REVIEW OF THE NORTHERN TERRITORY HEALTH AND COMMUNITY SERVICES COMPLAINTS ACT (1998)

"Respecting and Protecting the Rights and Responsibilities of Users and Providers of Health and Community Services"

REVIEW STEERING COMMITTEE

APRIL 2004

1 EXECUTIVE SUMMARY

The Independent Review of the Health and Community Services Complaints Act (HCSCC) has been conducted by a Steering Committee appointed by the Minister for Health and Community Services in December 2002 and is the culmination of over fifteen (15) months work.

The Terms of Reference as approved by the Minister involved:

- examining the effects and operation of the Act since commencement;
- comparing the operation of the Act with similar legislation in other jurisdictions;
- determining the effectiveness of the current model;
- determining the appropriateness of existing practices and procedures in the Act; and
- recommending any amendments to the legislation that might further improve its effectiveness and efficiency and enhance its workability to ensure its relevance to current and future needs of the Territory.

HCSCC strengths lie in its existence as a low cost and free complaint resolution scheme that is an alternative to the courts. HCSCC has the support of providers, users and consumer organisations, which is essential to its role as a government funded scheme. Its processes are considered to be fair and just, and there is a high level of respect for its work by providers and users alike.

The five benchmark areas considered by the Steering Committee were accessibility, independence, fairness, accountability, efficiency and effectiveness. The Final Report is arranged so that Chapters cover each of these areas.

1.1 OVERVIEW OF FINDINGS

The Steering Committee examined the current model and concluded that it provided an independent, just, fair and accessible mechanism for resolving complaints. However they identified a number of amendments which, if implemented, would improve the efficiency, effectiveness and accountability of the model. The most significant of these are:

1.1.1 Accessibility/Efficiency

Rec 7: Community Services
The definition of Community Services be expanded to include most major categories of community services, with the exception of child protection services.

1.1.2 Accountability/Effectiveness

Rec 10: Own Motion
Consideration be given to the Commissioner having "own motion" powers.

Rec13: Unregistered providers
The Commissioner be given more power to deal effectively with unregistered providers. Such powers to include the ability to make enforceable determinations.

1.1.3 Fairness/Independence

Rec 17, 18 and 19: Community Visitor Scheme/Advocacy Service
Establishment of either an independent Community Visitor Scheme or an Advocacy Service or a combination of both and that such a service be delivered independently through community based organisations.

1.1.4 Efficiency/Effectiveness

Rec 20 – 73: Procedural amendments
The Steering Committee generally endorsed the current complaints model as effectively meeting its objectives. It was also satisfied that the model was independent, just and fair and that it was effective in promoting the resolution of complaints, and in promoting broader service improvement outcomes from individual complaints. However the Steering Committee saw the need for a number of procedural amendments to improve the efficiency and effectiveness of the current model. These recommendations are discussed more fully in Chapter 9 and total 54 in number.

The most significant of these are:

- **Name Change:** The name of the Act be changed and for it to be known as the *Community and Health Services Complaints Act* and the person responsible for the working of the Act be known as the "Community and Health Services Complaints Ombudsman" (**Rec 20**).
- **Discretionary Powers:** Greater flexibility be given to the Commission to informally resolve complaints by allowing the Commissioner discretion to increase the number of days to asses a complaint and providing the Commissioner with an additional option to informally resolve a complaint through mediation. (**Rec 28, 29 and 30**)
- **Investigative powers:** To allow the Commissioner to investigate issues raised in a withdrawn complaint where it raises significant issues relating to safety, health or the practice and procedures of a provider. (**Rec 38**)
- **Mentors and experts:** To provide greater flexibility to the Commission in engaging mentors and experts to provide opinion and assistance as required. (**Rec 39 – 43**)
- **Review Committee:** To improve the functioning of the Review Committee by providing for "alternative members", allowing for members to be appointed for three years, allowing expertise to be co-opted as required, providing for the payment of sitting fees and establishing timeframes for the review process. (**Rec 56 – 67**)
- **Absolute privilege:** To provide "absolute privilege" to any person making a complaint, or referring a complaint to the Commission. (**Rec 68**)

1.2 FUNDING

There were concerns regarding accessibility and the shared Commission/Ombudsman roles which are discussed in Chapter 8. The Steering Committee acknowledged the Commissioner's concerns that broader initiatives to improve the effectiveness of the model have been limited by inadequate funding. For example, in raising awareness of rights and responsibilities amongst users, providers and consumers of services, the development of the *Code of Health and Community Services Rights and Responsibilities* has been an invaluable document. However, the Steering Committee were concerned that a lack of funding had compelled the Commission to focus on complaint resolution rather than the important task of promoting the Code for users, providers and consumers.

A number of the recommendations require funding if they are to be implemented. Chapter 10 provides an estimate of funding requirements which cover:

• Improved education, access and awareness activities by the Commission throughout the Territory (**Rec 4, 9, 15, 16 and 23**)	$85,000
• Improved administrative arrangements for the Review Committee. (**Rec 60, 61, 62**)	$6,500
• Expansion of jurisdiction and services (**Rec 7, 17, 18 and 19**)	$321,000
Total	**$412,500**

1.3 Conclusion

The *Health and Community Services Complaints Act* has been effective since it commenced operation in 1998. The Review Committee has concluded however that its effectiveness could be enhanced by broadening its jurisdiction, expanding its investigative function, providing greater flexibility to resolve complaints informally and providing greater opportunities to undertake access and awareness initiatives throughout the Territory.

If this increased effectiveness is to be achieved then a commitment will need to be made by the Minister to provide the Commission with additional funding as identified in this report.

2 LIST OF RECOMMENDATIONS

2.1 REVIEW PROCESS

1. Further reviews of the Act be scheduled every five years as required by the Act and adequate funding be provided by government to undertake the review. (Pg 20)

2.2 RECOMMENDATIONS RELATING TO THE CURRENT ACT'S EFFECTIVENESS

2. The Code of Health and Community Services Rights and Responsibilities be reviewed to take into account:
   - review submissions relating to more equitable treatment of provider rights in the Code; and
   - promoting understanding by Aboriginal people. (Pg 57)
3. That the Code also be reviewed whenever the Act is reviewed. (Pg 57)
   -
4. That sufficient budget be available for:
   - preparation of materials about the Code in appropriate formats and media;
   - regular reprinting and distribution of the Code to providers across the Northern Territory; and
   - annual access and awareness visits to all major Northern Territory centres and to prescribed providers. (Pg 57 - 58)
5. That the Commissioner write annually to provider organisations promoting the existence of the Code, its use in staff training and orientation programs, and in internal complaints handling systems. (Pg 58)

2.3 RECOMMENDATIONS RELATING TO THE COMPLAINTS MODEL

6. That the definition of health services be expanded to include services to a deceased person. (Pg 61)
7. That the definition of community services be expanded to include most major categories of community services, with the exception of child protection services and that "community services" be defined in regulations as at Appendix 11.6. (Pg 64)
8. That the Commissioner's current powers and functions be retained. (Pg 66)
9. That adequate resources and funding be provided to ensure that the Commissioner can address the broader promotional and systems improvement functions and roles as required under the current Act. (Pg 66)
10. That the Minister decide on which of the following "Own Motion" options he supports for inclusion in the revised legislation:
    a) No change
    b) Similar to Section 16 of the *Ombudsman (Northern Territory) Act*
    c) Similar to the amended Police provisions associated with the review of the *Ombudsman (Northern Territory) Act*

d) Similar to Sections 59 and 60 of the NSW *Health Care Complaints act*
e) A combination of c) and d) (Pg 73 - 74)

11. That if "Own Motion" powers are supported, the following additional provisions should be included:
    - The Commissioner, where reasonable, should be required to give consideration to the effect on individuals or providers about possible implications of an own motion investigation; and
    - The Commissioner, where appropriate, should be required to access relevant expert opinion or mentoring advice in undertaking the own motion investigation. (Pg 74)

12. **Option 1 (preferred option)**
    That the Commissioner retain recommendatory, rather than determinative powers.

    OR

    Option 2 (Not preferred).
    That the Commissioner be provided with determinative powers for use as a last resort when providers do not cooperate with the complaints process findings. (Pg 77)

13. That the Act be amended in order to deal more effectively with unregistered providers by:
    - providing for the enforcement of determinations made by the Commissioner, where due process has led to the determination that the quality of service provided by unregistered providers has fallen below acceptable standards and constitutes unreasonable risk to public health and safety.
    - providing the Commissioner with the power to enforce orders compelling unregistered providers to undertake relevant training or education or to refund fees and costs charged to the complainant;
    - requiring the unregistered provider to attend at, or participate in, proceedings where such an order is being contemplated. (Pg 80)

14. That, providing a significant public health or safety issue or a significant concern regarding the practice and procedures of a provider has been confirmed through due process, the Act be amended to provide the Commissioner with 'naming' powers in relation to both registered and unregistered providers. (Pg 83)

15. That the Act be amended to empower the Commission to work with Professional Associations of unregistered providers to implement appropriate complaints handling mechanisms. (Pg 84)

16. That the Act be amended to require that members of Professional Associations of unregistered providers implement appropriate internal complaints handling mechanisms. (Pg 84)

17. That the Act be amended to trial the establishment of either an independent Community Visitor Scheme or an Advocacy Service or a combination of both. Such a service to be:
    - adequately resourced and funded to allow for the three year trial;
    - administered by the Commissioner for Health and Community Services Complaints; and

- delivered independently through appropriate community based organisations. (Pg 93)

18. That the Commission's coordination/administration role in relation to the Community Visitor/Advocacy Service include:
    - contracting appropriate service providers;
    - monitoring the delivery of the service by the independent providers;
    - managing the selection of Advocacy/Community Visitors;
    - preparing protocols for use by service providers; and
    - coordinating the delivery of training and support to the selected advocates/visitors. (Pg 93)

19. That the trial scheme be based on the following principles:
    - seeking to identify and resolve problems and complaints at the lowest possible level;
    - striving for a positive and respectful approach to working with service providers;
    - commitment to an empowerment advocacy framework;
    - prioritising advocacy services to those who are least in a position to advocate for themselves. (Pg 93)

2.4 RECOMMENDATIONS RELATING TO PRACTICES AND PROCEDURES

20. That the name of the Act be changed to "Community and Health Services Complaints Act." (Pg 94)

21. That the title of the person charged with responsibility for the working of the Act, be the "Community and Health ServicesComplaints Ombudsman." (Pg 95)

22. That current provisions aimed at ensuring that users of health and community services are made aware of complaint resolution mechanisms be retained. (Pg 96)

23. That the Commission be provided with adequate resources and funding to develop and implement an appropriate communication strategy, distribute a comprehensive and culturally appropriate range of promotional materials, and to undertake adequate on-going awareness raising activities. (Pg 96)

24. That the Act be amended to clearly obligate both registered and unregistered providers to establish internal complaints handling processes and to promote them in conjunction with relevant external complaints handling mechanisms. (Pg 96)

25. That the Act be amended to allow the Commissioner to consider the best interests of the consumer over those of the complainant, if the interests conflict and to inform the parties. (Pg 98)

26. That the Act be amended to enable a person who has attained the age of 16 to determine whether he/she wishes to be represented in regard to a complaint and, if so, by whom. But if it can be demonstrated that he/she lacks capacity and is not acting in his/her best interest then the Commissioner can accept representation from a person who can demonstrate sufficient interest in the complaint such as a parent or guardian. (Pg 98)

27. That the Act be amended to allow the Commissioner to accept simple and straightforward complaints via the internet or by e-mail and other electronic media such as the facsimile machine. (Pg 99)

28. That the Act be amended to require the Commissioner to assess the complaint in 60 days after receiving it, or within such longer periods as may be necessary to accommodate any delays that may occur whilst the Commission or another person takes steps required under the Act, or whilst the Commission is undertaking preliminary inquiries. (Pg 102)

29. That the Act be amended to require that all parties to the complaint are informed when an extension is granted. (Pg 103)

30. That the Act be amended to:
    - provide the Commissioner with an additional assessment option to informally resolve a complaint through mediation;
    - ensure the mediation process is privileged and confidential;
    - provided all mediation parties agree, allow relevant information on agreements reached in mediation to be provided to the relevant Professional Boards and to the provider organisation; and
    - require that the informal mediation process be undertaken within a 60 day time period. (Pg 104)

31. That the Act be amended by adding an additional subclause under S12(1)(j)(iv) to read "use reasonable endeavours to encourage the parties to resolve a complaint where appropriate". (Pg 104)

32. That the Act be amended to explicitly require a provider to provide the following when applicable and as and when requested to do so by the Commission:
    - a written response to the issues of complaint;
    - medical records;
    - patient information;
    - medical opinions; and
    - other information or documents. (Pg 106)

33. That the Commission consult with the Department of Health and Community Services to determine appropriate and reasonable protocols for establishing the identity of complainants and consumers. (Pg 106)

34. That the Act be amended to allow the Commissioner to take no further action on a complaint where, in the opinion of the Commissioner, a reasonable explanation has been provided. (Pg 107)

35. That in the event of such a decision being made, the complainant be advised that the decision may be reconsidered in the event of further substantial evidence becoming available to support their issues. (Pg 107)

36. Any additional information must be provided by the complainant within 60 days of being notified of the Commissioner's determination to take no further action. (Pg 107)

37. That the Act be amended to allow the Commissioner to decline to take action on a complaint if there is another body appropriately empowered to deal with it at substantially the same level as the Commission. (Pg 108)

38. That the Act be amended to allow the Commissioner to investigate issues raised in a withdrawn or abandoned complaint, where the complaint raises significant public health and safety or public interest issues, or significant questions as to the practices and procedures of the provider. (Pg 110)

39. That a general provision be included in Miscellaneous Provisions of the Act to authorise the Commissioner to obtain information, an explanation or assistance from a Professional Mentor, as and when required. (Pg 112)

40. That the following requirements for engaging and working with Professional Mentors be incorporated into the mentoring provisions:
    - that every attempt be made for them to be sourced through the relevant Professional Board/s and or Colleges and Associations;
    - that their role will be to assist the officer dealing with a complaint to understand the issues of complaint;
    - that they will be required as far as possible to base their advice on existing relevant and approved standard treatment protocols/guidelines/clinical care pathways and referenced scientific information;
    - that material provided to the mentor may be de-identified;
    - that the parties will not be made aware of the identity of Professional Mentors. (Pg 112)

41. That Section 52 of the Act be amended and incorporated into the Miscellaneous Provisions (Part 10) as a general provision allowing the Commission to obtain an expert report at any stage of the complaint process. (Pg 113)

42. Any such expert report is to be utilised only for a purpose under the Act and is not to be used in any other proceedings except where a matter is before the Board. (Pg 113)

43. That the Act be amended to support the principle that, wherever possible, Experts selected to provide an opinion in relation to a complaint, be from the same field of expertise as the professional being complained about or have qualifications relevant to the issues of complaint. (Pg 114)

44. That the Act be amended to allow, in exceptional circumstances, for information obtained during conciliation, to be provided elsewhere, only with the consent of all parties and the approval of the Commissioner. (Pg 115)

45. That new provisions relating to disclosure of information obtained during conciliation define "exceptional circumstances", and clarify the purpose of further disclosure as being to assist in effective complaints resolution. (Pg 115)

46. That the current powers and functions of conciliators be retained and the Act not be amended to explicitly provide Conciliators with the power to take action as necessary to successfully conciliate a complaint. (Pg 116)

47. That the Act be amended to require that, where an individual provider is named in the complaint, that the named provider must be:

- informed about the complaint and actively encouraged to respond to the issues of complaint where applicable; and
- where conciliation is agreed, given the option of attending conciliation along with the appointed provider representative of the organisation. (Pg 118)

48. That the Act be amended to explicitly allow information obtained during the course of conciliation to be provided to an expert, provided all parties to the conciliation agree. (Pg 119)

49. That Section 97, relating to preservation of confidentiality, be amended to include Experts as persons involved in the administration of the Act. (Pg 119)

50. That the Act be amended to ensure that the Commissioner, during an investigation, has the power to obtain any object that may be required as part of that investigation. (Pg 120)

51. That the Act be amended to provide the Commissioner with the power to re-assess a complaint at any stage to determine how to deal with it more appropriately. (Pg 121)

52. That, pending changes arising from the Omnibus legislation, only minor changes be made to provisions relating to Professional Boards. (Pg 122)

53. That the Act should be amended to provide a Registration Board with the ability to refer a complaint back to the Commission. (Pg 123)

54. That the Act be amended to give immunity and protection to a person whose grievance to a Registration Board, or any other body, is notified to the Commission. (Pg 124)

55. That the Act be amended to give immunity and protection from civil action to a person whose complaint to the Commission is referred on by the Commission to another body. (Pg 125)

56. That persons appointed to the Review Committee under Section 78 (3) be amended to include:
    - that one of the provider representatives will represent the interests of Indigenous providers;
    - that one of the consumer representatives will represent the interests of Indigenous consumer. (Pg 126)

57. That the Act be amended to allow for the appointment of alternative members for when permanent members are unavailable. (Pg 126)

58. That the Act be amended to allow the Review Committee to co-opt relevant expertise as required. (Pg 126)

59. That the Act be amended to specify terms of appointment and grounds for dismissal for Review Committee membership. (Pg 126)

60. That the Act be amended to require that each Review Committee member, or alternate member, who is not a government employee, receives an agreed sitting

fee, with all travel and other disbursements met, subject to guidelines issued by the Minister. (Pg 127)

61. That the Act be amended to provide designated administrative support and budget to support the effective operations of the Review Committee. (Pg 128)

62. That budget and support for the Review Committee be provided through consolidated revenue by, or through, the Minister's office. (Pg 128)

63. That the Act be amended to provide a time limit of 60 days after notification of a determination on a complaint, for a request for a review of the complaint process to be lodged with the Review Committee. (Pg 129)

64. That the Act be amended to provide the Chairperson of the Review Committee with the discretion to extend this period for exceptional circumstances, but such extensions to be no longer than six months in total. (Pg 129)

65. That the Act be amended to oblige the Commission to advise complainants in writing of their need to request a review under the Act, and of the applicable time limits. (Pg 129)

66. That the Act be amended to specify that the Review Committee must complete a review of a complaint within a reasonable time period, and no later than 6 months from the time the request for review was lodged. (Pg 130)

67. Any further extension of time to complete a review must be specifically approved by the Minister. (Pg 130)

68. That the Act be amended to provide "absolute privilege" to any person or complaint received by, or referred to, the Commission. (Pg 131)

69. That the Act be amended to give the Commissioner the ability to serve documents by electronic media. (Pg 132)

70. That provisions relating to the status of the Code remain unchanged and that the Commissioner's powers in relation to the Code also remain unchanged. (Pg 133)

71. That the Act be amended to ensure that upon approval of the Code by the Minister, the Code must be recognised by providers and consumers and the parties must make all reasonable efforts to adhere to the spirit and intent of the Code. (Pg 133)

72. The Act be amended to enable the Commission to notify / consult with another complaint handling body such as the Aged Care Complaints Resolution Scheme, Anti-Discrimination Commissioner or the Ombudsman, once a complaint has been received. (Pg 134)

73. That the Act be amended to ensure:
    - preservation of medical records should a health service provider move outside the Northern Territory ;
    - that where medical records may be relevant to a matter raised in a complaint, the records are not destroyed without the approval of the Commissioner. (Pg 135)

2.5 RECOMMENDATIONS RELATING TO FINANCIAL IMPLICATIONS

74. That additional funding in the amount of $412,500 be made available to assist with the implementation of the recommendations associated with the review of the *Health and Community Services Complaints Act* and that this $412,500 be made available as follows:
    - $3,000 being transferred to the Commission from the Employee Assistance Service (EAS).
    - $213,000 being provided direct to the Commission as additional ongoing appropriation
    - $6,500 being provided to another agency (as determined by the Minister) as additional ongoing funding
    - $190,00 being allocated to the Commission, in the first instance, for a three year trial period. (Pg 144)

75. That the implementation of the Community Visitor/Advocacy Service lapse if, after the first eighteen months of the Director Advocacy Services being employed, adequate funding has not been negotiated for this purpose with both the NT and Commonwealth Governments. (Pg 144)

76. That, in addition to the NT and Commonwealth funding as recommended in 75, funding allocated to non-government organisations currently providing visitor/advocacy services to the community services sector (not including the NT Mental Health Visitor Scheme) be pooled with the funds provided by the NT and Commonwealth. (Pg 144)

77. That tenders be called from the non-government sector to provide a Community Visitor/Advocacy Service throughout the Northern Territory and that the funding provided as a result of recommendations 75 and 76 be used for this purpose. (Pg 144)

78. That adequate funding (amount still to be calculated) be provided on a one-off basis to locate at least five personnel in new or already leased premises. This funding to allow for:
    - re-location costs;
    - leasing cost per $17m^2$ per person; and
    - fit out costs associated with partition walls, electrical and A/C modifications, reception counters (if applicable), furniture and equipment and toilet facilities. (Pg 145)

3 ABBREVIATIONS AND GLOSSARY

The Act:	*Health and Community Services Complaints Act* (1998)
The Commissioner:	The Northern Territory Health and Community Services Complaints Commissioner
The Commission:	The Northern Territory Health and Community Services Complaints Commission
The AMA:	The Australian Medical Association of the Northern Territory
"the review discussion paper":	*"A Discussion Paper To Seek Input from the Public Between 1 July and 29 August 2003 Review of the Health and Community Services Complaints Act 1998"* Review Steering Committee, 2003.
DHCS:	The Department of Health and Community Services (NT)

4 ACKNOWLEDGMENTS

The Steering Committee managing the review process consisted of:

- Ms Vicki O'Halloran (Independent Chairperson), Somerville Community Services Inc.
- Ms Vicki Geytenbeek, Department of Health and Community Services.
- Ms Sue Keys, Department of Health and Community Services (January 2002-July 2003).
- Mr Anthony Burton (from August 2003).
- Mr Peter Boyce, Health and Community Services Complaints Commissioner.
- Dr Barbara Bauert, the Australian Medical Association (from September 2003).
- Ms Kez Hall, Aboriginal Medical Service Alliance NT (AMSANT), (until August 2003).
- Mr Wayne Connop, AMSANT (from August 2003).
- Ms Deb Hall, Darwin Community Legal Services.
- Dr Lionel Crompton, Top End Division of General Practitioners.
- Ms Kathy de Bretton, Integrated disAbility Action.
- Ms Carolyn Wilson, Health Professions Licensing Authority.

Members of the Steering Committee wish to record their appreciation for the efforts of all those who made written submissions to the review, or attended review workshops. The submissions and workshops provided invaluable feedback on how the current complaints Act could be improved.

The Steering Committee also wishes to acknowledge the sustained effort and support provided by Ms Kathryn Ganley from the Health and Community Services Complaints Commission. The completion of the review within the time-frame would have been impossible without Ms Ganley's cheerful and efficient support. As project officer supporting the Steering Committee throughout the review, Ms Ganley provided a high level and willing support including:

- managing Territory-wide promotional, communication and consultation to maximise engagement in the review process;
- providing executive support for the Steering Committee;
- assisting with the drafting and distribution of the review discussion paper; and
- identifying and responding to day-to-day issues arising during the review process.

Mr Vic Feldman, also from the Commission, worked with Ms Ganley to draft the review discussion paper, willingly assisted with consultation and report writing processes and was Project Officer during the later part of the review.

Ms Sally Matthews was seconded from the Department of Health and Community Services to work on the review from August to November 2003. During this time Ms Matthews:

- conducted review consultation workshops across the NT;
- researched complaints processes and developments within the NT and Australia-wide;
- analysed submissions to the review; and
- drafted the Steering Committee's report to the Minister on review outcomes.

The Steering Committee thanks both Ms Matthews for her diligent effort, and the Department of Health and Community Services for supporting her release to undertake this important work.

Other Steering Committee members would also particularly like to acknowledge the efforts of their Chairperson, Ms Vicki O'Halloran, for her wise and inclusive stewardship of the review process and Mr Peter Boyce for his valuable contribution in clarifying legal and policy issues and his commitment in having the Health and Community Services Complaints Commission fund the Project Officer, travel, accommodation cost and secretarial support.

5 INTRODUCTION

5.1 BACKGROUND TO THE CURRENT ACT

The *Health and Community Services Complaints Act* (1998) (the Act) came into operation on July 1st 1998. Since commencing its statutory functions under the Act, the Health and Community Services Complaints Commission has provided an independent mechanism for the resolution of complaints about health and aged and disability services in the Northern Territory.

One of the objectives of the Act is:

> *(c) To develop the Code of Health and Community Rights and Responsibilities.*

In accordance with this objective, the Code was developed from extensive consultation with providers and consumers in the Northern Territory, and was formally launched by the Minister for Health and Community Services on August 12th 2002. The Code[1] provides a statement of the rights and responsibilities of users and providers of health, aged and disability services. Since its approval, the Code has formed a framework against which complaints under the Act are assessed.

5.2 REVIEW PROCESS

The Minister for Health and Community Services commissioned the review in accordance with Section 106 of the Act:

> *"The minister must cause a review and report to be made on the operation of the Act as soon as practicable after the expiration of 2 years after the commencement of this Act and thereafter at intervals not longer than five years."*

The Minister approved the Terms of Reference for the review on the 20th November 2002[2]. As documented in the Terms of Reference, the review's scope is as follows:

a) an examination of the effects and operation of the Act since commencement;

b) comparison between the operation of the Act and similar legislation in other jurisdictions;

c) the effectiveness of the current model;

d) the appropriateness of existing practices and procedures in the Act; and

e) the need to introduce amendments to further improve the effectiveness and efficiency of the legislation and to enhance its workability to ensure its relevance to current and future needs of the Territory.

[1] Refer Appendix 11.2
[2] Refer Appendix 11.1

In December 2002 the Minister for Health and Community Services appointed a Steering Committee consisting of representatives of the following organisations/departments:

- Ms Vicki O'Halloran, Somerville Community Services (Chairperson);
- Health and Community Services Complaints Commissioner or delegate;
- Executive Director, Royal Darwin Hospital, Department of Health and Community Services;
- Department of Health and Community Services, CEO's delegate;
- Health Professions Licensing Authority / Professional Registration Boards delegate;
- Top End Division of General Practitioners delegate;
- Integrated disAbility Action delegate;
- Darwin Community Legal Service delegate; and
- Aboriginal Medical Service Alliance of the Northern Territory delegate.

From July 1st to August 29th 2003, the Steering Committee managed a consultation process to canvass the ideas and opinions of government and non-government providers and consumers across the Northern Territory.

In June 2003, a discussion paper was distributed to more than 100 organisations, including complaints authorities in other jurisdictions. Steering Committee members assisted with further promotion and distribution of the paper within their constituency groups.

The review was widely advertised in the Northern Territory media during July 2003.

With the assistance of the Department of Health and Community Services, details of the review, along with the discussion paper and the current Act, were placed on the Health and Community Services Complaints Commission website. Links were established with key sites on the Northern Territory Government website and intranet.

During September 2003, workshops were held in Darwin, Katherine, Nhulunbuy and Alice Springs. The workshops were attended by government and non-government health and community services providers, and consumers and advocacy groups. Participants provided valuable insight into the effects and operations of the Act.

In September 2003, the Minister for Health and Community Services approved the inclusion of an Australian Medical Association representative on the Review Steering Committee. As the review process moved into its final phase, there were also changes to Steering Committee nominations by the Aboriginal Medical Services Alliance of the NT and the two Department of Health and Community Services positions.

The review received 24 submissions[3]. The submissions were analysed in September/October 2003, and complemented by further research on key issues. Other sources of information, such as the 2002 Bansemer Review into the Department of Health and Community Services, were also considered to gain further insight into issues raised during the consultation phase.

The Steering Committee managed the preparation of this paper based on the feedback received during the consultation process and relevant research.

[3] A list of submissions can be found at Appendix 11.3.

The Steering Committee noted with concern that the review was more than three years overdue. Further, the Committee was concerned that the review process, when finally instigated, was not funded.

The time and expertise and budget required to conduct such a review is considerable. The Committee is aware that considerable resources were diverted from the normal operations of the Commission and the Department of Health and Community Services in order to undertake much of the day-to-day review work for consideration by the Steering Committee.

The Steering Committee is particularly appreciative of the support provided by the Health and Community Services Complaints Commission both in funding and administratively. Further, the efforts of the Review Committee also took considerable time and in kind contributions from stretched individuals and organisations. Attendance of members of the Steering Committee at the eight (8) meetings was as follows:

Vicki O'Halloran:	attended 8 meetings
Peter Boyce:	attended 8 meetings
Royal Darwin Hospital representative:	attended 5 meetings
DHCS representative:	attended 5 meetings
Professional Boards representative:	attended 8 meetings
Top End Div of GPs representative:	attended 6 meetings
DisAbility representative:	attended 8 meetings
Darwin Community Legal Service:	attended 6 meetings
Aboriginal Medical service alliance NT:	attended 5 meetings
AMA representative:	attended 3 meetings[4]

The Committee considers that the relevance and quality of the legislation would be better protected if future reviews were scheduled at five yearly intervals, in accordance with the requirements of the Act. Further, the Steering Committee also strongly recommends that future reviews should be properly budgeted for by Government.

At its November 2003 meeting, consumer representatives on the Steering Committee also wished to record their concerns that the Committee was "provider heavy" with Ms Deb Hall and Mrs Kathy de Bretton representing the only "consumer" or "user" perspectives on the Committee.

RECOMMENDATION

1. **Further reviews of the Act be scheduled every five years as required by the Act and adequate funding be provided by government to undertake the review**

[4] Minister approved membership to Steering Committee in September 2003. Five (5) meeting had been held prior to this.

6 OPERATION OF THE ACT SINCE COMMENCEMENT

6.1 INTRODUCTION

The review Terms of Reference require the review Steering Committee to report on:

> *(a) an examination of the effects and operation of the Act since commencement.*

This section provides an overview of the operation and effects of the current Act.

A critique arising from issues raised during the consultation phase of the review and further research, along with key recommendations relevant to this term of reference can be found in Chapter 8 "Effectiveness of the Current Model."

6.2 OBJECTIVES OF THE ACT

The objectives of the current Act are defined in Part 1, Section 3:

a) To establish a health and community services complaints system that —

i) provides an independent, just, fair and accessible mechanism for resolving complaints between users and providers of health services and community services;

ii) encourages and assists users and providers to resolve complaints directly with each other;

iii) leads to improvements in health services and community services and enables users and providers to contribute to the review and improvement of health services and community services;

iv) promotes the rights of users of health services and community services; and

v) encourages an awareness of the rights and responsibilities of users and providers of health services and community services;

b) To set out the powers and functions of the Commissioner; and

c) To develop the Code of Health and Community Rights and Responsibilities.

6.2.1 The Code

In accordance with objective (c) of the Act, the Code of Health and Community Rights and Responsibilities[5] was developed by a Steering Committee appointed by the Minister. The Code was approved by the Minister in April 2002.

The Code is a statement of rights and responsibilities of users and providers of health, aged and disabled services, and is based on eight principles as follows:

[5] Refer Appendix 11.2

1. standards of service;
2. communication and the provision of information;
3. decision making;
4. personal information;
5. the relationship between user and provider;
6. involvement of family, friends, carers and advocates;
7. research, experiments and teaching exercises; and
8. complaints and feedback.

Under Section 5 of the Act, the Commissioner is required, following assessment of a complaint, to determine whether a provider has acted "reasonably" in providing a health or community service. In making the determination, the Commissioner is required to have regard to:

a) the Code;....
b) the generally accepted standard of health services or community service delivery expected of a provider of that kind; and
c) any other matter or information that the Commissioner considers relevant.

The Code is therefore a central element of the Act, as it provides a framework against which the "reasonableness" of provider actions can be assessed, taking into account generally accepted standards of service delivery. All community services and health providers providing services covered by the Act are required to take reasonable steps to comply with the Code, and promote it to all users by prominently displaying it where it is visible to users of the service.

Although central to the independent complaints system, the Code is not currently legally binding. For example, although providers and users are required to take all reasonable steps to comply with the Code, its provisions are not legally enforceable.

6.2.2 Powers and Functions of the Commissioner

Section 12 of the Act provides the Health and Community Services Complaints Commissioner with the power to inquire into, assess, conciliate, investigate, take no further action, and make recommendations on complaints relating to health, aged and disabled services (public and private). Under the Act, the Commissioner has the power:

a) to inquire into and report on any matter relating to health services or community services on receiving a complaint or on a reference from the Minister or the Legislative Assembly

b) to encourage and assist users and providers to resolve complaints directly with each other; to conciliate and investigate complaints;

c) to conciliate and investigate complaints;

d) to record all complaints received by the Commissioner or shown on returns supplied by providers and to maintain a central register of those complaints;

e) to suggest ways of improving health services and community services and promote community and health rights and responsibilities;

f) to review and identify the causes of complaints and to —

i) *suggest ways to remove, resolve and minimise those causes;*
ii) *suggest ways of improving policies and procedures; and*
iii) *detect and review trends in the delivery of health services and community services;*

g) to consider, promote and recommend ways to improve the health and community services complaints system;

h) to assist providers to develop procedures to effectively resolve complaints;

j) to provide information, education and advice in relation to —
i) *this Act;*
ii) *the Code; and*
iii) *the procedures for resolving complaints;*

k) to provide information, advice and reports to —
i) *the Boards*
ii) *the purchasers of community services or health services*
iii) *the Minister; and*
iv) *the Legislative Assembly*

m) to collect, and publish at regular intervals, information concerning the operation of this Act;

n) to consult with —
i) *providers;*
ii) *organisations that have an interest in the provision of health services and community services; and*
iii) *organisations that represent the interests of users;*

p) to consider action taken by providers where complaints are found to be justified;

q) to ensure, as far as practicable, that persons who wish to make a complaint are able to do so; and

r) to consult and co-operate with any public authority that has a function to protect the rights of individuals in the Territory consistent with the Commissioner's functions under this Act.

The Act also requires the Health and Community Services Complaints Commissioner to act *"independently, impartially and in the public interest when exercising his or her powers or performing his or her functions."* (Section 13)

Generally, complaints may be made about any unreasonable or unnecessary act or service provided, or not provided, by health and aged and disability services in the Northern Territory. Possible bases for potential complaints are detailed in Section 23, and specifically include denying or restricting access to a person's health records, breaching confidentiality or failure to exercise due care and skill.

The Commissioner may reject a complaint that he or she determines is vexatious, trivial, frivolous or lacking in substance, or that has already been dealt with by a court, tribunal or registration board.

