
- capacity building – s(1)a(1)k(i-ii) – 0.4 FTE
- systematic outreach to people with special needs.

The methodology used by Zed excluded counting any time an individual staff member, or the Commissioner, spent on a function if it was done for less 5% of their working hours each week. This means that any work done by an individual staff member, or the Commissioner, for less than 2 hours a week[6] was not taken into account. The aggregate impact of this failure to account for such work is significant, particularly as such work is commonly associated with these four functions.

It is unclear to HCSCC how Zed determined the appropriate level of effort on these prescribed functions and concluded that HCSCC effort was 'low'. It appears that 'low' is relative to effort on other prescribed functions, in particular complaints resolution.

[6] Per FTE

The Act does not indicate a hierarchy or priority of prescribed functions. HCSCC has necessarily prioritised, and consequently expends most effort on the core business: complaints resolution.

2. High Level of Administrative Effort

There appears to be a high percentage of administrative effort (4.2 FTE administrative effort for an organisation of 12.5 FTE), largely due to poor systems and labour intensive practices required to process complaints. This represents 34% of total staff establishment, evidenced by:

- 2.8 FTE administrative staff
- a further 1.4 FTE effort expended in administrative support for complaints management function.

The 2.8 FTE administrative staffing is comprised of:

- 1.0 FTE Executive Assistant to the Commissioner
- 1.0 FTE Administrative Officer, Complaint Resolution Service
- 0.8 FTE Reception, finance and general administration.

Zed's finding that 1.4 FTE equivalent is expended in administrative effort to support complaints management reflects the aggregate administrative tasks undertaken by the Information and Assessment Officers, the Complaint Resolution Officers, the Manager, Complaint Resolution Service and the Commissioner to record and complete other documentation associated with enquiries and complaints resolution.

It includes a wide range of tasks that are integral to good practice complaints resolution, in accordance with the Act and with administrative law obligations.
These tasks cannot be delegated to administrative staff.

HCSCC also notes that the SA Strategic Plan Progress Report 2010 for Target 1.9 Performance in the public sector - administrative efficiency includes explanatory notes highlighting the difficulties in differentiating administrative and operational roles.

3. Low Complaint Volumes

The volume of complaints managed by HCSCC appears low (average 3 complaints per day) especially in comparison with SA public hospital system (average 25 complaints per day).

It is unclear to HCSCC how Zed benchmarked and determined 'complaints volume'.

HCSCC provided Zed with the 2008-09 Annual Reports for counterpart statutory health and community services in other states and territories. HCSCC also provided contact details for key staff in these offices and recommended that Zed seek clarification about the information they published about complaints. [7]

HCSCC did so because there is no nationally consistent definition of the different steps in the statutory complaints resolution process, nor the thresholds for what is included and what is excluded in each jurisdiction. HCSCC has ascertained that Zed did not seek clarification from any interstate counterparts.

[7] DTF Guidelines Audit and Related Services August 2010 do not include Zed Business Management (Zed) as an approved supplier in any category, including performance (operational) audits. International Standard ISO 19011:2002(E) Guidelines for quality and/or environmental management systems auditing does not appear to have been followed by Zed, in particular 6.5.4 collecting and verifying information, including dealing with uncertainty.

Minister for Health advised HCSCC on 13 April 2011 that Zed Business Management was contracted to undertake an operational review of HCSCC, not an audit and that as Zed are not auditors they are not listed as an approved supplier by the Department of Business and Finance.

Since 2005-06 HCSCC has noted difficulties in benchmarking and reporting complaint metrics. These difficulties are also a feature of benchmarking and reporting complaints among:

- HCSCC statutory counterparts in other states, territories and countries
- service providers subject to the Act
- statutory complaints agencies covering sectors outside the Act.

