Health and Community Services Complaints Commissioner South Australia

ANNUAL REPORT 2013-14

Annual Report 2013-14
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30 September 2014

The Honourable Jack Snelling MP
Minister for Health
Citi Centre Building
11 Hindmarsh Square
ADELAIDE SA 5000

Dear Minister

It is my duty and privilege to submit the annual report of the Health and Community Services Complaints Commissioner for the year ended 30 June 2014, in accordance with the requirements of Section 16(1) of the *Health and Community Services Complaints Act 2004*.

This report provides a summary of the activities and achievements for the 2013-14 financial year.

Yours sincerely

Steve Tully
Health and Community Services Complaints Commissioner

About this Report

This report records HCSCC's achievements in contributing to the improvement of the safety and quality of health and community services in South Australia during 2013-14. The report also includes information about HCSCC's statutory obligations and financial position for the year.

The report is a key accountability document and the principle way in which the Health and Community Services Complaints Commissioner reports on HCSCC activities to the Parliament and the South Australian community.

Case studies

The case studies have been included to demonstrate HCSCC services. The details of some case studies have been changed and all case studies have been de-identified to protect the privacy of HCSCC complainants and their service providers.

Making HCSCC accessible

HCSCC is committed to being accessible to South Australians who need assistance with communication and to people from culturally and linguistically diverse backgrounds. HCSCC utilises a variety of support services to enable effective communication with people and is currently developing a new website with enhanced accessibility features.

If you need assistance to access this annual report, please contact our Enquiry Service on 8226 8666 or toll free 1800 232 007 (from a Country SA landline) and HCSCC will arrange the appropriate assistance to share this report with you.

If you are deaf, or have a hearing impairment or speech impairment, contact us through the National Relay Service:

- TTY users phone 133 677 then ask for (08) 8226 8666
- Speak and Listen (speech-to-speech relay) users phone 1300 555 727 then ask for (08) 8226 8666
- Internet relay users connect to the National Relay Service (www.relayservice.com.au for details) then ask for (08) 8226 8666

Feedback

HCSCC welcomes your feedback on this annual report. Please contact HCSCC Enquiry Service on 8226 8666 or toll free 1800 232 007 (from a Country SA landline), fax 8226 8620, email info@hcscc.sa.gov.au or complete the online contact form at www.hcscc.sa.gov.au.

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1. Snapshot of the HCSCC

Our Challenge

To optimise our efforts in responding to complaints across HCSCC's broad jurisdiction with particular effort to support and encourage those who would otherwise be unlikely to complain.

Our Vision

A complaint is an opportunity to:

- get information about what happened
- redress individual grievance and harm
- uphold the HCSCC Charter of Health and Community Services Rights
- ensure action to improve services and systems.

Our Values

HCSCC is guided by the following values:

- independence and impartiality
- integrity and professionalism
- accessibility
- a rights based and public interest focus to HCSCC work
- excellence in customer service
- responsiveness to criticism about HCSCC performance.

Our History

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

HCSCC provides free information and assistance to resolve complaints about public, private and non-government health and community services, including disability and child protection services. HCSCC encourages direct resolution with the service provider first. HCSCC may assist when direct resolution with the service provider would be unreasonable or has not succeeded.

Our Functions

Section 3 of the Act requires HCSCC:

(a) to improve the quality and safety of health and community services in South Australia through the provision of a fair and independent means for the assessment, conciliation, investigation and resolution of complaints

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

(c) to promote the development and application of principles and practices of the highest standard in the handling of complaints concerning health or community services

(d) to provide a scheme which can be used to monitor trends in complaints concerning health or community services

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

HCSCC also:

- promotes and upholds the statutory HCSCC Charter of Health and Community Services Rights
- investigates serious complaints about issues of public interest or safety
- conducts outreach with people who have special needs and their advocates
- provides training to improve the capacity to raise and resolve complaints locally
- promotes and upholds the statutory HCSCC Code of Conduct for Unregistered Health Practitioners.

2. History

Some of the key milestones in HCSCC's history are listed below.

August 2014

Entered into a contract to develop a new complaints database to improve HCSCC reporting on complaints. Expected to 'go live' in July 2015.

May 2014

Commenced Phase 2 of the Supported Decision Making Project.

April 2014

Commenced follow up on Coroner's recommendations.

December 2013

Established a partnership with Poche (Flinders University of South Australia) to develop an audit tool to assess racism in public health services.

November 2013

Issued the first public order under the Code of Conduct for Unregistered Health Practitioners.

August 2013

Commenced the two year Supported Decision Making Project.

August 2013

Signed a Memorandum of Understanding with the National Disability Insurance Agency.

August 2013

Reviewed the Memorandum of Understanding with the Aged Care Complaints and Investigation Scheme.

June 2013

Steve Tully appointed as Health and Community Services Complaints Commissioner for a term of seven years.

March 2013

The Code of Conduct for Unregistered Health Practitioners came into effect.

March 2013

HCSCC published public reports on individual service providers and issues of public interest.

February 2013

Since opening in October 2005, HCSCC has received 10,000 complaints.

October 2012

HCSCC published an academic paper and undertook other project work focussed on safeguarding of vulnerable people who have a disability.

July 2012

HCSCC undertook Aboriginal and Torres Strait Islander project work aimed at addressing racism and service coordination in country and remote areas.

June 2012

Action commenced with regard to the implementation of section 76 of the Act - Returns by prescribed providers and the development of a Code of Conduct for Unregistered Health Practitioners.

March 2012

Leena Sudano completed her contract as the first Health and Community Services Complaints Commissioner.

October 2011

HCSCC was awarded the *2011 South Australian Regional Award Runner Up for Project of the Year* at the IAP2 Australasian Core Values Awards. This recognised HCSCC's effort in involving public participation in the development of the HCSCC Charter of Health and Community Services Rights.

June 2011

The HCSCC Charter of Health and Community Services Rights officially came into effect.

May 2011

Statutory review recommendations that required changes to the *Health and Community Services Complaints Act 2004* came into effect in the *Health and Community Services (Miscellaneous) Amendment Act 2011*.

December 2010

Established the statutory Health and Community Services Advisory Council.

September 2010

The HCSCC Charter Consultation Report, including the proposed HCSCC Charter of Health and Community Services Rights was provided to the Minister for Health.

August 2010

HCSCC established a protocol with the Aged Care Complaints Investigation Scheme (ACCIS) about a new complaints scheme for Commonwealth funded aged care services.

July 2010

The *Health Practitioner Regulation National Law 2009* came into effect creating a single national registration and accreditation scheme for health practitioners. This created a co-regulatory role for AHPRA and HCSCC.

July 2010

Undertook public consultation on the draft *HCSCC Charter of Health and Community Services Rights*. HCSCC received a total of 148 written submissions from a range of individuals, groups and organisations.

June 2010

Secured once-off funding from SA Health to undertake a collaborative pilot project with the Council on the Ageing SA (COTA SA) and Health Consumers Alliance SA (HCA) to promote advance care planning and directives in the community.

January 2010

Enabled a Complaint Resolution Officer to work half time on progressing the recommendations of the *Ever Felt Like Complaining*? *Aboriginal and/or Torres Strait Islander Outreach project*.

December 2009

Publicly released the *Ever Felt Like Complaining*? *Aboriginal and/or Torres Strait Islander Outreach Project Report.*

December 2009

Amendments were made to the *Health and Community Services Complaints Act 2004* including enabling HCSCC to accept complaints directly from a child about a health or community service.

March 2009

Minister for Health tabled report on *Independent Statutory Review of the Health and Community Services Complaints Ac*t.

March 2009

Commenced the *Ever Felt Like Complaining*? *Aboriginal and/or Torres Strait Islander Outreach project* - to hear directly from Aboriginal and/or Torres Strait Islander people about their experiences of health and community services.

October 2008

Expanded the HCSCC Enquiry Service to two full-time Information and Assessment Officers.

July 2008

HCSCC established a Recommendations Register to monitor and report on service provider action and improvements in response to HCSCC recommendations.

June 2008

Initiated presentations to groups of community service users with special needs.

May 2008

The Minister for Health commissioned a review of the *Health and Community Services Complaints Act 2004*, as required by section 88 of the Act.

March 2008

HCSCC provided an initial submission to the SA Parliament -Social Development Committee Inquiry into Bogus, Unregistered and Deregistered Health Practitioners.

July 2007

Safer Conversations pilot project was initiated by HCSCC to provide training for nurses and midwives to improve communication in difficult clinical situations.

July 2006

Amendments were made to the *Health and Community Services Complaints Act 2004* to include child protection services in the definition of a 'community service', therefore broadening HCSCC's jurisdiction.

October 2005

HCSCC opened its doors. Leena Sudano appointed as inaugural Health and Community Services Complaints Commissioner.

3. Commissioner's Overview

Introduction

The Office again dealt with over 2,100 contacts of which 1,927 were complaints with a reduced dedicated complaints resolution workforce. A refreshed website proved its worth with a sizeable reduction in enquiries that were outside of the Office's jurisdiction. Other website visitors also commented to me about the usefulness and ease of access to information that provided them with the necessary means to take action to directly resolve their complaints and issues.

My view is that accordingly, the profile of complaints for the year shifted in their degree of complexity. This view can be given further weight by the greater involvement of expert opinions in the resolution process.

Staff experienced significant events within their own families and their dedication to their roles in such circumstances deserves special acknowledgement.

The Office ended the year with slightly more open complaints than it started with and the reasons relate to complexity and staff needing to attend to pressing family circumstances. The numbers of open complaints are manageable and the time devoted to their consideration will not be reduced.

Consumer Involvement

Complaint management by its nature considers matters after an event has occurred and complainants have continued to seek explanations and to ensure that the same issues do not happen to another person. The benefit of hindsight is always valuable but cannot undo an adverse experience or always take into full account the service environment at that time.

Time and money are inextricably linked; both can only be spent once and a continual observation is that more time, if invested prior to the event occurring, or indeed immediately after the event occurred, would produce a net saving in complaint handling time well after the event.

Admittedly, HCSCC only sees a relatively small number of complaints given the significant activity that occurs in the health and community services areas and it is not appropriate to draw unequivocal conclusions on opportunities to redirect efforts more generally.

HCSCC is, however, pleased to recognise that in health and community services, considerable effort is being devoted by providers to person centred care. In health this is being driven by National Standards; in Disability, by the National Disability Insurance Agency program; and in Child Protection, by top down policy on supporting families to avoid their child/ren being removed. All areas are redirecting effort and resources to greater and more effective consumer involvement.

Available Resources

I have stated many times elsewhere that HCSCC is bound by law to consider a service provider's available resources when assessing a complaint. My recent interpretations of this clause have been more robust than before in terms of considering the cost as a whole, and to include in that consideration, the future cost that could be avoided by immediate investment.

Examples of this more robust view are firstly the cost of maintaining people living with a disability in a hospital setting because community packages are not available. The costs related to an individual are generally far more expensive in a hospital setting. I thank the Disabilities and Health Ministers for resolving the situation for around 30 people in this circumstance. Secondly, HCSCC recognises the social determinants of health and wellbeing and believes that no matter the resource level available, the services should be balanced between prevention and treatment.

In last year's Annual Report, I raised the emerging issue of realistic expectations that impact on both service providers and service users. During the year, it became clear that there was an inevitability about reduced funding for health and that this would require a fundamental review of service capacity. Whilst the process of how the review will take place is being determined, any work by HCSCC will be suspended.

A common perspective is that in SA (and perhaps other parts of Australia) that the health system is unbalanced toward treatment and as a consequence the unavoidable cost in the future may be greater than investing in prevention now. HCSCC will publish a paper prior to December 2014 that it has commissioned which will contribute to considering the issues around an unbalanced health program.

Professional Relationships

HCSCC has again benefited from robust professional relationships with its Advisory Council and other statutory authorities including the Public Advocate, the Principal Community Visitor, public and private health and community service providers, peak bodies such as Carers SA, South Australian Council of Social Service, Council on the Ageing, Health Consumers Alliance and volunteer advocacy groups such as Health Rights and CASA.

Whilst there are many other groups in the safety and quality network that should also be mentioned, the above individuals and groups are indicative of important points of reference, vital to the Office's work when considering complaints.

The Coroner's office

During the year, HCSCC worked with the Coroner's office to ensure as far as practicable that the areas of interface worked smoothly. HCSCC is required to suspend any investigation that is the subject of a coronial inquest and always values the work of the Coroner, particularly in relation to the identification of system improvement issues for health and community services. Whilst the Coroner makes recommendations, the Coroner does not have the capacity to follow up progress on identified matters. HCSCC will now follow up on all recent relevant matters to ensure progress is being made.

The Crown Solicitor's office

HCSCC regularly seeks legal advice with particular recent reference to provisions relating to unregistered health practitioners and the issuing of interim orders prohibiting or limiting the practice of health practitioners who are not registered under national law. Interim orders are not able to be made public (until the investigation is complete and I determine it is necessary) and this can cause some complainants and other interested parties some concern.

The requirement for high level legal advice was recognised during the year and in the new funding arrangements for the Crown Solicitor's office, HCSCC was resourced accordingly. HCSCC values the assistance it receives from the Crown Solicitor's office.

Resources

HCSCC again worked within its financial imperatives and is fortunate to have staff who are experienced, relatively long serving and dedicated to assist it meet its budget obligations.

I thank staff for their efforts and I again thank complainants for their genuine approach to gain an insight into circumstances and consider that many should feel that they have achieved system improvement as well as individual explanations.

Steve Tully
Health and Community Services Complaints Commissioner

4. Highlights of 2013-14

Our Aims

- to promote and protect the rights of service users
- to improve the safety and quality 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
- to further improve HCSCC complaint resolution processes using service improvement tools
- to help build the capacity and skill of service providers in the direct resolution of complaints
- actively encourage and support the benefits of consumer centred care.

Our Achievements

- responded to a total of 2,114 contacts, of which 1,927 were new complaints
- closed over 83% of complaints within 21 days
- had a presence in various community forums and expos
- developed a working arrangement for relevant matters concerning the National Disability Insurance Scheme (NDIS)
- contributed to major work being undertaken in mental health and the safeguarding of vulnerable people living with disability
- implemented a plan to deliver the savings required by government whilst maintaining services
- launched a refreshed website
- provided an opportunity for all service users and service providers to offer feedback
- continued to strengthen engagement with service users, carers and service providers including the non-government and private sectors
- had a major presence and influence on significant consumer centred care procedures and policies including the Families SA redesign program
- commenced the first stage of the two year Supported Decision Making Project
- developed a set of arrangements in consultation with the Coroner's office to ensure report-back on Coroner's recommendations
- maintained an ongoing positive relationship with the Australian Health Practitioner Regulation Agency (AHPRA) and meeting regulatory obligations in relation to exchanging information with AHPRA.

Continuing Challenges

- maximising HCSCC's contribution to safety and quality of health and community services with reduced resources
- strengthening HCSCC's public reporting about HCSCC work, encouraging people to speak up and encouraging service providers to better handle complaints.