6.2.3 Processes under the Act

Sections 22 and 23 of the Act specify who is eligible to make a complaint, and the basis for, and manner in which, complaints can be made. These sections generally seek to *"maximise the ease of access to the Commission's services for people from every corner of the Territory....The government believes that the process should be aimed at encouraging users and providers to resolve problems together where possible through various forms of conciliation rather than litigation, and this legislation is formulated to reflect this principle."*[6]

Accordingly, the complaint process established under the current Act encourages informal resolution of complaints, and the Act provides the Commissioner with recommendatory (rather than determinative) powers.

In keeping with this focus on informal resolution where possible, processes established under the Act also:

- encourage the resolution of complaints at the point of service;
- provide an assessment process aimed at ensuring that an assessment takes place within a reasonable period of time;
- ensure that complaint resolution is possible during the informal assessment phase;
- utilise confidential conciliation as the preferred method for formal resolution under the Act; and
- primarily utilise formal investigation of complaints only where there is potentially a substantive or significant public health or safety issue inherent in provider practice.

There are three major stages in complaints processes under the Act:

1. **an informal assessment process**, including, if possible, resolution;
2. **the Commissioner's determination**; and
3. **a formal complaints process** following the Commissioner's determination.

The flow chart at Diagram 1 on the following page provides an overview of the complaints process under the Act. The Section and Part numbers on each element of the flow chart refers to relevant sections of the Act.

The linkage between internal complaints handling mechanisms within provider organisations and complaints mechanisms under the Act, is implied by Section 26 which requires the Commissioner to ensure:

(i) All reasonable steps have been taken by the complainant to resolve the complaint with the provider;

(ii) A reasonable opportunity has been given to the provider to resolve the complaint with the complainant; or

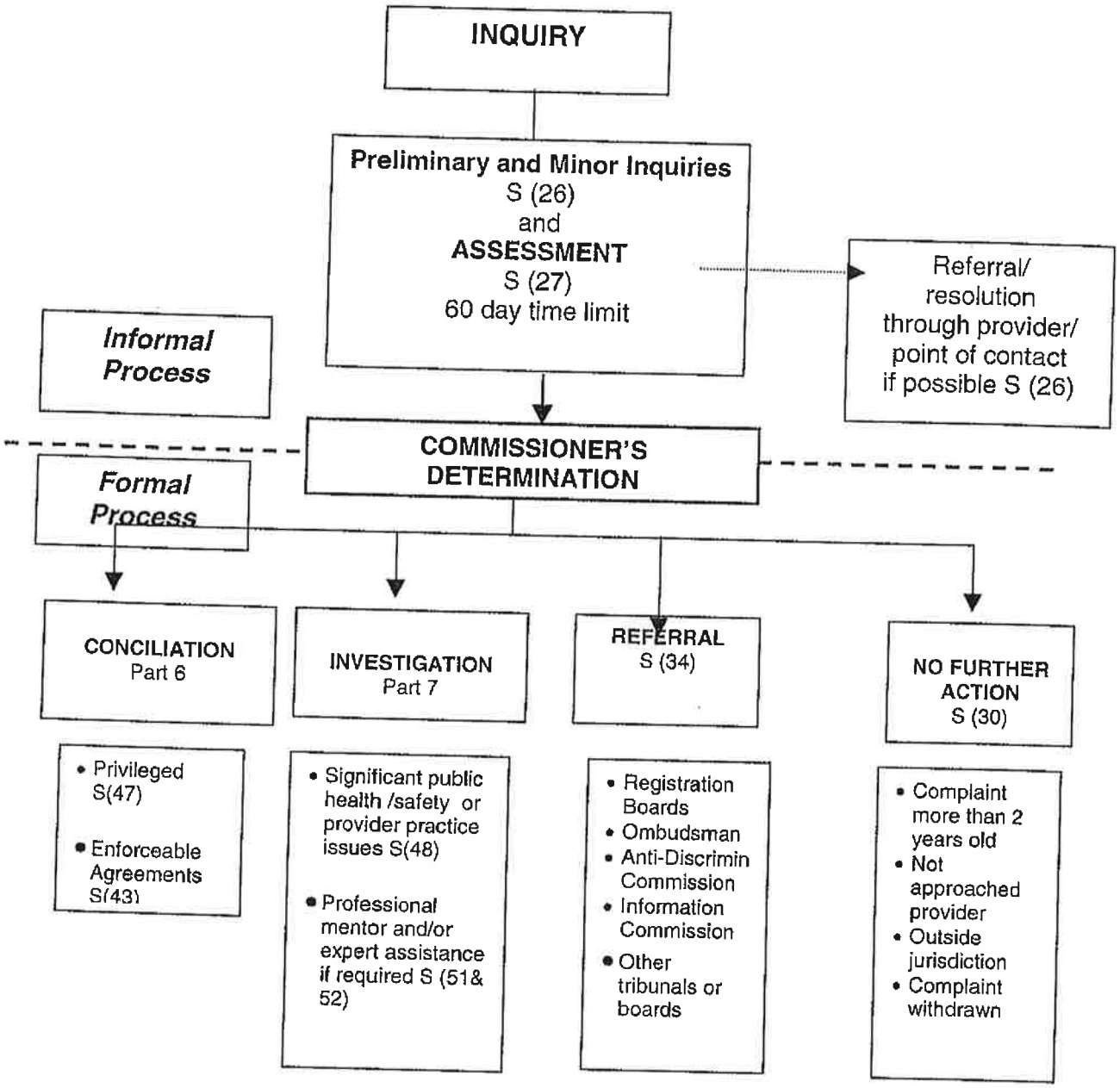
(iii) It is not practical for the steps mentioned in subparagraph (I) to be taken or for the opportunity to mentioned in subparagraph (ii) to be given.

Key features of the complaints process under the Act include:

- Approaches to the Commission may occur through an inquiry, or by the lodgement of a complaint;

[6] Second reading speech, December 1997, Minister for Health and Community Services

Diagram 1: Processes under the Health and Community Services Complaints Act (1998)



Notes:

1. Part 9 of the Act establishes a Health and Community Services Complaints Review Committee with the power to review the conduct of a complaint to determine whether procedures and processes were correctly followed, and to monitor operation of the Act. The review committee does not have the power to review the findings of, or to investigate a complaint.

2. The Health and Community Services Code requires that providers establish and promote an internal mechanism for users to make complaints about their care and treatment. The Code also requires that providers give information about external complaint mechanisms and any available advocacy services. The above independent complaints handling process is in addition to internal complaints handling mechanisms.

- The complaint must be assessed within 60 days of receipt. During the informal assessment phase, Commission Officers gather the information necessary to make appropriate recommendations for further action. Natural Justice is afforded to the named provider, and contact is made with both parties to the complaint. Where appropriate, effort is made to resolve the complaint directly with the relevant service provider (point of contact);
- Judgement concerning the validity of the complaint is not made until the Commissioner has considered all relevant information, including the provider's response to the complaint. The Commissioner's determination is made on the basis of an assessment report.
- The Commissioner may determine to:
  a) take no further action;
  b) conciliate;
  c) investigate; or
  d) refer the complaint elsewhere.

- **Conciliation**:
  The aim of conciliation is to encourage settlement of a complaint by:
  a) undertaking a voluntary conciliation process.
  b) arranging and assisting with discussions and negotiations.
  c) assisting the complainant and provider to reach agreement.

  If an agreement is reached, and put in a binding form, it is enforceable. All information made available or divulged by the parties in a conciliation is privileged information and cannot be used in any other forum unless agreed to by the parties.

- **Investigation**:
  The Commissioner can determine to undertake a formal investigation if he/she considers that the issue or question arising from a complaint appears to be a significant issue of public health or safety and public interest or to raise significant questions as to the practice and procedures of a provider.

  An investigator has all the powers and functions of the Commissioner when undertaking an investigation. An investigator can require a provider to produce relevant documentation, and a penalty of $5000 can be applied if the provider fails to do so. The investigator can also require witnesses to attend in order to examine the person on oath, or to verify information by way of a statutory declaration. Again, a person failing to comply with these powers can be penalised $5000. The Commission, in conducting an investigation, can apply for a search warrant to allow for legal entry and search of a premise.

  The aim of a formal investigation is to prepare a report for the Commissioner on findings and conclusions from the investigation, along with any comments, opinions or recommendations that the Commissioner thinks appropriate. Where the report includes recommendations to the provider, a notice of action is given to the provider, which then has 45 days to advise the Commissioner in writing of the action taken to comply with the report's recommendations.

- **Referral:**
  The Commissioner may determine to refer a complaint to relevant professional boards or other complaints bodies in order that it may exercise its powers and functions in accordance with the most relevant legislation.

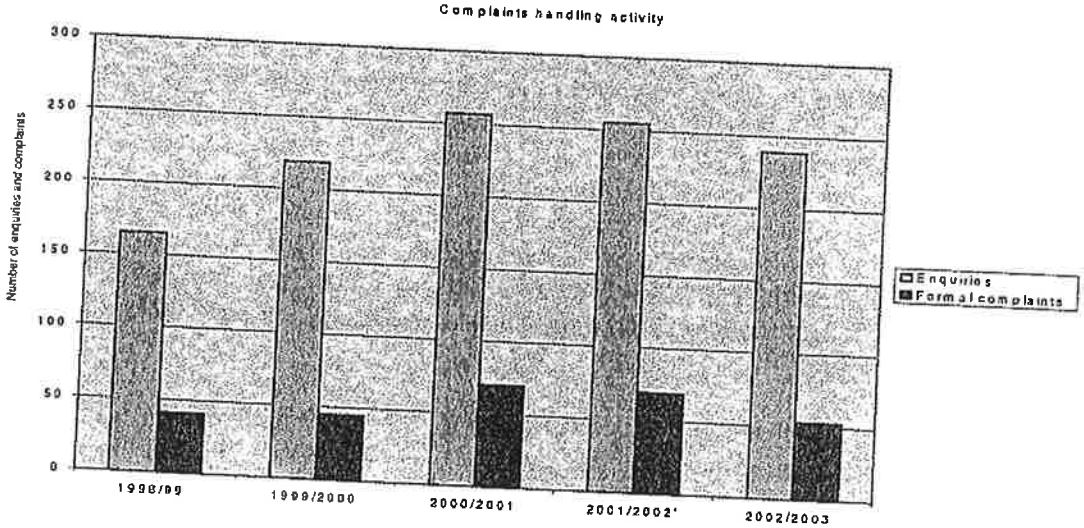
- **Take No Further Action:**
  The Commissioner must determine to take no further action on a complaint if he/she is satisfied that the circumstances giving rise to the complaint occurred more than 2 years before the complaint was made, or the complainant failed to take reasonable steps to resolve the matter with the provider, if the complaint lacks substance or is frivolous, vexatious or trivial or if further investigation is unnecessary or unjustified.

6.2.4 Activity under the Act

Complaints Activity

The level of complaints handling activity under the Act has remained fairly consistent for the five years it has been in operation. However, the Commission's 2002/2003 Annual Report, notes that total enquiry and complaint numbers have reduced for the first time since the establishment of the Commission in July 1998. The report suggests that:

> *"The number of enquiries received by the Commission has not significantly reduced. What has changed is the number of complaints received- 108 this financial year compared with 142 last year. This has been bought about, to a large extent, by the new Enquiry Officers becoming more effective in resolving issues on initial receipt of the enquiry and therefore reducing the number of enquiries that might previously become complaints. Only 22% of inquiries reverted to complaints this financial year compared to 28% the previous year. In addition, funding was reduced for access and awareness last financial year..."*[7]



Majority of complaints resolved informally

Data provided in the Commission's Annual Reports consistently demonstrates that the overwhelming majority of enquiries or complaints are solved informally. This data is further supported by the Commissioner's submission to the review which states:

[7] Health and Community Services Complaints Commission Annual Report 2002/2003 p 33

"Since the Act commenced on 1 July 1998 until 30 June 2003 there have been 1,700 approaches to the Commission. Over the same period of time approximately 75% - 80% of all approaches have been resolved at the assessment stage by either referring the complaint back to the point of service ... or by way of informal processes utilised by the Commission such as mediation, negotiation and/or preliminary inquiries so as to expeditiously resolve a complaint. Thus only a small proportion of the approaches received actually become formal complaints under the Act. Of the matters that became formal complaints under the Act approximately 60% are resolved by formal conciliation and 40% are the subject of an investigation."

The data and the Commissioner's submission support the notion that the complaints model set up under the Act has successfully acted as an alternative to formal litigation.

Low proportion of complaints from Aboriginal people

The low proportion of complaints from Aboriginal people when compared to non-Aboriginal people has remained an issue over the four years of activity under the Act. During the first year of operation, less than 5% of complaints were from Aboriginal people.

The Commissioner's submission to the review states:

Complaints from Aboriginal and Torres Strait Islanders has increased from 5 out of 86 (1998 / 99) to 19 out of 142 (2001 / 02), but still remains low compared to the rate of non-Aboriginal use of services.

The Commissioner acknowledged the seriousness of the issue in the Commission's first Annual Report:

"I am particularly concerned that Aboriginal people within the Northern Territory are significantly under represented in the complaints process and disproportionately over represented in health service utilisation. Within the Northern Territory, Aboriginal people represent 27% of our population and of these 66% live away from the major urban centres on remote communities, outstations and cattle stations. For most, English is a second language. Aboriginal morbidity and mortality is significantly higher than their non-Aboriginal counterparts and around 50% of people accessing the public health system in the Northern Territory are Aboriginal. However, less than 5% of the Commission's complaints this financial year have been from Aboriginal people.[8]"

Over the most recent three years of operation, the proportion of complaints from Indigenous people has remained steady at 13% of total complaints. Although undoubtedly an improvement, the issue is still of significant concern. It is for this reason that the review discussion paper canvassed stakeholder ideas about how the Commission could better engage with Indigenous stakeholders.

Submissions to the review proposed several possible reasons for low access rates by Indigenous people including that many are unaware that they have the right to make complaints or are frightened of victimisation or harassment if they do so.

[8] The First Annual Report of Health and Community Services Complaints Commission, 1998/99

Other suggested reasons were that providers did not adequately promote or explain complaints mechanisms, that some Aboriginal people did not follow up on lengthy complaints processes due to changes in life circumstances (thus allowing the complaint to lapse), and that many Aboriginal people do not feel confident that Western bureaucratic type systems can solve their problems.

Complaints About Aged and Disability Services

The NT, ACT and WA are the only Commissions in Australia which can receive complaints relating to aged services and services for people with a disability. Complaints relating to these services are detailed below:

Aged and Disability Services Complaints

PROVIDER TYPE	98/99	99/00	00/01	01/02	02/03
Hostel/Supported Accommodation	3	2	1	2	0
Nursing Homes	0	0	8	0	1
Mental Health (Public)	3	8	3	6	5
Community Based Support – Disabilities	2	2	2	1	0
Disability Services (Public)	1	1	0	1	0
Total	**9**	**13**	**14**	**10**	**6**

The table shows that the number of complaints against specific disability and aged services has decreased. In addition to the above identified aged and disability services complaints, there are a number of these types of complaints recorded against the public hospital system. Also, during the 2002/03 year, a complaint on behalf of a number of aged clients was lodged by another provider. The Commission referred the complaint to the Commonwealth Aged Care Resolution Scheme, where it was investigated, ultimately resulting in the provision of additional funding to the aged care service along with improved staff training.

The number of complaints from the Aged and Disabled and Aboriginal people are very low in numbers in relation to their numbers in the Northern Territory particularly so with their heavy and often constant reliance on health and community services. The statistics reinforce the acute need for additional advocacy and/or a community visitor schemes to be established.

Customer Satisfaction Levels

The Commissioner's Office routinely forwards customer satisfaction surveys to all parties once a complaint has been finalised. The surveys aim to ascertain each party's view as to service provided by the Commission.

According to the Commissioner's submission to the review:

> *"In the 2001/02 year 99% of providers surveyed indicated that they were satisfied to very satisfied with the processes and procedures followed by the Commission in relation to handling complaints. In 2002/03 the figure was 96% in relation to providers. In 2001/02 70% of complainants indicated that they were satisfied to very satisfied with the processes and procedures followed by the Commission and, in 2002/03 the figure was 68%."*

For more details on the Customer Satisfaction Surveys, please refer to Appendix 11.4.

Efficiency and Effectiveness Indicators
The following data was provided in the Commission's 2002/2003 Annual Report.

Performance Measures	Unit of Measure	2000/01 Achieved	2001/02 Achieved	2002/03 Achieved
Quality	1. Percentage enquiries/ complaints finalised	81%	79%	83%
	2. Percentage enquiries/ complaints informally resolved	68%	66%	72%
	3. Percentage investigations substantiated	100%	100%	100%
	4. Percentage recommendations supported	100%	100%	100%
Quantity	1. Number of enquiries and complaints received	395	397	347
	2. Number of enquiries and complaints finalised	318	408	345
	3. Number of investigations finalised	8	9	7
	4. Number of conciliations finalised	9	10	12
Timeliness	1. Time to acknowledge enquiry/complaint	2 days	2 days	2 days
	2. Average time to close a complaint	N/A	151 days	219 days

Difficulty addressing broader systems or awareness raising functions
For the first four years after establishment, the Commission's Annual Reports documented significant annual increases in complaints workload. In the latest Annual Report, the Commissioner outlines the difficulties in sustaining normal complaints management processes, whilst dealing with additional factors such as providing support for the review of the Act, or the absence of Commission staff for extended periods. The Commissioner concludes with the following comment:

> *"..in preparing submissions for the review of the Act and analysing the performance of the Commission, particularly over the past two years, it is apparent that the staffing level of the Commission is only sufficient to enable it to focus on the core function of handling and resolving complaints. The Commission has not been able to address and respond to other specific functions and responsibilities prescribed by the Act, in particular:*
> - *assisting providers to develop procedures for effectively resolving complaints; and*
> - *providing information, education and advice in relation to the Act, the Code and our procedures for resolving complaints.*

Where the Commission did attempt to meet its wider responsibilities it found itself ineffective in the broader context and its resources too thinly spread."[9]

The Committee views this issue with concern as it would appear that resource limitations have prevented the health complaints system under the Act from reaching its greatest potential. The Committee urges positive consideration of future resource requirements arising from this review.

Requests for Review of Complaints Handling

Part 9 of the Act establishes a Health and Community Services Complaints Review Committee[10]. According to the Commissioner's submission to this review:

"Another indicator as to the satisfaction level with respect to the current model for handling complaints in the Northern Territory is the number of requests for review that have been made to the Health and Community Services Complaints Review Committee. In the period 1 July 1998 until 30 June 2003 only eight requests for review have been made. This represents approximately .05% of all received approaches."

Complaints Commission data shows that only one of the nine requests for review were from health and community service providers.

[9] Health and Community Services Complaints Commission, Annual Report 2002/2003 p10
[10] Refer Note 1 on page 25 of this report.

7 COMPARISON OF THE ACT WITH OTHER JURISDICTIONS

The Northern Territory Health and Community Services Complaints Act (1998) was developed to give effect to an undertaking by the Northern Territory Government under the Australian Health Care Agreement (AHCA) to provide a commission to deal with complaints by users of health services.

In accordance with AHCA requirements, Victoria introduced health complaints legislation in 1987. Similar legislation was enacted by Queensland in 1991, ACT in 1993, NSW in 1994, Western Australia and Tasmania in 1995. With respect to South Australia the NT recently hosted a visit by that state's policy officers regarding implementation of a new Health and Community Services Complaints Commission

New Zealand enacted the *Health and Disability Commissioner Act* in 1994.

In presenting the Northern Territory Bill to the House for its second reading in 1997, the Minister said:

> *"I am pleased to say, Madam speaker, that we have had the benefit of learning from the interstate experience and have modelled our legislation on that in the majority of other states and territories, while addressing many of the functional difficulties they have experienced."*

The first Community Services Complaints Commission Annual Report expands on the Minister's comments by explaining that the Commission was established primarily along the lines of the ACT and Tasmanian models:

> *"The Tasmanian model in particular was seen as relevant because Tasmania had only recently introduced legislation to establish an independent health complaints body, co-located with the Ombudsman's Office. This was the same scenario that was envisaged for the Northern Territory complaints body."*[11]

7.1 A SUMMARY OF SIMILARITIES AND DIFFERENCES

Diagram 2 on the next page lists key elements found in most complaints models, and shows whether each Australian/New Zealand jurisdiction currently incorporates that element.

The Northern Territory's Under Treasurer argues in her submission to the review that:

> *"...the Commission should undertake functions that are broadly consistent with those performed by similar bodies in other jurisdictions."*

Broadly, the Diagram shows that the Northern Territory Health and Community Services Complaints Act is indeed generally consistent with similar legislation in the ACT, Victoria, Queensland, WA and Tasmania, with which it has certain common features.

[11] ibid p11

Diagram 2: Comparison between jurisdictions

COMPLAINT MODEL ELEMENT	NT	NSW	VIC	QLD	WA	ACT	TAS	NZ
Health Commission	•	•	•	•	•	•	•	•
Formal Investigation role	•	•	•	•	•	•	•	•
Formal Conciliation role	•		•	•	•	•	•	•
Advocacy role		•**						•**
Located with Ombudsman's Office	•						•	
Legislation includes services for people who are aged	•	#			•	•		
Legislation includes services for people with a disability	•	#			•	•		•
Consult with Boards	•	•	•	•	•	•	•	•
Prosecutorial function		•						•
Assessment timeframe	•	•	•	•	•		•	
Extension of Assessment option		•	•	•				
Commissioner has determinative powers		*						*
Commissioner has "own motion" powers						•	•	•
Complaints Review Committee	•							
Code	•			•			•	•
Act under Review	•	•			•	•	•	

* South Australia has not yet enacted health complaints legislation. However, the 2003 Health Complaints Bill includes "own motion" powers.

** Responsible for administering, rather than actually providing, the advocacy service. NSW has a separate Patient Support Scheme. NZ's advocacy support is tendered out to non-government organisations.

\# NSW Ombudsman now has jurisdiction over community services.

The common features of the ACT, WA, Victoria, Queensland, Tasmanian and NT legislation are:

- encouraging the resolution of complaints at the point of service;
- providing for, and encouraging informal resolution processes;
- providing an assessment process to facilitate the resolution of complaints at an appropriate level;
- requiring an assessment on the merits of a complaint within a reasonable period of time prior to implementing the formal processes under the Act;

- promoting conciliation as the primary means of resolving complaints;
- requiring formal investigation of complaints primarily where there are substantive/significant issues of public health/safety or of provider practice and procedure; and
- the provision of recommendatory, rather than determinative, powers.

Overall, the complaints models used in Tasmania and the Australian Capital Territory are most similar to the Northern Territory model. The complaints models used in NSW and New Zealand are least similar to the Northern Territory model.

7.2 COMPARING THE DIFFERENT SYSTEMS

Similarities

All Australian states and territories and New Zealand have a statutory complaint handling system. All the complaint systems aim both to resolve individual complaints, and to contribute to the overall improvement of services covered under the Act through systemic, policy or procedural changes arising from analysis of complaints. All the systems have certain common processes, including some form of initial assessment, conciliation, investigation and consultation with Professional Registration Boards. All jurisdictions have defined relationships with the Professional Registration Boards performing regulatory functions over registered providers.

Differences

There are basically two health complaints approaches operating within Australia and New Zealand. One approach emphasises the resolution of complaints through informal assistance or conciliation. This general approach is used in the Northern Territory, WA, Victoria, Queensland, the ACT and Tasmania. However, the provision of "own motion" powers to the Tasmanian Commissioner represents a difference even within this broad model.

The other approach can broadly be described as more adversarial, and includes the power to prosecute. This approach is used in NSW and New Zealand. Both the NSW and New Zealand Acts also provide advocacy services for complainants. Commissioners in NSW and New Zealand also have "own motion" powers.

However, even within the two approaches there are significant differences between jurisdictions in a number of areas. These include:

- the relationship between the Complaints Commissioner and Professional Registration Boards;
- whether the Act provides for an advisory or monitoring committee to oversight or assist the Commission and Minister on complaints issues; and
- the details of the processes to be followed in managing the complaints process.

The span of difference is exemplified by the varying relationships between the Complaints Commissioners and Professional Boards. Although this review found that this was not a hotly contested area in the Northern Territory, this is not the case in other jurisdictions where the degree to which the Complaints Commission or Professional Boards have primary responsibility for investigating breaches of professional standards by registered providers has become an area of concern in some jurisdictions. Some jurisdictions (eg, Tasmania) refer all professional issues to registration bodies. The WA, Qld and Victorian jurisdictions choose matters that will be referred to the Boards. NSW and New Zealand retain all complaints in order to

determine what action should be taken, and whether to prosecute through the relevant Boards, tribunals or other bodies.

In keeping with the underlying emphasis on resolution and conciliation, the review found that a collaborative relationship between the Commissioner and the Professional Boards has developed over time in the Northern Territory, and that this relationship is working well. The review suggests only minor changes to the Act in this area.

The following sections describe in more detail the complaints systems in the two jurisdictions upon which the Northern Territory legislation was largely based, and are therefore most similar, Tasmania and the ACT. The Acts in NSW and New Zealand are then summarised. For ease of reference, complaints legislation in the other states (Victoria, Queensland, and Western Australia) is summarised in table form at 12.1.

7.2.1 Australian Capital Territory Legislation

Purpose and objectives

The *Community and Health Services Complaints Act (ACT)* 1993 is an Act *"relating to the rights and responsibilities of users and providers of health services and to provide for the resolution of complaints arising out of the provision of those services*[12]*."*

The objectives of the Act are to provide an independent, fair and accessible mechanism for the resolution of complaints, to improve provision of health services, to promote the rights of health service users, and to encourage an awareness of the rights and responsibilities of both providers and users.

Powers and Functions of the Commissioner

The Act specifically requires that the Commissioner will encourage and assist users and providers to resolve complaints. Other functions include:

- reporting to the Minister and the Health Rights Advisory Council on issues relating to provision of health services provision and complaints;
- collecting and publishing information arising from operation of the Act;
- encouraging and assisting providers to develop and improve complaints procedures; and
- *"to do whatever is reasonably necessary to ensure that persons who wish to make a complaint are able to do so."* [13]

Act Coverage

Schedule One of the Act lists a broad range of health services covered by the Act, including natural or alternative health care. The list includes disability services, which are defined as *"a service provided in association with the use of premises for the care, treatment or accommodation of persons who are aged or have a physical disability or mental dysfunction".*

Other community services are not covered, as are opinions or decisions relating to workers' compensation.

Bodies Established by the Act

- The Office of the Health Complaints Unit.

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[12] *Community and Health Services Complaints Act 1993 (ACT), Long Title*
[13] S 9, *Community and Health Services Complaints Act 1993 (ACT)*

- Health Rights Advisory Council: the function of the Council is to advise the Minister and the Commissioner on the operation of the Act and related issues, and to refer relevant issues to the Commissioner.

Processes under the ACT Act

Section 53 of the ACT Act requires the Commissioner to develop a Code of Health Rights and Responsibilities based on principles provided within the Act. The principles include that both a provider or a person who provides care for a user *"should be given consideration and recognition for his or her contribution to health care."*

The Commission does not act as advocate for the user or provider, but facilitates a free, independent, impartial and objective investigation.

The ACT Act does not specify a time for the assessment period. Where it is administratively convenient to do so and in the interests of the consumer, Section 25 allows the Commissioner to split complaints. Although complaints must be in writing and signed, the Commissioner can accept an oral complaint where he or she is satisfied that there are good reasons to do so[14].

The Commissioner is required to assess each complaint and determine whether:

- it should be referred to another body
- it should be referred for conciliation
- it should be investigated
- no further action should be taken.[15].

The ACT Commissioner cannot usually take further action on a complaint if the consumer became aware of the circumstances that gave rise to the complaint more than two years before the complaint was made. However, where the Commissioner is satisfied that a complainant has good grounds for not having made the complaint within two years, the complaint can be actioned.[16]. The Commissioner can take no further action when a complainant withdraws a complaint.[17]

Under Section 38, the Commissioner may appoint a person with expertise in the field of dispute resolution to be a professional mentor to a conciliator. An agreement is enforceable when it is reached between the complainant and provider through conciliation, and it is put in an appropriate form within 14 days[18].

Relationship with Professional Boards

Part VII of the ACT Act covers the relationship between Commissioner and Professional Boards. Broadly, the legislation makes it mandatory for the Commission to refer relevant complaints to Professional Boards for action. That is, the ACT Commissioner must refer complaints about registered providers to the relevant Board "if it relates to a matter that falls within the functions given by a law" that governs that Board[19].

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[14] S 26 *Community and Health Services Complaints Act 1993 (ACT)*
[15] S 23 *Community and Health Services Complaints Act 1993 (ACT)*
[16] S 28 *Community and Health Services Complaints Act 1993 (ACT)*
[17] S 29 *Community and Health Services Complaints Act 1993 (ACT)*
[18] S 36 *Community and Health Services Complaints Act 1993 (ACT)*
[19] S 23 *Community and Health Services Complaints Act 1993 (ACT)*

Where a Commission investigation report recommends that a Board perform a function, the Board is required to notify the Commissioner as soon as practicable "whether or not it intends to do so.[20]"

The ACT legislation is currently under review and it is proposed that Professional Boards and the Commissioner will consult and make joint decisions about action to be taken. In the event that they cannot agree as to appropriate action to be taken, then the most serious view will prevail.

7.2.2 Tasmanian Legislation

Purpose
The *Health Complaints Act 1995 (Tas)* was enacted to *"provide for the making, conciliation, investigation and resolution of complaints against health service providers, to make provision in respect of the rights and responsibilities of health service users and providers and for related purposes.[21]"*

Powers and Functions of the Commissioner
The Commissioner is required to receive, assess, investigate and resolve complaints about health services and any other service given by a health service provider, both public and private.

The Commissioner is an independent statutory officer who provides a service to both consumers and providers in an impartial manner. The Commissioner may give advice, information and assistance to either party in order to expedite a satisfactory resolution of a complaint and has the power to receive, assess and resolve complaints, and has the powers necessary to perform any other function imposed on the Commissioner under the Act.

Act Coverage
Health services covered under the Act are listed in Schedule One. The list does not include any community services, except for those provided as part of a health service. Opinions provided in relation to Workers Compensation claims are specifically excluded from coverage.

Bodies Established by the Tasmanian Act
Committees: may be established by the Commissioner as appropriate.

Relationship with the Boards
Boards can, in consultation with the Commissioner, refer relevant complaints to the Commission and vice versa[22]. A Board to which a complaint is referred must take action using its powers and functions, and provide the Commissioner with copies of the report including findings and any action to be taken.

According to the paper prepared for the review of the Tasmanian legislation[23], the Tasmanian Commissioner has limited capacity to oversight the determination of complaints against a provider by the relevant board. This was raised as a significant issue requiring consideration in the review. The Commissioner reported in the 2000-2001 annual report that *"Significant progress has been made in respect of clarifying*

[20] S 59 *Community and Health Services Complaints Act 1993 (ACT)*
[21] Long title *Health Complaints Act 1995 (Tasmania)*
[22] Ibid, S 57
[23] *A review of the Health Complaints Act 1995- Call for Public Comment, Hopcroft, R, 2000*

and strengthening the relationship between the practitioner registration boards and the Health Complaints Commissioner's role....."[24]

Processes under the Tasmanian Act
Complaints must be made in writing and signed, although the Commissioner can choose to accept an oral complaint[25]. Assessment must take place within 45 days of receiving the complaint. There is no capacity to extend the assessment period.

The Commissioner must dismiss a complaint if the complainant became aware of the circumstances that gave rise to the complaint occurred more than two years ago. This requirement does not apply where the Commissioner is satisfied that there were good reasons for not lodging the complaint earlier.[26] The Commissioner must take no further action where a complaint has been withdrawn.[27]

The Commissioner must ensure that each conciliator has a professional mentor available to advise the conciliator in the performance of his/her role. [28]

7.2.3 New South Wales Legislation

Purpose
The New South Wales (NSW) Health Care Complaints Commission was established in 1994 *"to provide people with an effective means of making a complaint about health care practitioners and health care services and to have their complaints handled by an independent, accessible organisation.*[29]"

Section 3 lists the objectives of the NSW Act as:
1. facilitating the maintenance of health services standards,
2. promoting the rights of clients by providing clear and easily accessible mechanisms for the resolution of complaints,
3. facilitating the dissemination of information about clients' rights throughout the health system,
4. providing an independent mechanism for assessing whether the prosecution of disciplinary action should be taken against health practitioners who are registered under health registration Acts.

Powers and Functions of the Commission
The powers and functions of the Commission are governed by the *Health Care Complaints Act 1993 (NSW.)* This Act provides for *"the making, conciliation, investigation and prosecution of health care complaints; to constitute a joint committee of members of Parliament, the Health Care Complaints Commission and the Health Conciliation Registry and to specify their functions; to amend certain Acts; and for other purposes.*[30]"

Section 59 of the Act provides the NSW Commission with powers to investigate health services:

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[24] Tasmanian Health Complaints Commissioner- Annual Report, 2001-2002 p1
[25] S 23 *Health Complaints Act 1995 (Tasmania)*
[26] Ibid, S 25
[27] Ibid, S 30
[28] S 38 *Health Complaints Act 1995 (NSW)*
[29] (Website: www.hccc.nsw.gov.au accessed 13/10/03)
[30] *Health Care Complaints Act 1993 (NSW)*, p1

"which may not be the particular object of a complaint but which arises out of a complaint or out of more than one complaint if it:
a) raises a significant issue of public health or safety, or
b) raises a significant question as to the appropriate care or treatment of clients, or
c) provides grounds for disciplinary action against a health practitioner."

Coverage of the Act

The NSW Act has a wide coverage over public and private health services, including services provided by both registered and non-registered health practitioners, and "alternative" health services.

Community Services are <u>not</u> covered by the Health Care Complaints Act. Under the separate *Community Services (Complaints, Reviews and Monitoring) Act (2002)*, the NSW Ombudsman now has a new statutory division to carry complaints functions in the area of government and non-government community services, including child-protection or out-of-home care decision-making. This separate Act defines community services broadly to include: disability day support, respite and accommodation services, children's services, ageing and home and community care services; and family support services.

Bodies established under the Act

The NSW Act establishes:

- a Health Care Complaints Commission;
- a Parliamentary Joint Committee, to monitor and review the Commission's activities, and
- a separate body corporate Health Conciliation Registry, to manage complaints which are referred to it by the Commission for conciliation.

Processes under the NSW Act

The NSW Commissioner:

- can discontinue action on a complaint if it is made after 5 years unless sufficient reason is given[31];
- must carry out its assessment of a complaint within 60 days after receiving it. However an extension may be granted under certain circumstances.[32].