In addition to difficulties due to different laws, these difficulties also arise due to:

- ill defined terminology e.g. feedback, contact, enquiry, complaint
- inconsistent terminology e.g. informal complaint, formal complaint, informal mediation, conciliation, preliminary inquiries, investigation
- underdeveloped policies and procedures for managing and reporting feedback and complaints among service providers
- inadequate information systems and governance processes among service providers to record, and report complaints, including action taken in response to them.

The Zed finding that HCSCC handles an average 3 complaints per day is at odds with HCSCC's experience. Following a manual audit HCSCC included the following information in the 2009-10 Annual Report (page 20):

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 validity and purpose of the Zed comparison between HCSCC and SA Health complaint numbers is unclear to HCSCC. SA Health is a major service provider with primary responsibility for complaints management as a part of normal business operations. HCSCC is a second resort, independent statutory complaints service governed by an Act, with an extensive jurisdiction beyond SA Health.

HCSCC notes that the SA Health complaints report 1 July 2009 - 31 March 2010 records that SA Health services averaged 20 complaints a day, of which HCSCC escalated complaints comprised 1.5% and Ministerials 9.1%.

4. High Cost per Enquiry\Complaint

Interstate comparison identified that the average cost per enquiry\complaint for SA is $1,526 representing the second highest cost behind Queensland (at $2,342) and double that of WA (at $738), based on 2008\2009 Annual Report data.

It is unclear to HCSCC how Zed benchmarked and determined 'average cost per enquiry\complaint'. HCSCC's comments at 3. above are also applicable to this finding.

HCSCC provided Zed with the table set out in Attachment 1. HCSCC also included this table in the 2009-10 Annual Report and the 2010 submission to the Economic and Finance Committee. HCSCC has repeatedly highlighted the difficulties of trying to make comparisons based on reported activities as they are not comparable.

In the absence of nationally agreed consistent terminology and systems to describe and report complaints, HCSCC submits that expenditure per head of population, combined with a more rigorous analysis than that undertaken by Zed, is preferable.

HCSCC notes that the calculation and reporting of cost per enquiry or complaint by statutory complaints offices to date has been rare.

HCSCC also notes that the classification and remuneration of HCE staff and Commissioners, accommodation and goods and services costs are also not uniform across Australia and this also hampers valid comparisons.

5. Low Number of Enquiries\Complaints per FTE

Based on 2008\2009 Annual Report data, SA recorded the second lowest ranking across all jurisdictions for enquiries\complaints per staff member evidenced by:

- SA recorded 67 enquiries\complaints per FTE
- WA recorded 203 enquiries\complaints per FTE
- Victoria was the highest at 383 enquiries\complaints per FTE.

It is unclear to HCSCC how Zed calculated this ranking. HCSCC's comments at 3. above are also applicable to this finding.

In addition, HCSCC notes:

- inappropriate aggregation of enquiries/complaints - health complaints entities (HCEs) have no control over enquiries and have variable statutory provisions that determine which enquiries each HCE can accept as a complaint

- inappropriate aggregation of enquiries/complaints - as with HCEs above, the same is true among statutory complaints agencies covering community services, including disability and child protection services complaints

- having queried Zed's findings directly with the WA HCE [8]: in 2008-09 WA HCE received 2151 contacts, 24% (419) of which were out of jurisdiction. Of the remaining 1732 contacts within jurisdiction, 1283 (74%) were single contacts, 449 (28%) were lodged as written complaints and 343 (19%) were accepted as complaints. WA HCE could not provide any information about the number of the 343 accepted complaints that were resolved in 2008-09, however 21 (6%) were referred to conciliation and 6 (1.7%) were referred to investigation.

6. Low conciliations and Investigations

There is only 0.4 FTE effort identified by HCSCC contributing towards conciliations and investigations supported by jurisdictional comparisons which indicated that SA has the lowest number of conciliations and investigations as a percentage of total complaints (at 1%) with the next lowest being Queensland (7%).

It is unclear to HCSCC how Zed calculated this figure. HCSCC's comments at 3. and 5. above are also applicable to this finding.