5. Future Directions

For the year 2014-15 HCSCC anticipates directing resources to the following:

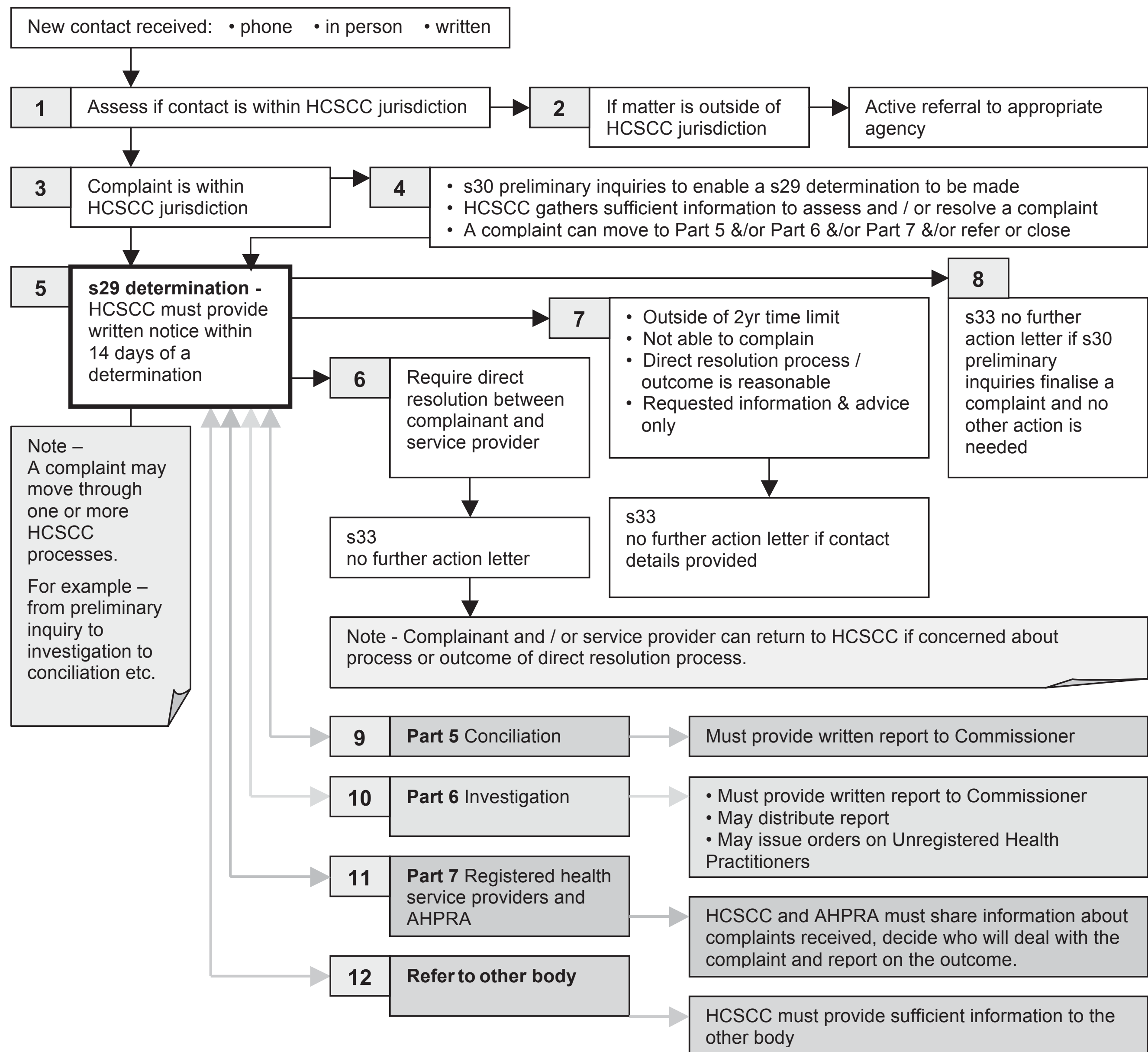
- providing capacity for dealing with around 2000 complaints
- finalising Stage 2 of the Supported Decision Making Project as a major rights based safeguarding strategy for vulnerable people living with a disability
- further refining the use of experts in considering more complex complaints
- increasing the potency of Charter Champions by leveraging service wide effort to increase consumer involvement
- continuing to refine processes relating to interim and public orders under the Code of Conduct for Unregistered Health Practitioners
- preparing for the introduction of a customised complaint database in July 2015
- monitoring complaint trends in prison health, restraint and seclusion in health settings, child protection and disability services and informing program leaders of those trends
- contributing to national efforts with regard to:
  1) unregistered health practitioners;
  2) safeguarding for people living with a disability; and
  3) the Australian Health Practitioner Regulation Agency
- follow up on all recommendations made by the Coroner in respect to health and community services
- promoting awareness of the Code of Conduct for Unregistered Health Practitioners, specifically to aged care services employers.

6. Complaint Resolution Service

The actions of the South Australian Health and Community Services Complaints Commissioner (HCSCC) are governed by the provisions of the *Health and Community Services Complaints Act 2004* (the Act).

In compliance with the Act, the flowchart below provides a pictorial overview of HCSCC's complaint resolution process. The following explanatory notes supplement the details of the flowchart.

Flowchart: HCSCC Complaint Resolution Process



Note:

- **Split complaints** – HCSCC can split a complaint. For example, deal with one aspect in an investigation and refer another aspect to AHPRA.
- **AHPRA** – HCSCC has a legal relationship with AHPRA.
- **Review of HCSCC actions and decisions** – 1. Parties can request reviews by the Commissioner and / or the State Ombudsman. 2. Some Part 6 investigation reports can be reviewed by the District Court.
- **HCSCC recommendations and monitoring of safety and quality improvements** – HCSCC tracks progress and outcomes of recommendations and agreed improvement strategies.
- **Withdrawal of complaints** – HCSCC can decide to investigate a complaint in the public interest if a complaint is withdrawn. Written notice of withdrawal and decision to investigate is required.
- **Annual report** – the *Health and Community Services Complaints Act 2004* requires HCSCC to report on all HCSCC complaints activities.

Flowchart Explanatory Notes – HCSCC complaint resolution process

1	Assess if the contact is within HCSCC jurisdiction (a) Is it about an SA health, community or child protection service? (b) Is the person entitled to complain? (c) Is the person complaining about a ground under the Act?
2	If the contact does not fall within the Act it is assessed as being 'outside jurisdiction'. (a) HCSCC will explain the reasons HCSCC cannot deal with their complaint and make every attempt to refer them to the appropriate place.
3	If the contact does fall within the Act then one or more of the following actions can occur.
4	Section 30 of the Act allows HCSCC to make preliminary inquiries into a complaint in order to gather sufficient information to make a determination about what action to take. Some complaints are only dealt with in this part while others can move to investigation and/or conciliation and/or referral to another agency. HCSCC preliminary inquiries can include requiring service providers to provide written information and responses, attend meetings, review policies etc. Some complaints are closed in this section when the complaint is finalised and no further action is needed.
5	The Act requires HCSCC to make an s29 determination about how a complaint will be dealt with. The following actions can be determined: (a) s33 take no further action - such as in 4. 6. 7. & 8. (b) Pt 5 conciliation and/or - see 9. (c) Pt 6 investigation and/or - see 10. (d) refer to another agency - see 11.
	Sometimes HCSCC will assess a new complaint and decide to take no further action for the following reasons:
6	The Act requires, where it is reasonable, that people first make their complaint to the service provider before asking HCSCC to consider it. HCSCC calls this direct resolution and deals with it in two ways: 1. HCSCC will provide the complainant with detailed information about how to complain and will provide accurate information about who to complain to in the service. • Both the complainant and the service provider are able to return to HCSCC at any time. 2. HCSCC will facilitate direct resolution by sending a copy of the complaint to the service provider asking them to respond to the complainant and provide a copy of their response to HCSCC. HCSCC will review the service provider's response and assess if further action is needed. • Both the complainant and the service provider are able to return to HCSCC at any time.
7	HCSCC will not take action on a new complaint when: 1. The complaint is over two years old and the Commissioner assesses there would be no benefit in taking action. 2. The complainant provides HCSCC with information about the outcome of direct resolution with the service provider and HCSCC assesses that the response is reasonable and that there would be no benefit in taking action. 3. The complainant is not entitled to complain under the Act - e.g. they were not the service user and/or do not have the service user's authority to represent them.
8	Section 30 preliminary inquiries reveal information which allows a complaint to be finalised with no further action needed - see 4.
9	HCSCC can invite the complainant and service provider to conciliate a matter. This is a voluntary process and the issues addressed and decisions reached are private between the parties.
10	HCSCC can investigate matters arising from an individual complaint and/or systemic matters that are identified and/or as a Commissioner's own motion. Investigations can include requiring service providers to provide written information and responses, attend meetings, review policies, HCSCC seeking expert opinion etc. HCSCC can impose conditions or orders relating to Code of Conduct for Unregistered Health Practitioners.
11	HCSCC has a legal relationship with the Australian Health Practitioner Regulation Agency (AHPRA) in relation to individual registered health practitioners such as doctors, dentists, psychologists etc. HCSCC and AHPRA must decide which agency will deal with the complaint and share information about relevant complaints received and the outcome of those complaints.
12	Where appropriate, HCSCC can refer a complaint to relevant agencies such as the federal Aged Care Complaints Scheme, State Ombudsman etc.

6.1 Assessment (section 29 of the Act)

During 2013-14, HCSCC made a total of 1,896 determinations under section 29 of the Act. A summary of the determinations are listed below:

s29 Determinations	
s29 (2) (b) investigate the complaints under Part 6	31
s29 (2) (c) deal with the complaint under Part 7	72
s29 (2) (d) refer the complaint to another person or body	23
s29 (2) (e) determine to take no further action on the complaint	1062
s29 (3) (b) referred to Aged Care Complaints Scheme (ACCS)	1
s29 (5) direct resolution required	707
s3 (b) referred to another authority	0
Total	**1896**

Case study - Assessment outside of HCSCC's jurisdiction

Helen contacted HCSCC complaining about the actions of a lawyer. HCSCC explained that this was not within HCSCC jurisdiction. HCSCC provided her with detailed information about the appropriate agency to contact.

Direct resolution

HCSCC encourages people to resolve their complaint directly with the service provider if this is reasonable. Callers to the Enquiry Service receive tailored information and advice about how to take appropriate steps to try and resolve their complaint with the service in the first instance. Each telephone call is an opportunity to build the capacity and confidence of individuals to deal with their current concerns and any future complaints without the intervention of HCSCC.

People who visit the HCSCC website looking for advice about how to deal with complaints are directed to a HCSCC brochure - Guide for Consumers and other information that outlines step-by-step guidance about how to make a complaint directly to the service.

HCSCC provides further assistance to people who need help to resolve their complaint directly. For example, if it would be unreasonable to expect the person to approach the service, if a person has tried to resolve a complaint directly but this has not worked, or if a complaint is serious enough to warrant HCSCC's consideration in the public interest. In these situations HCSCC can take action immediately, if necessary, and this often results in prompt resolution of matters.

Facilitated direct resolution

In some situations HCSCC is able to facilitate direct resolution of a complaint; for example, when a complainant has identified they have special needs that make it more difficult for them to make a complaint without HCSCC assistance. This usually involves HCSCC forwarding a copy of the complaint to the service provider with a cover letter from HCSCC explaining HCSCC's expectations in relation to the service provider's response. This has proven to be a very effective way of addressing a relatively large number of complaints that do not involve serious safety or quality issues but warrant follow up.

In general HCSCC has found that service providers are receptive to this approach and mostly provide good quality responses to the complainant.

Case study – Facilitated direct resolution

Mr Bracken attended a specialist outpatient appointment with his wife at a public hospital after experiencing "funny turns". Mr and Mrs Bracken thought he may have had a stroke. Mrs Bracken complained that during the appointment with the specialist, firstly, the specialist's young child was in the room causing a disturbance and secondly that the specialist could not find a cause for Mr Bracken's condition and told him "it was all in his head". Unfortunately since the appointment, Mr Bracken passed away and Mrs Bracken decided to make the complaint on his behalf.

HCSCC initially consulted with the Australian Health Practitioner Regulation Agency (AHPRA) about whether HCSCC or AHPRA should deal with the complaint. It was agreed that HCSCC would undertake facilitated direct resolution. This means that HCSCC sends a copy of the complaint to the specialist and asks for a response to be sent directly to Mrs Bracken, with a copy to HCSCC. HCSCC gives service providers guidelines about what is expected when they respond.

The service provider responded with a thoughtful response. He apologised that his young child was at the outpatient clinic, explaining that he had been left unexpectedly without a childminder and opted to hold his clinic regardless rather than cancel it and reschedule appointments, which could have resulted in delays of up to six months. In relation to his medical care, the specialist carefully explained that he had undertaken the appropriate diagnostic tests, could not find evidence of a stroke and was unable to determine the cause of Mr Bracken's symptoms. The specialist recalled that Mr Bracken asked if his symptoms were "all in my head" to which the specialist responded that he did not think Mr Bracken was faking symptoms. He acknowledged that Mr Bracken did not agree with his diagnosis and offered to refer him for a second opinion.

The response provided by the specialist included an apology, explanations, and offered for Mrs Bracken to contact him again with any other queries. HCSCC assessed this as an appropriate and reasonable response to the concerns raised.

Case Study – Outside the two year time limit provided for in the Act

Jack attended HCSCC and spoke with staff about a concern that a dentist had left a portion of a file in his tooth in 1986. He stated it was subsequently removed by a different dentist in 2008. Although this was clearly an issue that remained of concern to Jack, both the initial event and the subsequent treatment were well outside of HCSCC's two year time frame and HCSCC decided to take no action on the complaint.

Case study – Refer to other body

Janet's father attended a day respite service at an aged care facility. On one occasion he was sent home in a taxi looking very unwell and barely able to walk. When he was later examined at a hospital he was found to have fractured his hip. Janet complained that the staff should not have sent him home in a taxi and instead should have called an ambulance.

Whilst HCSCC deals with complaints about individual unregistered health practitioners in Aged Care settings, HCSCC does not deal with complaints about aged care services that involve systemic care. HCSCC referred the complaint to the Aged Care Complaints Scheme.

Case study

Noah lives with mental illness. Sometimes Noah likes to take part in a local support group with others who have mental illnesses.

When Noah went to the group to put his name down for an upcoming outing he was told that he wasn't allowed to come on the next trip. Noah was told that because he had behaved badly on the last trip, the group's organisers had decided he wouldn't be allowed to come the next time. Noah thought it wasn't right that he had to miss out when he had not been given a chance to defend himself. Noah felt there were good reasons for the way he had behaved the last time. Noah told the group's organisers but they told him the group had decided he was not allowed to come.

Noah asked an advocate to make a complaint to HCSCC on his behalf.

HCSCC facilitated a meeting between Noah's advocate and the organisers of the group. In the meeting the group's organisers listened to the advocate tell Noah's story and agreed that they had not provided Noah with the chance to put his case. The organisers agreed that it wasn't a fair process, to stop someone going on an outing before telling them about a problem with their behaviour.

The group organisers agreed to provide Noah with an apology and told the advocate to tell Noah that if he wanted to come back to the group they would like to meet with him to talk about behaviour and what they expect.

Noah wanted the apology in writing and the organisers of the group were happy to write Noah a letter and apologise for not being fair to him.

6.2 Preliminary Inquiries (section 30 of the Act)

30 – Preliminary Inquires

(1) The Commissioner may, in such manner as the Commissioner thinks fit, undertake a preliminary inquiry in connection with making a determination under section 29.

(2) For the purposes of an inquiry, the Commissioner may require a health or community service provider to provide information, or any response or explanation, about any matter relevant to an inquiry.

As can be seen from this quote, section 30 of the Act gives HCSCC the legal authority to require health and community services, or anyone else who may have relevant details or facts, to provide HCSCC with information about the circumstances of a complaint.

The information provided to HCSCC as a result of section 30 inquiries often leads to a better understanding of the complaint issues. With a better understanding of the complaint issues HCSCC is able to work with complainants and service providers to sort out more satisfactory ways of dealing with their complaints.

Seeking clarification under section 30 can also uncover broader, systemic issues of concern that might be badly affecting many people. These concerns may require HCSCC to investigate or recommend immediate action to improve the safety and quality of a service. Then again, section 30 inquiries may open up the facts of a situation in such a way that the concerns that were raised in the complaint dissolve of their own accord.

When inquiries made by HCSCC under section 30 of the Act establish a cause for HCSCC to take further action, HCSCC makes a section 29 decision about what action to take. Under section 29, HCSCC may decide to investigate, conciliate, refer the matter to another authority or close the complaint. A section 29 determination completes the section 30 preliminary inquiry process.

Because the preliminary inquiries section of the Act provides HCSCC with the legal authority to request information, access documentation and facilitate informal mediation between the parties, many complaints to HCSCC are resolved while technically being considered under section 30. This means that the section 29 determination to complete the preliminary inquiries process is often a decision to take no further action and close the complaint because the matter has been resolved.