Relationship with the Boards

Part 2 of the NSW Act enables the NSW Commission and Registration Boards to act collaboratively. This section allows complete information sharing, with a decision to investigate only being made after consultation. Where disagreement occurs as to appropriate action, both bodies retain the right to refer the matter for investigation. Both jurisdictions are able to investigate a complaint that has been subject to Conciliation[33].

NSW is the only Australian jurisdiction that empowers the Commission to:

"(c) Make complaints concerning the professional conduct of health practitioners and to prosecute those complaints before the appropriate bodies, including registration authorities, professional standards committees and tribunals." [34].

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[31] Ibid, S 27
[32] Ibid, S 22
[33] Ibid, S 56, and section 48(2) of *the Health and Community Services Complaints Act 1998 (NT)*
[34] S 80(1)(c) *Health Care Complaints Act 1993 (NSW)*

7.2.4 New Zealand Legislation

Purpose
The *Health and Disability Commissioner Act (New Zealand)* was enacted in 1994. The purpose of the Act is: *"to promote and protect the rights of health consumers and disability services consumer, and, to that end, facilitate the fair, simple, speedy, and efficient resolution of complaints relating to the infringement of those rights."*

Powers and Functions of the Commissioner
The Act created the Office of the Health and Disability Commissioner (New Zealand), whose powers and functions are:

- to draft and promote a Code of Health and Disability Services Consumers' Rights;
- to investigate and refer complaints as appropriate;
- to investigate *"on the Commissioners own initiative, any action that is or appears to the Commissioner to be in breach of the Code"* [35];
- refer complaints or own initiative investigations to the Director of Proceedings for deciding whether further action should be taken in relation to alleged breaches;
- prepare guidelines for the operation of advocacy services; and
- advise the Minister on any matter relating to health and disability consumer rights or administration of the Act

Bodies Established by the Act
An independent Director of Health and Disability Services Consumer Advocacy. The functions of the Director are to administer and promote advocacy services agreements, to oversee training of advocates, and to monitor and report on advocacy to the Minister. In accordance with Section 26 of the Act, *"advocacy services shall operate independently to the Commissioner, the Ministry, purchasers, health care providers, and disability services providers."*

The Commissioner is required to issue guidelines relating to the operation of advocacy services, including provisions on procedures to be used by advocates. The guidelines must be approved by the Minister. The Act specifies the functions of advocates[36], which include assisting an aggrieved person resolve the problem with the provider, and assisting the consumer through the complaints process.

An independent prosecutor, the Director of Proceedings[37]; The Director has responsibility for deciding whether to institute proceedings before the Complaints Review Tribunal or disciplinary proceedings or both.

An independent Complaints Review Tribunal with the power to declare defendants are in breach of the Code, issue orders restraining defendants from continuing or repeating the breach, award damages and order the defendant to perform any acts specified in the order.

Processes under the Act
The New Zealand Act employs the *Code of Health and Disability Services Consumers' Rights*, which has a binding effect on service providers. In New Zealand, once a complaint is acknowledged, a triage team assesses it and recommends to the

[35] Section 14 *Health and Disability Commissioner Act 1994*
[36] Section 30 *Health and Disability Commissioner Act 1994*
[37] http://www.hdc.org.nz/about us/index.html

Commissioner how it should be handled. If the complaint is investigated, the Commissioner then determines whether there has been a breach of the Code, and may make recommendations to the provider, the health professional body, the Minister for Health or another body. In reporting his/her final opinion the Commissioner may refer a complaint to the Director of Proceedings, who may bring disciplinary and / or other proceedings. The principal avenues of redress are a claim before the Human Rights Review Tribunal and disciplinary proceedings before a health professional body[38].

Complaint Procedures

Verbal or written complaints can be received by an advocate or by the Commissioner. On receiving complaints, the Commissioner may:

- investigate the complaint;
- refer the complaint to an advocate for the purpose of resolving the complaint;
- decide to take no further action
- advise the complainant and provider of decision made.

The Act does not specifically provide for an assessment process to assist the Commissioner to make a determination on how to proceed with the complaint.

Relationship with Boards

Where the Commissioner receives a complaint directly involving a registered provider, he/she may notify the relevant professional body, or consult with it as to appropriate action. After investigation of a complaint involving a registered practitioner, the Commissioner must notify the Board of proposed action.

[38] http://www.hdc.org.nz/complaints/index.html

8 THE EFFECTIVENESS OF THE CURRENT MODEL

The Review Terms of Reference require the Steering Committee to report on:

(h) The effectiveness of the current model.

This chapter addresses this term of reference, and commences with an overview of the Northern Territory complaints model. The effectiveness of the Northern Territory model is then assessed in relation to each of the Act's objectives. Key trends emerging in health complaints systems in other jurisdictions are briefly examined.

The chapter concludes with a discussion and recommendations relating to possible enhancements of the current model to assist in more effectively meeting the needs of Territorians in the future.

It is the view of the Steering Committee that the current model is generally effective, and that the complaints system established under the Act largely meets its objectives. Therefore, the recommendations in this chapter seek to strengthen or enhance the existing model.

8.1 AN OVERVIEW OF THE NORTHERN TERRITORY COMPLAINTS MODEL

The Northern Territory complaints model has coverage over Government and Non-government health services, and over aged and disability services within the Community Services sector.

The Northern Territory complaints model:

- aims to be fair, just, independent and accessible;
- promotes the resolution of complaints through informal means such as mediation and conciliation, without recourse to litigation;
- is concerned with supporting health and community service improvement outcomes through learning from complaints issues and applying relevant recommendations into broader health and community services systems; and
- is concerned with raising awareness of the rights and responsibilities of users and providers of health and community services.

In keeping with the focus on resolution and systems improvement outcomes, the Northern Territory model promotes a respectful and collaborative approach to complaints resolution. The Commissioner for Health and Community Services Complaints has recommendatory (rather than determinative) powers. The advantages of recommendatory models are that they tend to promote ownership, collaboration and co-operative resolution of complaints. A disadvantage of the recommendatory model is that many of the outcomes under the Act remain confidential, and the model is therefore frequently perceived to result in few outcomes. From the point of view of many consumers, recommendatory models are seen as "having no teeth", or likely to side with powerful health service providers.

The model differs from adversarial complaints models (such as NSW and New Zealand systems), which include determinative and prosecutorial powers. This type of model creates an adversarial and defensive process, and because all complaints are potentially subject to judicial proceedings, parties are more likely to exercise extreme

caution in venturing opinions, or admitting problems or fault. Adversarial models can therefore be highly resource intensive, and frequently involve recourse to judicial review of decisions made. However, adversarial complaints models can be seen as preferable by consumer groups who believe they offer more protection and power to consumers through having the capacity to legally enforce change.

An important initiative with the potential to impact substantially on the NT complaints model is the current development of "Omnibus" legislation to replace separate legislation establishing the professional registration boards. The directions proposed in the new legislation will facilitate collaboration between the Complaints Commission and the Professional Boards. It is understood that the legislation will enable more immediate and proactive responses to complaints about professional misconduct.

The current NT complaints model is also consistent with the national tort law reform agenda which has developed over the last few years. Broadly, the reform agenda seeks to encourage the economical and early resolution of potential damages claims through the establishment and use of pre-litigation processes. Mechanisms which are gradually becoming available in the pre-litigation phase under various Acts include conferences, mediation, conciliation, sharing of information and serving of notices.

8.2 Is the NT model independent, fair, just and accessible?

Introduction

Objective (a) of the Act requires the establishment of a health and community services complaints system that:

> *"provides an independent, just, fair and accessible mechanism for resolving complaints between users and providers of health services and community services[39]."*

The Steering Committee endorses the current model as generally effective in providing *"an independent, just, fair and accessible mechanism for resolving complaints."*

The Steering Committee bases this broad endorsement on:

- the similarity of the underlying complaints model with complaints systems in most other Australian jurisdictions. This model (as outlined in the previous section) has generally been endorsed as providing the most appropriate mechanism for balancing the competing interests evident in any complaints process.
- the comment made by the Department of Health and Community Services in its submission to this review that *"Overall, the value of the Commission's work to Department of Health and Community Services has been its independent standing between provider and service user(s). This has given consumers the opportunity to make known their concerns to a neutral arbiter.[40]"*
- the consistently predominantly positive assessments made by both complainants and providers in Satisfaction Survey forms that are forwarded by the Commission to

[39] Section 3 NT *Health and Community Services Complaints Act 1995*
[40] Submission covering letter

ascertain views as to the quality of services provided under the Act. (Refer Appendix 11.4 Customer Satisfaction Surveys 1998-2003)

- the small number of requests for review made to the Health and Community Services Complaints Review Committee. Since the Act commenced, there have been 1,700 approaches to the Commission, and only 8 requests (.05%) for review of the complaints process.

- the fact that most changes suggested in submissions to the review relate to specific procedures and protocols under the Act, rather than expressing major concerns with the underlying complaints model.

- the fact that 12 out of 15 review submissions commenting on questions relating to coverage of the Act supported some level of expansion of coverage under the Act into further community services sector areas. The Steering Committee considered it unlikely that increased coverage would have been supported unless the complaints model was seen to be generally independent, fair, just and accessible.

- the assessment by the Commissioner for Health and Community Services Complaints that:

> *"It is my submission that, at a fundamental level, the model as currently contained within the legislation has operated effectively and continues to be a basis for the best approach and best practice dealing with complaints in the Northern Territory context*[41]*."*

The Steering Committee notes however, that not all review respondents would agree with its overall endorsement of the current model as "an independent, just, fair and accessible mechanism for resolving complaints.[42]"

Endorsement not unanimous

The Australian Medical Association of the Northern Territory (The AMA) expressed strong reservations about the degree to which the model is independent, fair, accessible and just:

> *"Sadly, the concerns of the Australian Medical Association and a number of other "provider representatives" appear to have been realised with the intent behind the legislation seemingly lost and the evolution of the Health and Community Services Complaints Commission over the past nearly five years into an advocate for consumers as opposed to an independent body designed to ensure that all parties subject to its jurisdiction are dealt with fairly. .....*
> *All of these factors have combined to result in a Commission that sees itself as an advocate for consumers rights and there have been many instances where the rights of providers have been obliterated in the rush to provide a complainant with their requested outcomes - outcomes ranging from apologies (not unreasonable in proven circumstances) to financial compensation.*
> *The experience of increasing numbers of medical professionals of what can at best be termed unreasonable treatment by the Health & Community*

[41] Submission by the Health and Community Services Complaints Commissioner, p2
[42] Objective a) I) of the Act

Services Complaints Commission raises serious concerns at the manner in which the legislation is being managed and pursued and the Review of the Act is considered long overdue. In short, there are serious problems of interpretation and understanding of the role of the Commission and those problems must be addressed now...Primary to resolving the problems faced must be a closer adherence to the requirements of the legislation, by ALL parties involved and far greater communication between the Commission's office and the party against whom the complaint is made..."

One other provider also expressed concerns about independence, justness and fairness issues. However, the provider saw difficulties in the application of the model, rather than in the model itself. In commenting on the appropriateness of the current functions and powers of the Commissioner, the provider said "*In our view, the current powers of the Act are broadly speaking, appropriate. It is in the interpretation of those powers that potential difficulties lie.*"

The concerns expressed by the AMA and the provider regarding alleged bias of the Commission *towards* complainants were in stark contrast to comments made by some complainants in relation to alleged Commission bias *towards* providers. The following comment, indicating perceived bias in the opposite direction, was made on a Satisfaction Survey Sheet distributed by the Commission to a complainant "*Have your people in a position to help and represent the patient, not as a neutral body obviously leaning towards the hospital side of complaints.*"

The Steering Committee understood that the complaints process can be threatening, frustrating, challenging and demanding to both complainants and providers. The Committee believes that perceptions about the independence, fairness and justness of a complaints process will always be open to interpretation, and that perceptions can, at times, be influenced by outcomes from the process.

A fair, independent and accessible complaints model therefore requires strict adherence to the principles of natural justice and procedural fairness. The Committee is satisfied that the current model provides sufficient procedural integrity and checks and balances in the form of:

- protocols relating to assessment, conciliation and investigation;
- right of reply to complaints;
- independent expert opinions;
- effective protocols and processes for working with professional registration bodies; and
- the existence of the Complaints Review Committee.

Overall, the Steering Committee stood by its broad assessment that the current model generally provides an independent, just, fair and accessible mechanism for resolving complaints. In making this broad assessment however, the Committee identified two areas of some concern, warranting further research and possible improvement or change. These were:

- **concerns regarding accessibility; and**
- **concerns regarding the shared Commissioner/Ombudsman roles.**

Steering Committee concerns re accessibility

The Committee has concerns about the degree to which the current model provides an *accessible* mechanism for all sections of the Northern Territory community. As discussed in Section 6.2.4 of this report, the relative proportion of complaints received

by the Commission from Aboriginal people is much lower than those received from non-Aboriginal people. This problem is also acknowledged in the review discussion paper[43] and in the Health and Community Services Complaints Commission Annual Reports.

One submission to the review suggested reasons for the relatively low proportion of complaints from Aboriginal clients as follows:

> *"Complaints from Indigenous people are low due to two main reasons. The first is due to literacy constraints. Many people, not only indigenous people, will not make a complaint if they have to write it down. If there was a mechanism for receiving spoken complaints which the Commission wrote down and the complainant then signed for, this would help, Many Indigenous people are also uncomfortable around bureaucracies and non-Indigenous organisations and will avoid interacting with them, where possible..."*[44]

Discussions during public consultation workshops consistently reinforced that some Aboriginal people fear retribution or future victimisation if they were to complain about the services they receive.

Submissions to the review included a number of suggestions aimed at increasing the accessibility of the complaints system to Aboriginal people. Suggestions range from the Commissioner having "own motion" powers to allow investigation of issues impacting on Aboriginal health in the absence of complaint, to the establishment of Community Visitors Scheme/Advocacy service, to improved promotional materials and more frequent education and awareness visits.

At its meeting of November 2003, the Steering Committee also expressed concern that people who are aged and have a disability may also have difficulty accessing the complaints mechanism. Commission data is not available to confirm or deny this concern. However, the need for special support for people who are aged or have a disability, to ensure that their rights as consumers and people with particular needs has been acknowledged in other jurisdictions with the establishment of Community Visitor or Advocacy Schemes.

Each of the potential mechanisms to address accessibility issues is examined in detail in the final section of this chapter. The Steering Committee supports serious consideration of each potential strategy as a means of addressing an acknowledged weakness in the current model.

Stakeholder concerns over shared Commissioner/Ombudsman roles

The Steering Committee noted that two submissions raise concerns about issues arising from the Commissioner for Health and Community Services Complaints also having the separate role of the Ombudsman for the Northern Territory.

The Department of Health and Community Services raises this as a significant issue in its covering letter to the submission:

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[43] A Discussion Paper to Seek Input from the Public Review of the Health and Community Services Complaints Act 1998, p9

[44] Comments by Dr Fiona MacDonald, Danila Dilba Health Service, 29/7/03

"An issue not raised in the Discussion Paper is the perceived conflict of interest due to the Ombudsman and Commissioner being the same person. For example, if a provider/complainant has difficulties with the complaint process or decision of the Commissioner, two avenues of redress would be referral to the Ombudsman and/or Review Committee. The Commissioner is part of both these avenues of redress. The apparent conflict of interest could be a disincentive to appeal or make a complaint. The conflict of interest could be mitigated, if the two positions were to continue to be the same person, by enhancing the role of the Review Committee..."

The AMA's submission argues that the current powers and functions of the Complaints Commissioner are inappropriate because they confuse the roles of the Ombudsman and the Commissioner. The AMA suggests that if the functions are to be performed by one person, that there be some specific amendments made to the Complaints Commissioner role and functions, and concludes with:

"If there is to be no change to the powers of the Commissioner then serious consideration must be given to separation of the roles of Ombudsman and Health Complaints Commissioner. The basis for this suggested change is simple. Health is and will always be a complex issue and as such requires a dedicated overseer of any legislation intended to resolve complaints in this area, particularly if a component of the resolution process is to suggest ways that health and community services might be improved. As such it requires the Commissioner to be a person with an appropriate background in health and/or community services, obviously not a requirement for a person holding the position of Ombudsman.

Again it must be reiterated, unless the position is a dedicated one, the role of the Health Complaints Commissioner held jointly by the Ombudsman should be restricted to issues of process i.e. conciliation, investigation and resolution".

History of Role-Sharing Arrangements

The Steering Committee revisited the history of this role-sharing arrangement. According to the Historical Background chapter of the first Annual Report of the HCSCC, a draft Cabinet submission was prepared in early 1996 addressing how the Northern Territory would implement the Medicare funding requirement to establish an independent health complaints mechanism. The submission, prepared jointly by the Ombudsman and by Territory Health Services, sought Cabinet approval for the establishment of an Independent Health Complaints Unit, attached to the Office of the Ombudsman. The submission was never formally presented to Cabinet. In response to an unrelated Cabinet submission requesting additional budget for the Ombudsman, Cabinet advised that the Ombudsman had been given approval to service health complaints. No additional information or funding was provided.

In October 1996 a Project Officer was appointed to implement Cabinet's decision, and to manage the process of establishing the health complaints service. In December 1996, the Minister endorsed the following:

1) that the service be co-located with the Office of the Ombudsman;
2) that the service would:
   a) have its own legislative framework;
   b) employ its own staff;

c) have an identifiable budget;
d) be given the powers of investigation, conciliation and recommendation, but not the powers of adjudication;
e) include all health services provided by the Public Sector, excluding Northern Territory –funded non-Government services.

Following the Minister's endorsement, all interstate health complaint legislation was to be examined. It was decided that the Northern Territory Health Complaints Commission would be established primarily along the lines of the ACT and Tasmanian models. The Tasmanian model was seen to be particularly relevant because it had recently established a health complaints body co-located with the Ombudsman.

Cabinet approved the establishment of the Northern Territory Health Complaints Commission in 1997, along with recurrent funding of $167,000. Following community consultation, the Government approved the extension of coverage of the Act to include non-government health services, and aged and disability services.

Following assent to the Act in March 1998, the Ombudsman, Mr Peter Boyce, was formally appointed as Commissioner for Health and Community Services Complaints.

Possible Changes to role-sharing arrangements in Tasmania

The Steering Committee further noted that the Review Advisory Committee oversighting the 2003 review of the Tasmanian Health Complaints Act recommends the appointment of a full time Health Complaints Commissioner:

> *"The Committee believes that the health complaints jurisdiction is significant and sufficiently specialised to warrant a full-time Commissioner and a separate budget.*[45]"

The Tasmanian report examines the advantages and disadvantages of the current shared-roles arrangement in order to reach this recommendation.

The Steering Committee considered that:

- concerns raised in submissions,
- the history of the Commissioner/Ombudsman role-sharing arrangement in the Northern Territory ;
- recent developments in Tasmania; and
- an absence of comment about this issue in the Commissioner's submission to the review-

warranted a request that the Commissioner comment specifically on the effectiveness of the current complaints model in relation to the joint role-sharing arrangement.

Effectiveness of the current co-location model

The Commissioner was asked to comment on the effectiveness of the current co-location model. He stated that it was important to understand that although the Office of the Ombudsman and the Health and Community Services Complaints Commission were co-located they were for all intent and purposes separate identities in that they have:

- separate and distinct legislation;
- separate and distinct budgets;

[45] *Review of the Health Complaints Act 1995 Report of the Review Advisory Committee April 2003, p6*

- separate and distinct statutory office holders appointed by the administrator (It so happens that the one person has been appointed to both statutory offices);
- separate staff;
- separate delegations;
- separate policies and procedures; and
- separate management complaint systems, albeit that they use the same data base.

It was recognised at the time government made the decision to co-locate the two offices that there may have been a perception that there was no avenue for the administrative actions of the Commission to be reviewed by the Ombudsman because the Commissioner would in effect be reviewing himself. Although in practice this would not have been the case as such a complaint would go to staff within the Ombudsman's Office, an independent review committee was established under the *Health and Community Services Complaints Act* to review such matters. There is no review process similar to that set up in the NT legislation and this is an important difference in terms of providing a right of review.

It was also recognised by government at the time that there were a number of benefits that would accrue from such a co-location, these being:

- savings in rental costs as there was no need for separate accommodation;
- savings in power, telephone and IT costs;
- flexible and efficient use of administrative resources;
- flexible use of staff for access and awareness purposes;
- savings in having only one person as the statutory office holder for the two agencies; and
- ability to utilise the staffing resources of the Alice Springs office.

The co-location model developed between the Office of the Ombudsman and Commission has proved to be very effective and efficient. Not only that, but there have been no complaints received over the five year period that related in any way to there being a conflict between the two roles of Ombudsman and Commissioner.

Because the Commission is separated from the Office of the Ombudsman as described above, if government decide, it can be separated off at any time as the legislation and current structure would allow this to happen. To do so however, would require additional ongoing funding in the order of $300,000 to $400,000 for the following new requirements, and the Commissioner does not consider this to be cost effective given that there has been no problems identified with the current co-location arrangements:

- accommodation;
- full time Commissioner;
- reception/enquiry officer;
- administrative support; and
- additional power, telephone and IT costs.

8.3 DOES THE MODEL ASSIST IN COMPLAINTS RESOLUTION?

Introduction

Objective a (ii) of the Act is to:

"establish a health and community services complaints system which encourages and assists users to resolve complaints directly with each other."

Other Sections of the Act requiring, encouraging or assisting direct complaints resolution are:

- Section 26, under which the Commissioner may make preliminary or minor enquiries in respect of a complaint to satisfy him/herself that *"a reasonable opportunity has been given to the provider to resolve the complaint with the complainant"* or that it is not practical to do so;
- Section 30, under which the Commissioner must take no further action if the complainant has failed, without good reason or cause, to take reasonable steps to revolve the complaint with the provider; and
- Section 38, which includes the functions of conciliators as assisting the complainant and provider to reach agreement and resolving the complaint in any other way.

These provisions are designed to give effect to the Northern Territory Government's direction that *"the process should aim at encouraging users and providers to resolve problems together where possible through various forms of conciliation rather than litigation."*[46]

The Steering Committee commends the current model as highly effective in encouraging and assisting users and providers to resolve complaints with each other. This positive assessment is based on:

- complaints data provided by the Commission;
- the establishment by the Commission of an expeditious complaints resolution process during the assessment phase; and
- efforts by the Commission to promote pro-active complaints resolution by service providers in order to prevent concerns escalating into major complaints.

Complaints Resolution Data

The Steering Committee considered the fact that 75% - 80% of all approaches to the Commission have been resolved at the assessment stage as strong evidence of the model's effectiveness in assisting complaints resolution. The use of informal processes such as mediation, negotiation and/or preliminary inquiries so as to expeditiously resolve a complaint were also seen as evidence of a pro-active approach to complaints resolution.

Expeditious Complaints Resolution

The Health and Community Services Complaints Commission submission to the review describes how procedures have been established under Section 26 of the Act to facilitate resolution of complaints during preliminary and minor inquiries:

"(Section 26) ....accommodates the possibility of ascertaining whether all reasonable action by the parties has been considered prior to recourse to the assessment process. The aim is to facilitate communication between the parties with a view to resolving the issues of complaint without recourse to outside intervention..... The Commission is of the opinion that an informal process that enables "expeditious resolution" is not only appropriate in that it allows flexible compliant

[46] Second Reading Speech

resolution practices (sic) it meets the current and future needs of Territorians"[47].

The Commission submission later describes the expeditious resolution process:

> *"...the Commission has employed a process of "expeditious resolution" outside the assessment timeframe to assist informal resolution of complaints without having recourse to the formal processes of conciliation.*
> *The Commission adopts a 'mediation' framework to assist the process. The mediation is confidential to the parties and is usually restricted to one meeting. The issues are normally less serious and do not warrant recourse to the conciliation process, which utilises an expert opinion for clarification of issues. The mediation model is consistent with the principles of "open disclosure"*[48]
>
> *If mediation is not successful the Commissioner may then give consideration to referring the complaint for further assessment as to whether the complaint should be referred elsewhere, conciliated, investigated or taken no further.*
> *It is submitted that within the legislation there be specific provision to proceed to informal mediation within the context of the assessment process and as already submitted this should be a privileged confidential environment and legislation should provide for it*[49].

The Steering Committee endorses the expeditious complaints resolution process as consistent with the spirit of the Act, and will address formalising procedural aspects of this process in Chapter 9 of this report[50].

Commission efforts to promote effective resolution processes

The Steering Committee considered that Chapter 1 of the 2001/02 Commission Annual Report provides evidence that the Northern Territory's complaints resolution model encourages and assists the direct resolution of complaints, and that this approach is actively promoted by the Commission. The chapter, "Consumer Complaints Provide a Risk Management Opportunity for Providers", argues the case for direct resolution of complaints between providers and users, and outlines the opportunities to do so through the existing processes under the Act.

The report identifies several opportunities available to providers under the Act to resolve user complaints. These opportunities are:

- internally before an inquiry is made to the Commission;
- during the Commission's assessment phase; and
- during conciliation.

According to the chapter, the Commission generally receives complaints because *"either the complainant is not satisfied with the provider's explanation or the complainant has valid reasons for not going to the provider direct. Reasons or causes for a complainant not previously contacting the provider might include:*

- *the person not being physically or emotionally capable;*

[47] Submission by the Health and Community Services Complaints Commission p 18
[48] Australian Health Law Bulletin, Vol 1, No 4
[49] Submission by the Health and Community Services Complaints Commission p 20
[50] Refer to sections 9.7 and 9.8

- *a perceived power imbalance by the complainant;*
- *the complainant having a strained and negative relationship with the provider; or*
- *the very nature of the complaint eg attitude of the provider, lack of knowledge by the complainant or sexual misconduct.*[51]"

The report advocates that providers take a "risk management approach" to complaint resolution by making early decisions regarding:

- *"the extent of detail required to respond adequately and openly to issues of complaint;*
- *the provision of an expression of regret, ie saying sorry for the mistake or harm done;*
- *the realism of the outcomes sought by the complainant; and*
- *how they can participate in resolving a complaint."*

The report argues that if this approach is taken, it will be *"more likely...that a complainant will accept the response and move on."*

The Steering Committee considered that the chapter demonstrated a commendable proactive approach by the Commission to encourage providers and users to resolve complaints.

Further, the Committee considered the possible reasons that complainants may not approach a provider about a complaint in the first place were especially useful in considering the grounds on which the Commissioner may decide not to immediately refer a complainant back to the provider.

Opportunity for Procedural Improvement

The Committee considered that an AMA submission comment suggesting a need for some procedural refinements within the Commission's complaints handling system. The AMA recounts "anecdotal" evidence from "a number" of providers that the first a provider hears about a complaint is a letter from the Commission. The Committee supports the AMA's contention that "*surely the staff of the Commissioner's office have an obligation to at least ensure the provider is aware of the complaint prior to embarking on the formal assessment /investigation process?*"

The Steering Committee believes that a telephone call from the Commissioner's Office to the relevant provider informing them that a letter regarding a potential complaint is forthcoming, would assist in establishing a cordial and mutually respectful relationship. Such relationships have the potential to be more effective in the direct resolution of complaints.

The Committee understands that such courtesies were once routinely in place, but have more recently not always been followed due to increasing case load and work pressures. In the interests of seeking informal resolution of complaints it is suggested that this courtesy be re-instigated.

The Commissioner noted the AMA's submission but maintained that it is important to separate a realistic need for legislative change from the need to refine and develop processes within the context of the overriding legislation.

[51] Annual Report Health and Community Complaints Commission, 2001/2002 pp 10-11

Overall, the Steering Committee concluded that the current complaints resolution model has been remarkably successful in encouraging and assisting users and providers to resolve complaints directly with each other. However, the Committee commends a number of procedural amendments to further strengthen this approach. The recommended amendments are discussed and listed in Chapter 9.

8.4 HAS THE MODEL IMPROVED SERVICES?

Objective a (iii) of the Act is:

> *"to establish a health and community services complaints system which leads to improvements in health services and community services and enables users and providers to contribute to the review and improvement of health services and community services."*

Provisions within the Act potentially allow user and provider contribution to service improvement at all stages of the complaints process.

Service Improvement Outcomes as described in Annual Reports

In assessing whether the current complaints model is effective in this area, the Steering Committee considered information provided in the Health and Community Services Complaints Commission Annual Reports since its establishment in 1998. Each Annual Report specifies achievements in relation to "improved delivery of health services and community services". This information was used to assess whether the current model is effective in the area of service improvement outcomes.

Complaint case studies outlined in Annual Reports provide information on the nature of the complaint, the issues raised by the complaint, the investigation and/or conciliation process, recommendations made, and how the recommendations were responded to by the provider.

The Committee was pleased to note evidence of improved service delivery through the complaints process in the following areas as outlined in the case studies:

- establishment of guardianship arrangements;
- development and implementation of service provision guidelines by a home and community care provider;
- improved procedures for dispensing of Schedule 8 drugs by a chemist;
- promotion of appropriate use of authority prescriptions;
- improved security arrangements at a mental health facility;
- improved access for people with a disability at a public hospital;
- improved security of records at a community health clinic;
- up-dated regulatory provisions regarding dispensing of medication by Aboriginal Health Workers;
- improved policy, protocols and systems in relating to duty of care to carers;
- improved assessment systems for home care services;
- improved systems in relation to access to medical care in prisons;
- better management of renal/diabetes patients in Central Australia;
- improvements to an Aboriginal Aged Care facility;
- better reporting to the Coroner;

The Commissioner made the following qualification as to the extent of information that he was able to make available in reporting:

> *"It is perhaps important to note that in regard to formal conciliations under the legislation, the confidentiality provisions prevent such matters being reported upon. It is important, however, to note that many complaints to the Commission are resolved by conciliation and conciliation provides a wide scope for innovative and effective resolution of complaints, including the payment of compensation in matters akin to negligence issues."*

Please find at Appendix 11.5 full details of three of the above complaint outcomes as provided in Health and Community Services Complaints Commission Annual Reports.

The Steering Committee:

- endorses the case studies as evidence that the complaints model has been effective in bringing about demonstrable improvements to various aspects of the health and community services system;
- recognises that the case studies selected for inclusion in the Annual Reports, represent a proportion of a range of other improvements which will also have occurred as a result of complaints processes;
- understands that the case studies also demonstrate that complainants and providers, by their involvement in the complaints resolution process, are active contributors to service improvement outcomes; and
- commends the information provided in the case studies to policy makers, managers and educators as useful tools for future improvements to health and community services systems.

Committee concerns re impact of Health and Community Services Complaints Commission resourcing

In spite of these positive outcomes however, the Steering Committee was concerned to note comments made by the Commissioner in his submission to the review:

> *"Due to resource and workload constraints the Commission's current core business is predominantly complaint handling. Accordingly, rather than taking a pro-active approach, as envisaged by the Act, the approach taken is reactive. It is my view that the objectives of the legislation evidenced by the powers and functions of the Commissioner may be subject to some criticism in the review of the legislation as not being achieved. The reality is that I believe the legislation in its current form is adequate and the effectiveness of the Commission in this area is primarily a resource issue. Whilst I do believe the Commission has added value in terms of advocating and initiating improvement in service delivery its impact could have been more significant.[52]"*

While the Committee has concluded that the current model has had a positive impact on improving services, it also acknowledges the Commissioner's concerns that potential broader systems improvement initiatives have been limited by inadequate resources. Any expansion of coverage of the Act into other community services has the capacity to exacerbate resourcing issues.

[52] P 10

Chapter 10 of this report assesses the budget implications of possible changes arising from the report's recommendations.

8.5 HAS THE MODEL RAISED AWARENESS OF RIGHTS AND RESPONSIBILITIES?

Objective a (iv) of the Act is:

> *"to establish a health and community services complaints system that encourages an awareness of the rights and responsibilities of users and providers of health services and community services".*

The Steering Committee endorses the current complaints system as partially effective in achieving this objective.

The Code of Health and Community Services Rights and Responsibilities

The Committee largely bases this assessment on the successful development and promulgation of the Code of Health and Rights and Responsibilities[53] (the Code) as required under Section 104 of the Act.

As outlined in Section 6.2.1 of this report, the Code is a significant document that defines the rights and responsibilities of both users and providers of health and community services in the Northern Territory, and is used as the framework for determining whether a provider has acted "reasonably" in providing a service.

The Steering Committee understands that since its approval by the Minister, the Code has been printed and widely distributed by the Commission to provider organisations and advocacy groups, and has been actively promoted in education and outreach visits by Commission staff.

However, it was evident during review consultation workshops that many consumers and providers were unaware of the existence of the Code, and therefore also unaware of its potential significance as a benchmark for evaluating and improving day-to-day delivery of services and as a framework for complaints handling.

Anecdotal feedback from provider groups also indicated that the Code is not generally referred to in organisational training or orientation programs. Availability of the document to the public on display stands is, at best, spasmodic, and is dependent on regular supplies of copies from the Commission.

Concerns re appropriateness of the Code for some Aboriginal people

Informal feedback during review consultation workshops also indicated concern that the Code, in its current form, was inappropriate for some Aboriginal people. Interestingly, at least one provider organisation is attempting to re-write the Code using plain English, in order to promote it more effectively with Aboriginal people.

Several submissions to the review emphasised the importance of providing information about all the Commission's activities in an appropriate format for Aboriginal people. The importance of this issue is highlighted by the comment from Danila Dilba that many Aboriginal people do not make complaints because:

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[53] Refer Appendix 11.2

"they first need to know that they are entitled to make a complaint. This may mean changing a long held perception that people have to settle for the service offered, as to object could result in no service at all."

Concerns about user/provider balance in Code

The Northern Territory Code is unique amongst similar documents developed in other jurisdictions in that it addresses both user *and* provider rights and responsibilities. However, the Steering Committee notes concerns about the Code expressed in submissions from the AMA and a provider.

In the background to its submission, the Australian Medical Association argues that the Commission *"sees itself as an advocate for consumer rights"* and later goes on to say:

> *"The development and release of the Code of Conduct with its terminology focusing on the rights of the user and the responsibility of the provider and the very brief acknowledgement in Principle 5 of the rights of providers only served to further reinforce the community view that any and all concerns, real or imagined, would be investigated to the fullest extent of the law with little if any requirement on those making a complaint to prove the basis for a complaint prior to its proceeding".*

This submission implies that the Code was developed by the Commission when in fact it was developed by the Steering Committee representing all parties.

One provider, although welcoming the Code, suggests a number of specific changes aimed at *"providing more equitable treatment of both users and providers under the Code."* In particular, changes are suggested under "Principle 5: The Relationship between User and Provider" to address what should happen in the event of irreparable damage to a therapeutic relationship.