[8] Commissioner phone conversations and email exchanges with Angela Caple WA Office of Health Review 8 September 2010.

In addition HCSCC notes the following:

6.1 Conciliation

- unlike other HCEs, HCSCC is excluded from mediating or conciliating a matter of significant public interest, safety or importance or a significant question about the practice of a service provider - sections 30(8) and 39(3)

- HCSCC has scope to use informal mediation, during Preliminary inquiries section 30(7)-(12), as an alternative to Part 5 Conciliation, a flexible provision unavailable under most counterpart HCE Acts

- HCSCC conciliation is voluntary

- service provider delays and other poor practice complaints management contribute to entrenched positions which makes conciliation an unsuitable option to resolve a complaint

- conciliation is a new process for service providers and they have been reluctant to accept HCSCC invitations to conciliate[9]; some reluctance appears to be to protect clinicians, control perception of corporate risk and/or to minimise interruption to services provided by clinicians

- the Medicare Recovery Program is a barrier to conciliation involving financial payments over $ 5000

- doctoral research about statutory complaints, including the use of mediation and conciliation, being undertaken by the Victorian Deputy Disability Services Commissioner, confirms a wide variation in terminology, statutory provisions and reporting for conciliation

- in the 2009-10 Annual Report (page 38) HCSCC reported a significant increase in conciliation.

6.2 Investigation

- until the amendments to the Act are endorsed by the SA Parliament, HCSCC, unlike all other HCEs, does not have any powers in the event of non compliance with HCSCC recommendations arising from a Part 6 Investigation. This is a deterrent to Part 6 Investigation.[10]

- among statutory complaints agencies it is acknowledged that investigations like those under Part 6 of the Act require different knowledge, skills and experience compared to other approaches to dispute resolution. This skill set is under developed among HCSCC staff and the use of outside investigators has been unsuccessful.

- rigorous investigation is resource intensive and expensive, for example an HCSCC investigation conducted at the request of the former Minister for Mental Health took nearly a year to complete and required the equivalent of 1 FTE senior complaints resolution officer for 3 months. [11]

- the KPMG operational review report of the Victorian HCE recommended an additional $ 100 000 per year to fund external investigators.

[9] HCSCC sought Dr Sherbon's assistance to develop SA Health guidelines, released in October 2007, to provide impetus for SA Health services to participate in conciliation, without results to date.
[10] The proposed amendment to the Act arose from HCSCC's recommendation during the section 88 statutory review of the Act in 2009.
[11] HCSCC Annual Report 2007-2008 page 33.

- HCSCC does not have prosecution powers, unlike NSW and ACT HCEs.

HCSCC takes a responsive regulation approach to the use of the powers available under the Act. This approach is underscored by the unique HCSCC statutory requirement to have regard for the contribution of service providers - section 22(d).

A responsive regulation approach assumes that service providers responding to HCSCC complaints want to resolve complaints well, are substantially competent and honest but are constrained by many factors.

The majority of service providers are partial, contingent or incompetent compliers with the generally accepted standards expected in the circumstances complained about to HCSCC - section 85. It is rare for HCSCC to deal with a wilfully non compliant service provider.

Evidence indicates that a responsive, helpful approach by a statutory complaints office, one that assumes service providers share the objective of responding well to complaints and providing good quality, safe services, is fairer, more effective and more efficient than formal, and potentially punitive, investigation.

Although HCSCC does not have the power to compel service providers to do so, the majority of service providers provide HCSCC with regular reports about progress towards undertakings that they have given to provide redress and to minimise recurrence of the circumstances that gave rise to a complaint.

7. Inability to Provide Appropriate Business Support to HCSCC

The business support and reporting function within HCSCC has been adversely impacted due to redirection of vacant staff positions (2 FTE) to support perceived high volumes of enquiries and complaints.