6.3 Reasons for Closure of Complaints

Within the Act, the Commissioner may determine at any stage to take no further action on a complaint, or to suspend action on a complaint.

During 2013-14, HCSCC made a total of 1,896 determinations to close complaints.

A summary of determinations are listed below:

Reasons for closure of complaints	
Advice and information provided	367
Outside Jurisdiction	7
Part 6 – s54 Report	28
Part 6 – s55 Notice of action to provider	1
Part 6 – s56 Order	2
Part 7 - s58 Referred to registration authority	72
s33 (1) (a) not entitled to make a complaint	14
s33 (1) (b) does not disclose ground of complaint	51
s33 (1) (c) should be determined by legal proceedings	3
s33 (1) (d) proceedings have commenced before a tribunal authority or other	15
s33 (1) (e) reasonable explanation(s) or information provided	109
s33 (1) (g) grounds should have been disclosed earlier;	3
s33 (1) (h) the complainant has failed to comply with a requirement	106
s33 (1) (j) the complaint is abandoned	89
s33 (1) (j) the complaint is resolved	57
s33 (1) (k) reasonable cause - agreement to take reasonable steps to resolve complaint and/ or prevent recurrence	19
s33 (1) (k) reasonable cause - differing versions of events - unable to prefer one over the other	12
s33 (1) (k) reasonable cause – individual complaint raises issues best dealt with as a systemic matter	2
s33 (1) (k) reasonable cause - other	228
s33 (1) (k) reasonable cause - s27 outside of time limit	12
s33 (1) (k) reasonable cause - s29 (2) (d) referral to another agency	13
s33 (1) (k) reasonable cause - s29 (3) referral to ACCS	1
s33 (1) (k) reasonable cause - s29 (5) attempting direct resolution	627
s33 (1) (k) reasonable cause - service provider met reasonable standards	28
s33 (1) (k) reasonable cause - service providers resources are limited and equitably provided	23
s34 (1) complaint withdrawn	7
Total	**1896**

Note: Seven files were accepted as complaints and later determined to be outside jurisdiction.

6.4 Conciliation (Part 5 of the Act)

HCSCC invites parties to conciliation when there is sufficient agreement that issues need to be addressed. It's a voluntary process and there is no statutory obligation for the parties to participate.

Conciliation and section 30 informal mediation under the *Health and Community Services Act 2004* (the Act) provide the complainant the opportunity to discuss their complaint with the service provider. Both processes often conclude with the complainant and the service provider reaching a confidential agreement about how the complaint can be resolved, and how services can be improved and steps taken to prevent similar complaints in the future.

Informal mediation is less formal than conciliation and provides an opportunity for a faster resolution process.

Due to the flexibility of section 30 preliminary inquiries, particularly the scope to use informal mediation, only one complaint went to conciliation for the 2013-14 reporting period. The outcome of this matter is confidential in accordance with section 40 of the Act.

Whilst the numbers of complaints that reach conciliation under Part 5 of the Act are low, HCSCC will continue to promote and offer conciliation as a way of resolving complaints to complainants and service providers where financial compensation is sought due to an adverse event/harm.

Case study – Conciliation

Frank was in hospital with a bowel condition. When nurses gave Frank medication to relieve his pain, they made a mistake. Frank received 12 times the prescribed amount of pain medication. Frank's family noticed that he was unwell and told the nurse on duty. Frank was rushed to Intensive Care because of respiratory failure and seizures. Frank nearly died.

Frank's daughter contacted HCSCC. Frank and his family wanted to know what happened to him and why, and they wanted to know that it would not happen again, to Frank or to anyone else.

HCSCC referred Frank's complaint to the Australian Health Practitioner Regulation Agency (AHPRA) for investigation. AHPRA found that the nurses who had given Frank too much medication had made a serious mistake and they were fined. Because Frank was still unwell, his daughter asked HCSCC to assist Frank with his complaint about the hospital.

Based on the findings of AHPRA, HCSCC decided that the nurses and the hospital had not met the generally accepted standards for providing nursing care and determined under s29 of the Health and Community Services Complaints Act to attempt conciliation of Frank's complaint.

Frank was too unwell to participate in face-to-face negotiations with the service provider about his complaint.

HCSCC conducted shuttle conciliation. Shuttle conciliation means that HCSCC found out from Frank what he wanted to settle his complaint and then HCSCC contacted the hospital and explained what Frank had said. HCSCC then spoke with Frank about the hospital's response to his proposal, shuttling back and forth between the parties to reach agreement.

A confidential settlement was reached and the complaint resolved to the satisfaction of Frank and the service provider.

6.5 Investigations (Part 6 of the Act)

During 2013-14, HCSCC commenced or continued work on a total of 48 investigations under Part 6 of the Act.

Number of investigations	Reasons for investigation	Comments and examples
16	Individual complaints requiring independent expert opinion	Sometimes an individual's complaint is moved into an investigation because Part 6 of the HCSC Act allows HCSCC to obtain expert advice. Most of these complaints relate to medical issues and the expert opinion assists HCSCC to identify whether: - the generally expected standard was met and/or - there are issues to address for the individual and/or - whether there are systemic issues to be addressed. HCSCC has also obtained expert opinions in relation to individual complaints about Families SA and disability services.
30	Systemic issues	Examples of systemic investigations: Public health services: improving management of waiting lists for gastroenterology services Public mental health services: sexual safety of health clients during hospital admissions Public prison health services: adequate credentialling of staff to perform specific treatments All disability services: ensuring the rights of people with a disability are protected Private hospital: ensuring adequate discharge documentation and processes are in place Families SA: improvement of case management processes
2	Own motion	In June 2014 the Commissioner decided to commence investigations into recommendations made by the Coroner that relate to HCSCC jurisdiction.

Case study - Part 6 Investigation

In June 2009, a complaint was made to HCSCC about the misdiagnosis of diabetes. The complainant claimed that many treating health professionals had failed to understand the HbA1c blood test and its limitations when it came to patients with red blood cell conditions. For the complainant this had led to a lack of diabetes treatment and poor health outcomes over a long period of time.

After seeking advice on the matter from an independent expert, in November 2012 HCSCC decided there were two separate issues that needed to be dealt with as separate complaints. The complaint was split into two; HCSCC began an investigation into the identified concerns about the use and reporting of the HbA1c blood test; alongside HCSCC's continued investigation into the issues affecting the complainant as an individual.

In September 2013, the Commissioner released a report on the initial findings of the investigation into HbA1c. HCSCC was seeking feedback, information and advice from the experts in the field. The initial report with recommendations was sent to peak organisations from all over Australia. These organisations represented professionals in diabetes diagnosis, testing, treatment, care and education, as well as those working in the development and maintenance of relevant service standards. All were asked to provide HCSCC with comment on the results of the initial investigation into HbA1c.

After investigating the use and reporting of HbA1c, HCSCC has learnt that HbA1c, like all tests, is subject to variability; nonetheless HbA1c remains a mostly reliable and very important tool in the managing diabetes toolkit. However, patients with shortened red blood cell survival for whatever reason will have lower HbA1c results than the normal population. It is this fundamental finding that underpins the need for widespread change in the way HbA1c is used and reported.

When HCSCC received advice and information from the organisations and specialists in the field, the information was incorporated into a final set of recommendations that it is hoped will encourage change and bring about necessary system-wide improvements.

Recommendations:

The Health and Community Services Complaints Commissioner South Australia recommended that:

1. Peak professional bodies such as the Australian College of Nursing, the Australian Diabetes Society and the Australian Diabetes Educators Association, singly or in partnership, seek support to fund, develop and provide education programs on HbA1c which includes current and accurate information on the part played by HbA1c in the diagnosis and monitoring of diabetes, its fallibilities/limitations and the new unit measures introduced in 2013. There should be general and specific education programs and material developed to ensure that information on HbA1c targets those in general practice caring for diabetic patients; and those patients with co-morbidities that may affect their HbA1c results;

2. Organisations, such as Therapeutic Guidelines Limited, the National Health and Medical Research Council and the relevant Colleges of practice, already producing or endorsing clinical practice guidelines, should be made aware of, and include, information about the limitations of HbA1c in clinical practice guidelines; to allow information about HbA1c to be disseminated widely within existing guidelines;
3. Eligibility for PIP (Performance Incentive Payments) must be improved so that practitioners receiving PIP have the necessary training and are accredited to provide diabetes care;
4. "< 6 = non diabetic" should be generally removed from educational material, reports, information and advice regarding HbA1c scores unless accompanied by a disclaimer that explains when this may not be the case;
5. Revise and update all educational material, reports, information and advice regarding HbA1c scores to include a written subscript related to scores of 6.5% and below, such as or similar to:

Note: Misleadingly low HbA1c levels may occur in: anaemia, B12 & folate deficiency, recent transfusion, haemoglobinopathies, haemolysis, or any chronic disease with reduced red cell survival including chronic liver disease, cirrhosis and renal failure. Severe iron deficiency may result in higher levels;

6. Implement changes to HbA1c pathology request forms so that they include the space for referring practitioners to provide pathologists with a "diabetic history" for the patient being tested.

These recommendations are practical and achievable and it is hoped that their implementation will generally improve the vast and complicated system that makes up diabetes care in Australia.

Since releasing the final report and recommendations in May 2014, HCSCC has been advised of real progress that has already been made by organisations and individuals in diabetes. For example it is intended that the following statement will soon be seen on pathology reports:

> *"HbA1c is not a reliable gauge of glycaemic control in patients with variant haemoglobins or with shortened red blood cell lifespan for any reason".*

Every step towards making these system-wide improvements to HbA1c benefits everyone - those working in the field, those who live with diabetes but most especially those who have diabetes and any other condition that affects their individual HbA1c scores.

Glossary

Diabetes – Diabetes Mellitus is a chronic condition in which the levels of glucose (sugar) in the blood are too high. Blood glucose levels are normally regulated by the hormone insulin, which is made by the pancreas. In people with diabetes, the pancreas doesn't produce enough insulin, or there is a problem with how the body's cells respond to it.

HbA1c – Glycated haemoglobin (haemoglobin A1c, HbA1c, A1C, or Hb1c; HbA1c) is a form of haemoglobin that is measured primarily to identify the average plasma glucose concentration over prolonged periods of time. Normal levels of glucose produce a normal amount of glycated haemoglobin. As the average amount of plasma glucose increases, the fraction of glycated haemoglobin increases in a predictable way. This serves as a marker for average blood glucose levels over the previous months prior to the measurement.

HCSCC Improvements Register

In order to improve the safety and quality of health and community services during a complaint HCSCC may:

- recommend service improvements to a service provider
- note the areas of improvement identified by a service provider in the course of a complaint
- require a service provider to report on the implementation of identified service improvements.

Examples of service improvements on the HCSCC Improvement Monitoring Register for 2013-14 are:

- Public health services - uniform policy to ensure duty of care is provided by health workers to prisoners who are physically restrained in hospitals as required by Correctional Services policies
- Health and disability services – improve options for people with disability who are ready to be discharged from hospital and needing disability services in the community
- Unregistered Health Practitioners – educational letters and meetings to highlight the need for compliance with requirements of the Code of Conduct for Unregistered Health Practitioners
- Private health services – review eligibility criteria to access service
- Disability services - ensure appropriate policies and procedures are in place for contracted unregistered health practitioners
- Public health services – review all patients with inferior vena cava filter (IVC filter)
- Prison health services - uniform stop smoking programs that are transferable across all prisons
- Public health services – review and improve management of waiting lists for gastroenterology services
- System wide – improvements needed in information about management of diabetes and use of HbA1c test
- Unregistered Health Practitioners – remove misleading information from website and other promotional materials
- Community services – improved complaints process for participants by now allowing a fairer, balanced review of complaints
- Prison health services – improved actions to ensure relevant prisoners are referred to mental health specialists for assessment
- Public health services – improved notification processes to patients, detained under the Mental Health Act, regarding the parking of patient vehicles on hospital grounds
- Aboriginal Health Services – review of service and access to service by staff via new policy proving clearer directions.
- Public health services – update policies and procedures for ensuring that applications for continuation of Community Treatment Orders are completed according to required time frames.
- Public health services – ensure that clear information is provided to patients about option for fees to be waived in cases of financial hardship.

Service Evaluation

During 2013-14, service users and service providers involved in complaints were invited to provide feedback on their experiences with HCSCC.

Feedback was received from 9 service users. Whilst service providers did not provide written feedback, their informal responses indicated satisfaction with the HCSCC's handling of complaints.

The tables below summarise the views of service users:

Service Users - Collated Responses

	1 = Strongly Disagree / 5 = Strongly Agree						
Questions	**1**	**2**	**3**	**4**	**5**	**N/A**	**Total**
I found it easy to contact HCSCC				5	4		9
I found HCSCC staff helpful and easy to understand				3	6		9
I thought it took the right amount of time to deal with my complaint		1	2	3	3		9
I felt confident HCSCC would keep my personal information safe			1	3	5		9
I was kept informed and knew what to expect from HCSCC and the complaint process			1	4	3	1	9
I think HCSCC was fair and the final decision about my complaint was based on the information available	1			3	4	1	9

HCSCC will continue to invite feedback and look at a range of ways to ensure that it is aware of how HCSCC services are perceived. HCSCC also notes research that surveys with low response rates are often minimally less accurate than surveys with higher response rates.

6.6 Registered Health Service Providers (Part 7 of the Act)

On 1 July 2010 a national agency, the Australian Health Practitioner Regulation Agency (AHPRA) commenced operation to support the implementation of the National Registration and Accreditation Scheme under a national law, the *Health Practitioner Regulation National Law 2010* (the national law).

Fourteen health professions are now regulated by national boards, supported by AHPRA.

Commencing 1 July 2010, the first 10 nationally registered professions were chiropractic, dental, medical, nursing and midwifery, optometry, osteopathy, pharmacy, physiotherapy, podiatry and psychology. On 1 July 2012, four additional professions were registered and included in the national scheme; occupational therapy, Aboriginal and/or Torres Strait Islander health workers, Chinese medicine and medical radiation practitioners.

The role of AHPRA and the national boards is to protect the health and safety of the public by maintaining professional standards of competence and conduct. Information about AHPRA and the 14 national boards is available at www.ahpra.gov.au.

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

A Memorandum of Understanding (MOU) was developed between AHPRA and, except in NSW, all the state/territory Health Complaints Entities (HCE's).

The MOU represents the agreement between AHPRA and the HCE's to achieve timeliness and consistency about:

1) notifying each other about the receipt of complaints and notifications
2) consulting about the future management of a complaint or notification and
3) sharing information.

The MOU describes the legal obligations of HCSCC and AHPRA to one another and how HCSCC and AHPRA will meet them. The MOU is available at www.hcscc.sa.gov.au

HCSCC and AHPRA meet fortnightly to exchange information and consult about the management of notifications and complaints involving individual nationally registered health practitioners.

The following tables provide information about HCSCC-AHPRA consultations during 2013-14.

HCSCC consultations with AHPRA and referral of complaints to AHPRA by HCSCC

	Number of HCSCC complaint consultations with AHPRA	Number of HCSCC complaints referred to AHPRA	Number of HCSCC complaints split* with AHPRA
Medical	126	48	9
Dental	13	10	0
Nursing & Midwifery	25	2	6
Pharmacy	0	0	0
Chiropractic	7	7	0
Physiotherapy	5	3	0
Optometry	4	1	0
Osteopathy	0	0	0
Psychology	1	0	0
Podiatry	3	1	0
Chinese Medicine	0	0	0
Medical Radiation Practice	1	0	0
Occupational Therapy	1	0	0
Aboriginal and Torres Strait Islander Health Practice	0	0	0
TOTAL	**186**	**72**	**15**

*Part of the complaint involving a registered health practitioner is referred to AHPRA and part of the complaint is dealt with by HCSCC.