At its November 2003 meeting, the Steering Committee considered issues around the status of codes, and the circumstances under which they should become binding, that is, be legally enforceable. The Committee asked that this issue be further researched.

The Committee subsequently considered a 1998 paper prepared by the Minister for Customs and Consumer Affairs.[54] The paper defined a Code as a *"document which sets out specific standards of conduct for an industry in relation to its customers"*. It described codes as one of many possible industry regulation mechanisms.

The paper proposed a regulatory spectrum:

> *"Between the extremes of no regulation and regulation by legislation, there has emerged a range of options to govern behaviour. Progressing from the least regulatory to the most regulatory, the spectrum could be described by the following diagram.*

No Regulation Self-Regulation Quasi-Regulation Co-Regulation Legislation ▶

> *Codes of conduct can be described in terms of any of these options depending upon the extent of Government involvement, community*

[54] Codes of Conduct Policy Framework , Hon Warren Truss, Department of Consumer Affairs, March 1998

perception about the need to comply with a code and the presence or absence of public enforcement." [55]

The paper argues that regulation should only be strengthened as a last option. The paper proposes that voluntary codes are the preferred form of self-regulation as compliance costs are minimised, and they allow the industry to be responsive to changing consumer expectations. However, the paper warns that, to be effective, Codes must be supported by:

- providing avenues of redress where the standards in the Code are breached;
- promoting the Code and its standards to the industry and consumers;
- ensuring some form of accountability and reviewing of industry performance in relation to the Code.
- committing financially to properly administering the Code; and
- continually reviewing and improving the Code.

The Steering Committee supported the paper's thesis that Codes were a valuable regulatory mechanism, particularly when properly supported. However, in light of the above paper, the Steering Committee considered that increased ongoing effort was required both by the Commission and the health and community services industry to increase the Code's effectiveness.

Overall, the Committee sees the development and initial promulgation of the Code as a valuable mechanism to raise awareness of the rights and responsibilities of both users and consumers.

However, the Committee supports an assessment of the Code in light of comments made to the review, and more effective promotion of the Code as a high priority. Furthermore, the Committee suggests that the Code be reviewed every time the Act is reviewed.

The Committee is concerned that resource limitations resulting in the need to focus on complaints resolution at the expense of Code-related activities may have curtailed effectiveness of efforts in this area.

The Committee considers that a sufficient budget should be provided to develop and continually improve the support systems necessary to ensure effective use of the Code. If such support systems are properly implemented and monitored, the Committee agrees that the Code should not be made binding.

RECOMMENDATIONS

2. The Code of Health and Community Services Rights and Responsibilities be reviewed to take into account:

- **review submissions relating to more equitable treatment of provider rights in the Code; and**
- **promoting understanding by Aboriginal people.**

3. That the Code also be reviewed whenever the Act is reviewed.

4. That sufficient budget be available for:

[55] ibid p8

- **preparation of materials about the Code in appropriate formats and media;**
- **regular reprinting and distribution of the Code to providers across the Northern Territory; and**
- **annual access and awareness visits to all major Northern Territory centres and to prescribed providers.**

5. **That the Commissioner write annually to provider organisations promoting the existence of the Code, its use in staff training and orientation programs, and in internal complaints handling systems.**

8.6 Overall effectiveness of the current model in the NT context

In summary, the review Steering Committee generally endorses the current complaints model as effectively meeting its objectives. The Committee is satisfied that the model is independent, fair and just, and assesses the model as effective in promoting the resolution of complaints, and in promoting broader service improvement outcomes from individual complaints.

The Committee has some concerns about the accessibility of the complaints system to the Northern Territory's Aboriginal population, the aged and people with a disability, and the degree to which the system has been successful in promoting increased understanding of user and provider rights and responsibilities in relation to health and community services.

Overall, the Committee is therefore of the opinion that the basic features of the current complaints model should be retained. The Committee considers that the underlying model may be further enhanced in some areas.

8.7 Emerging Trends in Complaints Management

Increased focus on health complaints management

In July 2003, the Australian Council for Safety and Quality in Health Care sponsored a consultancy to undertake a literature review on innovation and best practice in complaint management. According to this review[56], there are several significant developments in health sector complaints management including:

- the discovery in the early 1990's of the unacceptable level and rate of adverse events in the provision of medical care and health services;
- increased policy attention from individual to system-wide approaches to improving safety, risk management and quality in health care;
- general heightened concern about consumer issues and rights, and in particular in the establishment of health care complaints commissions in each State and Territory in the 1990's;
- the development in most states and territories of policies, standards or guidelines on complaints management in health care services; and
- considerable attention paid to identifying and dealing with the "epidemic" of medical litigation.

[56] Turning wrongs into rights: learning from consumer reported incidents. An annotated literature review July 2003, Department of Health and Ageing, 2003

Together, these developments have provided a context in which complaints management has been given increased attention and focus.

Mediation and conciliation in preference to litigation
In an increasingly litigious era (with associated high-level stakes arising from legal costs and imposed penalties), the focus on non-litigious approaches to complaints resolution has increased across Australia. The need for such approaches has also been reinforced by the current medical indemnity crisis.

Comments made by the ACT Health Complaints Commissioner in the Commission's 2002 Annual report reflect these concerns:

> *"The medical indemnity crisis has raised awareness about the cost of civil actions against health service providers and the high legal costs associated with those cases. This has highlighted the need for this office to make effective use of mediation and conciliation as a form of alternative dispute resolution. I also plan to make better use of conciliation in cases where consumers lodge complaints because they want to participate in the process of service improvement."* [57]

The rise of medical litigation and the increased costs for medical indemnity insurance have together increased interest in models of complaint management which promote the informal resolution of complaints through mediation or conciliation rather than adversarial/prosecutorial approaches. An acknowledged trend in all Australian jurisdictions is toward informal early resolution of complaints wherever possible.

Increased focus on systems-improvement
Traditionally, the focus of complaint management has been on the resolution of individual complaints. However, recent years have seen an increasing emphasis on routinely examining the complaint outcomes in order to clarify the broader lessons for improving health services and systems. Increasingly, complaints management models use a broad quality improvement approach by recognising the systemic nature of most adverse events, and by promoting open communication when things go wrong. Such systems improvement models require the development of an organisational culture and associated systems that ensure that adverse events and consumer feedback generate opportunities for learning.

Learning rather than blaming
Associated with systems improvement approaches is a desire to avoid blaming or punishing individuals who make mistakes. Instead, the new models seek to foster organisational cultures that support constructive learning and systems improvement from mistakes. This constructive approach has recently resulted in more frequent use of root cause analysis during complaints investigations. Root cause analysis is a structured and process-focussed framework for investigating organisational or systems factors which may have contributed to a problem. Once the analysis has determined which factors have contributed to the problem, changes can be made in an effort to prevent similar problems again. A cardinal tenet of such analyses is to avoid "the pervasive and counterproductive culture of individual blame."[58]

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[57] ACT Community and Health Services Complaints Commissioner Annual Report 2002-2003
[58] *Root Cause Analysis*, Wald H & Shojania K, p1, accessed at www.ahcpr.gov/clinic/ptsafety/chap5

The Steering Committee endorses the complaint's model implicit in the current Northern Territory Act as consistent with these developments and directions. Specifically, the NT health complaints model as it stands supports:

- the establishment and use of health complaints within provider organisations;
- fostering the informal resolution of complaints through point of service contact where possible;
- promoting the resolution of complaints through conciliation wherever possible;
- seeking to bring about improvements to broader health systems and services; and
- working collaboratively with registration boards to facilitate the maintenance of professional conduct standards across the diverse health and community services sector.

However, the Steering Committee was of the opinion that the effectiveness of the complaints model under the Act could be enhanced by:

- **providing training to provider organisations in how to undertake systems improvement-oriented approaches to internal complaints management, including how to conduct root cause analysis of significant adverse events internally;**
- **ensuring that the Commission is adequately funded to undertake its systems improvement functions;**
- **establishing and maintaining clear mechanisms to feedback systems-level complaints findings from the Commission to provider organisations;**
- **approving the recommended enhancements to the NT complaints model as outlined later in this Chapter; and**
- **approving amendments to procedures and practices as recommended in Chapter 9 of this report.**

8.8 ENHANCING THE CURRENT COMPLAINTS MODEL

The review discussion paper[59] canvassed opinions on a number of issues relating to the current Northern Territory complaint system. Some of the issues related to the appropriateness of the broader complaint model established by the Act. Other issues addressed by the report were at the practices and procedures level.

The purpose of this section is to outline possible changes to the underlying health and community services complaints *model* in the Northern Territory. As the changes are potentially quite significant, each one is discussed in detail, and a summary of review submission opinions about the issue is provided. Finally, the Committee makes specific recommendations in relation to each issue. Where submission opinions are clearly split, optional recommendations have been provided.

The following issues relate to the underlying complaints model in the Northern Territory:

- the breadth of coverage of health and community services under the Act;
- the appropriateness of the powers and functions of the Commissioner;
- whether the Code should have a binding effect on users and providers;
- whether the model should incorporate a Community Visitors Scheme;
- whether the Act should be amended to provide for enforcement of the Commissioner's determinations against unregistered providers.

[59] A Discussion Paper to Seek Input from the Public Between 1 July and 29th August 2003 Review of the Health and Community Services Complaints Act 1998.

8.8.1 Coverage of the Act

The Act sets out definitions of "health services" and "community services" to which the Act and the Code are applied. The review discussion paper sought to canvass opinions on the adequacy of these definitions, and therefore coverage, of the Act.

8.8.1.1 Health Services

In broad terms, "health services" are defined as all services provided in the Territory for the benefit of the health of a person. Coverage under this definition includes all government and non-government health-related services, including those provided by both registered and non-registered providers. Alternative and complementary health services are also included, as are mental health services and administrative actions undertaken to support the provision of services.

The health services definition used in the Northern Territory is similar to that used in other Australian jurisdictions.

The review discussion paper pointed out that the definition of health services does not make it clear whether a complaint can be accepted about the provision of a services to a deceased person, such as forensic or mortuary services.

The majority of submission responses recommended that the definition of health services should be expanded to include complaints relating to services to a deceased person.

RECOMMENDATION

6. **That the definition of health services be expanded to include services to a deceased person.**

8.8.1.2 Community Services

Section 4 of the Act defines Community services as: *"a service for aged people, or for people with a disability."*

The term *'community services'* by connotation would ordinarily be interpreted by the public to extend beyond this definition. It has been the experience of the Commission that the narrow definition has caused confusion and frustration on the part of persons wishing to complain about community services not covered by the Act.

The Northern Territory and the ACT are the only Australian jurisdictions in which their own specific complaints legislation provides coverage beyond health services. WA also handle complaints relating to the provision of services to the disabled, however they do that through provisions in Part 6 of the *Disability Services Act 1993*. New Zealand legislation covers health and disability services.

There are currently significant areas of community services not covered by any independent complaints scheme. These include Supported Accommodation services and a range of family support services.

The review discussion paper canvassed opinions on whether the current definition of community services (aged and disability services only) was appropriate.

Summary of review responses

- There were 15 responses to the questions: *"Should the definition of community services be expanded? If your answer is "yes", what services should be covered and why?"*

- Twelve responses supported some expansion of the definition of community services. Of these, several suggested that all community services provided by Department of Health and Community Services be included. Two respondents suggested that as disability services were already covered under the current Act, then at least supported accommodation should also be covered. Other services which were suggested for coverage included Home and Community Care, Family and Children's Services and counselling.

- The AMA and Central Australian Aboriginal Congress (Congress) did not support an expanded definition of community services.

- One submission, comprising notes from a workshop held with NGO's in Nhulunbuy had mixed opinions about this issue. Some participants at the workshop suggested that a separate Community Services Complaints Commissioner, with specialist expertise in this sensitive area, should be established, with jurisdiction over a broader range of community services.

Important issues raised in submissions

The submission from the Health and Community Services Complaints Commissioner stated:

> *"It is my view that the definition should be expanded but the critical question to be determined is to what extent so that the boundaries are clearly defined.*
> *"There are currently areas of community services specifically provided by the Department of Health and Community Services which are being covered by the Ombudsman. These include areas such as, the Pensioner Concession Scheme, the Patients Assistance Travel Scheme and Family and Children's Services, in particular the Child Protection Service area. There will need to be careful consideration given as to whether it is appropriate to shift jurisdiction in regard to areas such as Family and Children's Services from the Ombudsman to the Commission and/or in the context of a more expanded role."*

The Commissioner noted an increasing focus in other jurisdictions on a more specific and intensive approach with regard to the Family and Children's Services area.

The submission from Department of Health and Community Services described the possible expansion of the definition of Community Services as the primary issue for the Department. The Department concluded:

> *"The Department of Health and Community Services generally supports the extension of the scope of the HCSC Act to include all community services including those funded by Department of Health and Community*

Services and provided by the non-government sector. The benefits to clients of services and the opportunities to identify areas for improvement in services from the transparency the Commission could provide are well recognised."

The Department proposed however, that child protection services be excluded from the new scope of the Act at this point in time because accountability mechanisms are already in place, or are under further development through two projects that have potential to significantly reshape child protection services. The Department stated that the current reviews of the Community Welfare Act and of child protection services will both examine accountability measures for child protection services. Both reviews will bring about improved transparency in decision making and accountability in the child protection area.

Three submissions suggested that at the very least, the definition of community services should be expanded to cover supported accommodation, on the grounds that this was a complex and sensitive area of disability services. The Supported Accommodation Assistance Scheme has recently established a free, independent complaints service through the Employee Assistance Scheme.

Consideration of the Issues

As a general principle, the Steering Committee considers it appropriate that all community service consumers should have access to an independent, fair and accessible complaints scheme. There would also be distinct advantages in having a "one stop shop" for complaints services, thus reducing confusion and frustration about where to access such mechanisms. The Committee considered that issues of ease and simplicity of access to an independent community services complaints handling scheme were especially important in the NT context with its unique Aboriginal demographic.

The Committee is, however, well aware that the community services sector is large and complex, and is funded from a variety of sources. The sector includes services funded by the NT and Commonwealth Governments, and by both philanthropic/benevolent and "for profit" organisations. Again, the Committee considered that this complex web of services, and the unique NT demographic, underlined the need for an easily identifiable and accessible community services complaints scheme.

The Committee was concerned to note that at present, a large number of people accessing a significant proportion of community services in the Northern Territory do not have access to an independent complaint handling mechanism. Pending outcomes from this review, an interim complaints handling mechanism has been established through the NT Employee Assistance Scheme to provide such a mechanism for clients of approximately 35 non-government funded services within the Supported Accommodation Assistance Program (SAAP). These services are currently accessed by between 3-4000 people each year in the Northern Territory.

Prior to the establishment of this pilot program, anecdotal evidence suggests that complaints from individual recipients of SAAP services was usually handled by the Management Boards of the relevant non-government organisation, or, occasionally, by the funder organisation. The Steering Committee considered that either scenario represented a possible conflict of interest, and thus a significant potential barrier to effective complaints resolution and service improvement outcomes. Further, the Committee considered that the provision of a complaints handling service by the EAS

was appropriate on an interim basis, but that it would be preferable if the Act were amended to ensure that all SAAP services were covered in the future.

In addition to the SAAP services, various other family support services are also without access to an independent complaints mechanism. This was also of concern to the Steering Committee.

The Committee considered various options for establishing boundaries around the expanded coverage. However, the Committee decided that most community services should be covered, as per the definition included in Recommendation 7. This definition was developed in consultation with the Department of Health and Community Services and the Darwin Community Legal Service.

The Committee recognised that the proposed expansion of the definition of community services, and thus the scope of the jurisdiction of the Commission, will have resource implications. Monies currently provided to the Employee Assistance Scheme to provide the SAAP complaints service could assist in meeting some of the cost of providing the expanded coverage. However, a coherent and high quality service, addressing all the objectives of the Commission would be impossible to achieve without additional resources.

Chapter 9 of this report outlines resource requirements to address an expanded community services definition and estimates that $131,000 would be required for this purpose.

RECOMMENDATION

7. That the definition of community services be expanded to include most major categories of community services, with the exception of child protection services, and that "community services" be defined in regulations as at Appendix 11.6.

8.8.2 Commissioner's Roles, Functions and Powers

Under the current model, the Commissioner for Health and Community Services Complaints is appointed by the Administrator, and is accountable directly to the Legislative Assembly. As listed and discussed in 6.2.2, the Commissioner has the powers and functions necessary to resolve complaints through the informal and formal processes outlined in the Act, and to perform a range of other functions aimed at improving the health and community services system.

The review discussion paper canvassed comments on a range of issues relating to the Commissioner's powers and functions including:

- whether the Commissioner's current powers and functions are appropriate;
- whether the Commissioner should be given the power to undertake an investigation on his own motion;
- whether the Act should provide the Commissioner with the power to enforce determinations against unregistered providers.

Each of these issues will be discussed separately.

8.8.2.1 Current powers and functions

Section 12 of the Act provides the Health and Community Services Complaints Commissioner with the power to inquire into, assess, conciliate, investigate, take no further action, and make recommendations on complaints relating to health, aged and disabled services (public and private).

The review discussion paper canvassed opinion as to whether the Commissioner's current powers and functions are appropriate.

Summary of Review Responses

- There were 11 responses to the questions: *"Are the powers and functions of the Commissioner appropriate? If not, what amendments do you suggest and why?"*

- Two respondents, including the Commissioner for Health and Community Services Complaints, said that the commissioner's current powers and functions were appropriate.

  The Commissioner stated that although current powers and functions were appropriate, resource and workload constraints prevented the Commission from performing effectively in all areas. The Commission's current core business was complaint handling, with limited time and resources for functions related to systemic improvement functions.

  One provider said current powers and functions were appropriate, and that there should be no extension of powers.

- Five respondents said that the current powers and functions of the Commissioner were inappropriate.

  The Health Professions Licensing Authority suggested increased enforcement and monitoring powers over outcomes from individual complaints, but no increase in powers over systemic change.

  The Senior's Advisory Council said that the Commissioner should have prosecutorial powers.

  The AMA suggested some specific changes in powers, and clear separation of Commission and Ombudsman roles.

  Danila Dilba suggested consideration of powers in the areas of health policy and research.

  The Department of Health and Community Services said that power to mediate should be included in objectives.

Consideration of the Issues

Stakeholder opinion was split on whether the Commissioner should have powers of enforcement. The Health Professions Licensing Authority suggested that the Commissioner should have the power to enforce recommendations in relation to service delivery. One consumer representative suggested that the Commissioner should have the power to prosecute to assist those who are unable to afford legal action.

The AMA however, said that the Commissioner should not retain the existing power of suggesting ways to improve health systems, and that the Commissioner's powers and functions should be (reduced) to deal only with conciliation, investigation and resolution.

Given that the Northern Territory complaints model is broadly concerned with the resolution of complaints and systems improvement outcomes through a respectful, collaborative approach to the use of recommendatory powers, the majority of Steering Committee members deemed it inappropriate to extend the powers to incorporate prosecutorial functions. To do so would create a more adversarial and defensive process.

However, the Steering Committee supports the existing powers and functions relating to systems improvement and promotion as necessary to achieve objectives in these areas. If services in these areas were fully resourced, the Northern Territory community could see more and deeper long term value from the complaints system.

Again, activities in these areas should continue to be provided in a collaborative/recommendatory manner rather than through stronger enforcement powers. Moreover, it is evident from the Commission's Annual Reports that existing enforcement powers [60]have almost never been utilised. This would indicate that stronger enforcement powers are not required, and to do so might jeopardise future service improvement outcomes.

RECOMMENDATIONS

8. **That the Commissioner's current powers and functions be retained.**

9. **That adequate resources and funding be provided to ensure that the Commissioner can address the broader promotional and systems improvement functions and roles as required under the current Act.**

8.8.2.2 "Own Motion" Investigations

Part 4, Sections 20 and 21, allows for the Minister for Health and Community Services or the Legislative Assembly to refer any matter relating to a health service or community service to the Commissioner for investigation. These provisions have not been used.

The current Northern Territory complaints model does not allow the Commissioner to undertake an investigation in the absence of a complaint, that is, on his/her "Own Motion".

The review discussion paper canvassed opinions on whether the Commissioner should have the power to undertake "Own Motion" investigations. The paper stated that own motion powers can assist users of services who are reluctant to make a complaint because they feel they might be victimised, harassed or, indeed, not be eligible for future services.

[60] Section 43 relating to Conciliation Agreements, section 66 in relation to investigations

Summary of review responses

- There were 13 responses to the questions relating to own motion powers: *"Should the Act be amended to give the Commissioner power to investigate on his own motion? Should the Commissioner's own motion powers be engaged only in complaints involving a systemic nature, relating to a professional conduct matter, relating to a public health and safety, or a public interest matter?"*

- Ten respondents supported the Commissioner having power to undertake own motion investigations. Generally, support for such powers came from consumer groups, community organisations or advocacy groups, individual consumers and from complaints/regulatory organisations.

- The Department of Health and Community Services, the AMA, and one provider did not support the Commissioner having "own motion" powers.

Important Issues Raised in Submissions

The Department of Health and Community Services (DHCS) commented in its initial response that *"The Department's view is that the Ombudsman (sic) should not have the capacity to initiate a review of activities. If systemic issues become apparent, there are still appropriate senior officer mechanisms to raise those issues".* The Department went on to argue that experience in other jurisdictions which gave the Complaints Commissioner own motion powers was that such powers *"severely limited their capacity to manage ongoing service delivery".* Later in its submission, DHCS argued that own motion provisions would shift the balance away from the primary task of settling complaints through conciliatory processes.

One provider argued that giving own motion power to the Commissioner *"would undermine the independence and impartiality of the Commissioner, and is to be strongly discouraged."*

The Australian Medical Association argued that there are already sufficient avenues to raise problems of a systemic nature and to deal with professional conduct, and that adding another "overseer" would only create confusion.

The Health Professions Licensing Authority argued that this type of provision worked well for the Professional Boards, and should be extended to the Commissioner.

Central Australian Aboriginal Congress said that the Commissioner should have own motion powers because

> *"a complainant may feel intimidated because of perceived victimisation at a later date. Due to limited options for treatment, some users may not wish to be identified if they feel that at a later date they may receive poor treatment from a provider or individual because they have made a complaint against them."*

Danila Dilba had similar concerns to those expressed by Congress:

> *"Yes, the Commissioner needs the power to undertake an investigation into an own motion matter....This is particularly important if concerns over quality of services are not being addressed because of entrenched fears (well founded or otherwise) of potential harassment or victimisation."*

The Commissioner for Health and Community Services Complaints argued for own motion powers on the grounds that:

- Commission staff have significant expertise and experience in conducting investigations;
- own motion powers would provide the flexibility to investigate serious and systemic issues;
- the provision of own motion powers would be consistent with the independent nature of the Commission;
- own motion powers would be a powerful tool to assist the most vulnerable members of the community;
- primary opposition to own motion powers comes from provider groups, and their rationale for such opposition is often not justified;
- it would not be in the interests of the Commission to abuse or misuse the power by initiating frivolous or ill-informed own motion investigations;
- resource constraints, coupled with the need to provide individual complaints handling services, would necessitate a realistic approach to undertaking own motion investigations;
- any own motion power could require the Commissioner to consult on possible alternative review mechanisms before determining to proceed with an own motion investigation.

Jurisdictional Comparison

The Victoria, Queensland, and WA Acts do not provide the Commissioner with own motion powers.

The WA Act is currently under review. The Western Australian Complaints Director is recommending the provision of own motion powers on the grounds that such powers have the potential to allow a greater range of matters to be investigated without individual complainants having to identify themselves.

The SA Health Complaints Bill 2003 also proposes that the Commissioner have own motion powers.

The NSW, ACT, Tasmanian and New Zealand Complaints Commissioners have own motions powers to undertake investigations about issues:

- of a systemic nature;
- relating to a professional conduct matter;
- relating to public health or safety; or
- a public interest matter.

The 2002-2003 Annual Reports from the Australian jurisdictions with own motion powers revealed:

- that the ACT Commissioner did not undertake any own motion investigations in that year. The Commissioner did, however, undertake two investigations at the request of the Minister; one into Neurological Services at Canberra Hospital, and one into Mental Health Services for people at risk of harm;
- the Tasmanian Commissioner did not undertake any own motion investigations in that year.

Annual reports from the New Zealand Health and Disability Commission reveal more active use of own motion powers. For instance, during its first year of operation (1996-

1997) the New Zealand Commissioner undertook seven own motion investigations. Most of the investigations were *"as a result of anonymous complaints but others were commenced as a result of findings during an investigation which gave rise to concerns about public safety.*[61]*"*

Consideration of the Issues

All four organisations opposed to the provision of own motion powers are health or health and community services providers. Their grounds for opposing own motion powers as outlined in review submissions are:

- that mechanisms already exist to address problems or systemic issues;
- that the Commissioner is not subject to direction by any person when exercising his/her powers;
- that own motion powers would undermine the independence and impartiality of the Commissioner;
- that own motion powers would reduce the focus on complaints resolution through conciliation and investigation;
- the experience of other jurisdictions has been that their capacity to manage service delivery has been compromised by the number of reviews taking place;
- that it is difficult to make coordinated responses to identified problems due to the range of recommendations coming from independent review bodies.

The Steering Committee considered each of these grounds, and, in the absence of substantive evidence to some of the concerns, remained split on their validity. For instance, some Committee members were not clear on how the provision of own motion powers would undermine the independence and impartiality of the Commission. Others considered that possible difficulty in managing service delivery in the face of review processes could itself be an indication of systemic problems requiring independent examination. The Committee was generally in agreement that the Commissioner was not subject to direction by any person when exercising his/her powers, but some members believed that this could be an advantage by ensuring truly independent investigations of significant public health and safety issues.

Twelve individuals or organisations supported the provision of own motion powers on the following grounds:

- similar powers have worked well for the Professional Boards;
- complainants may feel intimidated because of perceived victimisation at a later date;
- some consumers have limited options for treatment and fear reprisals for complaining;
- the relative smallness of Northern Territory health and community services system could mean that own motion powers could be effective in addressing matters which might otherwise not be addressed;
- lifestyle, care and treatment issues can consume much time and energy and prevent people with valid concerns from making complaints;
- a belief by some consumers that the Complaints Commission does not have power to deal effectively with a complaint;
- the consumer has less power than service providers.

Again, in the absence of supporting evidence, the Steering Committee was unable to achieve consensus in assessing the validity of each of these arguments.

[61] Report

Own Motion Options Available
To assist the Steering Committee in their discussions, they requested that the various options be detailed. The following options were therefore identified:

1. No Change to legislation

The Act currently has no provisions to allow the Commissioner to undertake an "Own Motion" investigation. Ten (10) out of thirteen (13) submissions received supported the Commissioner having "Own Motion" power. In addition, the majority of Steering Committee members (9 out of 10) supported the Commissioner having a form of "Own Motion" power.

Although not unanimous, there is considerable support for the Commissioner to be given the power to undertake "Own Motion" investigations.

2. Provide "Own Motion" Powers

Although the Steering Committee generally agreed that the Commissioner should have the "Own Motion" power, there was a differing of opinion as to the extent of that power and the qualifications that should be placed on its use. There were a number of options put forward and these are detailed below.

(i) As per current Ombudsman's provisions

The "Own Motion" power as provided for by section 16 of the *Ombudsman (Northern Territory) Act* is unrestricted in that there are no qualifications or restrictions attached to it, ie. the Commissioner would be able to conduct an investigation on his own motion without referral or consideration elsewhere.

The general consensus of the Steering Committee was that such power was not appropriate and not generally supported.

(ii) As per the proposed draft amended Police provisions associated with the review of the *Ombudsman (Northern Territory) Act*

The model that is proposed by the Ombudsman as part of the review of the *Ombudsman (Northern Territory) Act* if introduced, would allow the Commissioner to undertake "Own Motion" investigations in accordance with the following provisions:

> *The Commissioner may raise a matter for investigation where he or she is satisfied that the matter:*
> - *raises a significant issue of public health or safety; or*
> - *raises a significant question as to the appropriate care or treatment of users of health services or community services; or*
> - *raises a significant question as to the practice and procedures of a provider*
>
> *The Commissioner shall notify the provider in writing of his or her intention to commence an own motion investigation and the nature of such an investigation.*
>
> *The provider can indicate his or her disagreement to such a proposed investigation and must do so in writing with reasons.*

Where the provider does express such disagreement then the Commissioner and the provider shall attempt to resolve any disagreement.

In the event that the Commissioner and provider cannot agree then the Commissioner may determine to investigate the matter personally.

The provider may challenge the jurisdiction of the Commissioner in the Supreme Court.

(iii) Similar to the NSW Health Care Complaints Act

Sections 59 and 60 of the NSW *Health Care Complaints Act* are applicable. If similar provisions to these were introduced they would allow the Commissioner to undertake "Own Motion" investigations in accordance with the following provisions:

The Commissioner may investigate the delivery of health and community services by a health and community services provider if it:

- *raises a significant issue of public health or safety; or*
- *raises a significant question as to the appropriate care or treatment of clients; or*
- *raises a significant question as to the practice and procedures of a provider*

Such an investigation may not be carried out by the Commissioner unless:

a) *the Commissioner has notified the provider that it intends to carry out the investigation and requests the provider to provide it with a report on the matter; and*
b) *the provider:*
   i) fails to provide the report within 30 days after receiving the Commissioner's request (or such longer period as the Commissioner may allow); or
   ii) provides a report to the Commissioner which, in the opinion of the Commissioner, is not satisfactory.

The Steering Committee agreed that the NSW provisions did not in fact allow the Commissioner to undertake an investigation on his or her "own motion" and that they were in fact very similar to the powers already available to the Commissioner under the current Act. The Commissioner did not support the introductions of these or similar provisions.

(iv) A Hybrid of (ii) and (iii)

This would read as follows:

That the Act be amended to give the Commissioner power to undertake an investigation into the provision of a health service or a community service on his/her own motion provided that the investigation addresses:

- *a significant public health or safety issue; and/or*
- *significant concerns as to the practices or procedures of one or more providers;*

Before undertaking an own motion investigation the Commissioner:

- *where appropriate, undertakes preliminary enquiries and reasonable consultation with the relevant provider prior to determining whether to undertake an own motion investigation as a last resort option; or*
- *must notify the provider in writing that he or she is proposing to undertake an investigation and the nature of such, and allow the provider to indicate in writing his or her disagreement to such a proposed investigation.*

The provider's response must be in writing and must include reasons for disagreement.

Where the provider disagrees with the Commissioner's views then the Commissioner and the provider must consult in an attempt to resolve any disagreement.

In the event that the Commissioner and provider cannot agree then the Commissioner may determine to investigate the matter.

The provider, as a last resort, may challenge the jurisdiction of the Commissioner in the Supreme Court.

3. Additional provisions

No matter which option is preferred, the following additional provisions should be included in any section dealing with "Own Motion":

The Commissioner, where reasonable, gives consideration to the effect on individuals or providers about possible implications of an own motion investigation; and

The Commissioner, where appropriate, must access relevant expert opinion or mentoring advice in undertaking the own motion investigation.

Steering Committee Discussions

The majority of the Steering Committee members supported the notion that own motion powers may be especially appropriate in the Northern Territory where more than 26% of the population are of Aboriginal and Torres Strait Islander descent, yet the current Northern Territory complaints system is not being accessed by Indigenous people at commensurate levels.

The strong support from Aboriginal organisations, the Health Professions Licensing Authority and legal bodies for own motion powers was endorsed by a majority of Committee members as a valuable means of independently investigating significant public health and safety issues impacting on the Northern Territory 's Indigenous population.

Furthermore, a majority of Committee members accepted the validity of the Commissioner's comments in his submission that:

"Resources do not allow significant use of such a power and there must always be a balance as to the need to service individual

complaints and the need to promote systemic change and improvement. Invariably, consideration of initiating an own motion investigation involves making appropriate inquiries to establish whether there is any realistic need for such an investigation and to provide an opportunity for any agency or provider likely to be the subject of such an investigation to comment on whether it was necessary and/or on the issues raised. Any own motion power could include a requirement to consult before determining to proceed. The need for independence however must mean that the Commission retains the right, ultimately to proceed or not."

Following the November Steering Committee meeting and further discussions between the Commissioner and the CEO of DHCS, the Department advised that their position in relation to the "own motion power was now as follows:

"I would suggest a NSW type approach to "other investigations" as an option that could meet Commission and DHCS strategic objectives. Essential to this approach would be:

- *The investigation may not be the particular object of a complaint but must arises out of a complaint or out of more than one complaint*
- *The investigation cannot be undertaken unless the service provider is notified of intent to carry out an investigation and is given the opportunity to provide a report within the specified time.*

With the revised view of DHCS, it is clear that there is substantial support, but not unanimous, for the Commissioner to have an "Own Motion" power that can only be used under certain conditions.

The issue relating to the Commissioner having "Own Motion" powers was further discussed by the Steering Committee at its meeting in February 2004 and because there was not unanimous support, it was agreed that all options should be put to the Minister for his consideration. At that meeting, the Australian Medical Association advised they would again canvass their members on the issue of 'Own Motion' powers to see if there was any change to their view. They have since advised that their members maintain their view that they do not support 'Own Motion' powers for the reasons previously stated[62].

As stated previously there was considerable support, both from submissions and the Steering Committee members for the Commissioner to be given some form of "Own Motion" power.

RECOMMENDATION

10. That the Minister decide on which of the following "Own Motion" options he supports for inclusion in the revised legislation:

a) No change
b) Similar to Section 16 of the *Ombudsman (Northern Territory) Act*
c) Similar to the amended Police provisions associated with the review of the *Ombudsman (Northern Territory) Act*

[62] Refer page 65

d) Similar to Sections 59 and 60 of the NSW *Health Care Complaints act*
e) A combination of c) and d)

11. That if "Own Motion" powers are supported, the following additional provisions should be included:

- The Commissioner, where reasonable, should be required to give consideration to the effect on individuals or providers about possible implications of an own motion investigation; and
- The Commissioner, where appropriate, should be required to access relevant expert opinion or mentoring advice in undertaking the own motion investigation.

8.8.2.3 Recommendatory powers

Section 65 of the Act requires the Commissioner to prepare a report on findings and conclusions resulting from an investigation into a complaint. Investigation reports may contain any information, comments and recommendations for action that the Commissioner thinks appropriate.