HCSCC lacks adequate business support. [12]

HCSCC has repeatedly highlighted the inadequacy of the HCSCC complaints database for complaints reporting.

8. Good Complaints Resolution Rates

HCSCC is achieving good resolution rates for enquiries and complaints at approximately 48% within 24 hours (ie 1 in every 2 complaints resolved).

See response to 9. below.

9. High Complaint Referral Rates

A high percentage (38%) of enquiries and complaints received by HCSCC are:

- closed within 24 hours (23%)
- referred to other authorities (15%).

[12] Excerpt HCSCC submission to the Economic and Finance Committee October 2010: paragraph 3. HCSCC noted the

- non replacement of a Manager, Projects and Business Services (AS08) since July 2008 - workload partly undertaken by the Manager, Complaints Resolution Service (AS08)
- non replacement of an Office Manager (AS04) since January 2009 - workload partly undertaken by a Finance and Administration Officer (AS03).

It is also worth noting that an additional 30% of complaints are re-directed to service providers to enable direct resolution and follow up after 30 days.

Like all other HCEs, and most other statutory complaints agencies, HCSCC receives a high volume of enquiries that are not within jurisdiction (OJ). For example WA HCE, Zed's preferred comparator, reported 24% of contacts as OJ in 2008-09.

HCSCC customer service standards include the statement: if we cannot assist you we will try to refer you to someone who can. The HCSCC Enquiry Service is committed to handling OJ enquires well: it assists the person who made the enquiry[13], improves the likelihood of resolution with the relevant authority, promotes awareness about HCSCC's role and establishes a favorable HCSCC reputation.

Section 29(5) of the Act requires a person with complaint to take reasonable steps to resolve the matter with the service provider (direct resolution). The majority of people who contact the HCSCC Enquiry Service are unaware of this obligation.

HCSCC facilitates referral to service providers (facilitated direct resolution) to increase the likelihood of successful resolution with the service provider.

Other factors impacting direct resolution include:

- widespread lack of awareness about who to contact to resolve a matter directly at service provider level [14]
- lack of confidence to attempt direct resolution
- fear of retribution if a complaint is made direct to a service provider.

HCSCC has worked to encourage SA Health services, and other services within HCSCC's jurisdiction, to publicise their complaints process and to make it accessible.

Two SA government endorsed recommendations arising from the section 88 statutory review have yet to receive attention:

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 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.

The majority of HCSCC referrals to other agencies involve matters about individual registered health professionals. These are matters that overlap with the jurisdiction of the registration authorities. HCSCC advised Zed about the imminent changes to the laws concerning notifications and complaints about registered health professionals. HCSCC predicted a significant increase in HCSCC workload associated with the changes.

[13] This is consistent with the SA Strategic Plan target to improve satisfaction with government services.
[14] SA Health Patient Evaluation of Hospital Stay survey 2008 found a higher awareness of HCSCC at 48% than of SA Health patient advisers at 38%.

Since 1 July 2010 HCSCC has manually documented consultation with, and referrals to, the Australian Health Practitioner Regulation Agency (AHPRA). HCSCC was the only HCE to publish a report about this work. A copy of this report was sent to the Minister for Health, among a wide variety of other stakeholders, in November 2010.

In summary, in the first quarter of 2010-11 HCSCC notified and consulted AHPRA about 89 matters, 19 of which were referred to AHPRA. Some of these matters are also likely to be referred back to HCSCC, for example for conciliation, after AHPRA preliminary assessment. The second quarter HCSCC - AHPRA report will be published in March 2011.

Based on AHPRA SA prediction of 750 - 1000 notifications a year, this area of HCSCC's work is expected to increase significantly. The inclusion of an additional four groups of health practitioners[15] from 1 July 2012 will further increase HCSCC's work, in preparation for these additional practitioners and after 1 July 2012.

10. Access to Expert Opinion

HCSCC and stakeholders identified that access to external expert\clinical opinions would greatly facilitate more effective and timely resolution of complaints and reduce unnecessary referral rates.