AHPRA investigation outcomes resulting from referral of complaints by HCSCC to AHPRA

	Number of outcomes notified by AHPRA of action taken from HCSCC complaint referrals	AHPRA notified outcome*	
Medical	28	21	No further action following assessment
		5	No further action following investigation
		1	Accept undertakings & Caution
		1	Conditions imposed & Caution
Dental	6	6	No further action following assessment
Nursing & Midwifery	2	2	No further action following investigation
Pharmacy	No complaints referred		No complaints referred
Chiropractic	4	4	No further action following investigation
Physiotherapy	2	2	No further action following investigation
Optometry	1	1	No further action following assessment
Osteopathy	No complaints referred		No complaints referred
Psychology	No complaints referred		No complaints referred
Podiatry	0	0	No outcome advised as at 30/06/2014
Chinese Medicine	No complaints referred		No complaints referred
Medical Radiation Practice	No complaints referred		No complaints referred
Occupational Therapy	No complaints referred		No complaints referred
Aboriginal and Torres Strait Islander Health Practice	No complaints referred		No complaints referred
TOTAL	**43**	43	

*Note: 44 ongoing investigations - no outcomes notified by AHPRA as at 30/06/2014

AHPRA consultations with HCSCC and referral of complaints from AHPRA to HCSCC

	Number of AHPRA complaint consultations with HCSCC	Number of AHPRA complaints referred to HCSCC
Medical	150	1
Dental	18	1
Nursing & Midwifery	15	0
Pharmacy	15	0
Chiropractic	9	2
Physiotherapy	2	0
Optometry	0	0
Osteopathy	0	0
Psychology	10	0
Podiatry	3	0
Chinese Medicine	0	0
Medical Radiation Practice	0	0
Occupational Therapy	1	0
Aboriginal and Torres Strait Islander Health Practice	0	0
Unregistered Health Practitioner	1	1
TOTAL	**224**	**5**

AHPRA outcomes and outcome of any AHPRA action taken on AHPRA complaints consulted with HCSCC

	Number of outcomes notified by AHPRA of action taken by AHPRA	AHPRA notified outcome	
Medical	92	70	No further action following assessment
		8	No further action following investigation
		5	Caution following assessment
		7	Caution following investigation
		2	Insufficient particulars
Dental	10	7	No further action following assessment
		2	No further action following investigation
		1	Caution following assessment
Nursing & Midwifery	8	7	No further action following assessment
		1	Caution following assessment
Pharmacy	8	5	No further action following assessment
		1	Conditions imposed following assessment
		1	Caution following assessment
		1	Caution following investigation
Chiropractic	1	1	No further action following assessment
Physiotherapy	1	1	No further action following assessment
Optometry	0	0	Nil consulted
Osteopathy	0	0	Nil consulted
Psychology	9	8	No further action following assessment
		1	No further action following investigation
Podiatry	1	1	No further action following assessment
Chinese Medicine	0	0	Nil consulted
Medical Radiation Practice	0	0	Nil consulted
Occupational Therapy	0	0	No outcome advised as at 30/06/2014
Aboriginal and Torres Strait Islander Health Practice	0	0	Nil consulted
TOTAL	**130**	130	

Outcomes following referral of a complaint or notification are discussed as matters are finalised.
As at 30/06/2014 AHPRA had 6 complaints open from HCSCC referrals to AHPRA in 2012-13
As at 30/06/2014 AHPRA had 3 complaints open from AHPRA complaints consulted with HCSCC in 2012-13

Case study - Registered health service providers and AHPRA

Ahmad had an accident and damaged his arm resulting in a severe laceration. He went to a small metropolitan hospital reporting that he had some loss of feeling in his hand as well as the open wound. The doctor stitched up the wound and recommended he see his GP in 10 days time.

When Ahmad went to his local GP he was told to immediately go to the accident and emergency department of a large public hospital where he was admitted and had surgery that night.

Ahmad was concerned that the first doctor who saw him did not consider that he may have had nerve damage to his hand thereby delaying the surgery that may have reduced or prevented permanent damage.

HCSCC referred Ahmad's complaint about the doctor to AHPRA. AHPRA investigates complaints about allegations of unprofessional conduct of doctors and other registered professionals.

Case study - Splitting a complaint with AHPRA

Jake was aged 71 when he was diagnosed with skin cancer and underwent surgery and radiotherapy to treat it. Several years later, new symptoms emerged and he visited his country GP on several occasions. Jake was eventually diagnosed with leukaemia and received treatment in a major Adelaide public hospital. Sadly, Jake passed away from his illness.

Jake's widow, Helen, approached HCSCC complaining that firstly, she felt the GP did not adequately explore Jake's symptoms and was concerned this may have delayed his diagnosis and treatment of leukaemia. Secondly, Helen was concerned that Jake's treatment at a major Adelaide public hospital may not have been coordinated well as he had several specialists involved in his care.

HCSCC consulted with AHPRA about Jake's GP. AHPRA decided they would investigate the GP involved in Jake's care. HCSCC is looking into the systemic issues about the care Jake received in hospital to identify if the hospital's care coordination was appropriate and if not, how it should be improved to benefit the care of others in similar circumstances.

6.7 Review of HCSCC Actions and Decisions

If people have concerns about the actions or decisions of HCSCC, they are able to:

1. request an internal review by the Commissioner;
2. complain to the State Ombudsman.

The Commissioner is obliged to write to every complainant when a complaint is closed. Information about the complainant's right to seek a review from HCSCC and contact details for the State Ombudsman are included in these letters.

Internal Review

Cases where reviews were requested are captured in the table below.

Review open prior to 1/7/13 and closed during 13-14	Review opened and closed during 13-14	Review opened during 13-14 and still open at 30/6/14
2	9	1

Of the eleven cases that requested an internal review during 2013-14, HCSCC, out of an abundance of caution, decided in three cases to undertake further inquiries. The original decisions of the cases were subsequently confirmed.

In the other eight cases, HCSCC upheld the original HCSCC decision without further inquiries.

Case Study

Josette complained to HCSCC about being declined to be accepted as a new patient at a private medical practice. HCSCC followed up with the practice, which responded that they undertake 'preliminary assessments' to assess whether the practice can meet the needs of potential patients. In this case they did not have a doctor available to meet Josette's particular needs.

HCSCC accepted the service's response and wrote to both parties saying it would close the file.

Josette requested a review of the decision, arguing that the practice's position was unreasonable. HCSCC requested further information from the practice about the reasons they could not take Josette on.

After being provided with a further response, and after the complaint was assessed by someone not involved in the original decision, HCSCC held to the view that the initial decision was correct.

Josette was provided with information about her right to seek a review of HCSCC's actions by the Ombudsman.

Ombudsman review

Section 86 (c) of the Act entitles a person who has made a complaint to HCSCC to request that the State Ombudsman reviews HCSCC decisions and actions in regard to their complaint. At various times during the HCSCC complaint process, HCSCC advises complainants of this right of review.

The Ombudsman does not advise HCSCC in all cases if a complainant has sought a review of an HCSCC decision or action. HCSCC only becomes aware that a review has been sought if the Ombudsman requests information from HCSCC. The Ombudsman requests information from HCSCC in order to decide if he should investigate a complaint more formally.

During 2013-14, the Ombudsman informed HCSCC of seven reviews. One remained open at 30 June 2014.

Open prior to 1/7/13 and closed during 13-14	Opened and closed during 13-14	Opened during 13-14 and still open at 30/6/14
0	6	1

Of the six matters closed in 2013-14, the Ombudsman found that HCSCC had not acted in a manner that was unreasonable, unlawful or wrong in five cases. The Ombudsman chose not to investigate one matter after a response from HCSCC.

Case Study

Bevan complained to HCSCC in 2013 about surgery he had in 2008. HCSCC declined to accept the complaint because it was considered ‘out of time’. The *Health and Community Services Complaints Act 2004* says that, generally, complainants must complain to HCSCC within two years of becoming aware of the circumstances they are complaining about. The Commissioner has the discretion to waive this rule.

HCSCC decided not to accept Bevan’s complaint. Bevan requested that HCSCC review the decision, which HCSCC did before upholding the original decision. Bevan then complained to the State Ombudsman. After requesting information from HCSCC, the Ombudsman found no wrong-doing on HCSCC’s part, noting that he could not direct HCSCC as to use of the discretionary power to waive the two year limit.

6.8 Complaint Resolution Data

The following HCSCC complaint resolution data for 2013-14 fulfils HCSCC's annual statutory reporting requirements. As reported previously, the HCSCC complaints management data system, Proactive, has significant limitations. Much of the following information has been made available due to the dedication and commitment of the HCSCC staff team, some of whom were involved in extensive manual data collection and analysis.

HCSCC complaint handling performance standards include:

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

Of all new complaints received in 2013-14:

- 83.04% were closed within 21 days
- 10.75% were closed within 22-44 days
- 6.21% were open more than 45 days.

No systemic files have been open more than two years.

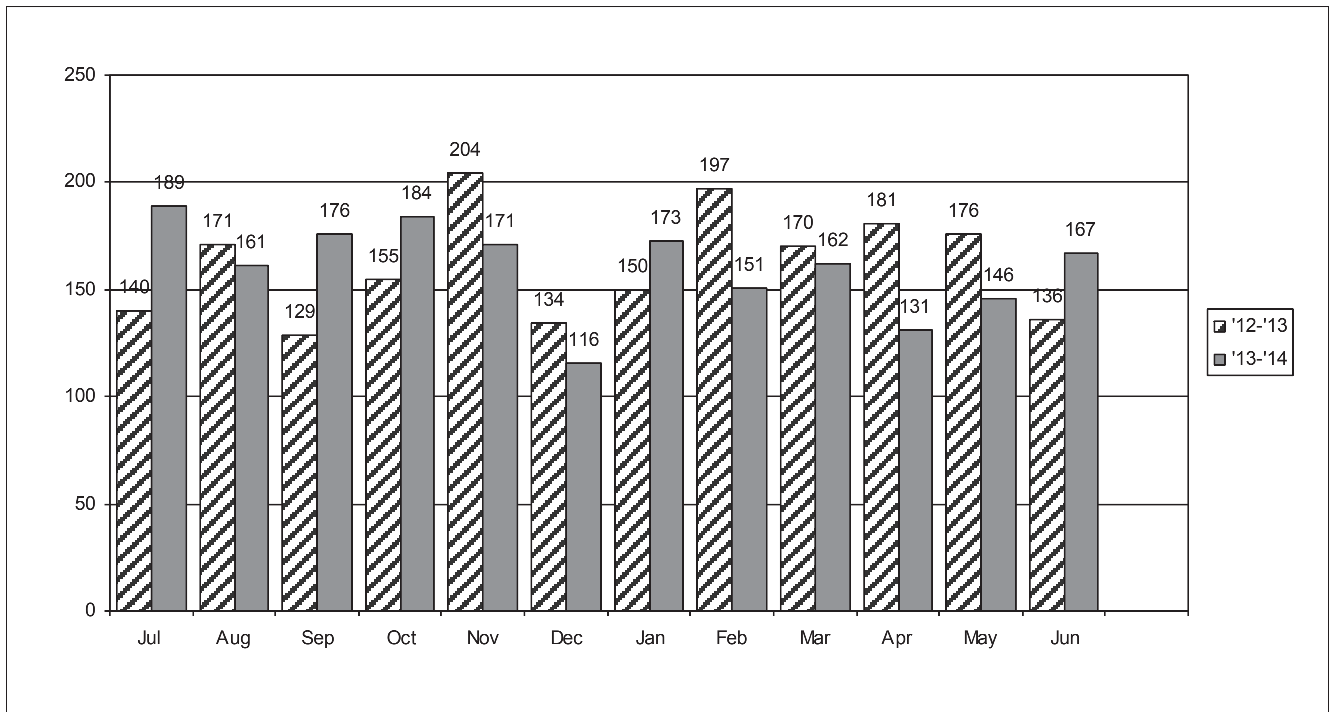
HCSCC was notified of seven HCSCC decisions being reviewed by the State Ombudsman. This equates to 0.36% of the total complaints received by HCSCC.

Number and type of complaint contacts

Service Provider Type	Health	Community Services	Child Protection	2013-14 Total
Public	1041	45	98	1184
Private	672	14	0	686
Non-Government Organisation	12	45	0	57
Out of Jurisdiction Contacts	0	0	0	187
Total	**1725**	**104**	**98**	**2114**

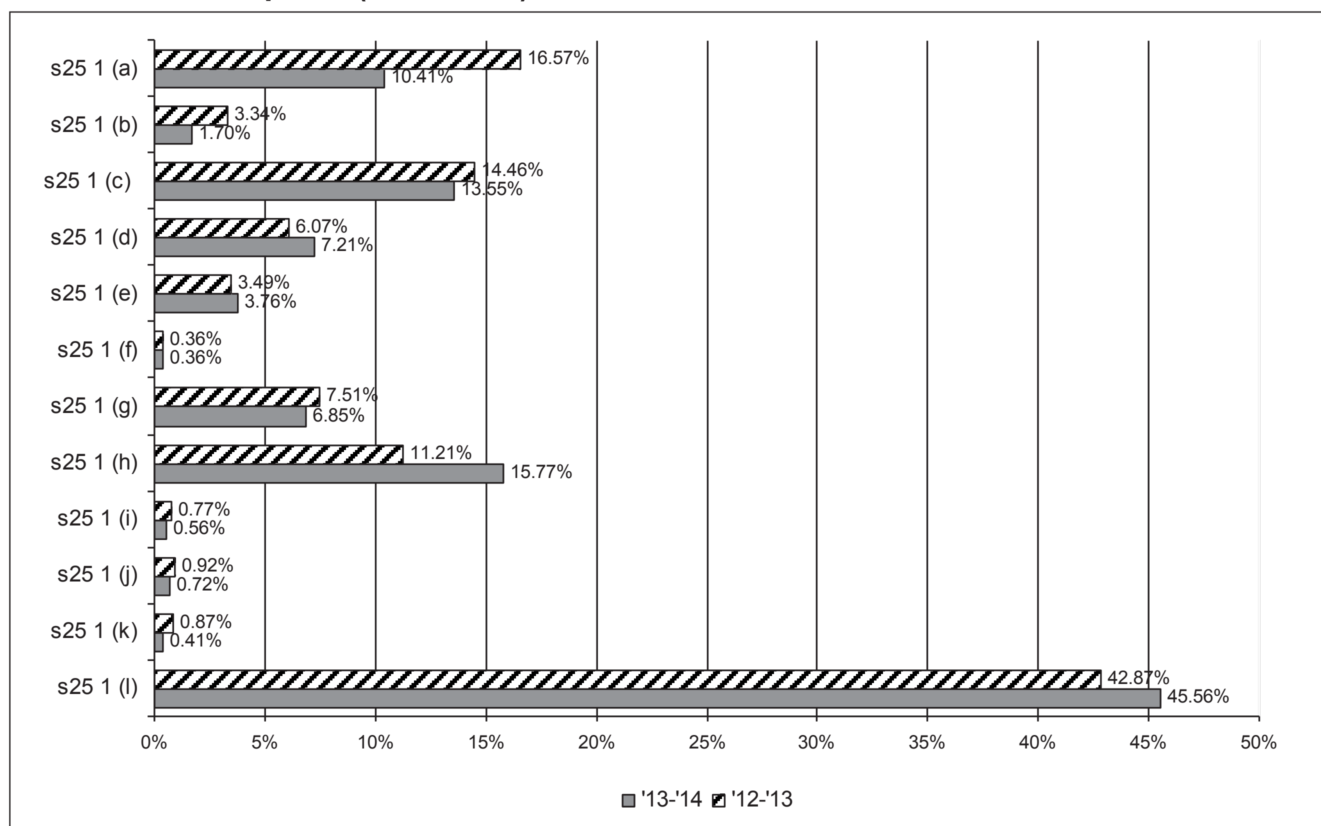
A total of 1725 complaints, equivalent to 89.5% of all new complaints received in 2013-14 related directly to health services.