If the report contains recommendations for action by a provider, the provider is required, within 45 working days of receiving notice in the report, to respond in writing to the Commissioner on *"what action he or she has taken to comply with the recommendations contained in the notice."*[63]

If the Commissioner is not satisfied with the provider's response to the recommendations, he/she may report to the Minister and the Legislative Assembly on the matter.

Providers are therefore not required under the Northern Territory legislation to implement any recommendations made by the Commission. That is, the Commissioner has recommendatory, rather than determinative powers.

Only the NSW and New Zealand Complaints Commissioners have determinative powers. That is, the NSW Commissioner can determine to prosecute and initiate prosecution against a registered provider in order to enforce change.

All other complaints Acts in Australian jurisdictions provide the Commissioner with recommendatory, rather than determinative powers. The underlying complaints model emphasises resolution of complaints through conciliation and cooperation rather than enforcement.

The review discussion paper canvassed opinion on whether the Northern Territory Commissioner should be provided with determinative, rather then recommendatory, powers.

[63] section 66(4)

Summary of review responses
There were 12 responses to the questions: *"Should the Commissioner be given the power to make determinations that are enforceable by law? If so, in what areas and what limitations should apply and why?"*

Five respondents supported amending the Act to give the Commissioner power to make determinations enforceable by law. Four of these respondents were consumers or consumer groups, plus the Health Professions Licensing Authority.

Seven respondents, including the Commissioner, did not support amendments in this area. Most respondents not in favour of this amendment considered that determinative powers would jeopardise the integrity of the conciliation process, and would create an adversarial climate. Respondents also indicated that there were already other avenues to facilitate enforcement.

Important Issues Raised in Submissions
The Victorian Health Complaints Commission commented that:

> *"Based on our experience, the HSC believes that a conciliatory approach works well, even in investigations. If the Commissioner's determinations were legally enforceable, there would be a need to monitor providers after a case was closed and there would also need to be a process of appeal. It seems a lot of additional work and infrastructure that may not be warranted."*

The Darwin Community Legal Service made a strong argument in favour of determinative powers to support consumers:

> *"In our experience some consumers have chosen not to lodge complaints because they lack confidence in the Commission's ability to enforce recommendations/influence providers by way of recommendations about their policy and practice....the Commission's lack of power to make enforceable determinations is a reason consumers choose not to use the Act. ..Consumers are conscious of the power imbalance between them and the provider, and this is a source of stress."*

The Legal Service argued that a provision for enforcing determinations would bring about changes to the conciliatory and co-operative complaints resolution environment, but that enforcement powers would only be a back up when timely action to implement recommendations had not taken place.

In arguing against determinative powers, the Australian Medical Association noted that: *"Should a complaint be found to be of such serious nature a judgement enforceable by law is required, it should have already been referred to the appropriate registration body to be dealt with which has such powers."*

The Health Professions Licensing Authority argued that it would be in the interests of public safety and best practice to provide the Commissioner with the power to enforce determinations. The Authority emphasised the particular importance of such powers when the complainant is disabled, a minor, or mentally frail etc.

The Tasmanian Health Complaints Commission argued that enforceable determinations provided: *"an adjudicative function and preferably left to the courts or the statutory bodies regulating registered practitioners. Unregistered practitioners could be subject to TPA and Consumer Affairs legislation."*

Ruby Gaea Rape Crisis Centre supported the Commissioner being given power to make enforceable determinations when change could not be brought about in a conciliatory and cooperative environment, after a mutually agreed upon time.

The Department of Health and Community Services does not favour determinative powers being given to the Commissioner because this *"would provide a very different relationship between the parties"* and diminish the strength of the current system.

The Northern Territory Health and Community Services Complaints Commissioner noted that, although he had powers to lodge reports with the Minister if he was dissatisfied with provider responses to recommendations, that he had never yet had occasion to do so. The Commissioner went on to argue that he does not believe there is a specific need for determinative powers, particularly in regard to registered providers who are accountable to professional boards:

> *"The recommendatory powers promote ownership and collaborative, cooperative resolution of complaints. Determinative powers create an adversarial process, and necessarily envisage the need for review processes such as the courts. Such processes are time consuming, resource intensive and costly, and ultimately detract from the prime objective of a timely and flexible process for resolving complaints".*

The Commissioner noted, however, that the case for use of determinative powers against recalcitrant unregistered providers may be more arguable.

On balance, the Steering Committee considered that the recommendatory powers currently available to the Commissioner were appropriate and consistent with the Northern Territory 's underlying complaint model. The Committee noted that existing powers to encourage implementation of recommendations had never been used, and considered that the use of such powers had the potential to ensure that even the most recalcitrant provider would implement recommendations appropriately.

However, the Steering Committee was not unanimous in supporting the Commissioner's current recommendatory powers. A consumer representative on the Steering Committee argued strongly for the provision of determinative *powers as a last resort option* when providers have demonstrably failed to implement recommendations arising from a complaint. The need for such powers was argued on the basis that there was considerable anecdotal evidence that some consumers did not lodge or pursue legitimate complaints because they were concerned that the Commissioner had no power to bring about real change as the result of a complaint. Where providers proved uncooperative, such powers would ensure that change could be enforced.

Other Committee members did not support the provision of determinative powers on the basis that, even if only used as a last resort, such powers would result in a more adversarial and defensive process.

RECOMMENDATION

12. Option 1 (preferred option)
That the Commissioner retain recommendatory, rather than determinative powers.

OR

Optional 2 (Not preferred)
That the Commissioner be provided with determinative powers for use as a last resort when providers do not cooperate with the complaints process findings.

8.8.2.4 Increased powers to act against unregistered providers

Under the definition provided in the Act, a "registered provider" means a provider registered by a relevant professional board. The Act requires the Commission to take all complaints directly involving a registered provider to the relevant Board as soon as practicable after it is received. The Board can then take appropriate action in relation to professional misconduct under its Act to protect the interest of the public.

Although the term "unregistered provider" is not defined in the current Act, it stands to reason that it means those providers of health and community services who are not subject to the control of relevant professional Boards through existing legislation.

There are currently two main groups of unregistered providers in the Northern Territory:
- mainstream: eg social workers, counsellors, dietitians, speech therapists
- alternative: eg acupuncturists, iridologists

Some unregistered provider groups have established professional associations with voluntary membership. The professional associations usually develop and support professional standards, codes of practice, and sanctions within the profession requiring compliance. However, some unregistered providers are not members of professional associations, and therefore operate without any agreed code of practice or standards. Other provider groups do not have any professional association to join, and therefore also operate without any agreed code of practice or standards.

The Northern Territory Commissioner's power in relation to unregistered providers is essentially the same as those for registered providers.

Under existing powers, the Commission's experience has been that most complaints against unregistered providers are resolved with their cooperation. However, in circumstances where an unregistered provider is uncooperative it is sometimes not possible to properly protect the interests of the public. Under the current Act, the Commissioner cannot compel participation in complaints resolution processes, and does not have powers to impose disciplinary sanctions on providers. The Commissioner can only resort to the coercive powers set out under Part 7 – Investigation.

The NSW Joint Committee on Health Care Complaints[64] recognised similar concerns at its meeting of June 2001.

> *"The Commissioner advised the Commission that it is continuing to receive complaints in respect of unregistered health service providers. In some cases the conduct is of a level of harm which causes the Commission considerable concern. In a number of cases the Commission has provided adverse comment and has been quite critical of people providing the health service. However, unless the Commission can form the view that the conduct of the unregistered provider reaches a criminal standard there is little recourse for the Commission to take disciplinary action."*

The Committee had previously examined the issue of unregistered providers and proposed three mechanisms to address these concerns:

- Court enforceable orders;
- Naming powers; and
- Internal complaints handling mechanisms for unregistered providers.

Each of these possible mechanisms was briefly outlined in the review discussion paper. The following section presents submission feedback on each mechanism.

a) Court enforceable orders against unregistered providers

The current health complaints model does not provide for court enforceable orders. The Act could be amended to make a Commission order enforceable under Local Court proceedings. Such orders could relate to the right of a user to receive a refund of costs associated with treatment and care from unregistered providers. Enforceable orders of this type could occur where the treatment had been the subject of investigation by the Commission and had been found to be of an unsatisfactory professional standard. Such a finding by the Commissioner would follow reference to established criteria, guidelines issued by professional associations or adverse comment by a qualified peer practitioner of good standing.

Summary of Review Responses

There were nine responses to the questions: *"Should the Act be amended to provide for enforcement of determinations made by the Commissioner against unregistered providers as proposed above? If yes, should the Commissioner be able to compel unregistered providers to attend at, or participate in, proceedings where such an order is being contemplated?"*

- Six respondents (including the Health Professions Licensing Authority, the Commissioner and the Department of Health and Community Services) supported the Commissioner having a range of enforcement powers in relation to unregistered providers.

- Two respondents did not support increased powers in this area. The Tasmanian Complaints Commission said that this would change the role of the Commission, and that there were already other avenues for addressing issues

[64] Unregistered Health Practitioners: The Adequacy and Appropriateness of Current Mechanisms for Resolving Complaints-December 1998, Committee on Health Care Complaints Commission, NSW

with unregistered providers. Integrated disAbility Action said that it would be discriminatory.

- The AMA said that there was a need to regulate unregistered providers, but that such powers should not lie with the Commissioner.

- No comments were made on whether the Act should compel unregistered providers to attend or participate in complaints processes.

Important Points Raised in Submissions
The AMA endorsed the critical need for regulation of unregistered providers, but said:

> *"The question must be asked however whether or not the Commission is the appropriate body to enforce determinations against unregistered providers or whether the broader issue of ensuring practitioners providing health services are registered should be dealt with outside of this review."*

The Health Professions Licensing Authority argued that enforcement powers against unregistered providers would "definitely" be in the public interest, but suggested that the *"power to enforce should be broader than only on a refund of costs as described and used in NSW. The Commissioner should have the power to enforce remediation requirements such as continuing professional development."*

The Department of Health and Community Services and the Commissioner both supported the concept of compulsory professional development being an enforceable requirement in relation to unregistered providers. The Department also argued that processes available to registered providers, such as right to appeal, would need to be extended to the unregistered provider.

The Northern Territory Council for Social Services also supported enforceable powers in relation to unregistered providers, *"...but only as an absolute last step/resort. Where a relevant professional association exists, the Act should require to work through it as part of the attempt to resolve the complaint informally in the first instance."*

The Northern Territory Health and Community Services Complaints Commissioner commented that increased enforcement powers against unregistered providers *"would be consistent with tort liability reform, which supports robust complaint processes to reduce negligence claims."*

According to the Commissioner's submission, the Commission

> "*should specifically focus on encouraging non-registered providers to form associations with the specific view of setting standards of practice in identified areas of expertise and practice. Such associations would be encouraged to establish effective complaint mechanisms, to resolve concerns and to promote the standing and quality of persons working in that area.*"

The Steering Committee discussed this issue at its final meeting on 22 March 2004 and agreed that if determinative powers and powers to enforce orders are given to

the Commissioner then there should be a specific stated right of appeal and review provided for in the legislation. The Steering Committee agreed that this right of appeal should be to the Health and Community Services Complaints Review Committee.

RECOMMENDATION

13. That the Act be amended in order to deal more effectively with unregistered providers by:

- **Providing for the enforcement of determinations made by the Commissioner, where due process has led to the determination that the quality of service provided by unregistered providers has fallen below acceptable standards and constitutes unreasonable risk to public health and safety.**
- **Providing the Commissioner with the power to enforce orders compelling unregistered providers to undertake relevant training or education or to refund fees and costs charged to the complainant.**
- **Requiring the unregistered provider to attend at, or participate in, proceedings where such an order is being contemplated.**
- **Allowing the provider to appeal against a determination of the Commissioner to the Health and Community Service Complaints Review Committee.**

b) Naming Powers

The NSW Health Care Complaints Committee submitted to the Parliamentary Joint Committee on the Commission that they should have the ability to name a provider publicly where a complaint has been investigated and substantiated. The Joint Committee considered this submission and proposed a model providing the Commission with the power to make or issue a public statement identifying and giving warnings or information in the public interest about any of the following:

- health products that are unsatisfactory or dangerous and persons who supply them;
- health services or community services supplied in an unreasonable manner and the persons who supply then;
- unfair business practices and persons who engage in those practices; and
- any other matter that adversely affects or may adversely affect the interest of persons in connection with their acquisition of products or services from providers

The Joint Committee stated that providers should be publicly named in the following circumstances:

- Where there is an immediate or urgent need for a warning because members of the public are likely to suffer inadequate or inappropriate treatment or care, or financial or other loss.
- As part of the Commission's longer term strategy to:
  - influence health service and community service providers to improve the standard of their treatment and products;
  - warn the public about particular unsatisfactory providers and products; and
  - provide information to the public about user rights and ways to avoid or deal with the problem.

It was intended that these public statements and warnings would only occur after a full investigation, when serious allegations had been substantiated, and when publication was in the interest of the public.

Under the Northern Territory Act, the Commissioner may at any time report to the Minister on any matter the Commissioner considers necessary arising from complaints or the operation of the Act, and the Minister must then table the report in the Legislative Assembly. In any such report the Commissioner may name any person involved in a complaint. To date, the Commissioner has not named any person under these provisions. These powers are far more limited than those suggested in the NSW model which could ensure greater protection of the public, and increase the likelihood of provider co-operation in resolution of complaints.

The review discussion paper canvassed opinion on whether the Act should be amended to provide the Commissioner with naming powers, and, if so whether such powers should be limited to unregistered providers.

Summary of Review Responses

- There were eight responses to the questions: "*Should the Act be amended to strengthen the Commissioner's 'naming' powers? Should the amendment, if introduced, refer to all providers or be limited to unregistered providers?*"

- Six respondents said that the Act should be amended to strengthen the Commissioner's 'naming' powers in relation to both registered and unregistered providers.

- Several respondents reiterated that that this power should presume full investigation (in accordance with procedural fairness and natural justice principles), and the finding of a significant public safety issue.

- Workshop respondents argued that a mechanism should be found to provide such names to interstate bodies, as remote employers were particularly vulnerable to practitioners who were "escaping" from problems in other jurisdictions.

- Two respondents did not support naming powers in relation to unregistered and registered providers.

- One respondent said that naming should be allowed, but not by the Commission.

Important Issues Raised in Submissions

One provider argued that when serious allegations against any provider have been substantiated, it is reasonable that the provider be named. However, the provider argued strongly that this should not be the role of the Commission, and that the 'naming' of providers in such instances should proceed along existing channels.

The Australian Medical Association also considered that the naming powers already provided to the Commission are sufficient, and therefore in no need of strengthening.

The Health Professions Licensing Authority emphasised that public statements and warnings should only occur after a full investigation has substantiated serious allegations, and when the Commissioner considers that publication is in the interest of the public.

Participants from non-government organisations in Nhulunbuy strongly supported the provision of naming powers against both registered and un-registered providers. The workshop participants stated that remote service providers often have difficulty recruiting staff, and that there should be some way of ensuring that they are informed when providers have been named.

The Department of Health and Community Services stated that where a full investigation has taken place, and where naming is in the best interest of the public, that the public should have the right to know. The Department supported naming powers for both registered and unregistered providers.

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The Northern Territory Health and Community Services Complaints Commissioner supported naming provisions as a mechanism to protect the public from future harm after a comprehensive investigation. The Commissioner outlined a situation where use of such provisions would be appropriate:

> *"....a de-registered psychologist commences practice as a counsellor but then immediately continues to carry on the behaviour of practices that brought about de-registration, ie, predatory conduct against persons at risk such as children, females etc."*

The Commissioner went on to outline the circumstances in which public statements / warnings should be authorised as follows:

- health products that are unsatisfactory or dangerous and persons who supply them;
- health services or community services supplied in an unreasonable manner and the persons who supply them;
- unfair business practices and persons who engage in those practices; and
- any other matter that adversely affects or may adversely affect the interest of persons in connection with their acquisition of products or services from providers
- where there is an immediate or urgent need for a warning because members of the public are likely to suffer inadequate or inappropriate treatment or care, or financial or other loss.
- as part of the Commission's longer term strategy to:
- influence health service and community service providers to improve the standard of their treatment and products; their treatment and products;
- warn the public about particular unsatisfactory providers and products; and
- provide information to the public about user rights and ways to avoid or deal with the problem.

RECOMMENDATION

14. That, providing a significant public health or safety issue, or a significant concern regarding the practices or procedures of a provider has been confirmed through due process, the Act be amended to provide the Commissioner with 'naming' powers in relation to both registered and unregistered providers.

c) Complaints Handling Requirements for Professional Associations of Unregistered Providers

It is recognised that professional associations of unregistered providers have a role in the self-regulation of unregistered providers through setting standards supported by codes of practice and ethics. However it is also recognised that the fragmentation of many unregistered fields of health care and community services is a barrier to the implementation of effective self-regulation.

The NSW Joint Parliamentary Committee on the Health Care Complaints Commission recognised the above concern, and developed a model which would enable the NSW Health Care Complaints Commission to require professional associations to put in place transparent complaints mechanisms. The Committee recommended that the NSW *Health Care Complaints Act 1993* be amended by including provisions that would:

> *"...require health practitioner, facilities and professional associations to make such arrangements as are....necessary to facilitate the resolution of complaints at a local level, ie to develop and implement effective complaints handling mechanisms. The HCCC could have a leading role in assisting service providers and professional associations in their development of complaint handling mechanisms and would act as a review body to monitor the effectiveness and accessibility of these mechanisms for patients and their families* [65]

It would appear appropriate that the current Northern Territory complaints model be enhanced by including a statutory power for the Commissioner to:

- formally recognise appropriate complaints handling mechanisms of professional associations of unregistered providers; and
- require members of professional associations of unregistered providers to have complaints handling codes and mechanisms aimed at internal resolution of complaints if they are providing services within the meaning of the Act.

Such an approach would strengthen existing self-regulatory schemes, and provide an additional safeguard for users of the services of unregistered providers who may wish to take their complaint to an unregistered provider's professional association rather than to the Commission.

The current Act requires prescribed providers (specific providers named in the Regulations) to implement internal complaints procedures as set out in the Regulations (section 100) and to provide annual returns to the Commissioner

[65] pp. 48 – 49).

setting out specifics of complaints received (section 99). It may be appropriate to make professional associations of unregistered providers accountable to these or similar provisions under the Act.

The review paper canvassed opinions on how the Commission should work to ensure unregistered providers had complaints handling mechanisms.

Summary of review responses

- There were nine responses to the questions: *"Should the Commission be empowered to require professional associations of unregistered providers to produce evidence of appropriate complaints handling mechanisms? Should Professional Associations be accountable to the same (or similar) provisions that regulate the complaint handling processes of prescribed providers?"*

- Five respondents said that the Commissioner should be empowered to require professional associations of unregistered providers to produce evidence of appropriate complaints handling mechanisms.

- Two respondents said this amendment should not be supported.

- One respondent said that Professional Associations should be accountable to the same or similar provisions that regulate the complaint handling processes of prescribed providers.

- Three respondents said they should not, and one respondent was unsure.

The Steering Committee considered that it would be in the long term interests of Territorians if professional associations of unregistered providers were required to implement appropriate complaints handling mechanisms, and be held accountable for similar provisions as those currently required of prescribed providers.

RECOMMENDATION

15. **That the Act be amended to empower the Commission to work with Professional Associations of unregistered providers to implement appropriate complaints handling mechanisms.**

16. **That the Act be amended to require that Professional Associations of unregistered providers work with their members to implement internal complaint handling mechanisms.**

8.8.3 Community Visitor Scheme

The Northern Territory is one of three Australian jurisdictions in which Complaints Commissions have some coverage in the community sector. According to the review discussion paper: *"The Northern Territory Commission has become increasingly aware of the vulnerability of some consumers of health and community services. The limited number of complaints received from aged and disabled people under the current*

provisions has reinforced that many users of community services are unlikely to make complaints." [66]

The review discussion paper outlined how, in order to alleviate similar concerns, NSW had introduced an "Official Community Visitor" function to its Community Services model. The paper also mentioned a similar scheme under the Northern Territory's *Mental Health and Other Related Services Act (NT),* and within the NZ Health and Disability complaints system.

Several submissions to the review commented that, in the absence of more information about Community Visitor schemes in other jurisdictions, they were unable to make an informed comment on this issue. The following sections outline the Community Visitor schemes in NSW, NZ and the NT.

NSW Community Visitor Scheme

The *Community Services (Complaints, Reviews and Monitoring Act) 1993* (CRAMA Act) established the Official Community Visitor Scheme as part of a broader community services complaints model managed by the NSW Ombudsman.

Official Community Visitors are appointed by the Minister for Community Services as independent monitors with specific statutory functions and powers.

Although the Community Services Commission is responsible for coordinating and administering the program, the Community Visitor Scheme is independent of the Commission. The Commission, with the assistance of an independent panel with expertise in disabilities, is responsible for the recruitment and induction of new Community Visitors. The scheme is also independent from service providers and government departments.

The aims of the NSW Community Visitors Scheme are to:

- promote improved services to people with a disability living in full time care;
- encourage and assist resolution of concerns raised by residents;
- give priority to visitable services where residents are least likely to be able to complain;
- inform the Minister and Commissioner for Community Services on matters affecting welfare, interests and conditions of residents and the conduct of accommodation services.

The necessary authorities to perform the Visitor functions are specified in Section 8 of the CRAMA Act. Visitors have the authority to:

- enter and inspect a service without prior arrangements at any reasonable time;
- confer alone with any resident or employee of the service;
- inspect any documentation relating to the operation of the service;
- seek the views of the person to whom the document relates;
- provide advice and reports to the Minister and Commissioner on matters relating to the conduct of a residence.

Under the CRAMA Act, "visitable" services include:

- community-based homes and units where staff support is available to residents;
- respite services where one or more people are in residence for more than one month; and

[66] p35

- schools where children and young people live-in during the week and go elsewhere on the weekends.

From June 2002 licensed boarding houses also became visitable.

According to one of the scheme's promotional documents: *"Over time, the Visitor's Scheme has become firmly established as an effective mechanism to ensure that people living in residential care have access to an independent person to promote their well-being and circumstances."*[67]

The promotional literature differentiates between the role of the Visitors and that of Community Advocates as follows:

> *"Visitors are not advocates in the normal sense of this role, even though they are responsible to identify and raise issues on behalf of an individual/and/or group of individuals within a service. For example, a visitor cannot be a substitute for an advocate as the visitor considers the interests of all residents, not just one person who may have a specific need. Visitors are only occasional visitors, whereas advocates should have a long term relationship with individuals. Visitors have a broader view, as to the conduct of the service generally, as well as the individual.*
> *However, Visitors do have a role to refer residents to advocacy services where available....."*

In 1995 Official Community Visitors began visiting 663 government and non-government services providing live-in care to people with disabilities. By June 2002 there were 1014 visitable services, and twenty five Community Visitors based in regional centres across NSW. The scheme's budget in 2002 was $677,000. All visitable services had two visits during 2002.

New Zealand

Free advocacy service to health and disability service consumers is a requirement under the *Health and Disability Commissioner Act (*1994). The advocacy service is independent from the Health and Disability Commission, and from providers and the Ministry.

The mission of the National Advocacy Service is to assist health and disability services consumers to know and uphold their rights, and to resolve complaints about breaches of the code at the lowest possible level.[68]

The aims of the service are to:

- take the side of the consumer and assist them in resolving complaints about a possible breach of the Code directly with the service provider, assisting resolution of the complaint at the lowest appropriate level;
- ensure the rights set out in the code are widely understood and enjoyed in practice;
- report to the Health and Disability Commissioner any matters relating to the rights of consumers that should in the opinion of the advocate, be drawn to the Commissioner's attention

[67] Community Visitors A Voice for People in Care NSW Commission, 2001 p3
[68] Proposed Revised Health and Disability Consumer Advocacy Guidelines Draft 6, August 2003, p 6

Advocates work with the consumer within an "empowerment" framework. According to draft advocacy guidelines[69] empowerment advocacy is consumer-focussed and directed, and is based on the principle that consumers already have skills and experience to assist them in resolving their concerns.

The Director of Advocacy within the Health and Disability Commission contracts three organisations to provide nation-wide advocacy services.

The Advocacy Service is currently undergoing a staged review process. Documents and reports already available from the review provide valuable information which could inform the establishment of any similar service in the Northern Territory.

Northern Territory Mental Health Visitor Scheme

Part 14 of the Northern Territory *Mental Health and Related Services Act (1998)* (MHRS Act), establishes the Community Visitor Program (CVP) which aims to safeguard the rights and health of people whose mental health problems limit their capacity to access existing complaint mechanisms. The CVP's jurisdiction includes all treatment facilities and agencies approved under the Act.

The Act requires that the Minister appoint a person to be the Principal Community Visitor (PCV) with the functions of:

- establishing community visitor standards, principles and protocols;
- establishing community visitor panels as required;
- developing and promoting the community visitor role;
- ensuring that the visitors perform their roles in accordance with established requirements;
- ensuring that each approved treatment facility and agency is inspected by panels at least once every 6 months.

The Principal Community Visitor role is primarily management, and does not usually include visiting. Since July 2001 the Anti-Discrimination Commissioner has been appointed as the Principal Community Visitor.

The role of community visitors is outlined in Part 14, Division 2 of the MHRS Act. The visitors are responsible for identifying consumer problems during regular informal visits to approved mental health facilities and agencies. In broad terms, Community Visitors have monitoring, inspection, inquiry and complaint handling functions. Visits by Community Visitors can be self-initiated, in response to direction from the Minister, or at the request of a person.

Community visitors may inquire into, and make recommendations about:

- adequacy of services provided by approved mental health treatment facilities and agencies;
- standard and appropriateness of facilities
- adequacy of information relating to rights of persons receiving care;
- accessibility and effectiveness of complaint procedures;
- failure of services to comply with the Act; etc

Under Section 105 of the MHRS Act, Community Visitors are required to be accessible to hear and resolve complaints, and to assist persons to *"make applications under this*

[69] ibid p7

Act relating to complaints, reviews or appeals and, where applicable, to present those applications."

Visitors have the authority to enter any approved premise without notice and undertake an inspection. Approved treatment facilities must ensure that a person receiving care has access to the community visitor service.

The community visitor must provide an inspection report to the Principal Community Visitor (PCV), who is required to provide the person in charge of the approved agency with a copy of the report. If, in the opinion of the PCV, the person in charge has not taken adequate or reasonable action to implement any recommendations in the report, the PCV may make a report to the Secretary of the Department responsible for the administration of the Act.

Division three of the MHRS Act requires that Community Visitor Panels are established in the Top End and in Central Australia. The panels are responsible for monitoring each approved mental health treatment facility and agency in their region. Each panel must consist of a legal practitioner, a medical practitioner and one other person. As far as possible, the panels are to include persons of both genders and of diverse ethnic backgrounds.

As a group, each panel is required to inspect all approved treatment agencies and facilities not less than once every six months. During the visits, the panels are required to inquire into many aspects of the approved mental health service, including adequacy of facilities, standards of care and treatment, and the effectiveness of internal complaints handling procedures. The panel may also choose to visit any person being treated or cared for by a facility and inspect all relevant records. A report on the visit is presented to the Principal Community Visitor.

The 2000-2001 and 2001-2002 Annual Reports of the Community Visitor Scheme revealed that the Community Visitor Panels had been convened, but had not undertaken any visits. The 2002/2003 Annual Report noted that "although the Panels have not yet visited facilities, the Community Visitors have been performing their function since the establishment of the program, with regular visits to facilities and all complaints being properly attended to within the statutory time-frame." [70]

The 2002/2003 Annual Report also states that most complaints handled by Community Visitors have been from users of in-patient facilities, although some have been from carers and carer support groups, and a few from staff. Categories of complaints include concerns about admission procedures, services, recreational activities and the physical environment at facilities. According to the report, the experience of the Community Visitors has been that most complaints can be handled informally through face-to-face discussions or telephone calls. The report argues:

> *"This is very different from the more formal, written process of most complaint-handling agencies such as Health Complaints or the Anti-Discrimination Commission. However, all parties to complaints appear to appreciate this quick and informal approach which has resulted in successful resolution of most complaints."* [71]

[70] Community Visitors Program 2002/2003 Annual Report p15.
[71] Ibid, p16

Mediation is another technique also used by the Community Visitors to help resolve complaints. *"This method has worked particularly well with complaints where carers feel that they are not being given adequate information or opportunity for involvement in the care of their loved ones*[72]*."*

The review discussion paper canvassed opinion on whether the current Northern Territory complaints model would be enhanced by the establishment of a official community visitor function, similar to that provided through the NSW Ombudsman.

Summary of Review Responses

There were 13 responses to questions relating to the establishment of a Community Visitor's Scheme: *"Would the incorporation of a community visitors scheme, similar to the NSW model described above, ensure the rights of consumers are respected and increase the capacity of consumers of health and community services to complain? Should such a scheme be included in the NT Act?"*

- Ten respondents generally supported the concept of a community visitor scheme, albeit with further research to determine outcomes from similar schemes, and assuming appropriate resourcing.

  Some of the supportive respondents acknowledged that people do not complain for many reasons, and that a CVS would not necessarily result in people acting on their concerns. The Commissioner stated that failure to include such a provision in the current Act represented a major flaw in the current model. Experience in other states indicated that schemes need to be properly resourced to be successful.

- Three respondents (The Department of Health and Community Services, the Australian Medical Association, Integrated disAbility) withheld a decision in this area pending further research.

Important issues Raised in Submissions

The Northern Territory Commissioner's submission notes that complaints from the community services sector *"have been surprisingly low given the extent of jurisdiction specified in the Act"*, and that a lack of resources to promote the complaints system within the sector might be a factor in this. However, the submission argues that interstate experience *"suggests that the current model for handling complaints lacks an interface that is considered relevant as between users, providers and the Commission. In particular, experience has shown that only where there is a comprehensive, effective and proactive advocacy/community support scheme in place that a meaningful process is available."* ....

The Commissioner's submission goes on to describe the visitor/advocacy schemes in NSW and New Zealand, and states that experience in those jurisdictions as observed by the NZ Commissioner *"is that with the involvement of advocates/patient support officers/community visitors, over 70% of complaints are able to be resolved at a low level with the assistance of the advocate."*

The NZ Commissioner describes the importance of constructive attitudes of advocates:

> *"... advocates under these schemes do not view providers as 'the enemy'. To do so would create a defensive reaction on the part of a*

[72] Ibid, p16

provider. This leads to a reduction in trust, respect and understanding. Ultimately it facilitates a fundamental breakdown in communication and effectively reduces the ability to reach a satisfactory resolution of a patients/consumers concerns.
Well trained and supported advocates view providers as professionals dedicated to their patient's welfare. Providers want to do well by their patients. They do not knowingly do things wrong. With this approach, advocacy can lead to a climate of openness and a focus on achieving a timely, flexible and low level resolution."

Darwin Community Legal Services underlined the importance of examining the role and scope of existing complaints services in aged and disability before deciding whether such a function should be established in the Northern Territory. The Legal Service points out that the increasing shift to community-based care through Community Aged Care Packages will require new models of service provision ensuring privacy and confidentiality, and asks how community visitors would make contact with community-based recipients of this form of aged care.

The Northern Territory Council of Social Services (NTCOSS) argues that *"Consumers should have free access to an independent advocate who can assist them through the complaints process. This advocacy service should not be provided by the Commission as it could compromise non-biased role, particularly from a provider perspective."* NTCOSS cautioned that such a scheme would need very clear definitions and key issues would need to be addressed: *"For example, could visitors come to visit a person being cared for in a private residence? How would you define "provider"?"*

Participants in the Non Government Organisations workshop in Nhulunbuy said that advocacy support could assist/support vulnerable people, and in particular may help Aboriginal people understand their basic rights. However, workshop participants could see many practical difficulties in establishing an effective service in remote locations. Practical issues included:

- How would visitors get to all the communities?
- How would they establish the trusting relationships necessary to ensure that people were open with them if they only visited very occasionally?
- How effective would Visitors be if they were unable to speak the language?
- What are reasonable and appropriate service standards for remote Aboriginal communities? How do you decide?
- Whether it might be better to identify a cohort of advocates in communities and train and support them to provide the advocacy service in the longer term.

Integrated disAbility Action was not convinced that a Community Visitor scheme would ensure that the rights of consumers would be respected or increased: "*We would need to know a lot more about the scheme and the type of people involved, before giving a definitive answer to this question."*

The Department of Health and Community Services endorsed the concept of a Community Visitor Scheme, but cautioned that the implementation of the Community Visitor Program (CVP) under the Northern Territory Mental Health Act has not realised its potential. The Department argued that *"Should a CVP be included in the Act, questions of adequate resources and independence would need to be addressed to avoid problems experienced in the mental health scheme. The Department does not necessary support this function sitting with the Commission. A non-quasi judicial setting such as an advocacy body might be better."*

Consideration of the issues

The failure to provide an advocacy/community visitor scheme represents a major flaw in the Northern Territory's current complaints model. The Steering Committee believes that the absence of such a function within the complaints model is significantly compromising the rights of a major proportion of the Northern Territory population.

Documented low levels of complaints from the aged and disability sector and from Aboriginal people generally, reflects systemic barriers to accessing the current complaints model. An advocacy/community visitor scheme could address some of these concerns.

The Steering Committee acknowledges comments made during the consultation about practical difficulties in establishing an effective Advocacy/Community Visitor Scheme in the Northern Territory context. Issues such as the challenges of establishing the trusting relationships necessary to undertake successful advocacy work in Aboriginal communities, and of the need for highly trained advocates to work successfully in a cross cultural environment were accepted as genuine challenges for a new function of this type. The experiences of New Zealand in implementing their advocacy model would be of assistance in this regard.

The Steering Committee supports suggestions made in several submissions to the review that such a service need not necessarily be within the HCSCC, and might best be located within the community. Indeed, the Committee supports that such a service would best be administered and coordinated by the Commission, but delivered independently by one or more non-government organisations with significant understanding and expertise in the community services sector.

The Committee was impressed by the approach taken to advocacy services in New Zealand, and particularly commends the "empowerment advocacy" principles and protocols currently under development. The application of similar principles and approaches in a Northern Territory Community Visitor/Advocacy service would be consistent with the Northern Territory Government's concern with community capacity strengthening.

Accordingly, the Committee recommends the trialing of a combined Advocacy/Community Visitor Scheme within a strong empowerment advocacy framework. Trained and skilled advocates would be employed to undertake two on-going functions:

- working with individual community services complainants to resolve their concerns at the lowest possible and most informal level;
- visiting approved community service providers on a regular basis in order to identify problems and work collaboratively with clients and service providers to resolve problems.

Where the performance of these functions identifies issues of a significant or systemic nature, which the advocate believes should be bought to the attention of the Complaints Commissioner, the Act should require that this happen.