HCSCC has an informal arrangement with several HCEs[16] with clinical staff, or who employ clinicians on a sessional basis, to provide independent opinions. These HCEs provide this service to HCSCC free of charge.

HCSCC also obtains independent opinions when necessary, however hourly rates for such opinions range from $200-450 an hour. Typically an independent opinion with a written report costs $ 1500-1800. HCSCC's budget for independent opinions, $ 5000 a year, constrains the number of paid opinions that can be obtained.

Since 1 July 2010 the new HCSCC - AHPRA arrangements have enabled HCSCC to obtain clinical opinions from AHPRA clinical advisors. AHPRA provides this service free of charge. This arrangement did not exist at the time of the operational review.

In addition, the Commissioner is a former registered nurse and midwife. The AHPRA SA Director of Notifications is a former medical practitioner and public hospital administrator. This combined experience is drawn on extensively during all steps in the HCSCC - AHPRA consultation and referral process.

11. Gap Between Defined Role and Delivery

Stakeholders agreed that, whilst the HCSCC role is clearly defined and well communicated at the strategic level, a number of core obligations are not being delivered, including:

- Charter of Rights
- establishment of the Health and Community Services Advisory Council
- systemic trends analysis and reporting
- increasing awareness
- training and education of service users and service providers.

Since 2005-06 HCSCC has repeatedly documented constraints on HCSCC's capacity to meet these functions.

[15] Chinese medicine, medical radiation, occupational therapy and Aboriginal and Torres Strait Islander health workers

[16] Health Quality and Complaints Commission QLD; Health Services Commissioner VIC; Health and Disability Services Complaints Office WA

In addition HCSCC notes:

1. HCSCC Charter of Rights

At the time of the operational review HCSCC had appointed a Senior Project Officer to develop the Part 3 Charter of Health and Community Services Rights (the HCSCC Charter of Rights). Zed was advised that this would be completed by 1 October 2010.

The HCSCC consultation report, including the proposed HCSCC Charter of Rights, was provided to the Minister for Health on 30 September 2010. HCSCC awaits the Minister's response.

2. Health and Community Services Advisory Council

At the time of the operational review HCSCC was awaiting the Minister's advice about the appointment of the Health and Community Services Advisory Council (HCSAC) members.

The Minister advised HCSCC about the appointment of the Presiding Member and the other members on 24 June 2010. The Minister further advised the appointment of the deputy members on 15 December 2010. The first meeting of the HCSAC was held on 16 December 2010 and the second on 27 January 2011. Bimonthly meeting dates have been confirmed throughout 2011.

3. Systemic trends analysis and reporting, increasing awareness and training and education of service users and service providers - please refer to HCSCC's response at 1. above

12. Lack of Emphasis on Key Stakeholder Groups

There is limited contact by HCSCC with the following key stakeholder groups, including:

- non-government sector
- private sector
- people with special needs (ie disability, mental health and child protection).

Please refer to the HCSCC 2009-10 Annual Report, 3. Fifth year highlights, page 12, and 5. External relationships and communication, page 44, for information about HCSCC engagement with key stakeholders.

13. Accessibility to HCSCC Services

There is a perceived lack of accessibility to core HCSCC services, particularly with the phone enquiry services only available from Mon – Thu (10 am – 4 pm) and no drop-in capacity. This is supported by:

- limited personal contact at first instance (ie message bank)
- no front counter.

It is worth mentioning that a number of other jurisdictions do not provide drop-in services for customers and first contact is through the internet or by phone.

Please refer to the HCSCC Telephone Enquiry Service snapshot June 2010 at 3. above. Since May 2010 the HCSCC Enquiry Service has been open Monday - Friday 9am - 5pm.

14. Quality of Services

Although services were valued by stakeholders, concerns were raised with regard to the quality of services being provided and perceived value for money.