Complaints opened by month



Average new complaints per month: 162

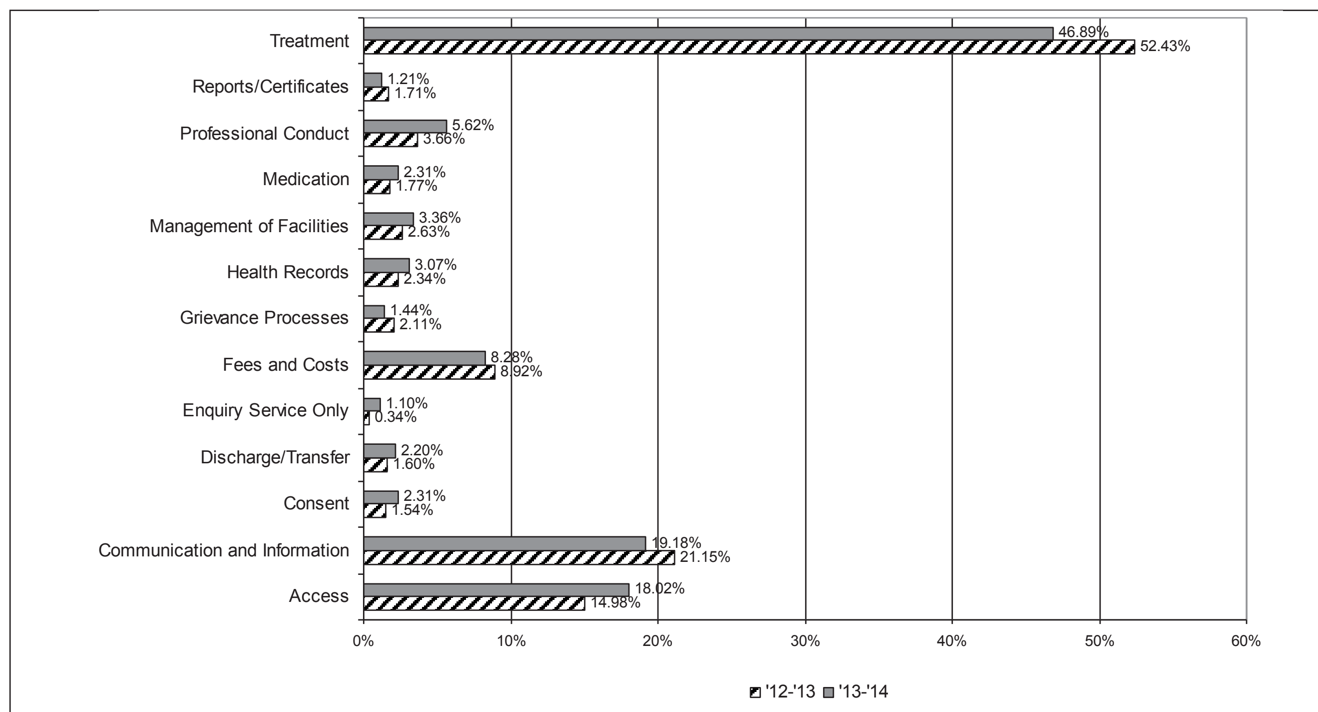
Grounds for complaint (section 25)



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

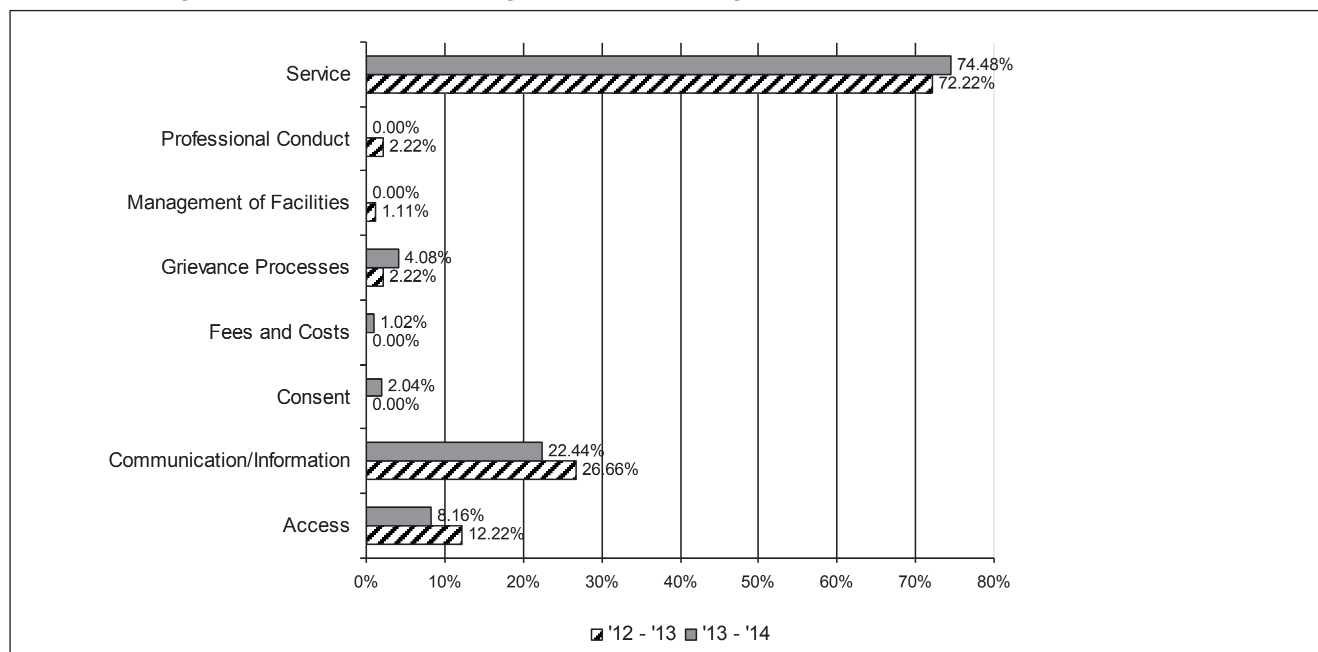
s25 1 (a) service not provided
s25 1 (b) service not necessary or inappropriate
s25 1 (c) unreasonable manner in providing service
s25 1 (d) lacked due skill
s25 1 (e) unprofessional manner
s25 1 (f) failure to respect privacy or dignity of service user
s25 1 (g) quality of information
s25 1 (h) access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

Issues complained about – Health complaints



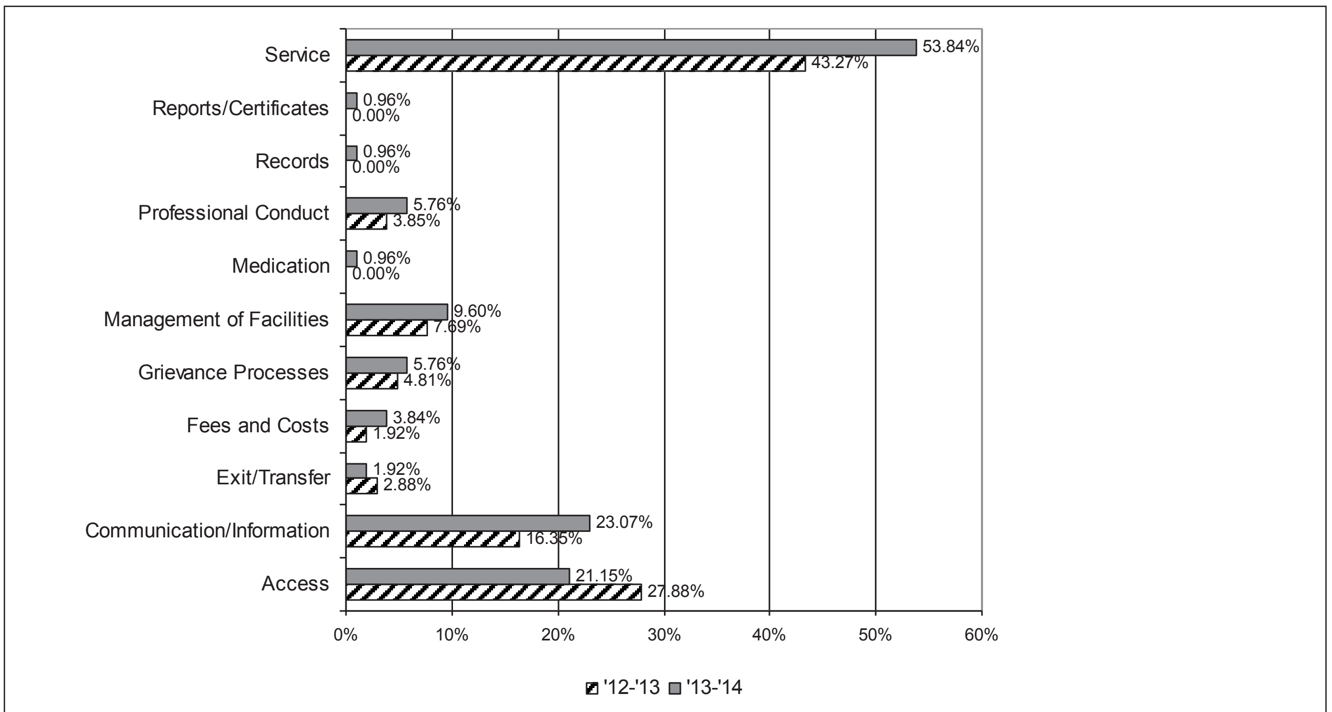
Note: a single complaint may raise more than one issue.

Issues complained about – Child protection complaints



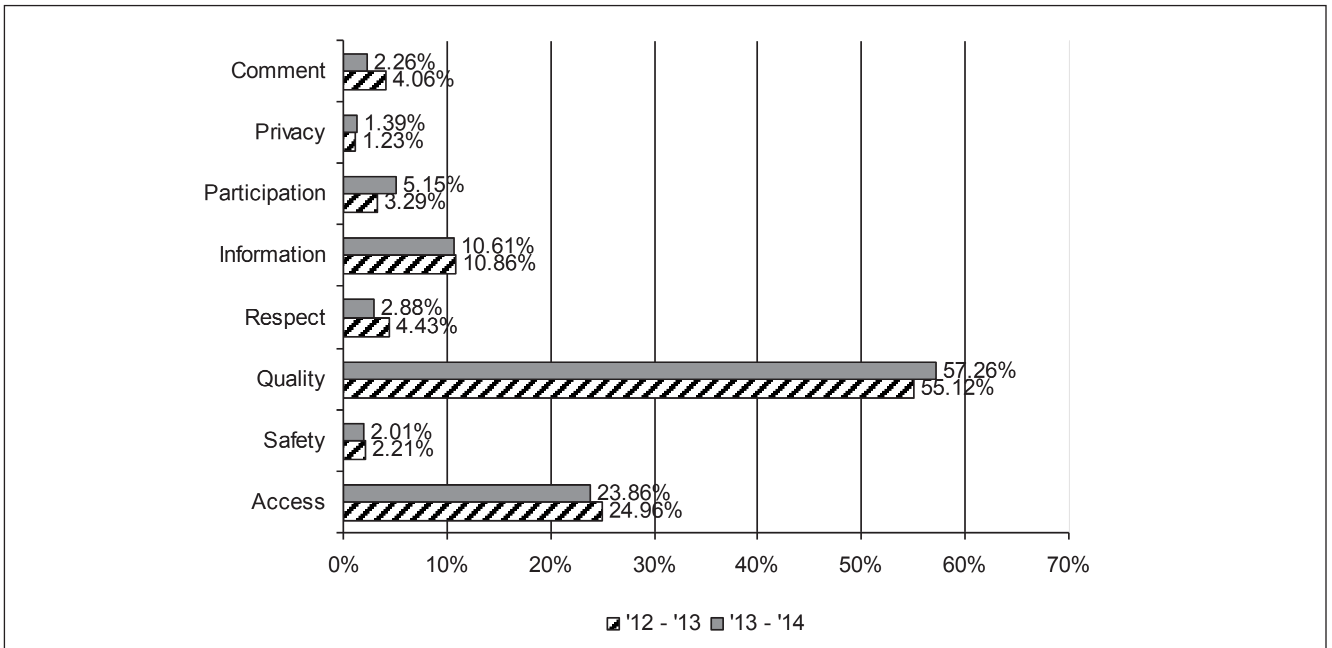
Note: a single complaint may raise more than one issue.

Issues complained about – Community service complaints



Note: a single complaint may raise more than one issue.

Complaints received aligned to the HCSCC Charter of Health & Community Services Rights



Note: a single complaint may relate be about more than one right.

HCSCC Charter of Health and Community Services Rights

The HCSCC Charter came into effect on 23 June 2011.

1. ACCESS - Right to access health and community services. I have a right to access health and community services that meet my identified needs.

2. SAFETY - Right to be safe from abuse. I have a right to be safe from abuse, or the risk of abuse, and to have my legal and human rights respected and upheld. I have a right to receive services free from discrimination and harassment.

3. QUALITY - Right to high quality services. I have a right to receive safe, reliable, coordinated services that are appropriate to my needs and provided with care, skill and competence. Services I receive should comply with legal, professional, ethical and other relevant standards. Any incidents involving me are managed openly to ensure improvements.

4. RESPECT - Right to be treated with respect. I have a right to be treated with courtesy, dignity and respect. I have a right to receive services that respect my culture, beliefs, values and personal characteristics.

5. INFORMATION - Right to be informed. I have a right to open, clear and timely communication about services, treatment, options and costs in a way that I can understand. When needed, I have the right to a competent professional interpreter.

6. PARTICIPATION - Right to actively participate. I have a right to be fully involved in decisions and choices about services planned and received. I have a right to support and advocacy so I can participate. I have a right to seek advice or information from other sources. I have a right to give, withhold or withdraw my consent at any time.

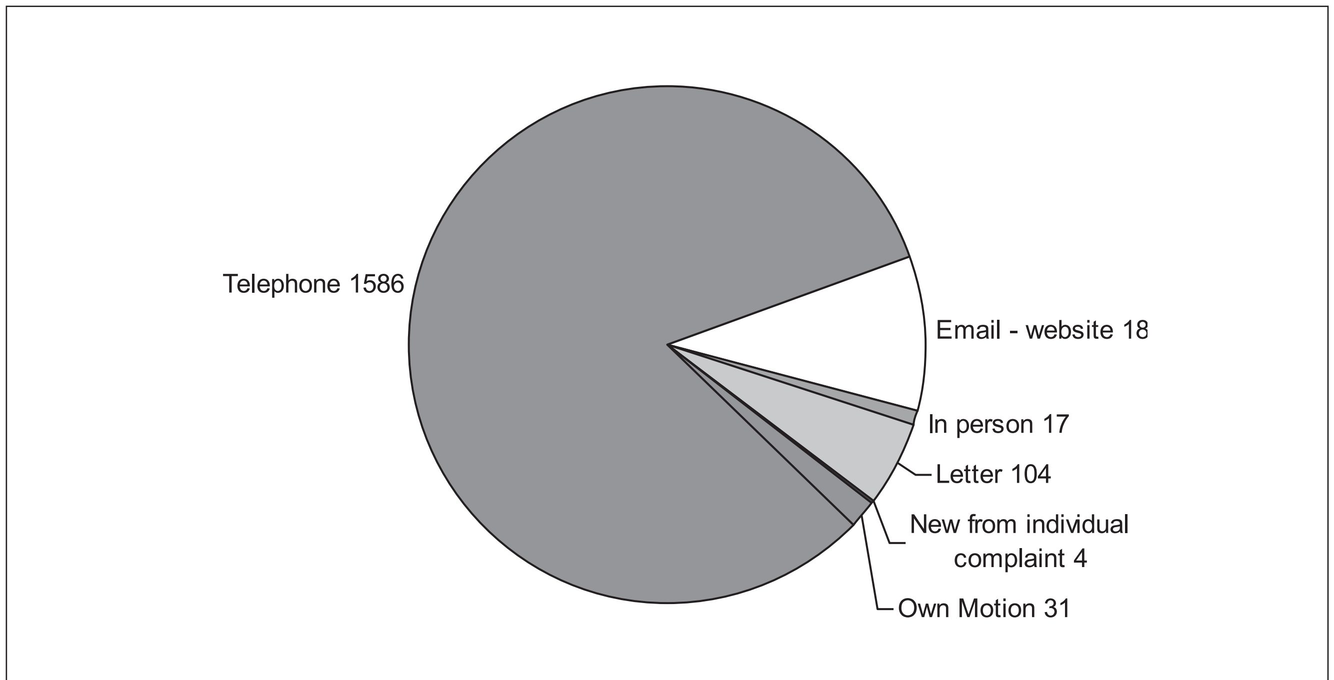
7. PRIVACY - Right to privacy and confidentiality. I have a right to have my privacy respected and my personal information kept confidential and secure. Personal information about me may not be disclosed without my consent, unless the disclosure is required to lessen or prevent a serious threat to life, wellbeing, or safety or is required by law. I have a right to request and gain access to my records, unless there is legal restriction in place. I can nominate person/s with whom information can be shared.