As per the New Zealand model, the Committee recommends that the Northern Territory Community Visitor/Advocacy Scheme:

- aims to resolve problems and complaints at the lowest level possible;
- seeks to empower complainants by using a strengths-based approach to advocacy;

- strives for a positive and respectful approach to problem solving with service providers; and
- strives to improve access to advocacy services by Aboriginal people, and by those who are least in a position to self-advocate.

The Committee recommends careful consultation with service providers as to which services will be visitable within the community services sector. Agreement should also be reached on protocols for visits emphasising collaborative problem solving at the local level.

The Committee recommends that the Advocacy/Community Visitor scheme be administered by the Northern Territory Health and Community Services Complaints Commission, but be delivered independently through appropriate community-based organisations with relevant expertise and experience. The Commission's coordination role would include:

- contracting appropriate service providers;
- monitoring the delivery of the Advocacy/Community Visitor Service by the independent providers;
- managing the selection of Advocate/Community Visitors;
- preparing protocols for use by service providers;
- coordinating the delivery of training and support to the selected Advocate/Visitors.

At the final meeting of the Steering Committee on 22 April 2004 the Integrated disAbility Action Group representative highlighted that some people with a disability were independent, did not live in supported or residential accommodation and did not have a caseworker. An Advocacy service would, in her opinion, enhance the power of these individuals to deal with providers in situations where their personal rights are limited.

The Steering Committee considered that difficulties which have been experienced in establishing the Community Visitor Scheme under the Northern Territory's Mental Health and Related Services Act underline the importance of proper resourcing of such functions. Indeed, adequate recurrent funding to support such a function is considered so essential for the effectiveness of such a service that the Committee believes it would be better not to attempt to establish such a service in the absence of the necessary funding.

A realistic budget would need to take into account:

- the number and location of visitable services;
- the costs associated with regular visits to remote communities in the Northern Territory;
- training individuals in the community;
- costs arising from the use of interpreters when undertaking advocacy /complaints resolution work;
- costs arising from the coordination of advocacy/community visitor services within the Health and Community Services Complaints Commission including:
  - a full time Community Visitor/Advocacy Service Coordinator;
  - provision of on-going training and support for advocates/community visitors; and
  - development and printing of protocols, contracts and other resource materials to be used by the service providers.

The Steering Committee considered that such a scheme would not be inexpensive, but that the return on investment through low level and informal complaints resolution, and through systems improvement, would be high.

The Committee recommended that resources for such a scheme may be able to be negotiated with the Commonwealth, possibly on a trial basis. Commonwealth funding might possibly be supplemented by consolidation of NT Government advocacy/community visitor funding into the one area.

At the final Steering Committee Meeting in February 2004, the principle of establishing an Advocacy/Visitor scheme was unanimously agreed, however they were unsure as to the breadth of the service. In this regard they agreed that the legislation should provide for either an Advocacy Service or a Visitor Service or a combination of both and that the Minister would be required to determine the preferred option.

RECOMMENDATION

17. That the Act be amended to trial the establishment of either an independent Community Visitor Scheme or an Advocacy Service or a combination of both. Such a service to be:

- **adequately resourced and funded to allow for the three year trial;**
- **administered by the Commissioner for Health and Community Services Complaints; and**
- **delivered independently through appropriate community based organisations.**

18. That the Commission's coordination/administration role include:

- **contracting appropriate service providers;**
- **monitoring the delivery of the service by the independent providers;**
- **managing the selection of Advocacy/Community Visitors;**
- **preparing protocols for use by service providers; and**
- **coordinating the delivery of training and support to the selected advocates/visitors.**

19. That the trial scheme be based on the following principles:

- **seeking to identify and resolve problems and complaints at the lowest possible level;**
- **striving for a positive and respectful approach to working with service providers;**
- **commitment to an empowerment advocacy framework;**
- **prioritising advocacy services to those who are least in a position to advocate for themselves.**

9 APPROPRIATENESS OF EXISTING PRACTICES AND PROCEDURES

9.1 CHANGING THE TITLE OF THE ACT

The Steering Committee endorsed the argument that the current title of the Act, *"The Northern Territory of Australia Health and Community Services Complaints Act (1998)"*, results in unnecessary confusion to the public because:

- It does not accurately reflect the jurisdiction of the Commission;
- The former Territory Health Services changed its name to the Department of Health and Community Services after the Act came into force.

The Committee accepted concerns expressed in three submissions that the similarity of the name of the Act, with the name of the Northern Territory Government Department with responsibility for delivering or funding many of the services over which the Act has jurisdiction could result in community perceptions that the Commission is not an independent statutory body.

The Committee also noted comments in the Commissioner's submission to the review that Enquiry Officers, who are the first point of contact to the Commission, frequently receive calls indicating confusion as to the independent status of the Commission with respect to the Department.

Submissions to the review suggested a range of alternatives. Several submissions commented that the title should be concise, but self-evident, and reflect the jurisdiction of the Act. Two submissions suggested that the word "independent" should be included in the amended title of the Act. One submission suggested that the word "Resolution" should appear in the Act.

In considering possible titles, the Steering Committee noted the names of the Act in other Australian jurisdictions.

- Victoria: *Health Services (Conciliation and Review) Act* (Health Services Commissioner);
- Australian Capital Territory: *Community and Health Services Complaints Act* (Community Health Services Complaints Commissioner);
- Queensland: *Health Rights Commission Act* (Health Rights Commissioner);
- Western Australian: *Health Services (Conciliation and Review) Act* (Director Health Services Review);
- Tasmania: *Health Complaints Act* (Health Complaints Commissioner);
- South Australia: *Health and Community Services Complaints Bill 2002* (currently the Ombudsman does public health complaints. Under the new Bill the proposed title will be the Health and Community Services Ombudsman);
- New Zealand: *Health and Disability Commissioner Act.* (Health and Disability Commissioner)

RECOMMENDATIONS

20. That the name of the Act be changed to the "Community and Health Services Complaints Act."

21. That the title of the person charged with responsibility for the working of the Act, be the "Community and Health Services Complaints Ombudsman."

9.2 Informing Consumers

Objectives (g) and (h) of the Act require the Commissioner to promote, inform, educate and advise about the Act, the Code and procedures for resolving complaints. In addition, Principle 8 of the Code of Health Rights And Responsibilities requires that providers promote both internal and external complaints mechanisms.

To date, promotion and education about the Act has been undertaken through publication of pamphlets and sporadic visits to regional and remote centres throughout the Territory.

Despite that fact that the Commission has been established for over four years, the consultation process revealed that many users of health, aged and disabled services are not aware of existing complaints mechanisms, or how to access them.

The Steering Committee considered that the under-representation of aged people, people with a disability and Indigenous people as complainants under the Act is a cause for concern and that effective provision of information about the Act could go some way towards addressing this situation.

Review submissions emphasised the importance of targeted and culturally appropriate educational and promotional materials. Specific strategies includes community educational materials such as posters, brochures and videos in Aboriginal and other major languages, and advertising on radio and television (including in the Indigenous media.) The identification of community liaison people in regional centres, and making sure that they were fully briefed about the Act was also suggested.

Other suggestions for promoting increased awareness of mechanisms under the Act focused on systems approaches such as ensuring that funding agreements with community-based organisations stipulated the requirement to establish and promote internal and external complaints mechanisms. Further suggestions along these lines included that:

- funding agreements include the requirement for providers to place notices about complaints mechanisms in waiting rooms and on invoices; and
- requiring that if a complaint is received there should be an obligation to provide the complainant with a card showing the Commission's contact details.

The Steering Committee noted with concern the Commissioner's comments that limited effectiveness in promotional and educational activities was primarily a resourcing issue. The Steering Committee also endorsed the Commissioner's submission that the current legislation generally reflects the intent to ensure that health and community services consumers are made aware of complaints resolution mechanisms available to them.

However, the Committee believes that the Commission's current promotional efforts could be enhanced if all Northern Territory Government Health and Community Services funding contracts incorporated a requirement to establish and promote both internal and external complaints mechanisms.

RECOMMENDATIONS

22. **That current provisions aimed at ensuring that users of health and community services are made aware of complaint resolution mechanisms be retained.**

23. **That the Commission be provided with adequate resources and funding to develop and implement a communication strategy, distribute a comprehensive and culturally appropriate range of promotional materials, and to undertake adequate ongoing awareness raising activities.**

9.3 REQUIRING PROVIDERS TO PROMOTE COMPLAINTS MECHANISMS

The Australian Standards for Complaint Handling[73] set out best practice standards for internal complaint handling, and the Commission consistently advocates for the use of such approaches in provider organisations.

The current Act provides some scope for the Commission to influence internal complaint handling mechanisms in regard to prescribed providers. For example, Objective a (ii) of the Act requires the Commission to encourage resolution of complaints as between user and provider directly, ie, at the point of service. There is therefore a need for providers to establish effective internal complaint mechanisms which encourage feedback, concerns and grievances. The Code of Health and Community Services Rights and Responsibilities also requires providers to have effective complaints mechanisms in place.

However, the Steering Committee considers that future public interest would be further protected if the Act clearly obligated any relevant health and community service provider to instigate effective internal complaint handling mechanisms, and to promote and advertise both those mechanisms/processes and relevant external complaint process. Anything less would not recognise the need for transparent and accountable processes. The Steering Committee supported the notion that this requirement apply to both registered and non-registered providers.

RECOMMENDATION

24. **That the Act be amended to clearly obligate both registered and unregistered providers to establish internal complaints handling processes, and to promote them in conjunction with relevant external complaints handling mechanisms.**

[73] AS 4269-1995 Australian Standard Complaints Handling Standards Australia, Council of Standards Australia

9.4 Effectively promoting the Commission to Indigenous people

The review discussion paper canvassed ideas on how the Commission could promote itself more effectively to the Northern Territory's Indigenous population, and whether legislative change was necessary to achieve more effective outcomes in this area.

Suggested strategies included: proactive culturally appropriate promotion, promotion via existing agencies and community organisations, information available in Aboriginal languages and the development of collaborative relationships with Indigenous organisations and trainers. The use of the BRACS system and other Aboriginal media outlets was also suggested. More regular distribution of Commission pamphlets and brochures, and decreased complaint handling time were also suggested.

Most submissions addressing this question did not consider that legislative change was necessary to address this issue. However the resources to do this effectively are the issue.

9.5 Considering best interests of the consumer

Section 22 of the Act stipulates who can make a complaint, and gives the Commissioner discretion to accept a complaint on the basis of public interest. The basis for complaints is also broad (section 23).

A complaint may be made *on behalf* of a consumer. In some circumstances it is difficult to determine whose interests are being served by the complaint - the complainant's or the consumer's.

The Steering Committee noted that it has been the Commission's practice to assess a complaint on the basis of what is in the best interests of the user, (ie, the person who receives the service) as opposed as what is perceived to be the appropriate outcome of a person making the complaint (ie, a representative or a relative). The Commission's assessment process may also involve seeking views of providers, users, concerned relatives, guardians and other representatives in order to determine what is in the best interests of the user.

The Committee noted that an appropriate provision to clarify this approach is included in the Community Services legislation in New South Wales.

The Steering Committee also noted the Commissioner's recommendation that:

> *"In the specific case of a user who has attained the age of 16, the Commission is supportive of an amendment which enables such a person to determine whether he/she wishes to be represented in regard to a complaint and, if so, by whom. This is consistent with legal cases which have determined that a person reaching the age of 16 is capable of making decisions in their own interest and their interest cannot be overridden other than in appropriate/exceptional circumstances by a representative."*

There were 12 formal responses to the relevant question included in the review discussion paper. Eight respondents said that the Commissioner should consider the best interests of the consumer over those of the complainant when the interests were

in conflict. Several of these respondents suggested that supporting the rights of the user over that of the complainant, was "in the spirit of the Act". Two respondents were "unsure".

At the final Steering Committee Meeting it was agreed that there should be a protective element introduced addressing the issue of the capacity of the complainant.

RECOMMENDATION

25. That the Act be amended to allow the Commissioner to consider the best interests of the consumer over those of the complainant, if the interests conflict and to inform the parties.

26. That the Act be amended to enable a person who has attained the age of 16 to determine whether he/she wishes to be represented in regard to a complaint and, if so, by whom. But if it can be demonstrated that he/she lacks capacity and is not acting in his/her own best interest then the Commissioner can accept representation from a person who can demonstrate a sufficient interest in the complainant such as a parent or guardian

9.6 ALLOWING ELECTRONIC LODGEMENT OF STRAIGHTFORWARD COMPLAINTS

Section 24 of the Act governs the manner in which a complaint can be made. Provisions within this Section allow complaints to be made either orally or in writing and signed by the complainant.

To date the provisions have not knowingly resulted in any barriers to making complaints.

However, the Commission has a website and the question has been raised as to whether a formal complaint can be made via the internet.

There would appear to be a number of problems that would need to be overcome to allow the lodging of a health or community service complaints via the internet. For example, the Act requires written complaints to be signed by the complainant. Other potential difficulties include how to ensure that:

- the complaint is genuine;
- the sender is correctly named;
- the complainant provides the necessary legal authority to access his or her records; and
- the information sent via the internet is secure.

Summary of Review Responses

The review discussion paper canvassed opinion on the electronic lodging of complaints.

There were 11 responses to this question: *"Should the Act continue to require that complaints be reduced to writing or be expanded to include complaints being made by other means including the internet?"*

Eight respondents said that complaints should be lodged using other means in addition to writing. Suggested mechanisms included internet-based forms, internet-based forms followed by written authorisation, tele-conferences, tapes and e-mails. However, several respondents commented that privacy and safety issues would need to be addressed before the internet is used for this purpose.

The NT Under Treasurer, said it was important that barriers to the making of complaints be reduced, particularly for people with low levels of literacy and that this may require alternative means of lodging complaints.

Three respondents said that complaints should continue to be reduced to writing.

Consideration of the issues

The Steering Committee notes that the possible lodging of complaints via the internet raises a number of issues at the heart of heated debate in electronic information security circles. Issues currently being contested in such circles include: "e-consent", threat assessment, risk management, data and identity authentication, attribute authentication and non-repudiation.[74] Many of these issues are particularly sensitive in the health and community services context, in which a complaint may involve use of medical records or other highly personal information.

Broadly, current directions in this rapidly evolving field of information science, indicates that agencies seeking to facilitate the use of electronic documents via the internet are increasingly taking a risk management approach to electronic information security. This involves developing policies and procedures defining the risks involved in using the internet, and then developing a risk management strategy and security information plan to address the various levels of possible threat.

In the complaints environment, this may involve developing policies and protocols around allowing the electronic lodging of complaints where the issue is considered to be relatively straightforward and likely to be resolved informally without recourse to the formal conciliation or investigation process. However, more serious complaints would require further attention to confirming the identity of the complainant and to seeking their informed consent and written authorisation for an assessment to take place.

RECOMMENDATION

27. That the Act be amended to allow the Commissioner to accept simple and straightforward complaints via the internet or by e-mail and other electronic media such as the facsimile machine.

9.7 PROVIDING FLEXIBLE ASSESSMENT TIME-FRAMES

Section 27 of the Act requires that the Commissioner assesses a complaint within 60 days of receiving it. During assessment the Commissioner can undertake preliminary and minor enquiries seeking further information.

[74] *Introduction to information security* Roger Clarke, 2001, accessed on line at http://www.anu.edu.au/people/Roger.Clarke/EC/IntroSecy/html on 3rd November 2003

During the 60 day assessment period, complaints may be withdrawn or resolved, and the Commissioner must then determine whether to conciliate, investigate, refer or take no further action on the complaint.

However, experience over the past four years has shown that it is not always possible to assess complaints within 60 days. This has led to the Commission going outside the 60 day time period to assess a complaint on many occasions (approximately 40% of the time).

Factors which have contributed to the need to go beyond the stipulated assessment time period include:

- complexity of the complaint;
- parties wishing to resolve the complaint without recourse to the formal processes of conciliation and investigation;
- time required to receive further information to assess a complaint;
- delays in receiving a reply from the complainant after the provider's response;
- delays in the provision of information, documents or medical records;
- delays or difficulties in accessing independent assistance from a mentor or expert; and
- key stakeholders to the complaint being interstate or otherwise unavailable.

The Steering Committee acknowledges that many of these issues are outside the control of the Commission.

There were 15 submissions to the review responding to the questions: *"Should the 60 day assessment period be amended? If so, should the Commissioner be given the power to extend the 60 day assessment period by 30 days with a discretion to extend for a further period of 30 days under the special circumstances?"*

All respondents were in favour of the 60 day assessment period being amended, however, opinion was divided on the length of time which should be available for the assessment process, and of any extensions. Several respondents emphasised that there was a need to inform parties if an extension was being applied. Two respondents said that a complaint should lapse if it was not assessed during the statutory period, and that the Commissioner should report on the number of lapsed complaints.

Important Points Made in Review Submissions

The AMA contended that a complaint not assessed within the specified timeframe, and which did not meet the requirements of an extension period, should lapse:

> *"In such circumstances the complainant and the person/organisation against whom the complaint has been made should be advised the complaint has lapsed, at the same time providing the complainant with the opportunity to resubmit the complaint."*

The AMA's submission went on to argue that if an extension of the assessment period is granted, and the complaint remains unassessed during the extended period, the complaint should also lapse and all parties notified accordingly. If a complaint is resubmitted for assessment, the AMA contended the Commissioner should delegate the complaint to an Assistant Commissioner and that "lapsed complaints" should be reported in the annual report.

Integrated disAbility Action supported use of the Victorian model of 28+28 days as: *"more suitable for the Territory. It may also encourage better use of the Act by Ethnic and Aboriginal groups."*

However, the Action group cautioned that:

> *"The circumstances would need to be "exceptional" rather than "special." The discretionary period should be 28 + 28 days. There would need to be a clear definition of "exceptional circumstances" under Section 4 of the Act, and at all times the complainant must be kept fully informed of any extensions of time and why."*

Central Australian Aboriginal Congress argued that the Commission should be required to *"show reasonable cause for extending the investigation period, and this should be able to be open to appeal."*

NTCOSS Darwin pointed out that "*Vulnerable groups can have difficulty following through an extended process. Therefore there should be a stated time limit and this should only be extended under specified criteria."* They *suggested the following criteria for extension:*

- factors outside the Commissions control
- complexity of complaint
- parties want to resolve the complaint informally
- complainant needs to agree to extension

Participants in the Non-Government Organisation Workshop in Nhulunbuy supported maintaining the current 60 day time limit, but with extension for 30 days if required. They also supported a further 30 day extension period under the exceptional circumstances, as listed in the Discussion Paper. Participants argued that the Act needed to set some time parameters, but needed to be flexible to address particular problems frequently encountered in remote areas such as difficulty locating people, or high staff turnover.

The Health Complaints Review Committee supported the current 60 days assessment period, with the Commissioner having the power to extend the 60 day period for up to a further 30 days in special circumstances. The Complaints Review Committee argued that any extension should be formally notified to all parties before the 53 day of the initial 60 day period stating the circumstances for the delay.

The Department of Health and Community Services argued that: *"Demographic, geographic spread, limited resources can combine to make the 60-day turnaround for complaints resolution unachievable. A 30-day extension with further extensions possible makes sense given that this delivers a better outcome. All parties need to be informed about any extensions and the reasons why."*

The Northern Territory Health and Community Services Complaints Commissioner stated that:

> *"The structure of the Act, its objectives, and legal advice, strongly supports the view that the 60 day timeframe is directory and not mandatory. No penalty is provided for failing to comply with the timeframe. Legal advice also suggests that the only remedy likely to be available is an application to the courts in the nature of a*

prerogative writ directing that the Commission proceed to assess a complaint as it is obliged to do so by legislation. Where there is good reason for exceeding the time limit it is unlikely a court would make such an order or, alternatively, it would establish a reasonable timeframe to comply with the obligation under the Act. There have, however, been instances where a provider has argued that the 60 days period is a mandatory requirement and if a complaint is not assessed within that timeframe it is automatically invalidated and the Commission can no longer entertain it."

The Commissioner goes on to say that

"whilst this argument is unlikely to succeed it does result in a provider potentially becoming unwilling to participate in the resolution processes set out within the Act" and that *"To avoid any debate and uncertainty in this regard the Commission strongly submits that the current provision of section 27 be amended to clearly convey the fact that the 60 day period is directory, not mandatory and it is submitted that a provision similar to that in the proposed South Australian Bill at section 26 be the basis for any amendment."*

Overall, the Committee considered that the Act should not present any potential barrier to achieving effective outcomes from the complaint process, and should therefore allow reasonable and appropriate flexibility to facilitate both informal resolution, yet timely resolution of complaints

The Committee endorsed Section 26 of the SA Bill as providing appropriate specification and flexibility for the assessment period. The provisions in the Bill read as follows:

"The HCS Ombudsman must assess a complaint and make a determination in accordance with this section within 45 days after receiving it (or within such longer period as may be necessary in view of any delays that have occurred while the HCS Ombudsman or another person takes steps required by or under this Act, or while the HCS Ombudsman is undertaking preliminary inquiry under section 27."

The Committee considered it appropriate to require that if the time limit is extended, that both the provider and user are informed of the extension without necessarily being told of the reasons for the extension, which should remain a matter of discretion for the Commissioner. The proposed amendment, would, in the opinion of the Steering Committee, remove any doubt as to the fact that a complaint will remain valid despite the specified time period being unable to be met.

RECOMMENDATION

28. That the Act be amended to require the Commissioner to assess the complaint in 60 days after receiving it, or within such longer periods as may be necessary to accommodate any delays that may occur whilst the Commission or another person takes steps required under the Act or whilst the Commission is undertaking preliminary inquiries.

29. That the Act be amended to require that all parties to the complaint are informed when an extension is granted.

9.8 ALLOWING INFORMAL RESOLUTION DURING ASSESSMENT

Section 27 requires the Commissioner to assess a complaint and make a determination within 60 days as to how the complaint will be handled ie to conciliate, refer, investigate or take no further action.

The review discussion paper proposed that the additional option of informal mediation outside the assessment period be available to the Commissioner.

The Commissioner's submission to the review outlined how the Commission has employed a process of "expeditious complaints resolution" outside the assessment timeframe *"to assist informal resolution of complaints without having recourse to the formal processes of conciliation".*

The submission described how the Commission has adopted a 'mediation' framework to assist in the expeditious complaints resolution process. The mediation is usually restricted to one meeting, and addresses less serious complaints that do not warrant recourse to the conciliation process or utilisation of an expert opinion. The Commission argues that the mediation model is consistent with the principles of "open disclosure".

The Commission subscribes to the notion that the mediation process should be subject to the principles of confidentiality and privilege, and that a set time-frame should apply. In the event of unsuccessful mediation, the Commissioner may then assess the complaint to determine further appropriate action on the complaint.

The review discussion paper canvassed opinions about the use of mediation during the assessment phase of the complaints management process.

Summary of review responses

There were 13 responses to the questions relating to mediation of complaints during the assessment phase: "*Should the Commissioner have an additional assessment option to determine that a complaint be informally resolved without the need to proceed to conciliation or investigation? Should the process be confidential and information obtained privileged? Should there be a specified time period to undertake the informal resolution?*"

Eleven respondents supported the additional option of informal resolution during assessment through mediation. Five of these respondents said that the process should be confidential and the information privileged, and take place within a designated time-frame. The Health Professions Licensing Authority said specific information should remain privileged (eg financial agreements), but that actions agreed to be taken by the provider should be available to the relevant Board. DHCS stated that the process should be confidential and privileged, but that the decision should be shared with the consumer and provider.

Two respondents did not support the Commissioner having the option of informal resolution during assessment. One rationale was that such an option *would "water*

down the independence of the process" and result in more potential for imbalance of power between the provider and consumer.

The Steering Committee considered that the spirit of the Act, and that the successful use of mediation under the current Act supported the formalisation of current practice in legislation.

The Committee also recognised the need for a balanced approach in that the Commissioner had an obligation to encourage both the provider and complainant to seek a resolution of the complaint. At the Steering Committee meeting in February 2004 the Commissioner suggested that this could best be achieved by introducing an additional subclause under S12 of the Act which deals with the Powers and Functions of the Commissioner.

RECOMMENDATION

30. That the Act be amended to:
- **provide the Commissioner with an additional assessment option to informally resolve a complaint through mediation;**
- **ensure that the mediation process is privileged and confidential;**
- **provided all mediation parties agree, allow relevant information on agreements reached in mediation to be provided to the relevant Professional Board/s and to the provider organisation; and**
- **require that the informal resolution process be undertaken within a 60 day time period**

31. That the Act be amended by adding an additional subclause under S12(1)(j)(iv) to read "use reasonable endeavours to encourage the parties to resolve a complaint where appropriate"

9.9 SPECIFYING REQUIREMENTS IN RESPONDING TO COMPLAINTS

Section 28 of the Act requires a provider to respond to issues raised in a complaint within a reasonable period of time. The Commission normally requests a response within three weeks, but will allow an extension of time if an application is made prior to the due response date. Failure to do so can result in a penalty of $5,000.

In order to appropriately assess a complaint and assist in its informal resolution, there is often a requirement for the Commission to obtain medical records, patient information and other information. Experience has shown that a few providers can be reluctant / unwilling to provide records, patient information or other information requested. This reluctance may result in a complaint being referred to Investigation, when it may have been resolved informally during the Assessment process.

The requirement for providers to provide medical records and patient information has been a source of contention in some quarters. The Committee notes that providers can argue that a letter from them acknowledging the issues of complaint could be regarded by some as "a response".

The review discussion paper canvassed opinions on procedures relating to the provision of information and documents on the request of the Commission.

Summary of Review Responses

There were 13 responses to the questions: *"Should section 28 of the Act be amended to explicitly require a provider to provide a written response to the issues of complaint along with records, other information or documents when requested to do so by the Commissioner*".

Nine responses supported amending the Act to explicitly require a provider to provide a written response along with records and other information. Most of these responses indicated that this requirement would assist in rapid determination of the complaint, whilst also ensuring proper recording of the complaint. The Commissioner argued that making this requirement explicit would ensure that providers did not defeat or unnecessarily delay the resolution of a complaint by refusing to provide information.

Strong concerns were expressed in this area by the AMA which argues that a complaint made to the Commission requesting investigation of concerns *"does not give automatic authority to a provider to release confidential patient information".* In its submission to the review, the AMA argued that GPs are not legally able to release reports written by a specialist or other third party. The AMA states that provision of information from third parties requires written consent specific to the release of that information and for its intended use from the patient who has made the complaint. The AMA further states that: *"in the event a third party has made a complaint on behalf of a patient, a provider again, cannot release confidential information without the specific consent of the patient or evidence the person acting on behalf of the patient holds power of attorney and as such can provide the written consent to release the confidential information."*

The AMA also states that documents cannot be released unless there is sufficient evidence that the person providing the authority to release information is who they say they are. The lack of a formal requirement that a complainant provides proof of his or her identity is seen by the AMA as a flaw in the current process. Proof of identity should, in the opinion of the AMA, be mandatory prior to any complaint being pursued.

The AMA contends that the current Act is sufficiently explicit on the issue, but that there should be a requirement for the Commission to ensure that appropriate consents are obtained, proof of identity has been provided or, alternatively, that the complainant has legal authority to seek such records on behalf of the consumer.

In addition to the AMA, two submissions indicated that the Act did not need to be amended in this area. One provider said that providers were already aware that the provision of a response and full information would assist with resolving the case, and that the current act was therefore adequate. The Department of Health and Community Services said that the Act already gave the Commissioner power to require this response.

Discussion of the issues

The Steering Committee considers that inclusion of a more explicit requirement to provide a written response to the issues of complaint, along with medical records, patient information and other information or documents when requested by the Commission will address some of the issues of concern to the AMA. Explicit statutory

requirements in this area will override the information privacy concerns expressed by the AMA.

The majority of the Steering Committee agreed that making response requirements more explicit will assist in ensuring that uncooperative providers do not defeat and/or unnecessarily delay the resolution of a complaint by refusing to provide information. The making of a complaint and thus invoking the Commission's roles and powers should be sufficient to impose upon a provider an obligation to fully inform the Commission so that it can carry out its legislative responsibilities. Provisions requiring providers to include relevant documents with their response would also reduce the necessity for the Commission to devote limited resources to accessing and copying records.

The Steering Committee endorses the response to this issue proposed in the South Australian Bill (section 27(2)) which empowers the HSC Ombudsman to require a health or community service provider to provide information, or any response or explanation, about any matter relevant to an inquiry.

However, the Steering Committee considers that the issue of confirming the identity of complainants or consumers requires some attention, particularly where the complaint appears to be of a serious or complex nature, or where it has been lodged on behalf of the consumer. The Committee understands procedures in the area of identity confirmation have recently been reviewed at Royal Darwin Hospital, and that simple and effective protocols are now in place.

RECOMMENDATIONS

32. That the Act be amended to explicitly require a provider to provide:
- **a written response to the issues of complaint**
- **medical records**
- **patient information**
- **medical opinions and**
- **other information or documents**

when applicable and as and when requested by the Commission.

33. That the Commission consult with the Department of Health and Community Services to determine appropriate and reasonable protocols for establishing the identity of complainants and consumers.

9.10 ALLOWING NO FURTHER ACTION ON COMPLAINTS

Section 30 of the Act details the circumstances under which the Commissioner must take no further action on a complaint. Experience has shown that a complaint will often resolve if a reasonable explanation is provided. However, there is currently no provision within Section 30 to allow the Commissioner to take no further action if a reasonable explanation is provided to the complainant.

The review discussion paper canvassed opinion on this issue.

Summary of Review Responses

There were 13 responses to the question: "*Should the Act be amended to allow the Commissioner to take no further action on a complaint where a reasonable explanation has been provided?*"

Eleven of these respondents supported the Act being amended to allow the Commissioner to take no further action on a complaint where a reasonable explanation had been provided. However, one submission said that the criteria for "a reasonable explanation" would need to be clear. Another submission said that the decision to take no further action would need to be supported by the complainant. One respondent said that such a decision would need to be supported by both the complainant and the provider. The Commissioner said that the decision to take no further action should not require the agreement of the complainant or the provider.

One provider and the AMA strongly supported this amendment and suggested further grounds for allowing the Commissioner to take no further action.

Two respondents did not support amendments allowing no further action. Darwin Community Legal Service argued that this power would result in the Commissioner becoming a complaints gatekeeper. Another submission said that the Commissioner should not have "sole responsibility" in this area.

Discussion of the issue

The Steering Committee considered that the Commissioner should be able to take no further action on a complaint where a reasonable explanation has been provided, and that such a decision should not need to be supported by either the complainant or provider. However, the complainant should be advised that if further evidence to support their complaint become available, that the Commissioner's decision could be reconsidered. The Steering Committee considered that where additional material relevant to the complaint became available, the complainant should have a further 60 days to provide that material to the Commission.

RECOMMENDATION

34. That the Act be amended to allow the Commissioner to take no further action on a complaint where, in the opinion of the Commissioner, a reasonable explanation has been provided to the complainant.

35. That in the event of such a decision being made, the complainant be advised that the decision may be reconsidered in the event of further substantial evidence becoming available to support their issues.

36. Any additional information must be provided within 60 days of being notified of the Commissioner's determination to take no further action.

9.11 ALLOWING THE COMMISSIONER TO DECLINE TO TAKE ACTION

There are various complaints mechanisms available to consumers. For example, a complaint about aged care in the Northern Territory could be considered within the Commonwealth aged care complaint process.

The Queensland Ombudsman has jurisdiction to decline or take no further action on a complaint, if another body exists that could deal with the complaint at the same level.

The review discussion paper canvassed opinions on allowing the Commissioner to decline to take action.

Summary of review responses
There were 11 responses to the question: *Should the Act be amended to allow the Commissioner to decline to take action on a complaint if there is another body appropriately empowered to deal with it?*

Nine respondents supported the Act being amended to allow the Commissioner to decline to take action on a complaint if there is another body appropriately empowered to deal with it.

One respondent expressed concern that it would be difficult to define the grounds on which to make such a determination.

The Department of Health and Community Services supported the concept, but said that such a decision could be made by the Commissioner without the Act being amended.

Consideration of the issues
The Steering Committee considered that in the interests of cost efficient use of resources, the Commission should be afforded the opportunity to decline action on complaints in circumstances where an alternative body has jurisdiction to deal with the issues raised by the complaint.

However, the Steering Committee considered that legislative amendments should require the Commissioner to be satisfied that the alternative body/organisation is able to deal with the complaint substantially to the same level as the Commission.

RECOMMENDATION

37. That the Act be amended to allow the Commissioner to decline to take action on a complaint if there is another body appropriately empowered to deal with it at substantially the same level as the Commission.

9.12 ALLOWING THE COMMISSIONER TO INVESTIGATE WITHDRAWN COMPLAINTS

Section 31 of the Act states that the Commissioner cannot investigate a matter if the complaint has been withdrawn.

Experience has shown that some complaints are withdrawn because the complainant "gave up" on the system, or moved interstate.

Other complainants have failed to keep in contact with the Commission, failed to contact the organisation representing their interests, or for various reasons, have failed to vigorously pursue their complaint. In these circumstances it could be argued that they had withdrawn or abandoned their complaints. This has particularly been the

case in regard to complaints made by persons from disadvantaged and/or non-English speaking backgrounds. In the Commission's experience, it has not necessarily been that they have specifically sought to withdraw their complaints, but their circumstances have made it extremely difficult to pursue an interest in a complaint.

If current provisions in the Act were applied literally, a number of complaints would not have proceeded beyond the assessment phase. This has been a matter of some concern to the Commissioner on the grounds that some of the complaints appeared to warrant further investigation because they either raised significant issues of public health / safety / interest, or significant issues as to the practice and procedures of a provider.

The review discussion paper canvassed opinions on whether the Commissioner should be able to deal with withdrawn complaints.

Summary of review responses

There were 14 responses to the question:

"Should the Act be amended to allow the Commissioner to investigate the issues of a complaint that has been withdrawn if, in the opinion of the Commissioner, the issues of complaint:

- *raises a significant issue of public health and safety or public interest; or*
- *raises a significant question as to the practice and procedures of the provider?*

Nine respondents said that the Act should be amended to allow the Commissioner to investigate issues raised in a withdrawn complaint. Two of these respondents said that the clear definitions of key terms would be required eg "significant" and "special circumstances."

Two respondents (a provider and the AMA) did not support amendments in this area on the grounds that the complainant's wishes should be respected, and the independence of the Commission should be maintained.

The Victorian Health Complaints Commission said that such an amendment raised privacy issues.