This finding lacks specificity. Please refer to HCSCC 2009-10 Annual Report, pages 41-42 for information about HCSCC service evaluation.

15. Ineffective HCSCC Organisational Structure

The current HCSCC organisational structure has not been designed to support the needs of the Commissioner and the deliver of functions legislated under the Act.

The organisational structure has changed every year since 2005-06 reflecting HCSCC's establishment phase.

HCSCC's establishment phase will continue until the following are consolidated:

- the enactment and implementation of the Health and Community Services Complaints (Miscellaneous) Amendment Bill 2010
- the enactment and implementation of the Part 3 Charter of Health and Community Services Rights
- the implementation of recommendations endorsed by the Commissioner arising from the Zed operational review
- the 2011-13 work plan for the HCSCC Health and Community Services Advisory Council
- the development and implementation of section 76 Regulations
- the implementation of the outstanding recommendations endorsed by the SA government arising from the section 88 statutory review [17].

16. Impact of National Registration Scheme on HCSCC

Due to the early developmental stage of the introduction of the national registration scheme from 1 July 2010, it is not possible to determine the resource impact (if any) to the HCSCC. This will need to be re-visited once operating protocols are further defined at a national and jurisdictional level.

Please refer to the response to 9. above about HCSCC - AHPRA statutory relationship and working arrangements.

For the period May - December 2010 HCSCC estimates that these new arrangements have required the following minimum input each week:

- 0.2 FTE Information and Assessment Officer
- 0.1 FTE Enquiry Service Coordinator
- 0.1 FTE Commissioner.

The indications are that this will increase during 2011, for example: AHPRA SA advised a case load of 450 complaints and notifications as at January 2011.

Indemnity providers have advised their members that complaints to HCEs and AHPRA are increasing and that this trend will gather pace, particularly as thresholds in tort law become higher and public expectations about health professional standards rise.

[17] 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.

FUNDING

The following findings relate to the funding and resources associated with the operations of HCSCC.

17. Strong Financial Performance

Over the past 3 years, the HCSCC has generally achieved a balanced budget.

HCSCC continues to tightly control expenditure to maintain a balanced budget.[18]

18. Lack of Financial Management Planning

There is no evidence of a strategic approach to budget planning (ie through the development of an annual work plan directly linked to the HCSCC budget).

HCSCC explained to Zed the then current 2 year HCSCC work plan and budget.
For the HCSCC budget 2009-10 the apportionment was 79% ($ 1,124,341) salaries and 18% ($ 262,937) goods and services.

At the start of each financial year HCSCC works with an SA Health finance officer to allocate the annual budget to meet the work plan across the 12 month period.

HCSCC also explained to Zed the delays with the HCSCC work plan and budgeted expenditure arising from factors beyond HCSCC's control, including:

- the SA government election care taker period and resultant delays with the Health and Community Services Complaints (Miscellaneous) Amendment Bill
- the delayed development of the HCSCC Charter
- the delayed appointment of the Health and Community Services Advisory Council
- repeated delays with the SA Health and DFC complaints management IT systems.

19. HCSCC Funding Base Appropriate

The HCSCC funding base of $1.25m per annum is appropriate to deliver the required services and meet the obligations under the Act as supported by the functional analysis and interstate comparison. This is evidenced through:

- the level of HCSCC staff effort in complaints resolution does not appear appropriate for the volume and complexity of complaints received by the HCSCC (ie 3 per day), indicating effort could be re-allocated to achieve other core HCSCC obligations (ie capacity building, training, education).

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[18] Excerpt HCSCC submission to the Economic and Finance Committee October 2010: paragraph 3: In 2009-2010 HCSCC took further action to improve the utilisation of existing resources. Additional measures taken since those set out in the HCSCC November 2009 submission to the Committee include:

- a reduction in permanent complaint resolution officer (CRO) positions - a resignation from a 1.0 FTE permanent CRO position March 2010 has been filled on a fixed term contract basis until March 2011
- further controlling goods and service expenditure on consumables.