8. COMMENT - Right to comment and/or complain. I have a right to be listened to and to comment on, or make a complaint about services sought or provided to me. I have a right to have my complaint dealt with properly and promptly, and without retribution as a result of having made a complaint. I have a right to a representative of my choice to support and advocate for me when making a complaint. My feedback and complaints are managed openly to ensure improvements.

Over 90% of all complaints align to three of the HCSCC Charter Rights:

- the right to quality (57.26%)
- the right to access (23.86%) and
- the right to information (10.61%).

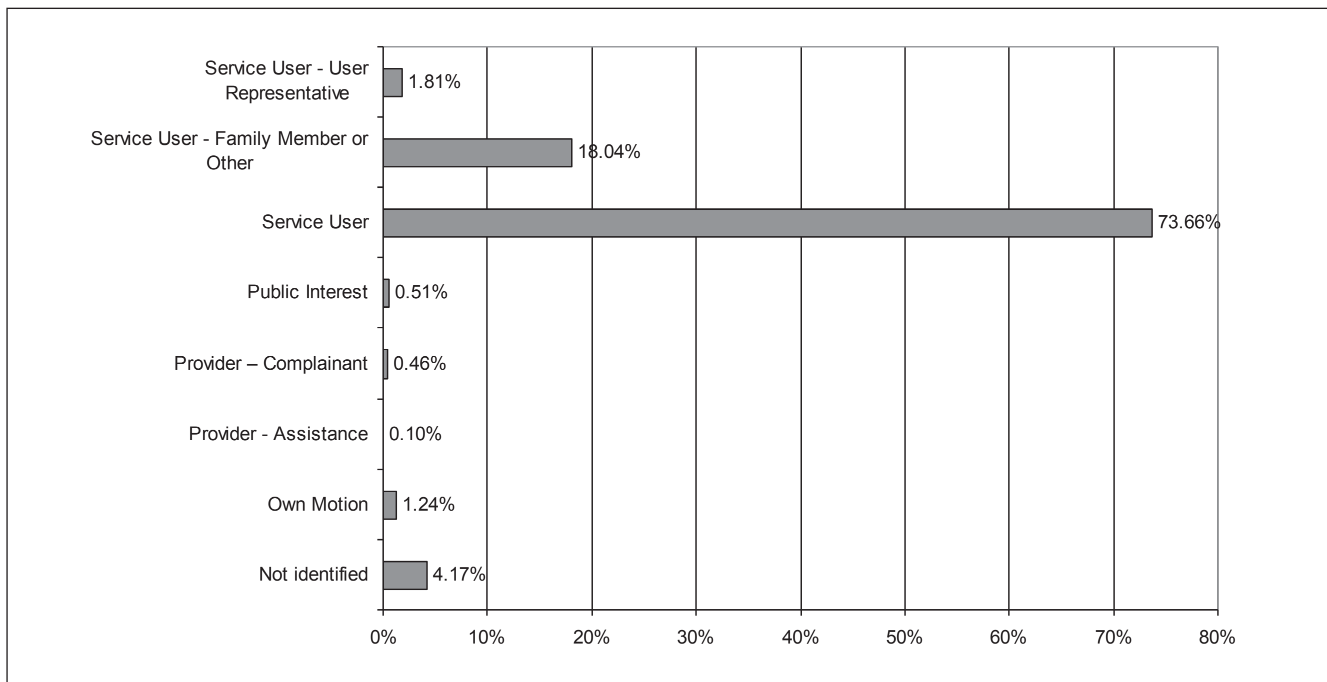
Method of contact with HCSCC



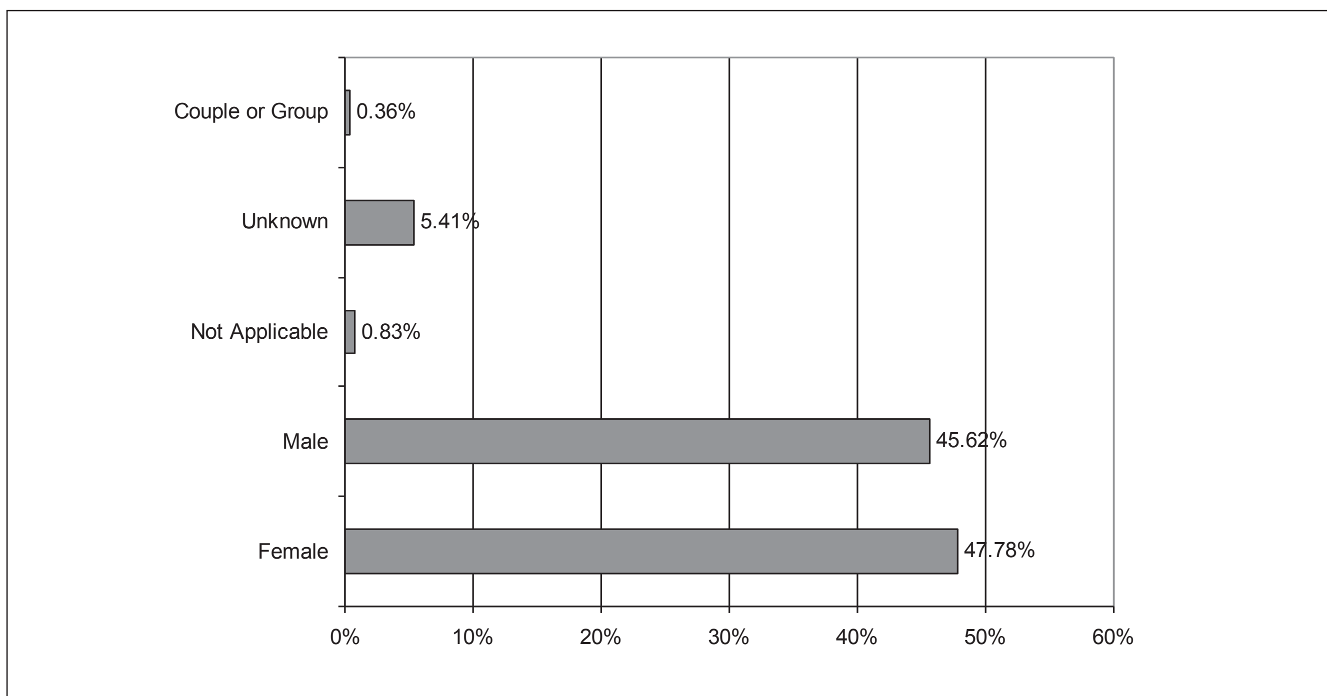
Statistics show that 82% of contacts with HCSCC regarding a complaint are made by telephone. HCSCC acknowledges that for many people telephone contact is often easily accessible and enables the immediate provision of information, advice or action.

Note this figure does not take into account those matters assessed as outside jurisdiction.

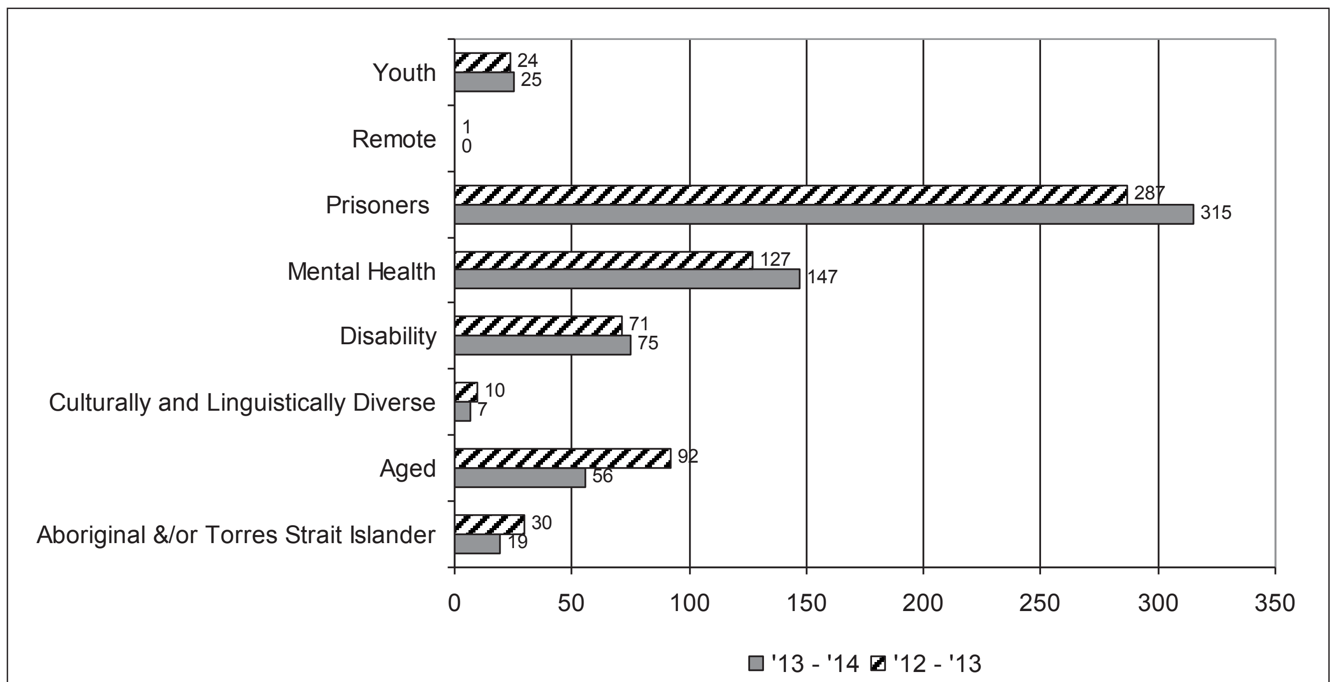
Role of contact person



Gender of contact person



Complaints from people who identify as having special needs



The Act uses the term special needs groups as "particular classes of persons who because of the classes to which they belong, may suffer disadvantage in the provision of services unless their needs are recognised".

Consumers of health services are not always comfortable with the term special needs as some consumer groups advocate that all complainants by definition have special needs.

A total of 644 special needs were identified in complaints received in 2013-14 (note: the service user may have had multiple special needs).

Complaints not finally dealt with

As at 30 June 2014, HCSCC had a total of 110 open complaint files.

As stated previously in the report HCSCC receives 160 complaints on average each month and closes more than 83% complaints within 21 days.

7. Other Functions

In addition to the HCSCC Complaint Resolution Service, the Commissioner also has a statutory obligation to promote and protect the rights of people who use health or community services and to improve the safety and quality of health and community services.

Much of this work is multi-dimensional and often involves a broad range of activities such as education and awareness raising, the development and distribution of resources, liaising with sector/consumer representatives, influencing strategic policy development, provision of specialist training in complaints resolution and undertaking community engagement activities such as outreach projects, to name but a few.

The following information provides a summary of HCSCC's supplementary actions during 2013-14.

7.1 HCSCC Charter of Health and Community Services Rights (Part 3 of the Act)

Given that the HCSCC Charter of Health and Community Services Rights (the HCSCC Charter) came into effect on 23 June 2011, HCSCC's focus continues to be meeting HCSCC's statutory obligations to provide information, education and advice about the HCSCC Charter[1]. This is a critical task in ensuring that the HCSCC Charter becomes an important statutory lever to uphold the rights of people seeking or using health or community services in South Australia.

The Charter Champion network currently has 68 registered Champions who are integral in promoting the Charter of Health and Community Services Rights.

HCSCC Charter Champions represent a broad range of consumer groups, health and community service providers, professional groups, local government, private hospitals, multicultural groups and other peak bodies.

HCSCC will take advantage of the timing of consumer engagement initiatives to promote Charter Champions and will look to double the numbers over the next twelve months.

Charter Champions have a critical role in extending knowledge of the HCSCC Charter. It is important that the valuable Charter Champion network consolidates and grows and information and resources are key in that effort. Further work with Charter Champions will continue in 2014-15.

In addition to promoting the HCSCC Charter, section 85 of the Act requires HCSCC to take the HCSCC Charter into account when managing complaints. The Act requires HCSCC to consider several elements:

- the HCSCC Charter
- the generally accepted standard of service delivery expected of the service provider
- the resources reasonably available to the service provider and
- anything else the Commissioner thinks is relevant.

7.2 Code of Conduct for Unregistered Health Practitioners (Part 6 of the Act, Division 5)

Made under the Health and Community Services Complaints Regulations 2005.

The Code of Conduct for Unregistered Health Practitioners came into effect on 14 March 2013.

Unless exempt by the Regulations all unregistered health practitioners must display this Code of Conduct and the information for clients about how a complaint may be made to the Health and Community Services Complaints Commissioner. If an unregistered health practitioner has relevant qualifications, these qualifications must also be displayed. All of these documents must be displayed in a position and manner that makes them easily visible and accessible to a person entering the relevant premises.

[1]Section 9(1)(d)(i) of the Act

This requirement to display material does not apply to the following premises:

- Premises of any hospital, whether public or private (within the meaning of the *Health Care Act 2008*).
- Premises of any health care service established or licensed under the *Health Care Act 2008*.
- Premises of any day procedure centre.
- Premises of the SA Ambulance Service Incorporated.
- Premises of an approved aged care services provider (within the meaning of the *Aged Care Act 1997* of the Commonwealth).

Schedule 2 − Code of Conduct for Unregistered Health Practitioners

1 − Preliminary

What is an unregistered health practitioner?

An unregistered health practitioner is someone who provides a health service and who doesn't have to be registered with a registration authority in order to provide his or her service. Examples of unregistered health practitioners are: personal support workers, counsellors, social workers, natural therapists etc.

In this schedule an unregistered health practitioner is called a health practitioner.

In this schedule a service user is called a client.

2 − Health practitioners to provide services in a safe and ethical manner

This code requires that health practitioners provide services in a safe and ethical manner. This means that the health practitioner must:

(a) Maintain a reasonable level of competence in his or her field of practice.

(b) Not provide health services that are outside his or her experience or training.

(c) Not use his or her qualifications to mislead or deceive clients about his or her competence to provide a particular treatment.

(d) Only prescribe treatment or devices that serve the needs of the client.

(e) Recognise the limitations of treatments they can provide and, where appropriate, refer clients to other competent health service providers.

(f) Recommend that a client seek additional opinions or services where appropriate.

(g) Assist a client to find other suitable health care professionals where appropriate.

(h) Encourage a client to inform his or her medical practitioner (if any) of treatment received from the health practitioner.

(i) Have a sound understanding of any adverse interaction between the therapies and treatments provided or prescribed and any other medications or treatments the client might be taking or receiving.

(j) Ensure that appropriate first aid is available if needed during a consultation.

(k) Obtain appropriate emergency assistance (such as an ambulance service) in the event of any serious misadventure or outcome during a consultation.

3 − Health practitioners diagnosed with infectious medical condition

Health practitioners who have been diagnosed with an infectious medical condition must:

(1) Ensure that any services provided do not put the client at risk.

(2) Take and follow advice from an appropriate medical practitioner regarding steps to avoid the possibility of transmission to clients.

4 – Health practitioners not to make claims to cure certain serious illnesses

(1) The health practitioner must not claim to be qualified, able or willing to cure cancer or other terminal illnesses.