Discussion of the issues

The Steering Committee considered that a core function of the Commission is to contribute to the betterment of health, aged and disability services in the Territory. Inability to take action on a significant complaint that has been withdrawn for personal reasons / circumstances limits the carrying out of this function. The Steering Committee supports processes similar to those proposed in Section 40(2) (c) of the South Australian Bill which says an investigation on similar grounds as the complaint may be carried out whether or not the relevant complaint has been withdrawn.

The Steering Committee supports the ability for investigative action to be taken on a withdrawn complaint in the circumstances set out as in Section 18 of the NSW Act as follows:

(1) *A complainant may withdraw the complaint at any time by notice in writing to the Commission*

(2) *On the withdrawal of a complaint, the Commission may cease to deal with it, but must continue to deal with the matter the subject of the complaint if it appears to the Commission that:*

a) *The matter raises a significant issue of public health or safety; or*
b) *The matter raises a significant question as to the appropriate care or treatment of a client by a health service provider; or*
c) *The matter provides grounds for disciplinary action against a health practitioner;*
d) *The matter involves gross negligence on the part of a health practitioner."*

The AMA at the Steering Committee in February 2004 stated that they only would endorse this recommendation on the basis that it was accepted that the Commission would require the appropriate professional mentors/experts to be made available to assist in determining any issues associated with professional practice. The Commissioner advised that this was the case now and would continue to be the case.

RECOMMENDATION

38. That the Act be amended to allow the Commissioner to investigate issues raised in a withdrawn or abandoned complaint, where the complaint raises:
- **significant public health and safety or public interest issues, or**
- **significant questions as to the practices and procedures of the provider.**

9.13 INCREASED ACCESS TO MENTOR SUPPORT

The Commissioner may appoint a person to be a professional mentor to a Conciliator under section 45, and to an Investigator under section 51. The mentor provides information, an explanation or assistance in his or her field of expertise.

Experience has shown that there is often a requirement for the Commission to call on the services of a mentor for information, an explanation or assistance during the assessment stage (prior to conciliation or investigation of a complaint) to enable a full appreciation of the issues of complaint.

Summary of review responses
There were 11 responses to the question: *"Should the Act be amended to allow the Commission to obtain a mentor's opinion / assistance on a complaint as and when required?"*

All responses supported the Act being amended to allow the Commission to obtain from a mentor information, an explanation or assistance as and when required. The major issue of contention in relation to mentors was in the level of transparency recommended by respondents in relation to the selection of mentors, and the sharing of information provided by the mentors.

Important points made in submissions
One provider strongly encouraged the definition of the terms of engagement of mentors and suggested the following:
- all parties be informed in writing that a Mentor's opinion will be sought and that any personal information of the user and provider will remain confidential.

- Mentors only be sourced from the provider's craft group, and relevant qualifications of the Mentor be made available to all parties.
- Mentors be required as much as possible to base their findings/recommendations not on personal experience but on existing relevant and documented practice guidelines / clinical care pathways and referenced scientific information.
- All parties be informed in writing and that the mentors findings will be documented and will be made available to all parties on request.
- Where any party believes that they have evidence to contradict the findings/recommendations of a mentor, the Mentor be asked to provide a documented comment on such discrepancies.

Congress suggested a screening process to ensure mentors had the required expertise, and that all parties should be allowed to question the impartiality or appropriateness of their use.

The Commissioner said that a general provision of "Professional Mentor" should be introduced into the Miscellaneous Provisions of the Act and that the provision should include:

- the Board may nominate a mentor that is appropriately qualified to assist the Commission;
- the "Professional Mentor" may be used as a tool for the Officer to gain an understanding of the issues of complaint;
- the material provided to the mentor may be de-identified to protect the identity of the parties;
- the nature of the discussions need not necessarily be disclosed to the parties or the Board.

The Commissioner said that the purpose of confidentiality clauses relating to appointment and use of professional mentors would be to:

- protect the mentor's informal adviser role in assisting with complex medical terms, procedures and clinical and practice standards;
- protect the mentor's identity;
- acknowledge the informal process and assistance to the Commission; and
- acknowledge the small size of the Territory community.

Discussion of the issues

The Steering Committee considered it reasonable and appropriate that the Act include some requirements for engaging and working appropriately with Professional Mentors. The Steering Committee supports the inclusion of the following criteria in the requirements in relation to Professional Mentors:

- that every attempt be made for them to be sourced through the relevant Professional Board/s;
- that their role will be to assist the officer dealing with a complaint to understand the issues of complaint;
- that they will be required as far as possible to base their advice on existing relevant and approved standard treatment protocols/guidelines/clinical care pathways and referenced scientific information;
- that material provided to the mentor may be de-identified;
- that the parties will not be made aware of the identity of Professional Mentors;
- that discussions between Commission staff and the Professional Mentor need not necessarily be disclosed to parties or the Board.

At the final Steering Committee meeting the Australian Medical Association stated that they did not endorse Recommendation 39 and 40. If they were to be accepted, the AMA stated that they would require that appropriate professional mentors/experts be made available to assist the Commissioner to determine any issues associated with professional practice. Notwithstanding the comments made by the AMA all other members of the Steering Committee unanimously agreed with the amendments to Recommendation 39 and 40 as drafted.

RECOMMENDATION

39. That a General Provision be included in the Miscellaneous Provisions of the Act to authorise the Commissioner to obtain information, an explanation or assistance on a complaint from a Professional Mentor, as and when required.

40. That the following requirements for engaging and working with Professional Mentors be incorporated into the mentoring provisions:

- **That every attempt be made for them to be sourced through the relevant Professional Board/s and/or Colleges and Associations**
- **That their role will be to assist the officer dealing with a complaint to understand the issues of complaint;**
- **That they will be required, as far as possible, to base their advice on existing relevant and approved standard treatment protocols/guidelines/clinical care pathways and referenced scientific information;**
- **That material provided to the mentor may be de-identified; and**
- **That the parties will not be made aware of the identity of Professional Mentors.**

9.14 Increased Access to Expert Opinions

Section 52 provides the Commissioner with the power to call for a report from an expert, a person who in the opinion of the Commissioner is sufficiently qualified or experienced to give expert advice on the matter being investigated, when carrying out an investigation under Part 7 of the Act.

As with the professional mentor, there are also other times when the Commission requires the assistance of an expert, such as in conciliation or when undertaking an assessment of the complaint.

During conciliation, the parties are asked to identify the issues they would like to see addressed. The Commission then contacts the College / Association / Interstate Commission for the names of three providers with similar qualifications to those of the provider being complained about.

The parties are asked to select the expert from the list of three. Once the expert is chosen, the Conciliator writes to him or her listing the questions identified by the parties, and asking for comment on the standard of care and treatment having regard to all relevant information gained during the assessment / conciliation process (as consented to by the parties).

The Conciliator provides a copy of the Expert's report to the parties requesting comment. The parties are encouraged to obtain legal advice, and reminded that the report is subject to the statutory provisions in the Act and cannot be used outside the process except for the purpose of obtaining advice. The Commission has found that the use of an expert report has been an essential component in the resolution process, particularly in respect to complaints involving complex medical issues in which the complainant's desired outcome is compensation.

Summary of Submissions
There were 11 responses to the question: *"Should the Act be amended to allow the Commissioner to appoint an expert to assist the Commission in resolving complaints as and when required?"*

All respondents supported amending the Act to allow the Commissioner to appoint an expert to assist the Commission in resolving complaints as and when required.

Discussion of the issues
The Steering Committee agreed that the axiom should be to have the best advice available to inform the complaint process, so changes to legislation enabling this are supported. The Committee considered that it is preferable that the expert be from the same field, and should be advised whether their input is for assessment or conciliation. The Steering Committee also re-enforced the view that expert reports be used only for the purposes of the Act and not for any other reasons.

RECOMMENDATION

41. **That Section 52 of the Act be amended and incorporated into the Miscellaneous Provisions (Part 10) as a general provision allowing the Commission to obtain an expert report during any stage of the complaint process.**

42. **Any such report is to be utilised only for a purpose under the Act and not be used in any other proceedings except where a matter is before the Board**

9.15 Appointing Appropriate Experts

-
- Principles of procedural fairness strongly suggest that an Expert selected to review a complaint should be from the same field of expertise as the professional (registered / unregistered) complained about.

Summary of Review Responses
There were 11 responses to the question: *"Should the expert selected to review the complaint be from the same field of expertise as the professional being complained about?"*

All respondents supported amending the Act to ensure that, wherever possible, experts selected to review a complaint are from the same field of expertise as the professional being complained about.

Several respondents warned that effort should be made to prevent experts having a conflict of interest.

Discussion of the issues
The Steering Committee understands that it can be difficult to identify any one area of expertise that is applicable to the problem at hand, particularly where the problem relates to systemic or organisational issues. A proper consideration of some complaints can require expert opinion from several fields in order to cover various issues. The Committee therefore supports the notion that legislative amendments in this area should not be so prescriptive as to prevent the Commission seeking expert advice from a variety of sources.

In relation to the issues surrounding "conflict of interest", the Steering Committee noted that these concerns were already provided for in Section 52(2) which states:

> *"The Commissioner must not obtain a report from a person who has a financial or personal connection with a person who is the subject of an investigation or who has any other connection with the person that may affect the impartiality of the report."*

RECOMMENDATION

43. That the Act be amended to support the principle that, wherever possible, Experts selected to provide an opinion in relation to a complaint, be from the same field of expertise as the professional being complained about or have qualifications relevant to the issues of complaint.

9.16 ALLOWING CONCILIATION INFORMATION TO BE PROVIDED ELSEWHERE

Part 6 of the Act, Sections 35 – 47, deals with the voluntary and confidential conciliation of complaints. Conciliation is emphasised as the focus of the Act for the purposes of formally resolving complaints. To encourage use of this process, and to avoid adversarial alternatives, all information and discussions throughout the conciliation stage is confidential and is not admissible in any other proceedings. Where agreement is reached during conciliation, parties are able to enter into a binding contract.

In the experience of the Commission there have been situations whereby a professional has wished that an expert report obtained in Conciliation be reviewed by a Registration Board. This cannot occur under the current provisions of the Act.

Summary of Review Responses
There were 11 responses to this question:" *Should the Act be amended to allow in exceptional circumstances for information obtained in Conciliation to be provided elsewhere if the parties unanimously agree?"*

Eight respondents supported amending the Act to allow, in exceptional circumstances, for information obtained during conciliation, to be provided elsewhere if the parties unanimously agreed. Several respondents emphasised that it was important that this should only occur with the unanimous agreement of all parties.

The Victorian Health Complaints Commission said that "all parties" should include the Expert, because many experts choose to co-operate because they know their report cannot be used elsewhere and it would be harmful to undermine this. The NT Commissioner advised however that experts provide their opinion on the basis that it may be challenged and can be used in other proceedings (refer section 52 of the Act).

Integrated disAbility Action said that "exceptional circumstances" needed to be clearly defined in the Act.

Congress said that the purpose of further disclosure needs to be defined in the Act.

The AMA did not support the further disclosure of information obtained during conciliation on the grounds that all discussions about the legislation has been premised on the underlying assumption of autonomy and confidentiality, and that there was no definition of "exceptional circumstances."

The Tasmanian Health Complaints Commission indicated that extreme caution was necessary in thinking about this amendment because conciliation was meant to have a "firewall" around it. The Commission suggested that if such a change were included, that it should be qualified by requiring the consent of the Complaints Commissioner.

The Department of Health and Community Services was concerned that this amendment could stifle the conciliation process in some cases.

The concerns raised by the AMA were discussed at the Steering Committee meeting of February 2004. There was general agreement that conciliation information could be provided elsewhere on the basis that "exceptional circumstance" was defined in the Act and that it would only occur with the agreement of all parties to the conciliation and the approval of the Commissioner.

RECOMMENDATION

44. That the Act be amended to allow, in exceptional circumstances, for information obtained during conciliation, to be provided elsewhere, but only with the consent of all parties and the approval of the Commissioner.

45. That new provisions define "exceptional circumstances" and clarify the purpose of further disclosure as being to assist in effective complaints resolution.

9.17 Retaining current powers and functions of conciliators

The functions of a conciliator are specified in Section 38 of the Act as to encourage settlement of complaints by explaining the voluntary conciliation process, arranging and assisting in discussions and negotiations between the complainant and the provider, assisting the reaching of agreement, and assisting in resolving a complaint in any other way.

These functions are similar to the functions performed by conciliators in Victoria, Tasmania, Queensland, ACT and WA.

It has been suggested that the Section 38 may not empower the Conciliators to the extent that has been assumed by the Northern Territory Commission. The review discussion paper therefore canvassed opinions on whether the Act should be amended to explicitly provide Conciliators with the power to take action as necessary to successfully conciliate a complaint.

Summary of Review Submissions
There were 10 responses to the question: *"Should the Act be amended to explicitly provide Conciliators with the power to take action as necessary to successfully conciliate a complaint?"*

Six respondents supported amending the Act to explicitly provide Conciliators with the power to take action as necessary to successfully conciliate a complaint.

Three provider respondents did not support the amendment of the Act in this area.

The AMA said that this would move the focus from the process of conciliation to that of enforcement, and was not in the spirit of the Act.

One provider said the proposed change was far too broad.

The Department of Health and Community Services warned that this would move the process out of conciliation to another process, and that the conciliator must act without bias.

One respondent said this would be very dangerous unless there were specific guidelines.

Discussion on the issues
Whilst the Steering Committee had some sympathy for the arguments for amending the Act to explicitly provide conciliators with the power to take action as necessary to successfully conciliate complaints, it endorses concerns raised by those organisations against amendments in this area.

The Committee believes that the powers and functions as provided in the current Act have been sufficient for high rates of resolution through conciliation, and provide sufficient flexibility as they stand. Furthermore, the similarity with the powers and functions provided to conciliators in other jurisdictions suggests that there is no need for amendment at this point in time. Indeed, to do so may, as suggested in some submissions, shift perceptions about the conciliator's primary role from "encouragement" to "enforcement".

RECOMMENDATION

46. That the current powers and functions of conciliators be retained and the Act <u>not</u> be amended to explicitly provide Conciliators with the power to take action as necessary to successfully conciliate a complaint.

9.18 INVOLVING INDIVIDUAL PROVIDERS

Under Section 40 of the Act, a provider can be represented in the conciliation process, but only in certain specified circumstances.

Where the provider is an organisation (such as a hospital) it has been the experience of the Commission that the individual provider named in a complaint (called the named provider) is often not a party to the conciliation process. It has even occurred that the individual provider is not aware that conciliation is taking place.

Whilst an organisation may want to be represented, as they may ultimately be responsible for the outcome of the conciliation, it is understood that it was not the original intention of the Act to specifically exclude an individual provider from the process.

The review discussion paper canvassed opinion on possible changes in this area.

Summary of Responses
There were 10 responses to the questions: *"Should the Act be amended to ensure that, where a complaint is made against an organisation and an individual provider is named in that complaint, the individual provider is specifically involved in the process? In what form should this involvement be addressed in a legislative format?"*

Six respondents supported amending the Act to ensure that, where a complaint is made against an organisation and an individual provider is named in that complaint, the individual provider is specifically involved in the process. Several respondents said that the principles of procedural fairness and natural justice dictated that the individual should be directly involved. However, opinion was divided on whether the individual or the employer organisation should determine how the individual should be involved.

Two provider respondents said although the principle of individual involvement is correct, that the organisation, not the individual, should determine *how* the person complained about should be involved in the process.

The Department of Health and Community Services said that employers should be informed and sourced for comment, but that the individual should have the option of the organisation responding on their behalf.

The Health Professions Licensing Authority said individuals should have the option of the organisation responding on their behalf.

Four respondents said they were uncertain or indicated the need for further expert advice on the issue.

The AMA said that the organisation should determine whether and how an individual named in a complaint is involved in the process.

Discussion on the issues
The Steering Committee considered that the principles of natural justice and procedural fairness dictated that, at the very least, an individual provider named in a complaint should be informed about the issues of complaint against them. Ideally, direct involvement in the complaints process would provide the individual with the opportunity

to learn and to think about the implications of the complaint for improved service delivery.

However, the Committee also accepted submissions from provider organisations that, as the employer, they also have a significant stake in the outcomes of the process. The employer interest may not only be financial (as in compensation payments made to complainants as a result of conciliation), but also about maximising the chance of systems improvement through the appropriate level of representation in the complaints process.

The Committee therefore considers that the Act should be amended to require that the named individual provider must be notified of the complaint, and given the option of attending conciliation along with any appointed provider representative. The Australian Medical Association and the Department of Health and Community Services were particularly concerned that it be made clear that all parties be named in the complaint, that is, the named provider who was the individual practitioner as well as the employee organisation. All members agreed to the amendments in Recommendation 47.

RECOMMENDATION

47. That the Act be amended to require, where an individual provider is named in the complaint, that the named provider must be:

- **informed about the complaint and actively encouraged to respond to the issues of complaint where practicable: and**
- **where conciliation is agreed, given the option of attending along with the appointed provider representative of the organisation.**

9.19 Allowing conciliation information to be provided to an Expert

Section 47 of the Act only allows a Conciliator to disclose information obtained during the course of the conciliation process to a professional mentor or a person the Commissioner has arranged to assist the Conciliator.

During the course of conciliation the Commission has often found that, in order for parties to reach agreement, documents and records obtained by the Commission must be referred to an Expert for an opinion on specific issues of the complaint. The Commission currently allows this action where the Conciliator has the agreement of both parties.

The review discussion paper canvassed opinions about whether Section 47 should be expanded to explicitly allow the Conciliator to disclose such information to an Expert, so a report can be obtained.

Summary of responses

There were 9 responses to the question: *"Should Section 47 of the Act be amended to explicitly allow information obtained during the course of conciliation to be provided to an expert?"*

All respondents supported amending the Act to explicitly allow information obtained during the course of conciliation to be provided to an expert. However, several respondents said that this should only occur with the agreement of all parties.

The Department of Health and Community Services said this should occur only as a last resort as it represented slippage in confidentiality.

Discussion of the issues
The Steering Committee considered that such an amendment would facilitate the resolution of complaints, and should be supported. The Committee also considered that penalties relating to disclosure of information obtained from a Conciliator would need to be changed to include an expert.

RECOMMENDATION

48. That the Act be amended to explicitly allow information obtained during the course of conciliation to be provided to an expert, provided the complainant and provider agree.

49. That Section 97, relating to preservation of confidentiality, be amended to include Experts as persons involved in the administration of the Act.

9.20 ALLOWING THE COMMISSIONER TO OBTAIN OBJECTS

Sections 50 and 51 of the Act provide the Commissioner with the powers necessary to conduct aa investigation of a complaint. These powers, which are only applicable to investigations under this Part, enable the Commissioner to:

- require persons to answer questions, provide documents or records;
- obtain information on oath or in affidavit statement;
- enter and inspect premises with consent or a warrant;
- secure the safety of any person in need;
- obtain independent expert advice and opinion to assist the investigation; and
- do all things deemed necessary in the investigation of the matter.

Section 55 relates to the Commissioner obtaining information and documents during an investigation. The Act is silent on whether the Commissioner can obtain objects such as specimens, which may be required for the purposes of gaining a better understanding of the procedure, or an independent expert opinion.

The discussion paper canvassed opinion on whether provisions should be expanded to ensure the Commissioner is able to obtain objects associated with a complaint if required.

Summary of submissions
There were 10 responses to the question: *"Should the Act be amended to ensure that the Commissioner, during an investigation, has the power to obtain any object that may be required as part of that investigation?"*

Eight respondents supported amending the Act to provide the Commissioner, during an investigation, with the power to obtain any object that may be required as part of that investigation.

The AMA did not support an amendment in this area on the grounds that it considers the powers currently imbued in the Commissioner in this regard to be too broad. The AMA argued that current investigation powers may need to be reduced rather than increased, because the focus of the Act should remain on conciliation. The AMA said that they would vigorously oppose any amendment in this area.

One respondent said they were not sure that they understood the question.

Discussion of the issues

The Steering Committee considered that amending the Act to allow the Commissioner to obtain any relevant object as part of an investigation would assist in ensuring a proper and thorough investigation to occur, based on the best and most comprehensive evidence available. As such, the amendment should be supported.

RECOMMENDATION

50. That the Act be amended to ensure that the Commissioner, during an investigation, has the power to obtain any object that may be required as part of that investigation.

9.21 ALLOWING THE COMMISSIONER TO RE-ASSESS COMPLAINTS

Sections 65 – 67 of Act set out what action must be taken by the Commissioner at the conclusion of an investigation. Specifically:

- the Commissioner must submit an investigation report to the appropriate parties;
- the Commissioner must give parties notice of the recommendations made in a report;
- a provider must advise the Commissioner of what action is being taken in relation to any recommendations made; and
- the Commissioner can report to the Minister for Health and Community Services if dissatisfied with the action taken by a provider and that report must be tabled in the Legislative assembly.

There is no specific provision to allow the Commissioner, on receiving a report to reassess the complaint to determine whether some other action, such as conciliation, is required to resolve the complaint.

The review discussion paper canvassed opinion on the inclusion of a provision that would allow the Commissioner to re-assess the complaint at any stage to determine how it could be dealt with more effectively.

Summary of review responses

There were 10 responses to the question: *"Should the Act be amended to provide the Commissioner with the power to re-assess a complaint at any stage to determine how to deal with it more appropriately?"*

Nine respondents supported amending the Act to provide the Commissioner with the power to re-assess a complaint at any stage.

The Australian Medical Association did not support an amendment in this area on the grounds that if processes were correctly employed under the current Act in the first instance, there would be no need to re-assess the complaint. The Australian Medical Association considers that correct usage of the process requires that Commission staff have adequate training and experience.

Discussion of the issues
The Steering Committee considered that the aim of any legislative change was to support effective complaints resolution, and that the suggested amendment would provide the Commissioner with additional flexibility to undertake complaints work in the light of emerging issues and information. The majority of the Committee agreed that the proposed amendment should be supported.

RECOMMENDATION

51. That the Act be amended to provide the Commissioner with the power to re-assess a complaint at any stage to determine how to deal with it more appropriately.

9.22 Relationship with Professional Boards

Part 8, Sections 68 – 77 of the Act, describes the relationship between the Commissioner and the Professional Boards. The provisions require both the Commissioner and Professional Boards to report complaints to each other which relate to a registered provider, and consult on the best way to manage the complaint. There is a requirement for written protocols to ensure consultation occurs and that disagreements regarding management of a complaint are resolved.

The Act recognises the role and functions of Professional Boards, and their statutory responsibility to manage the professional conduct of registered providers.

According to both the Commissioner and the Health Professions Licensing Authority, protocols with the relevant Professional Boards have been drawn up and, along with the provisions of Part 8, appear to be working effectively.

However, the Steering Committee was aware that some jurisdictions had experienced difficulties in clarifying the roles and functions of the complaints Commissions in relation to Professional Boards. The review discussion paper therefore canvassed opinion on whether there need to be change to the provisions relating to Professional Boards.

Summary of responses
There were 10 responses to the question: *"Are any changes to the provisions involving Professional Boards required? If so, in what way?"*

Four respondents stated that no changes were required to provisions relating to Professional Boards.

Five respondents suggested minor changes to the existing provisions in this area as follows:

- if required, allow the Commissioner to take action on complaints which have been referred to Boards, without the Board referring it back;
- change the time limit for Boards notifying the Commission whether it intends to exercise its powers to 90 days; and
- require the Boards to assess what constitutes an acceptable standard and report on whether the practitioner meets that standard- or, alternatively, make sure this is within the province of the Commission.

One respondent made no comment

Discussion of the issues
The Steering Committee formed the opinion that the current provisions relating to Professional Boards were generally working well, and required only minimal procedural change.

RECOMMENDATION

52. That, pending changes arising from the Omnibus legislation, only minor changes be made to provisions relating to Professional Boards.

9.23 Referring complaints back from Professional Boards

Section 71 of the Act allows the Commissioner to refer a complaint in its entirety to a relevant Professional Board for it to be dealt with in accordance with the relevant legislation. Once the Board has dealt with the complaint it must report back to the Commissioner within 30 days on what it found, and any action taken or proposed in relation to the complaint.

If it becomes apparent to the Board that some of the matters of complaint do not fall within its jurisdiction, and the Commissioner agrees with the Board's view, there is currently no mechanism to allow the Board to refer the complaint back to the Commission. The review paper canvassed opinions on whether the Board should be able to refer complaints back to the Commission.

Summary of Responses
There were 10 responses to this question: *"Should the Act be amended to provide a Registration Board with the ability to be able to refer a complaint back to the Commission?"*

All respondents said that the Act should be amended to provide a Professional Board with the ability to be able to refer a complaint back to the Commission.

Discussion of the issues
The Steering Committee considered that the current inability of the Boards to refer complaints back to the Commission was a flaw. The Committee noted that the Tasmanian Act was amended to address a similar flaw.

RECOMMENDATION

53. That the Act should be amended to provide a Registration Board with the ability to refer a complaint back to the Commission.

9.24 IMMUNITY AND PROTECTION FOR REFERRED COMPLAINANTS

The current Act does not appear to provide statutory immunity from civil action for complainants whose complaints have been made to a Professional Board, whereas complainants whose complaints made directly to the Commission receive statutory protection under Sections 91, 93 and 95 of the Act.

The Commission was recently involved in a complaint which raised the significance of this issue. The complainant lodged a complaint with a Professional Board about a provider. The Board undertook enquiries, but determined not to take any action on the complaint. The Board then chose to publish the complaint in its entirety to the provider, despite the fact that it contained some negative comments the complainant purported to have heard from other persons. These comments became the basis of a defamation action by the provider. In accordance with the current Act, the initial complaint was notified to the Commission by the Board, but the complaint was left for the Board to action.

The protection under section 96 of the Act did not extend to complaints dealt with by the Board, and was limited to complaints made in "good faith". The provider's civil claim alleged that the complaint to the Board and the Commission was not made in "good faith". Whilst the onus was on the provider to prove lack of good faith, the complainant was required to defend the action at significant cost, whereas the provider used medical defence association funds to pay for the claim.

This concern has been raised with the Health Professionals Licensing Authority who have advised that the current draft of the 'Omnibus' legislation will provide protection in this regard.

The Commission expressed the view that safeguards should be implemented in the interim to extend the protection of Sections 95 (giving of information protected) and 96 (protection from civil actions) of the Act to cover complaints made to a Board and notified to the Commission and vice versa.

The review discussion paper canvassed opinion on whether immunity and protection should be provided to a person whose complaint to a Professional Board or other body is notified to the Commission.

Summary of Responses
There were 10 responses to the question on this issue.

Eight respondents said that the Act should be amended to give immunity and protection to a person whose grievance to a Professional Board, or any other body, is notified to the Commission. The Health Professions Licensing Authority, the Department of Health and Community Services and others said that failure to provide such protection could result in loss of witnesses due to fear of reprisal or intimidation. The Tasmanian Health Complaints Commission said that the Tasmanian Act had been amended to address this issue.

The Australian Medical Association and one provider did not support amendments in this area, partly due to the belief that this issue should be addressed in the Omnibus legislation.

Discussion on the issues
The Steering Committee supported the notion that statutory protection should be extended to complaints made to Registration Boards or any other body, which are subsequently referred to the Commission. Complainants and providers should not be discouraged from utilising complaints mechanisms, and providers should be protected against vexatious or malicious complaints.

RECOMMENDATION

54. That the Act be amended to give immunity and protection to a person whose grievance to a Professional Board, or any other body, is notified to the Commission.

As in the situation previously described, the current Act also appears not to provide statutory immunity from civil action for people whose complaint to the Commission is notified to a Professional Board or any other body.

Again, the possible concern is that failure to provide this protection may act as a disincentive to use available complaints mechanisms. The discussion paper canvassed opinion on whether such protection should be afforded to people whose complaints to other bodies are referred to the Commission.

Summary of Responses
There were 11 responses to this question: *"Should a person, whose complaint to the Commission is referred on to another body be covered by immunity and protection from civil action?"*

Eight respondents said that the Act should be amended to give immunity and protection from civil action to a person whose complaint to the Commission is referred on to another body.

The Health Professions Licensing Authority said that such protection should be provided by both the Commission and the body referred to.

Three respondents (a provider, the Australian Medical Association, the Department of Health and Community Services) did not support amendments in this area. The nature of Department of Health and Community Services concerns was unclear. The Australian Medical Association and one provider said that this issue would be better covered by the legislation under which the other body operated.

Discussion of the issues
The Steering Committee considered that the effectiveness of the current Act would be enhanced by providing immunity and protection from civil action to a person whose complaint to the Commission is referred to another body.

RECOMMENDATION

55. That the Act be amended to give immunity and protection from civil action to a person whose complaint to the Commission is referred on by the Commission to another body.

9.25 Ensuring appropriate representation on the Review Committee

Part 9 of the Act (Sections 78 – 84), establishes a Review Committee designed to oversee the operations of the Act, and to ensure that Commission processes and procedures are proper, fair, thorough and consistent with the Act.

Members of the Committee represent the interests of both users and providers, and include expertise in alternative dispute resolution. The Review Committee is appointed by the Minister, and consists of:

- a Chairperson (legal practitioner of not less than five years standing);
- two user representatives ; and
- two provider representatives.

The Act sets out the procedures that the Committee must follow and the information it can receive. Under Section 79, the Committee has the following functions:

- to review the conduct of a complaint;
- to monitor the operation of the Act;
- to advise the Commissioner and Minister on the operation of the Act.

The Committee does not have the power to investigate a complaint or review the Commissioner's decisions in relation to a complaint.

To date the Committee has received 8 requests for a review of a complaint over 4 years.

The Review Committee has, on occasions, found it difficult to constitute a quorum, and it has been difficult to quickly identify alternatives to fill absences for meetings. The Legal Practitioners Complaints Committee recently addressed this issue and used a number of strategies, including expanding the number of members and providing alternatives to specific members who, for various reasons, could not be available.

Currently, no other Australian jurisdiction has a similar committee within its health complaints model. Some other jurisdictions (eg NSW) have a parliamentary committee with a broad role in monitoring the health complaints system.

Some concern has been expressed about the NT Review Committee's membership, particularly whether Aboriginal users and providers, the ethnic community and disability groups should be specifically represented. Such concerns raise the issue as to

whether the Review Committee should include more diverse representation. This issue was raised in the review discussion paper and generated considerable response.

Summary of Review Responses

There were 10 responses to the questions: *"Should the Act be amended to:*

- *provide additional permanent representation on the Review Committee? If yes, where should this representation come from?*
- *provide flexibility to the Review Committee to co-opt members as required to better represent the nature of the complaint?"*

Six respondents said that the Act should be amended to provide additional permanent representation on the Review Committee. A provider and the Australian Medical Association said there should be medical practitioner and hospital representation. Two respondents suggested specific additional Indigenous representation. The Commissioner suggested that there be nominated alternative representatives to ensure that meetings can go ahead in the absence of permanent committee members.

Three respondents said that there should be no expansion of the Committee. The Health Professions Licensing Authority and the Review Committee both said that an expanded committee might be unwieldy. The Health Professions Licensing Authority and the Department of Health and Community Services said that the Act should specify grounds for termination of committee membership and normal length of appointment.

Six of the respondents said that the Committee should be able to coopt members or expertise as required.

Discussion of the issues

The Steering Committee considered that a larger Review Committee could become unwieldy to manage and likely to experience even greater difficulty attracting suitable members willing and able to attend meetings as required. However, the Steering Committee assessed that concerns about Indigenous representation on the Committee had some validity, particularly given the relative lack of complaints from Indigenous people in the Northern Territory. The Committee therefore recommends the following:

RECOMMENDATION

56. That persons appointed to the Review Committee under Section 78(3) be amended to include that:

- **one of the provider representatives will represent the interests of Indigenous providers; and**
- **one of the consumer representatives will represent the interests of Indigenous consumers.**

57. That the Act be amended to allow for the appointment of alternative members for when permanent members are unavailable.

58. That the Act be amended to allow the Review Committee to coopt relevant expertise as required.

59. That the Act be amended to specify a three year term of appointment and grounds for dismissal for Review Committee membership.

9.26 CLARIFYING REVIEW COMMITTEE ENTITLEMENTS

Review Committee positions are currently voluntary. There has been some difficulty in recruiting to the panel.

The review discussion paper canvassed opinion as to whether the Committee should receive remuneration for its work.

Summary of Responses
There were 13 responses to this question.

Nine respondents said that the Act should be amended to provide remuneration to panel members. Several of these respondents said that remuneration would assist in recruiting and retaining high calibre members.

Three respondents said that expenses should be reimbursed.

The Department of Health and Community Services said that although remuneration might assist in attracting members, this decision was a resource issue for Government.

Consideration of the issues
The Committee considered that the Review Committee members, or alternate members, who are not government employees, should receive an agreed sitting fee, with all travel and other disbursements met on guidelines issued by the Minister.

RECOMMENDATION

60. That the Act be amended to require that each Review Committee member or alternate member, who is not a government employee, receive an agreed sitting fee, with all travel and other disbursements met, subject to guidelines issued by the Minister.

9.27 PROVIDING ADMINISTRATIVE SUPPORT TO THE REVIEW COMMITTEE

There is currently no separate funding to support the operation of the Review Committee. The Health and Community Services Complaints Commissioner's Executive Assistant provides administrative support to the Committee by default.

The secretarial support necessary to support the Review Committee's activities is considerable, and includes: photocopying of files for the five members, liaising with committee members to set up meetings, arranging complainant contact and submissions, taking minutes and typing correspondence.

The review discussion paper canvassed opinions on this issue.

Summary of Responses
There were 10 responses to the question: *"Should the Review Committee receive secretarial support? If so, who should provide the administrative support?"*

All ten respondents said that the Act should be amended to ensure secretarial support for the Review Committee. However, the responses varied as to who should provide the secretarial support. Suggestions included the Ombudsman, the Department of Health and Community Services, the Commissioner or as provided by the Health Professions Licensing Authority.

The Commissioner argued that the current practice of support being provided by his Executive Assistant could be seen to compromise the independence of the Review Committee.

Discussion of the issues
The Steering Committee agreed that the current situation was unacceptable in that it could lead to perceptions of bias or conflict of interest. Furthermore, the time taken to provide secretarial support to the review committee could reduce the Commission's capacity to perform its primary statutory role of complaints resolution.

The Steering Committee supports amendments to the Act to clearly provide for a secretariat for the Review Committee to be nominated and/or provided for through the auspices of the Minister. Furthermore the Act should specifically exclude the Commission from providing secretariat support to the Review Committee.