These measures are in addition to:

- non replacement of a Manager, Projects and Business Services (AS08) since July 2008 - workload partly undertaken by the Manager, Complaints Resolution Service (AS08)
- non replacement of an Office Manager (AS04) since January 2009 - workload partly undertaken by a Finance and Administration Officer (AS03) and
- $ 7,709 accommodation cost recovery from the Guardian for Children and Young People since 2009.

- comparison of volumes, staff numbers and budgets with other jurisdictional bodies, particularly WA
- comparison of volumes, staff numbers and classification levels with complaint\patient advisors across the SA public health system
- comparison of volumes, staff numbers and classification levels with the MBSA
- inefficiencies\avoidable costs (ie high level of administrative effort, labour intensive systems) which could be re-directed towards core services.

Please refer to HCSCC responses elsewhere in this document.

HCSCC remains of the view that *at a minimum* HCSCC should be funded at the same rate per head of population as the WA HCE. Based on the 2008-09 WA HCE budget figure of 92 cents per person, this would result in an increase of $ 115,190 (9%) to HCSCC's 2011-12 funding.

This would enable HCSCC to start to develop systematic programs for

- outreach, in particular to targeted special needs groups: Aboriginal people; people with a disability; CALD populations; rural and remote residents
- capacity building and training
- HCSCC Charter promotion.

It would not enable HCSCC to replace the complaints management IT system.

20. Ineffective Use of funding Base

There are inefficiencies and avoidable costs currently incurred by HCSCC within the current funding base which could be re-directed to achieving key obligations under the Act. This is evidenced by:

- high level of administrative effort which could be re-directed
- labour intensive systems and processes
- high cost associated with poor IT system
- re-direction of effort by complaints resolution officers to other core functions (ie capacity building, training, education) in line with requirements under job and person specifications.

Please refer to the HCSCC response at above. HCSCC has explored the Resolve database used by the majority of statutory complaints agencies in Australia. The capital, establishment and operating costs are unaffordable for HCSCC.[19]

Resolve was implemented in several statutory agencies [20] within the SA Attorney General's Department (AGD) four years after an initial feasibility assessment, with capital costs and full time business management provided centrally by the AGD.

SYSTEMS AND PROCESSES

The following findings relate to the systems and processes associated with the operations of HCSCC:

21. Poor Data Quality

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. This was evidenced by:

- data not recorded within the complaints IT system and identified late during the course of this review

[19] Existing HCSCC complaints management IT system ProActive costs: 2005-06 establishment costs $ 54 887 and upgrades to improve reporting 2007-2009 $ 69 396, plus annual costs: software licences $ 1491 and server $ 13 600. Resolve 'lite' costs: establishment $ 80 630 and recurrent $ 20 159 (excluding GST) N.B. does not include data migration from ProActive to Resolve 'lite' or service costs (no local support and $ 1500-2500 per day).
[20] Including the State Ombudsman; the Equal Opportunity Commission; the WorkCover Ombudsman and the Police Complaints Authority.

- incorrect reporting of complaints management activities.

22. Inadequate HCSCC Data Capture Process

Current data capture processes are inadequate, evidenced by approximately 1800 enquiries\complaints not recorded within the HCSCC complaints IT system in accordance with the documented processes.

23. Inadequate HCSCC Complaints IT System

The current complaints IT system is inadequate, outdated and ineffective, resulting in significant wasted administrative time and effort.

Findings 21. - 23. inclusive

These shortcomings are due to a combination of:
i. inadequate complaints management IT system, ProActive, despite significant staff and financial investment
ii. disengagement of staff with reporting due to i.
iii. reliance on time consuming manual recording of information on various template documents[21] that can not be aggregated.

The findings are equally applicable to the service providers within HCSCC's jurisdiction, including SA Health and DFC.