(2) Health practitioners must not claim the ability to treat, alleviate or cure serious illnesses unless the claim can be substantiated.

5 – Health practitioners to take precautions for infection control

Health practitioners must take appropriate precautions for the control of infection while providing a service.

6 – Appropriate conduct in relation to treatment advice

(1) Health practitioners must not attempt to dissuade a client from seeking or continuing treatment by a registered medical practitioner.

(2) The health practitioner must accept a client's right to make an informed choice in relation to his or her own health care.

(3) Health practitioners should communicate and cooperate with colleagues and other health care practitioners and agencies in the best interests of the client.

(4) Health practitioners who have serious concerns about the treatment provided to a client by another health practitioner must refer the matter to the Health and Community Services Complaints Commissioner.

7 – Health practitioners not to practise under influence of alcohol or drugs

(1) Health practitioners must not provide services while intoxicated by alcohol or any other substance.

(2) The health practitioner on prescribed medication must obtain advice from the prescribing health practitioner on the impact that medication might have on his or her ability to practise and must not treat a client if his or her ability might be impaired.

8 – Health practitioners not to practise with certain physical or mental conditions

A health practitioner must not provide a service while physically or mentally impaired, including if he or she is impaired by addiction to alcohol or a drug, or if his or her impairment may lead to the client being harmed.

9 – Health practitioners not to financially exploit clients

Health practitioners must not:

(1) Accept a financial inducement or gift for referring a client to another health practitioner or supplier of medications or therapeutic goods or devices.

(2) Offer a financial inducement or gift in return for a referral from another health practitioner.

(3) Provide a health service or treatment to a client unless they are designed to maintain or improve the client's health or wellbeing.

10 – Health practitioners required to have clinical basis for treatments

Health practitioners must have a valid clinical basis for treating a client. Health practitioners must not diagnose or treat an illness or condition unless there is an adequate clinical basis to do so.

11 − Health practitioners not to misinform clients

(1) Health practitioners must be truthful about their qualifications, training or professional affiliations if asked by a client.

(2) Health practitioners must not make claims, either directly or in advertising or promotional material, about the efficacy of treatments or services if the claims cannot be substantiated.

12 − Health practitioners not to engage in sexual or improper personal relationship with client

Health practitioners must not engage in sexual or other close personal relationships with clients.

Before engaging in a sexual or other close personal relationship with a former client, a health practitioner must ensure that a suitable period of time has elapsed since the conclusion of his or her therapeutic relationship.

13 − Health practitioners to comply with relevant privacy laws

Health practitioners must comply with State or Commonwealth laws relating to the personal information of clients.

14 − Health practitioners to keep appropriate records

Health practitioners must maintain accurate, legible and up to date clinical records of each client consultation.

15 − Health practitioners to keep reasonable insurance

Health practitioners should ensure that his or her practice has reasonable indemnity insurance.

Actions taken under the Code of Conduct

In 2013-14, there were six matters that involved the consideration of prohibition orders for unregistered health service providers who breached the code. One matter resulted in a final order that was made public whilst interim orders were considered or imposed on the remaining five cases.

New South Wales and South Australia are currently the only states with a Code of Conduct for Unregistered Health Practitioners and both states have provided valuable input into a proposed national code. Consultation on the national code will occur during 2014-15.

7.3 Health & Community Services Advisory Council (Part 8 of the Act)

The Health and Community Services Advisory Council includes a diverse membership representing people who use health and community services, health and community service providers and health practitioner registration authorities. During 2013-14 the following people were members or deputies on the Council:

Stephanie Miller Presiding Member	**Jennifer Hall** Member representing the interests of users of health services	**Vacant** Member representing the interests of users of health services
Athena Karanastasis Member representing the interests of users of community services	**Dr David Walsh** Member representing the interests of health and community service providers	**Jennifer Hurley** Member representing the interests of health and community service providers
Josephine Bradley Member of registration authorities representing interests of the public	**Linda Starr** Member of registration authorities representing interests of the public	**Dr Naquibul Islam** Member representing the interests of users of community services
Lynette Woodforde Member representing the interests of carers	**Virginia Wilkinson** Member with appropriate experience in relation to the quality and safety standards of health care	**Vacant** Deputy Member representing the interests of users of health services
Lorraine Sheppard Deputy Member of registration authorities representing interests of the public	**Carolyn Donaghey** Deputy Member representing the interests of carers	**Dr Elaine Pretorius** Deputy Member with appropriate experience in relation to the quality and safety standards of health care
Konrad Gawlik Deputy Member representing the interests of users of community services	**Harold Stewart** Deputy Member representing the interests of health and community service providers	

The term of office for all Council members finishes November 2014, except for Dr Islam whose term finishes January 2017.

Functions

The functions of the Health and Community Services Advisory Council are to advise the Minister and the Commissioner in relation to:

- the means of educating and informing users, providers and the public on the availability of means for making health or community service complaints or expressing grievances in relation to health or community services or their provision; and
- key strategic issues that arise in relation to the resolution of complaints made in relation to the provision of health or community services; and
- the operation of this Act; and
- any other matter on which the Minister or Commissioner requests the advice of the Council.

The Council met six times in 2013-14 and the Commissioner provided Council members with information about HCSCC's activities and work plan. The Council also provided the Commissioner with support and helpful and timely advice on strategic directions and relevant contextual information for considering significant matters.

7.4 Assistance to service providers

One of HCSCC's roles is to assist service users, complainants and service providers to improve the safety and quality of services provided and to improve management of complaints.

A wide variety of service providers contact HCSCC seeking assistance with issues that may never become a complaint which is dealt with by HCSCC.

HCSCC seeks to provide sufficient information or appropriate referrals to assist the service provider to manage the situation. Sometimes HCSCC identifies that formal action needs to be taken and HCSCC will either request the matter be referred or will take own motion action based on the information provided.

The following are examples of assistance service providers sought from HCSCC during 2013-14. HCSCC provided information and advice to service providers on:

- how to meet obligations under the HCSCC Code of Conduct for Unregistered Health Practitioners
- whether particular complaints could be dealt with by HCSCC, including about the actions of other service providers
- concerns about the actions and decisions of legal guardians
- resolution of ongoing complaints including information about mediation services
- dealing with persistent complainants and aggressive behaviour from relatives of clients
- where to lodge complaints that are outside of HCSCC jurisdiction.

HCSCC also received requests from service providers for feedback on their complaints policies and guidelines.

7.5 Community Engagement

The breadth and complexity of HCSCC's jurisdiction requires HCSCC to develop a broad range of networks and professional partnerships. The following information provides a brief summary of HCSCC's key initiatives for 2013-14.

External Relationships

HCSCC met regularly throughout the year with a number of key stakeholders, some of which include representatives from SA Health, Health Consumers Alliance SA, Carers SA, Council on the Ageing (COTA), the Department for Communities and Social Inclusion (DCSI), Disability SA, Department for Education and Child Development (DECD), Department for Aboriginal Affairs and Reconciliation, Families SA, the South Australian Council of Social Service, the Public Advocate, other South Australian statutory authorities networks, interstate complaints bodies, the South Australian Parliament and Ministers of relevant portfolios.

Much of this work relates to the direct exchange of information, the progression of individual matters and/or to influence the development of strategic policy or service initiatives for the purpose of addressing identified systemic issues.

Examples of some of this work include:

- Principal Community Visitors Advisory Committee with SA Health and DCSI
- SA Health Partnering with Consumers
- SA Health Open Disclosure Program
- Office of the Public Advocate Supported Decision Making Project
- Advance Care Directives groups
- Safeguarding and rights for people living with disabilities

Submissions

Throughout 2013-14, HCSCC provided submissions and comment in response to a number of papers including:

- Australian Council on Safety and Quality in Health Care – End-of-Life Care in Acute Hospitals
- Attorney General's Department – Review into screening those that work or volunteer with children and vulnerable adults
- DCSI – Postcard Unregistered Health Practitioners
- DCSI – Rights Based and Person Centred Consultation
- DCSI – Safeguarding Women with Disability Policy
- SA Health – Draft Directive Providing Medical Treatment to Prisoners within SA Health
- Draft National Code of Conduct for Unregistered Health Practitioners consultation
- Minister for Education and Child Development (MECD) Child Development Bill 2013
- Office of the Public Advocate - Mental Health and Voting
- SA Health – Mental Health Intermediate Care Services
- SA Health – Draft Strategy for Safeguarding Older People 2014-2021
- SA Health – Patient Assistance Transport Scheme Review Consultation Paper
- SA Health – Practitioner Tribunal
- SA Health – Proposed Amendment to the Consent to Medical Treatment and Palliative Care
- SA Health – Protocol for Exchange of Information between SA Health Correctional Services
- SA Health – Review of the *Mental Health Act 2009*
- SA Health – Review of the Mental Health System of Care and Service Capacity

- SA Health – Mental Health Services Pathways to Care Policy series
- The National Disability Insurance Agency Strategic Plan consultation

Communications

HCSCC promotes its activities through its newsletter, *Rights Insights* (formerly known as Buzz).

During 2013-14 HCSCC distributed one newsletter of Rights Insights to its registered subscribers and key stakeholders with updates about HCSCC's activities and work program.

HCSCC was promoted at diverse forums and events and information about these activities follow.

Southern Reconciliation Event - Aboriginal and Torres Strait Islander Outreach

In May 2014, HCSCC attended the Southern Reconciliation Event held at Colonnades Shopping Centre, Noarlunga as part of the ongoing commitment to community engagement/ outreach with Aboriginal and Torres Strait Islander people.

Despite the cold and at times heavy rain, the event was well attended by over 300 community members including students from the local public and private schools.

It was another valuable opportunity for HCSCC to provide information direct to the Aboriginal and Torres Strait Islander community about its role and function, their rights under the *Health and Community Services Complaints Act 2004* and be available to answer any concerns community members may have about the delivery of health or community services for themselves or their loved ones.

Whyalla Disability Expo

Unfortunately the Whyalla Disability Expo scheduled for March 2014 was cancelled. As the Expo's cancellation happened after HCSCC had organised outreach visits to Whyalla services it would have been unfair to cancel these visits. A HCSCC officer travelled as planned to Whyalla in March 2014 and met with staff and consumers from Northern Community Carers, the Aboriginal Wellness Centre and Whyalla Hospital.

These service providers and users were given information, brochures, posters and advice about the role of HCSCC and information about the process involved when complaints are made to HCSCC.

Homelessness Expo

In October 2013 HCSCC attended the annual Homeless Connect Expo at Whitmore Square. This event is organised by Shelter SA in conjunction with the Adelaide City Council and Housing SA. The expo provides an opportunity for people who are homeless, or at risk of being homeless, the chance to connect with information about product and services. These include services such as housing, government assistance, legal services, health advice, employment and more.

The 2013 Expo attracted 41 agencies representing in excess of 55 services. It is estimated that approximately 510 people attended plus 120 staff and volunteers from the agencies and services.

One of the benefits of HCSCC's attendance at this type of event, aside from promoting HCSCC services to the public, is that it gives HCSCC the chance to network with service providers, leading to them referring people to HCSCC.

Disability and Ageing Expo

In August 2013 HCSCC attended Disability Expo 2013. The Disability Expo was very well attended by the community, with many people on the look out for information and advice and learning about the latest innovations in disability care. HCSCC had a corner position that provided greater exposure to the passing crowds resulting in hundreds of information brochures being given out.

Disability Expo offers HCSCC an excellent opportunity to meet with members of the community and provide them with information and advice about their health and community service-user rights and discuss complaints.

HCSCC Presentations

During 2013-14, HCSCC staff provided a total of 21 external presentations which included:

- Northern Carers Network
- Aged and Community Services, SA and NT
- Office of the Public Advocate, Victoria
- Bedford Industries
- City of Playford
- South Australian Health and Medical Research Institute
- Our Voices AGM
- Arthritis SA
- Community Support Inc
- Paradise Community Care
- SA Privacy Information Committee
- WCH Grand Round
- Our Voices
- Attorney General's Department, Consumer and Business Services
- Community Care Northern - St John Ambulance
- Northern Community Carers Whyalla
- Whyalla Hospital
- Nunyara Aboriginal Wellness Centre, Whyalla
- Brighton Ladies Probus Club

HCSCC Resources

During 2013-14, HCSCC distributed 11,402 consumer brochures, 8,101 rights brochures and 1,082 provider brochures in response to requests from a wide variety of individuals and organisations. Demand for other HCSCC resources also included high levels of interest in the Speak Up brochures and Speak Up posters developed for the Aboriginal and Torres Strait Islander communities and services.

In addition to the resources that are available in printed format, HCSCC also made a wide range of resources available to download directly from the HCSCC website including:

- Code of Conduct for Unregistered Health Practitioners
- HCSCC Charter Information Sheet
- *'Know Your Rights - a guide to the HCSCC Charter in South Australia'* brochure
- HCSCC Charter posters and bookmarks
- HCSCC Charter PowerPoint presentation and alignment slides.

Media

Any statements made by the Commissioner are released on the HCSCC website. This year, statements included a paper on Vaccination and Children's Health.

Training

HCSCC has a range of courses that can be tailored to meet an organisation's needs - the majority are free of charge. For more information please contact HCSCC.

7.6 HCSCC Supported Decision Making Project

The HCSCC Supported Decision Making (SDM) Project is part of HCSCC's ongoing commitment to improving the safety and quality of services provided to vulnerable people with disability.

The HCSCC Charter of Rights and the United Nations Convention on the Rights of Persons with Disabilities, Article 12 of the Convention, *"Equal Recognition before the Law"*, describes the right of a person with disabilities to make their own decisions, that is, "expressed wish" while utilising support of their choosing rather than "best interest".

In August 2013, HCSCC employed Ms Cher Nicholson to extend the work started with the Office of the Public Advocate (OPA) SDM project. There will be two rounds of activity in the project. Round one commenced in October 2013 and closed in May 2014. The second round commenced in August 2014 and will close in May 2015 and will be independently evaluated.

The model is centred on a person with a disability, the 'decision maker', and one or more supporters. The decision makers are people with complex needs including physical and intellectual disabilities, with some being non-verbal. Some live in institutional settings and/or are dependent on disability services for most of their needs.

The supporters are preferably drawn from the decision makers natural networks, are of their choosing and are not paid workers. The decision maker supported by their supporter makes an agreement/commitment about what decisions they want to make and how support will be delivered. Informal and formal networks are co-opted to form a team around the decision maker to aid with the decisions and to help enact their wishes. The aim of the team is to connect and mainstream the decision maker outside of disability services. Their progression is then not dependent on finances or service provision.

The model works with what is possible rather than what is available in disability services. It aids in maintaining and renewing the social relationships of the decision maker. The model focuses on current and future opportunities for the decision maker, their wishes and dreams rather than their experiences, or the limitations of organisations that work with them.