24. Operational Communication Mechanisms

Whilst regular communication with the Commissioner occurs, there is a lack of formal and effective communication mechanisms at an operational level.

A variety of factors have constrained the ability of the HCSCC Manager, Complaint Resolution Service and the HCSCC Complaint Resolution Officers to establish formal communication with key stakeholders.

These include:

i. Manager, Complaint Resolution Service (CRS) priority being placed on coaching less experienced staff in complaint resolution and supporting the enquiry service coordinator
ii. Manager, CRS complex complaint caseload
iii. discontinuity among service provider staff with responsibility for managing clinical governance, including complaint resolution
iv. service provider resistance and obstruction of direct relationships between Manager, CRS and key service provider staff
v. key stakeholder expressed preference for communication with the Commissioner.

During 2010 HCSCC initiated a revised and agreed standard approach to complaints management with SA Health regional services, DFC and a number of other major service providers. This approach facilitates communication between the Manager, CRS and service provider counterparts.

Within Country Health SA (CHSA) effective communication at the operational level has been assisted by HCSCC Safer Conversations training, conducted by the Manager, CRS and a Complaint Resolution Officer, with 64 CHSA Directors of Nursing, or equivalent, with responsibility for complaints handling in 2008 and 2009. While other service providers have expressed interest in

[21] Staff manually maintain, and management reviews on a quarterly basis, the following registers: Aboriginal complaints; HCSCC - AHPRA (notifications, referrals, consultations, progress and outcomes both ways); Part 5 Conciliations; Part 6 Investigations; Case Studies; Service Provider Improvement Monitoring; Unregistered Service Provider Complaints; Complaints Resolution Service Evaluations and SA Ombudsman Reviews.

this training, none have yet confirmed a training program with HCSCC. HCSCC has also been unable to offer this or other training on a consistent basis due to CRS workload.

25. Lack of Success Criteria

There is no defined and agreed list of success criteria to measure and monitor the performance and outcomes of the HCSCC.

This is acknowledged as an underdeveloped area for the majority of statutory complaints agencies, particularly those without an industry or sector levy like HCSCC.

Success criteria to measure and monitor the performance and outcomes of HCE work has been a workshop topic at HCE conferences in 2008, 2009 and 2010.
As yet this work has not resulted in an agreed or consistent approach.

HCSCC started a Service Provider Improvement Register in 2008-2009 as one step towards demonstrating the impact and outcomes of HCSCC complaints resolution beyond individual complaint outcomes.

Lack of success criteria is also a feature of complaints handling among service providers within HCSCC's jurisdiction, including major service providers such as SA Health and DFC.

Outcomes based on HCSCC key performance indicators (KPIs) and complaints resolution service evaluation are reported in HCSCC Annual Reports. Please refer to the 2009-10 Annual Report pages 28, 41 and 42.

26. Lack of formal Staffing Strategy

There is no formal staffing strategy in place to support the delivery of HCSCC core roles and responsibilities, which has led to:

- a high reliance on a small number of individuals
- high staff turnover levels (26% turnover per annum)
- high levels of sick\carers' leave (4% per annum, equivalent to 0.5FTE per annum)
- perceived skills gaps.

27. Lack of Formal Planning

There is no formal approach to developing and implementing:

- a strategic plan to guide the direction of core services
- an annual work programme to drive HCSCC activities and link to financial management.

Findings 26 and 27: Please refer to the response at 15. and 18. above.

28. Relationship with Stakeholders

The relationship between HCSCC and stakeholders at the strategic level was perceived as good. However, the relationship was viewed as less effective at an operational level.

Please refer to the response at 24. above.

Attachment 1. HCSCC submission Economic and Finance Committee SA Parliament October 2010

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

This information was obtained from published 2008-2009 annual reports and additional information provided on request.

State/Territory	Population 2006 Census	AHCC budget 2008\09	Cost per head	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 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
VIC	4,932,422	2,320,146[8]	**0.47**	Includes Health Records Act 2001

[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