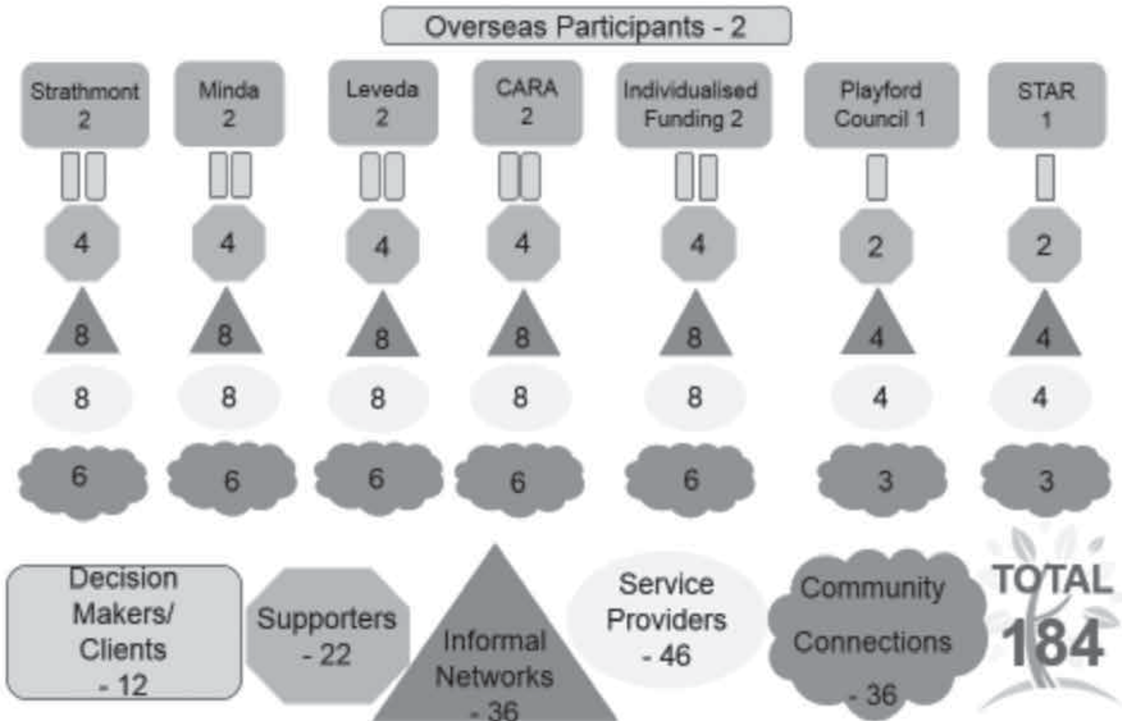
Cher's role in the project is to train, mentor and coach disability service workers to run the SDM processes. Eight key disability service providers have taken part in the training and coaching/ mentoring program. They are from both government and non-government services, a local council and two participants from overseas.

Paid peer consultants with lived experience of disability who took part in the previous OPA SDM project, assisted with the training. The trainees reported that meeting the peer consultants was a powerful way for modelling the practise of SDM. Similarly, the paid peer consultants reported that they felt affirmed and valued by the process.

A Community of Practise led by Cher was held monthly with key guest speakers and discussions to further the skills, experience and knowledge of the trainee facilitators.

The model allows all parties to measure success in a different way. Success may not be the enacting of a decision, but creating an environment where decisions can be made and rights have been upheld.

hcscc


Overview of SDM Facilitation Training
Trainer – Cher Nicholson HCSCC
Overseas Participants - 2
Strathmont 2
Minda 2
Leveda 2
CARA 2
Individualised Funding 2
Playford Council 1
STAR 1
4
4
4
4
4
2
2
8
8
8
8
8
4
4
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8
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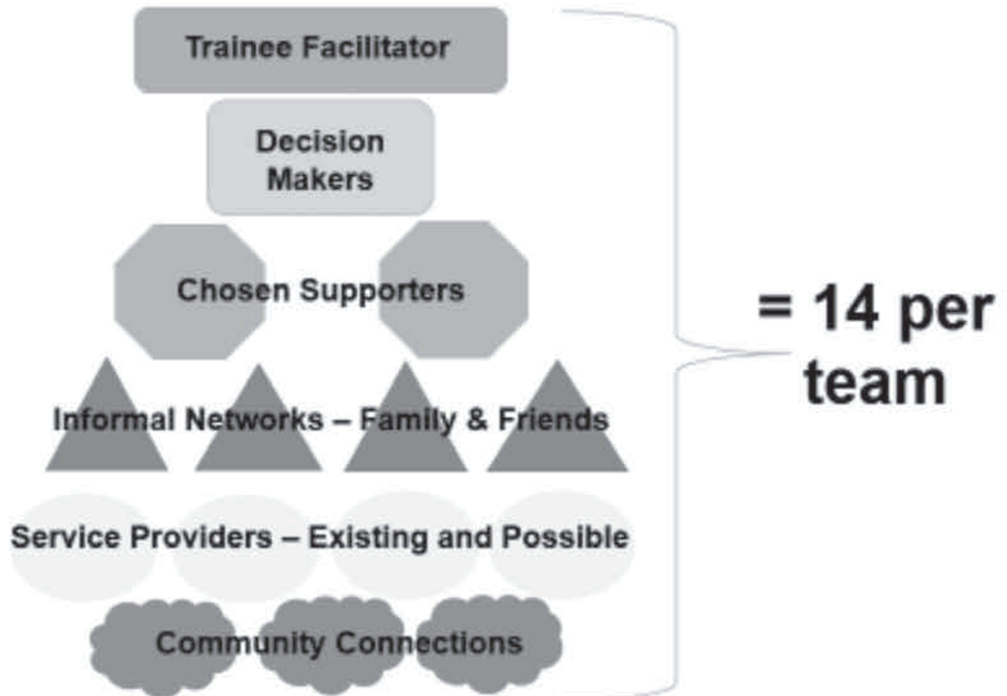
8
8
4
4
6
6
6
6
6
3
3
Decision Makers/ Clients - 12
Supporters - 22
Informal Networks - 36
Service Providers - 46
Community Connections - 36
TOTAL 184


SA SDM Model
Trainer – Cher Nicholson HCSCC
Trainee Facilitator
Decision Makers
Chosen Supporters
Informal Networks – Family & Friends
Service Providers – Existing and Possible
Community Connections
= 14 per team
Numerous connections occur outside the SDM structure

Future Directions for the HCSCC SDM Project

The first round of training has shown that a short intervention of three to four months can and did change the lives of decision makers. They required less support and opportunities grew for them to take their rightful place in the community regardless of their finances or service availability. They emerged from their disability to gain recognition of their citizenhood to live real lives that are self-authored.

The aims of the second round are to maximize the impact in the culture and service change within two selected organisations. As well as five participants from each organisation, their work supervisors will also be trained. The two facilitators from those organisations who undertook the initial training, will support and coach from within. Cher will continue to mentor the trainees closely to maintain the integrity of the model.

A memorandum of understanding has been forged with HCSCC and the two agencies with the organisations, government and non-government working together wherever possible to share learnings.

The Community of Practise will continue with facilitators from the first round and grow with the trainee facilitators from the second group thus spreading the influence of the training.

For more information about the HCSCC SDM Project, please contact Cher Nicholson on 08 8226 8652, or email info@hcscc.sa.gov.au

Links

HCSCC report: www.hcscc.sa.gov.au/wp-content/uploads/2013/10/h_disability_public_report_march_2013.pdf

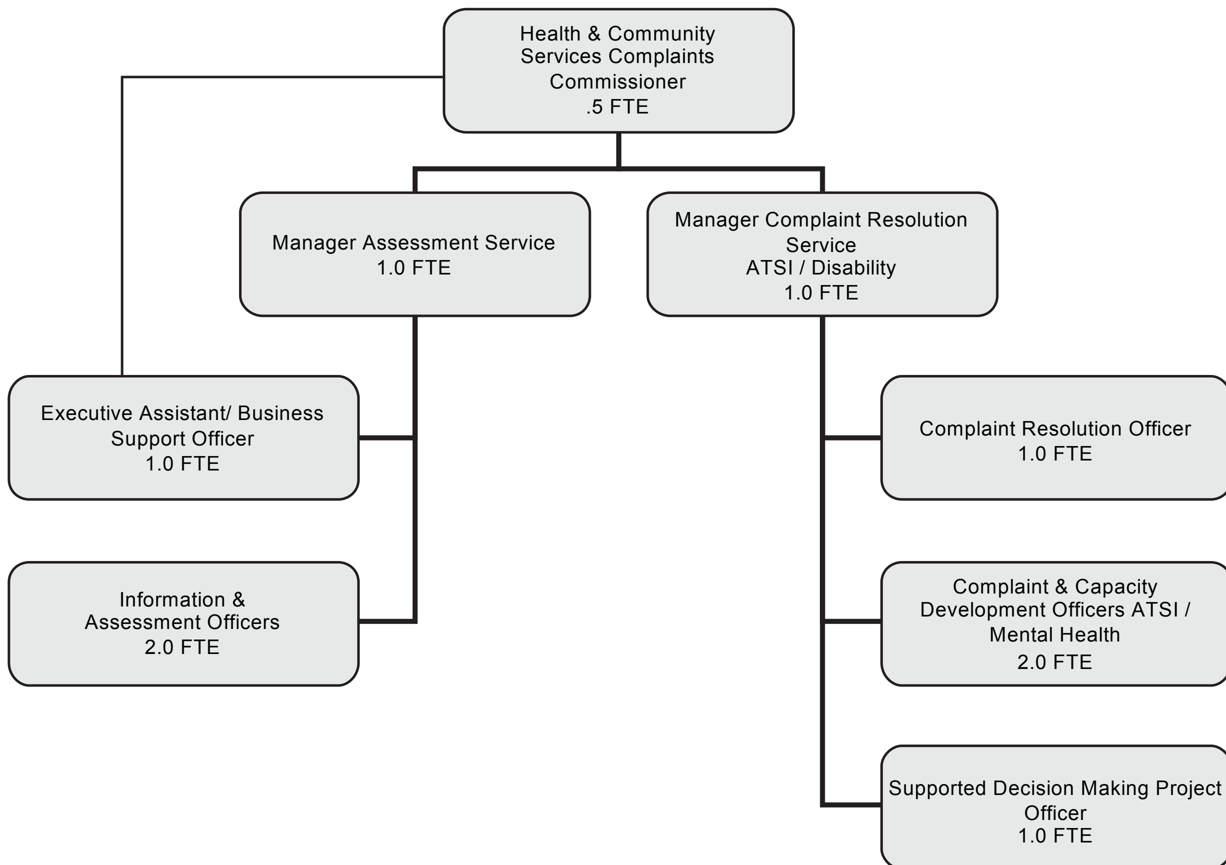
HCSCC context paper: “Towards safety and quality in disability services: Confronting the corruption of care”: www.hcscc.sa.gov.au/wp-content/uploads/2013/10/h_towards_safety_and_quality_in_disability_services.pdf

UN Convention: www.un.org/disabilities/convention/conventionfull.shtml

OPA SDM Project: www.opa.sa.gov.au/resources/supported_decision_making

8. Human Resources

HCSCC organisational chart as at 30 June 2014.



Staff of the office of the HCSCC (excluding the Commissioner) are employed by the Department for Health. Statistical reporting relating to HCSCC staff is also captured in the Department for Health 2013-14 Annual Report.

Employee Numbers, Gender and Status

Total Number of Employees	
Persons	11
FTEs	9.98

Gender	% Persons	% FTEs
Male	27.27%	25.05%
Female	72.73%	74.95%

Number of persons during the 2013-14 financial year	
Separated from the agency	1
Recruited to the agency	1

Number of Persons as at 30 June 2014	
On Leave without Pay	0

Number of Employees by Salary Bracket

Salary bracket	Male	Female	Total
$0 - $54,799	0	0	0
$54,800 - $69,699	1	3	4
$69,700 - $89,199	1	3	4
$89,200 - $112,599	0	2	2
$112,600+	1	0	1
Total	**3**	**8**	**11**

Status of Employees in Current Position

FTEs	Ongoing	Short-Term Contract	Long-Term Contract	Other (Casual)	Total
Male	2	0	0.5	0	2.5
Female	4.58	2.9	0	0	7.48
Total	**6.58**	**2.9**	**0.5**	**0**	**9.98**

Persons	Ongoing	Short-Term Contract	Long-Term Contract	Other (Casual)	Total
Male	2	0	1	0	3
Female	5	3	0	0	8
Total	7	3	1	0	11

Executives by Gender, Classification and Status

	Ongoing		Term Tenured		Term Untenured		Other (Casual)		Total			
Classification	M	F	M	F	M	F	M	F	M	%	F	%
Commissioner			1									
Total			**1**						**1**	**100%**	**0**	**0**

Leave Management - Average Days Leave Per Full Time Equivalent Employee

Total Days Leave Taken – 2014 Average FTE – 8.9days

Leave type	2010-11	2011-12	2012-13	2013-14
Sick Leave	14.00	9.60	7.4	9.0
Family Carer's Leave	1.40	1.50	1.1	0.5
Miscellaneous Special Leave	2.80	1.40	1.6	7.0

Workforce Diversity – Aboriginal and/or Torres Strait Islander Employees

One staff member is Aboriginal: Ngarrindjeri-Ramindjeri; Gurindji.

Salary Bracket	Aboriginal Employees	Total Employees	% Aboriginal Employees
$0 - $54,799	0	0	0%
$54,800 - $69,699	0	4	0%
$69,700 - $89,199	1	4	25%
$89,200 - $112,599	0	2	0%
$112,600+	0	1	0%
Total	**1**	**11**	**9.09%**

Workforce diversity – Employees by Age Bracket and Gender

Age Bracket	Male	Female	Total	% of Total
15-19			0	0
20-24			0	0
25-29			0	0
30-34			0	0
35-39	0	2	2	18.18
40-44	1	1	2	18.18
45-49	1	0	1	9.09
50-54	0	2	2	18.18
55-59	0	1	1	9.09
60-64	1	2	3	27.27
65+			0	0
Total	**3**	**8**	**11**	**100**

Workforce diversity – Cultural and Linguistic Diversity

	Male	Female	Total	% of Agency
Number of employees born overseas	1	3	4	36.36%
Number of employees who speak language(s) other than English at home	0	1	1	9.09%

Workforce Diversity – Disability (According to Commonwealth DDA Definition)

Male	Female	Total	% of Agency
0	1	1	9.1%

Types of Disability (Where Specified)

Disability	Male	Female	Total	% of Agency
Disability requiring workplace adaptation	0	1	1	9.1%
Physical	0	0	0	0%
Intellectual	0	0	0	0%
Sensory	0	1	1	9.1%
Psychological/Psychiatric	0	0	0	0%

Voluntary Flexible Working Arrangements by Gender

	Male	Female	Total
Purchased leave	0	0	0
Flexitime	2	8	10
Compressed weeks	0	0	0
Part time	1	2	3
Job share	0	0	0
Working from home	0	0	0

Documented Review of Individual Performance Management

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

Employees with…	% Total Workforce
A review within the past 12 months	100%
A review older than 12 months	0%
No review	0%

Leadership and Management Training Expenditure

Training and Development	Total Cost	% of Total Salary Expenditure
Total training and development expenditure	$0	0%
Total leadership and management development expenditure	$0	0%

Accredited Training Packages by Classification

Classification	Number of accredited training packages
AS06	1

Accredited training does not include customised training with regard to Cultural Sensitivity Training and other specialist ‘one-off’ training programs.

Work Health and Safety and Injury Management

HCSCC Work Health and Safety and Injury Management information is included in the SA Health Annual Report.

9. Financial Statements

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

HCSCC's funding and expenditure for 2013-14 as provided by the Department for Health is summarised below.

Recurrent Base as at 01/07/12	**$1,415,774**
Crown Solicitor's Office Budget	$39,000
Revised Annual Budget as at 30/06/2013	**$1,454,774**

Summary of Revenue and Expenditure

Total Revenue	**$1,905**
Salaries and Wages	**$962,352**
Goods and Services	$473,102
Total Expenses	**$1,435,454**
Net Operating Result	**$1,433,549**
Under / (Over) Budget Result	**$21,225**

Account Payment Performance 2013-14

Paid by due date	Number of Accounts paid	% of Accounts Paid by Number	Value in $A of Accounts Paid	% of Accounts Paid by Value
Paid by due date	69	100%	$375,993	100%
Late but <30 days	0	0%	0	0%
>30 days past due date	0	0%	0	0%
Total	**69**	**100%**	**375,993**	**100 %**

Freedom of Information Statement

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

Fraud

This section of the report deals with resourcing issues. For completeness, it is reported that the HCSCC had no incidence of fraud or theft to report.

Energy Efficiency

HCSCC took all reasonable steps during the reporting period to reduce its expenditure on energy.

Contractual Arrangements

HCSCC did not enter into any major contracts.

Reporting Against the Carers Recognition Act 2005

HCSCC did however expend monies on supporting a staff member in their capacity of carer and provided carers leave to staff as warranted.

Notes

hcscc

health & community services
complaints commissioner