RECOMMENDATION

61. That the Act be amended to provide designated administrative support and budget to support the effective operations of the Review Committee.

62. That budget and support for the Review Committee be provided through consolidated revenue by, or through, the Minister's office.

9.28 SPECIFYING TIME LIMITS TO LODGE A REVIEW REQUEST

There are currently no time limitations for lodging complaints with the Review Committee.

A number of complaints have been lodged with the Review Committee a significant period after the determination of the Commissioner not to take further action on a complaint. On one occasion a request was made a year after the relevant determination.

The review discussion paper canvassed opinions on whether time limits should be applied.

Summary of Responses
There were 11 responses to the question: *"Should there be a time limit to lodge complaints with the Review Committee?"*

Ten respondents said that the Act should be amended to place a time limit on the lodging of complaints with the Review Committee. One respondent said there should be no time limit.

Discussion on the issues
The Steering Committee considers that the effectiveness of the Act would be enhanced if a limitation for seeking a review of a complaint should specifically be imposed within the statute. However, the Review Committee should have the discretion, in exceptional circumstances, to extend the time limit, but such extensions should be no more than a further 60 days.

The Steering Committee considers it appropriate and in accordance with the principles of natural justice, to oblige the Commission in its correspondence to specifically inform the parties to the complaint of review rights and the applicable time limits. In terms of any discretion to extend, it is submitted that the Review Committee should not be able to extend in any circumstances where a period of six months has lapsed since notification in writing or the original determination on the complaint.

The Steering Committee considered that it was in the spirit of the legislation to provide an extension of 60 days for a review of a complaint and the Chairperson of the Review Committee have a discretion to extend this period in exceptional circumstances but not beyond six months in total.

RECOMMENDATIONS

63. That the Act be amended to provide a time limit of 60 days after notification of a determination on a complaint, for a request for a review of the complaint process to be lodged with the Review Committee.

64. That the Act be amended to provide the Chairperson of the Review Committee with the discretion to extend this period, for exceptional circumstances, but such extension to be no longer than 6 months in total.

65. That the Act be amended to oblige the Commission to advise complainants in writing of their right to request a review under the Act, and of the applicable time limits.

9.29 Providing reasonable time limits for Review Committee processes

The Act does not currently specify time periods in which the Review Committee should complete its review of a complaint.

The review discussion paper canvassed opinion on whether there should be a time limit placed on reviews undertaken by the Committee.

Summary of Responses
There were 11 responses to this question: "*Should there be a time limit placed on the Review Committee to consider complaints under review?*"

Eight respondents said that the Act should be amended to place a time limit on the lodging of complaints with the Review Committee. Suggestions for the time limit ranged from 3 months to 6 months, with options for extension.

Three respondents said it would be inappropriate to impose a time limit due to the voluntary nature of the Committee and to the variety of complaints put to it.

Discussion on the issues
The Steering Committee considered that a realistic time limit on Review Committee activities would assist the Commission in its efforts to be efficient and effective. Although the Steering Committee was sympathetic with the issues involved in imposing time limits on a busy committee, it believed that the provision of a sitting fee would assist Committee members in giving the review timely and adequate attention. The Steering Committee considered that to encourage closure of complaints any further extension of time outside the six month provision should be specifically approved by the Minister

RECOMMENDATION

66. That the Act be amended to specify that the Review Committee must complete a review of a complaint within a reasonable time period, and no later than 6 months from the time the request for review was lodged.

67. Any further extensions of time to complete a review must be specifically approved by the Minister.

9.30 PROVIDING "ABSOLUTE PRIVILEGE"

Section 95 of the current Act states that an action, claim or demand, either civil or criminal cannot be made against a person who provides in "good faith" any information or document for the purpose of a complaint or investigation.

However, it is possible that the complainant may still be required to defend a claim that the provision of information was made in good faith.

The review discussion paper canvassed opinions on the granting of absolute privilege.

Review Submissions
There were 11 responses to this question. "*Should the Act be amended to provide "absolute privilege" to any person or complaint received by the Commission?*"

Four respondents said that the Act should be amended to provide "absolute privilege" to any person or complaint received by the Commission. The Commissioner and the Health Professions Licensing Authority provided a rationale for extending privilege as follows:

- complainants who make a complaint in "good faith" should not be afraid of acts of reprisal against them;
- schemes for resolving complaints should be predominate and complaints should not be discouraged;
- the "good faith" exemption does not prevent the instigation of civil or criminal proceedings;
- where a legal action for defamation is lodged, the complainant/user must defend the claim otherwise he/she faces the risk of the defamation claim being proved;

- or run the risk of the defamation action being heard ex parte;
- providers are well protected by the fact there are penalty provisions within the Act to discourage false complaints;
- the Act encourages users of health, aged and disability services to complain about the service received, and should provide sufficient protection;
- most health providers are covered by private insurance or if public providers, by the Government, however the user / complainant must personally bear the cost of defending a defamation action (legal aid funding does not usually extend to such actions); and
- the tort law reform agenda requires parties to use complaint resolution processes prior to recourse to legal action.

The AMA and a provider said "absolute privilege" may not be appropriate, and that current provisions protected those making complaints in "good faith".

Four respondents were wary of extending "absolute privilege" as the issues were complex. For instance, Department of Health and Community Services said that there should be some protection, but not "absolute privilege", and the Tasmanian Health Complaints Commission had concerns about possibly protecting those making serious and substantive, but maliciously motivated complaints. Integrated disAbility Services said that this protection might hinder sharing of information.

Discussion of the issues
The Steering Committee considered the case for the extension of "absolute privilege" to be strong, particularly in the light of the current national focus on tort law reform. There was some concern as to how to deal with vexatious complainants if the words 'absolute privilege' remained in the Act. The Commissioner explained that the Act dealt with vexatious complainants under Section 30 of the Act.

RECOMMENDATION

68. That the Act be amended to provide "absolute privilege" to any person or complaint received by, or referred to, the Commission.

9.31 SERVING DOCUMENTS ELECTRONICALLY

Section 103 of the Act refers to the serving of documentation on a person or corporation by delivering it in person, by posting it, or by leaving it at the person's usual or last known place of residence or business.

The question arises as to whether the Commission should have the ability to serve a document utilising electronic media such as facsimile machines or e-mail.

The review discussion paper canvassed opinions on this issue.

Summary of responses
There were eight responses to this question: "*Should the Commissioner be given the ability to serve a document by electronic medium? If so, what safeguards need to be considered?*"

Four respondents said that the Act should be amended to allow serving of documents by electronic media.

One respondent said that safeguards were not yet adequate.

Three respondents said that further legal and other advice should be sought in order to determine whether appropriate confidentiality requirements could be met.

Discussion on the issues
The Steering Committee considered that the nature and remoteness of much of the Northern Territory jurisdiction required maximising use of every possible legal medium for serving documents. However, the Committee believes that formal legal advice should be sought from the Department of Justice to ensure that legal, policy and privacy issues have been covered.

It was unanimously agreed at the Steering Committee meeting in November 2003 that the Commission formally seek legal opinion on whether documents can be legally served using electronic media, and, if so, on the nature and type of safeguards which might be necessary to do so. Legal opinion was subsequently obtained which confirmed that documents could be legally served using electronic media, the contents of documents could be protected and the requirements of the Act could be satisfied.

RECOMMENDATIONS

69. The Act be amended to give the Commissioner the ability to serve documents by electronic media.

9.32 MAINTAINING CURRENT STATUS OF THE CODE

The Health and Community Services Code of Rights and Responsibilities confers a number of rights and responsibilities on users and providers of health, aged and disability services. However, the rights and responsibilities are not absolute in that the Code is not currently binding. Accordingly, if users or providers fails to "take reasonable action in all circumstances to give effect to the Code" the Commissioner's powers are limited to finding a breach and making recommendations which are not enforceable.

In New Zealand, upon finding a breach of the Code, the Commissioner's options may include furnishing a report and recommendations to the provider, a professional health body, the Minister for Health, or any other person the Commissioner thinks fit. The recommendations may incorporate a written apology to the consumer, reimbursing the consumer, training, implementation and review of systems to prevent future breaches.

Summary of responses
There were 9 responses to the question: *"Should the Code have a binding effect on users and providers. If so, should the Commissioner' be given power to follow up and monitor any recommendations made as a consequence of a breach of the Code?"*

Three respondents (the Commissioner, the Health Professions Licensing Authority, and the Seniors Advisory Council TC) said the Code should have a binding effect on users

and providers, and that the Commissioner should be given power to follow up and monitor any recommendations made as a consequence of a breach of the Code.

The Commissioner submitted strongly that the Code should be binding *"not only to ratify the importance of the principles, but to empower the Commission to follow up and monitor breaches to achieve the overall aim of the Commission – to improve the delivery of health, aged and disability services in the Territory."*

Five respondents said that the code should not be binding. The AMA and a provider said that the Code was designed to provide a framework and enforcement was unworkable. The Tasmanian Commission said that binding powers would create a prosecutorial model.

One respondent said that the Code already had a binding effect.

Discussion of the issues
On balance, the Steering Committee considered that the Code should not be made binding, as its current status was more consistent with the Northern Territory's recommendatory complaints model.

It was generally recognised and accepted by Steering Committee members that providers and consumers should give force and effect to the spirit and intent of the Code, that the Code must be recognised by providers and consumers and that all reasonable efforts should be made to comply with it.

RECOMMENDATION

70. That provisions relating to the status of the Code remain unchanged and that the Commissioner's powers in relation to the Code also remain unchanged.

71. That the Act be amended to ensure that, upon approval of the Code by the Minister, the Code must be recognised by providers and consumers and the parties must make all reasonable efforts to adhere to the spirit and intent of the Code.

9.33 NOTIFYING AND CONSULTING WITH OTHER COMPLAINTS HANDLING BODIES.

It is possible under both Northern Territory and Commonwealth legislation, that a person could make a complaint about a nursing home or an aged care facility to the Commission (Northern Territory) and the Aged Care Complaints Resolution Scheme (Commonwealth). The legislation at present does not allow the Commission to notify the Commonwealth scheme, or to consult during the assessment process to determine who is the most appropriate body to resolve or investigate the complaint.

The Commission may need to notify / consult with other complaints bodies such as the Aged Care Complaints Resolution Scheme to ensure that:
- the most effective option for resolving the complaint is taken;
- complainants do not have to shop around to make their complaints;
- duplication of effort and inefficient use of resources does not occur;

- complaint organisations are provided with an opportunity to work with each other if appropriate; and
- an accurate picture is gained of complaints relating to particular issues.

Summary of responses
There were 12 responses to this question: "*Should the Commission be able to notify / consult with another complaint handling body such as the Aged Care Complaints Resolution Scheme or the Ombudsman, once a complaint has been received?*"

All respondents said that the Commission should be able to notify / consult with another complaint handling body such as the Aged Care Complaints Resolution Scheme or the Ombudsman, once a complaint has been received. Respondents commented that this would facilitate more efficient and effective complaints resolution.

Discussion on the issues
The Steering Committee considered that the failure to provide such a provision was a flaw in the current Act, and that the oversight should be amended.

RECOMMENDATION

72. That the Act be amended to enable the Commission to notify / consult with other complaint handling bodies, such as the Aged Care Complaints Resolution Scheme, the Anti-Discrimination Commission or the Ombudsman, once a complaint has been received.

9.34 RETAINING MEDICAL RECORDS

The Commission has received a number of complaints relating to the unavailability of a person's medical records. In several cases, the problem has occurred because a doctor has retired from practice or moved interstate. There is currently no process to allow access, or to ensure that providers of health services are not able to destroy any records that might be relevant to a particular investigation being undertaken by the Commission.

The review discussion paper canvassed opinion on this issue.

Summary of responses
There were 10 responses to the question: *"Should provisions be included in the Act to ensure:*
- *preservation of medical records should a health service provider move outside the Northern Territory ; and*
- *where medical records may be relevant to a matter raised in a complaint, the records are not destroyed without the approval of the Commissioner".*

Eight responses supported ensuring consumer access to medical records for a certain period and amendments to the Act to allow this, if required.

Three respondents (the Health Professions Licensing Authority, the Department of Health and Community Services and Integrated disAbility Action indicated that any

amendments in this area should take into account requirements under the Northern Territory Information Act or other existing relevant legislation.

The Tasmanian Commission supported approaches to ensure access.

The AMA and a provider said that no changes were necessary due to existing requirements. The provider said that any further regulation required should be addressed through broader tort law reform.

Discussion on the issues
At the February 2004 meeting of the Steering Committee it was unanimously agreed that provisions should be included to preserve medical records.

RECOMMENDATION

73. That the Act be amended to ensure:
- **preservation of medical records should a health service provider move outside the Northern Territory ;**
- **that where medical records may be relevant to a matter raised in a complaint, the records are not destroyed without the approval of the Commissioner.**

10 FUNDING IMPLICATIONS

There are a number of recommendations that have resourcing implications attached to them. This section will highlight these recommendations and provide some indication of what the resourcing and funding implications might be.

There are three areas where additional resources are required as a result of the recommendations. These are:

- improved education, access and awareness activities by the Commission throughout the Territory;
- improved administrative arrangements; and
- expansion of jurisdiction and services.

The Steering Committee is adamant that recommendations with resourcing implications should only be approved if adequate funding is going to be provided by NT Government to ensure they are effectively implemented.

10.1 IMPROVED EDUCATION, ACCESS AND AWARENESS

The recommendations and associated resourcing implications that relate to this area are as follows:

> ***That sufficient budget be made available for the preparation of materials about the Code in appropriate formats and media, and that the Code be regularly printed and distributed across the NT. In addition, access and awareness visits relating to the Code be undertaken annually to all major NT centres and to prescribed providers (RECOMMENDATION 4).***
>
> AND
>
> ***That adequate resources and funding be provided to ensure that the Commissioner can address the broader promotional and system improvement functions and roles as required under the current Act (RECOMMENDATION 9).***
>
> AND
>
> ***That the Act be amended to empower the Commission to work with professional associations of unregistered providers to Implement appropriate complaints handling mechanisms (RECOMMENDATION 15)***
>
> AND
>
> ***That the Act be amended to require that Professional Associations work with their members to implement appropriate internal complaints handling mechanisms (RECOMMENDATION 16).***
>
> AND
>
> ***That the Commission be provided with adequate funding and resources to develop and implement an appropriate community strategy, distribute a comprehensive and culturally appropriate range of promotional materials, and to undertake adequate ongoing awareness raising activities (RECOMMENDATION 23)***

10.1.1 Activities to be undertaken

The above recommendations all require the Commission to become more active and effective in;

- conducting appropriate access and awareness activities;
- educating the public about their rights and responsibilities; and
- educating the public about the Commission.

In addition, the Commission is empowered to work with professional associations and providers (registered and unregistered) to implement appropriate complaints handling mechanisms.

The Commission would need to be provided with an additional dedicated resource in order to implement these recommendations. This position, to be titled Education Officer (AO6), would be required to undertake the following activities:

- review, develop and distribute appropriate material such as brochures, pamphlets, etc and update and maintain the web site in order to promote:
  - the Commission; and
  - the Code;
- undertake access and awareness visits to all major centres, targeted communities and prescribed providers;
- develop culturally appropriate materials to promote the role of the Commission and the rights and responsibilities under the Code; and
- facilitate the introduction of "best practice' complaints handling mechanisms with professional associations and providers (registered and unregistered).

10.1.2 Funding requirements

The additional funds required by the Commission to implement these recommendations is estimated to be:

• Education Officer (AO6)	$57,000
• **PLUS** on-costs of 50%	$28,000
Total:	**$85,000**

The figure of 50% on-cost has been identified to take into account the following requirements as identified in the body of the report:

- the number and location of visitable services;
- the costs associated with visits to remote communities;
- development and printing of brochures and pamphlets; and
- providing the materials in appropriate formats and media, ie. for radio, television, video, newspaper, etc

10.2 Improved Administrative Arrangements for Review Committee

The recommendations and associated resourcing implications that relate to this area are as follows:

> **That the Act be amended to require that each Review Committee member, who is not a government employee, receive an agreed sitting fee, with all travel and other disbursements met, subject to guidelines issued by the Minister (RECOMMENDATION 60).**

AND

That the Act be amended to provide designated administrative support and budget to support the effective operations of the Review Committee (RECOMMENDATION 61).

AND

That the budget and support for the Review Committee be provided through consolidated revenue by, or through, the Minister's office (RECOMMENDATION 62).

10.2.1 Sitting fees

There are no hard and fast rules in relation to what should be paid in relation to sitting fees. However the estimate is based on $70.00 (equivalent to an AO7) per hour.

Given that there are four permanent members who are not NT public servants, the meeting last around four hours and there are four meetings each year, the total funds required to pay sitting fees is estimated at $4,500.

All meetings are held in Darwin and four of the five members reside there. One member resides in Alice Springs and to date there has not been a need for her to travel to Darwin. However, on the odd chance that this may be required once a year, funds required for travel and accommodation are estimated at $700.

The additional funds that the Minister would need to make available for the purposes of paying members sitting fees etc is estimated as:

• Sitting fees	$4,500
• Travel, accommodation, etc	$700
Total:	**$5,200**

10.2.2 Administrative Support

The administrative support currently provided to the Review Committee consists of:

- receiving and acknowledging requests for review;
- advising Committee members of the need for a review;
- organising, in consultation with the Chairperson, meetings of the Review Committee;
- taking minutes of the meetings; and
- preparing correspondence for the signature of the Chairperson

Up until the end of the 2002/03 financial year, there had been eight requests for a review and some of these reviews required more than one meeting. Based on current numbers, it is not likely that the Review Committee would meet more than three or four times a year.

Should the jurisdiction of the Commission be expanded, as per the recommendations in this report, then it is envisaged that the number of requests for a review would increase. It is difficult to determine to what extent.

The time and funding required to provide administrative support to the Review Committee is estimated to be:

• Number of hours/meeting	7
• Number of meetings per year	4
• Hourly rate (at AO4 level)	$45
Total Cost:	**$1,300**

10.2.3 Total funding

It is estimated that total additional funds required to improve the administrative arrangements for the Review Committee is:

• Sitting fees, etc	$5,200
• Administrative support	$1,300
Total:	**$6,500**

10.3 Expansion of Jurisdiction and Service

The recommendations and associated resourcing implications that relate to this area are as follows:

10.3.1 That the definition of community services be expanded to include most major categories of community services with the exception of child protection services and that community services be defined in the regulations as provided for in Appendix 11.6 (RECOMMENDATION 7).

10.3.1.1 Expanded definition of Community Services

The additional services that would come under the jurisdiction of the Commission should this recommendation be approved are

- **Personal and social support services**: eg information advice and referral, individual and family support, independent and community living support, domiciliary support, employment services specifically for people with a disability.
- **Child care and pre-schools services:** ie provision of care by persons other than parents under the supervision of a paid coordinator in a group setting or another home; eg centre –based day care, family day-care, occasional child care, before and after school hours care, vacation care, pre-schools.
- **Residential care and accommodation support services:** ie services which assist people who are disadvantaged to access suitable housing and accommodation, crisis accommodation, or special purpose accommodation.
- **Financial and material assistance services:** ie services that are designed to enhance personal functioning and to facilitate access to community services through the provision of emergency, or immediate financial assistance and material goods, and transport. For example, financial assistance, provision of equipment or goods during crises or disaster, Taxi Subsidy Scheme.
- **Policy or service development support services:** ie services which aim to articulate and promote improved social policies and practices eg development of public policy submissions, training, volunteer development, etc.

The following services are specifically excluded from the definition of community services:

- Baby sitting;
- Long term housing assistance such as public housing;
- Income support services such as social security, pensions, benefits and rental assistance;
- Services which provide protection from physical, sexual or emotional harm or physical neglect through statutory intervention;

- Concession relief activities including concessions on taxation, transport (not including the Taxi Subsidy Scheme), water and energy, municipal rates etc;
- Training, vocational rehabilitation and employment services which assist people who are disadvantaged in the labour market by providing training, job search skills, help in finding work, and rehabilitation. Employment services specifically for people with a disability are **not** excluded;
- Services involving correctional or rehabilitative supervision and protection of public safety through corrective arrangements and advice to courts and parole boards.

10.3.1.2 Funding

The Commission would therefore need to be funded in order to take on this expanded jurisdiction.

Services Already Funded
There are however a number of organisations which already handle complaints relating to some of these additional service, namely:

- **NT Employee Assistance Scheme (EAS)** regarding complaints associated with the Supported Accommodation Assistance Program (SAAP); and
- **Office of the Ombudsman** regarding administrative complaints associated with all community service functions undertaken by the Department of Health and Community Services (DHCS), in particular activities such as:
  - Pensioner Concession Scheme;
  - Patients Assistance Travel;
  - Adoptions and substitute Care;
  - Child and Family Protective Services; and
  - Family and Children's Services.

Funding Requirements
An estimate of the funds expended on these services by EAS and the Office of the Ombudsman and an estimate to fund the remaining services currently unfunded are:

i) EAS $3,000

EAS advised that for the calendar year 2003 they received 9 complaints in total of which 7 were resolved over the phone and 2 required mediation. The estimated time taken in relation to these complaints was as follows:

- Resolved over the phone 10 hours
- Mediated 11 hours

As the hourly rate for the EAS service is costed at $127, the total costs of providing the SAAP complaint handling service for a period of 12 months is estimated to be $2,700 ($130 x 21 = $2,730).

ii) Ombudsman $Nil

During the financial year 2002/03 the Office of the Ombudsman received 11 Enquiries and 28 complaints associated with Community Services activities. Of the 28 complaints, the vast majority were associated with child and family protection services and fostering which will remain the responsibility of the Ombudsman. In addition, a major proportion of the child protection complaints were resource intensive requiring lengthy formal investigations.

On the basis of the number and complexity of the Ombudsman's workload that would be transferred to the Commission due to the expansion of the definition for community services, there is no justification to identify and transfer any funds.

In addition, the workload for the Ombudsman's Office in the past two years has increased by approximately 30%and the trend appears to be continuing in the current financial year. This means that the Ombudsman's resources are being stretched by the existing workload and there is no capacity to transfer resources to the Commission.

The other point to note is that the Commission already receives significant unfunded resources from the Ombudsman, as a result of co-location, and it would be a contradiction to transfer resources in such circumstances.

iii) Unfunded Services $90,000

In addition, there will be a need to provide funding to allow for the acceptance and resolution of complaints relating to those community services not covered or funded by either the EAS or the Ombudsman. These services would include:

- Patients Assistance Travel;
- Pensioner Concession Scheme;
- Personal and social support services;
- Child care and pre-schools services;
- Residential care and accommodation support services; and
- Financial and material assistance services.

There is no way of anticipating or estimating what the workload associated with complaints about these services might be. Anecdotal evidence would tend to suggest that this is an untapped area and once the community is made aware of the provision of this service, it will generate a large number of inquiries.

Because it is difficult to estimate the workload associated with complaints from these services it has been assumed that, at the very least, the workload would be enough to occupy the time of a Senior Investigation Officer at the AO7 level.

Assuming that at least another 150 enquiries and complaints would be generated from the expanded jurisdiction, at least 120 of these would need to be resolved at the enquiry or assessment stage. This workload would also justify an additional Assessment Officer (AO4) position.

As the annual salary of an AO7 is $64,000, the estimated expenditure for the Commission to provide these services is:

• Snr Investigation Officer (AO7)	$64,000
• Assessment Officer (AO4)	$43,000
• **PLUS** on-costs of 20%	$21,000
Total:	**$128,000**

iv) Total Funding

The total estimated additional funds required by the Commission to handle complaints associated with the expansion of its jurisdiction is:

• Transferred from EAS	$3,000
• Transferred from Ombudsman	$Nil
• Additional appropriation	$128,000
Total:	**$131,000**

10.3.2 That the Act be amended to trial, for a period of three years, the establishment of either an independent community visitor scheme or an advocacy service or a combination of both, and that such a service be adequately resourced and funded, administered by the Commission, and delivered independently through appropriately funded community based organisations (RECOMMENDATIONS 17, 18 & 19)

10.3.2.1 Commission Requirements

There will be a requirement for a position of Director Advocacy (AO8) to organise and coordinate the Community Visitor and or Advocacy Service on a Territory-wide basis. The responsibilities of this position would include:

- contracting appropriate service providers;
- monitoring the delivery of the Visitor/Advocacy services by the independent providers;
- managing the selection of Advocate/Community Visitors;
- preparing protocols for use by service providers; and
- coordinating the delivery of training and support to the selected Advocate/Visitors.

In addition to the Director there will be a need to have a position (possibly AO6) responsible for assisting the Director and in particular being responsible for:

- the development and monitoring of protocols; and
- the selection, training and support of Advocates.

The estimated funds required by the Commission to implement this recommendation are:

• Director of Advocacy (AO8)	$69,000
• Advocacy Officer (AO6)	$58,000
• **PLUS** on-cost of 50%	$63,000
	Total: $190,000

The figure of 50% on-cost has been identified to take into account the following requirements as identified in the body of the report:

- the number and location of visitable services;
- the costs associated with visits to remote communities; and
- development and printing of protocols, contracts brochures and other resource materials to be used by the service providers.

10.3.2.2 Non-government Requirements

There are currently a number of community organisations which are funded to provide advocacy services and it is envisaged that all these resources would be pooled and a contract developed and tendered for organisations to express their interest in providing such services. The services would then be contracted out across the Territory with the Commission being responsible for coordinating and monitoring the provision of the services.

It would be the responsibility of the Director of Advocacy to initially give priority to negotiating with both the NT and Commonwealth governments to obtain appropriate funding for this purpose. Should funding not be forthcoming, within a period of 18 months after the Director has been employed, then the establishment of such an Advocacy/Visitor Service would not be viable and the initiative would lapse.

10.4 Overall Funding Implications

10.4.1 To Implement the Recommendations

There are a number of recommendations throughout the report where the Steering Committee has highlighted, if they are to be implemented, need additional funding. The cost of implementing these recommendations has been estimated above and can be summarised as follows:

Areas	Rec	Funds	Comments
Education, Access and Awareness	4, 9, 15, 16, 23	$85,000	Funding needs to be provided as an additional ongoing allocation.
Review Committee	59, 60, 61	$6,500	This additional funding would be provided through consolidated revenue by the Minister to whoever provides the admin support.
Expansion of jurisdiction • Definition of Community Services • Advocacy/Visitor service	7, 17	 $131,000 $190,000	Of the $131,000, $3,000 transferred from other agencies and $128,000 as an additional ongoing allocation. The $190,000 needs to be provided on a trial basis for three years. Additional funding will need to be negotiated with both NT and C/wealth to provide grants to non-government organisations
	Total:	**$412,500**	

In relation to the requirement for an additional $412,500:

- $3,000 would be transferred to the Commission from EAS;
- $219,500 would need to be provided as additional ongoing appropriation ($213,000 to the Commission and $6,500 to another agency);
- $190,000 would need to be allocated to the Commission, in the first instance, for a three year period.

10.4.2 Consequential Funding Requirements

Implementation of the above recommendations will result in the Commission employing an additional five staff members:

- Education Officer (AO6);
- Senior Investigation Officer (AO7);
- Assessment Officer (AO4);
- Director of Advocacy (AO8); and
- Advocacy Officer (AO6).

The current accommodation where the Commission and Office of the Ombudsman are co-located does not have any more room for expansion. Additional office space would

therefore need to be made available to house these additional staff members or relocate other staff members. The cost of leasing and fitting out such accommodation for these purposes would also need to be funded to allow for the implementation of these recommendations.

Indicative costs for re-locating staff to a new location, based on estimates provided by NT Property Management in March 2002, are:

- $2,000 per head if moving into currently leased premises; or
- $3,000 per head if the premises have not been leased by the NT Government.

Costs of locating at least five personnel to one premise could therefore range between $10,000 and 15,000. It should be noted however that these estimates do not include:

- leasing cost per 17m^2 per person; and
- fit out costs associated with partition walls, electrical and air conditioning modifications, reception counters (if applicable), furniture, equipment and toilet facilities.

A realistic estimate of cost can only be determined when a floor plan of the required office space has been designed.

RECOMMENDATION

74. That additional funding in the amount of $412,500 be made available to assist with the implementation of the recommendation associated with the review of the *Health and Community Services Complaints Act* and that this $412,500 be made available as follows:

- **$3,000 being transferred to the Commission from the EAS.**
- **$213,000 being provided direct to the Commission as additional ongoing appropriation**
- **$6,500 being provided to another agency (as determined by the Minister) as additional ongoing funding**
- **$190,00 being allocated to the Commission, in the first instance, for a three year trial period.**

75. That the implementation of the Community Visitor and or Advocacy Service lapse if, after the first 18 months of the Director Advocacy Services being employed, adequate funding has not been negotiated for this purpose with both the NT and Commonwealth Governments.

76. That, in addition to the NT and Commonwealth funding in recommendation 75, funding allocated to non-government organisations currently providing visitor/advocacy services to the community services sector (not including the NT Mental Health Visitor Scheme) be pooled together with the funds provided by the NT and Commonwealth.

77. That tenders be called from the non-government sector to provide a Community Visitor and/or Advocacy Service throughout the Territory and that the funding provided as a result of recommendations 75 and 76 be used for this purpose.

78. That adequate funding (amount still to be calculated) will be provided on a one-off basis to locate at least five personnel in new or already leased premises. This funding to allow for:

- Re-location costs;
- Leasing cost per $17m^2$ per person; and
- Fit out costs associated with partition walls, electrical and air conditioning modifications, reception counters (if applicable), furniture, equipment and toilet facilities.

11 APPENDICES

11.1 TERMS OF REFERENCE

Review of the *Health and Community Services Complaints Act (1998)*

The Minister for Health and Community Services, the Honourable Jane Aagaard MLA, has initiated a review of the *Health and Community Services Complaints Act* in accordance with section 106 of the Act.

Background

The *Health and Community Services Complaints Act* commenced on 1 July 1998. Pursuant to section 106 of the Act "the Minister must cause a review and report to be made on the operation of the Act as soon as practicable after the expiration of 2 years after the commencement of this Act and thereafter at intervals not longer than 5 years". The Minister has asked the Commissioner for Health and Community Services Complaints to undertake the review with the assistance of the Department of Health and Community Services.

Steering Committee

A steering committee has been established to undertake the review and produce a report and comprises representatives of the following departments / organisations:

- Vicki O'Halloran, Somerville Community Services (Chairperson);
- Health and Community Services Complaints Commissioner or delegate;
- Executive Director, Royal Darwin Hospital, Department of Health and Community Services;
- Department of Health and Community Services, CEO's delegate;
- Health Professions Licensing Authority / Professional Registration Boards delegate;
- Top End Division of General Practitioners delegate;
- Integrated disAbility Action delegate;
- Darwin Community Legal Service delegate; and
- Aboriginal Medical Service Alliance of the Northern Territory delegate.

Scope of the Review

The *Health and Community Services Complaints Act* has been referred for review and report on:

a) an examination of the effects and operation of the Act since commencement;
b) comparison between the operation of the Act and similar legislation in other jurisdictions;
c) the effectiveness of the current model;
d) the appropriateness of existing practices and procedures in the Act; and
e) the need to introduce amendments to further improve the effectiveness and efficiency of the legislation and to enhance its workability to ensure it is relevant to the current and future needs of the Territory.
f) A report should be made to the Minister on or before 31 December 2003.

JANE AAGAARD

11.2 Code of Health and Community Rights and Responsibilities

Introduction to the Commission

The Health and Community Services Complaints Commission came into operation on 1 July 1998, under the *Health and Community Services Complaints Act* 1998. The Commission's role is to receive and respond to complaints about the delivery of health and community services in the Northern Territory. The overall aim of the Commission is to improve the delivery of health and community services.

Health and community service providers are defined within the legislation to include anyone providing or claiming to provide any sort of health, aged care or disability service, whether public or private. The definition is very broad. For example, health service providers are not only hospitals, doctors, nurses and Aboriginal health workers, but include health professionals, such as physiotherapists and dental practitioners and alternative health providers such as homeopaths and naturopaths. A provider may be an employer, an employee or a volunteer. A user is a person who seeks, uses or receives a health or a community service.

A more detailed explanation of the services covered by the Act can be found in the *Health and Community Services Complaints Regulations*.

Introduction to the Code

The Code confers a number of rights and responsibilities on all users and providers of health and community services in the Northern Territory. The rights and responsibilities set out in the Code are not absolute. The obligation imposed on users and providers is to take reasonable action in all circumstances to give effect to the Code.

When a complaint is made, the Commission will consider the reasonableness of the action taken by the provider, in light of the circumstances. The circumstances in a particular case may include the user's state of health or well-being and any resource constraints operating at the time.

The Code does not override duties, which are set out in Territory or Commonwealth legislation.

Principle 1: Standards of Service

1) Users have a right to:
   a) timely access to care and treatment which is provided with reasonable skill and care[75];
   b) care and treatment which maintains their personal privacy and dignity;
   c) care and treatment free from intimidation, coercion, harassment, exploitation, abuse or assault;
   d) care and treatment that takes into account their cultural or ethnic background;
   e) providers who seek assistance and information on matters outside their area of expertise or qualification;
   f) services provided in accordance with ethical and professional standards, and relevant legislation;

[75] Reasonable skill and care refers to the generally accepted standard of health or community service delivery.

g) services which are physically accessible and appropriate to the needs arising from an impairment or disability; and
h) services provided without discrimination, as set out in relevant Territory and Commonwealth legislation.

PRINCIPLE 2: COMMUNICATION AND THE PROVISION OF INFORMATION

1. Providers have a responsibility to:
   a. provide accurate and up to date information responsive to the user's needs and concerns, which promotes health and well-being;
   b. explain the user's care, treatment and condition in a culturally sensitive manner, and in a language and format they can understand. This includes the responsibility to make all reasonable efforts to access a trained interpreter;
   c. answer questions honestly and accurately;
   d. provide information about other services, and as appropriate, how to access these services;
   e. provide prompt and appropriate referrals to other services, including referral for the purpose of seeking a second opinion; and
   f. provide the user with a written version or summary of information, if requested.

2) Users have a responsibility, to the best of their ability, to:
   a) provide accurate and timely information, about their past care and treatment and issues affecting their condition; and
   b) inform the provider of issues that might interfere with participation in care or treatment recommended by the provider.

PRINCIPLE 3: DECISION MAKING

1) Subject to any legal duties imposed on providers, users have a right to:
   a) make informed choices and give informed consent to care and treatment;
   b) seek a second opinion;
   c) refuse care and treatment, against the advice of a provider;
   d) withdraw their consent to care and treatment, which includes the right to discontinue treatment at any time, against the advice of a provider;
   e) make an informed decision about body parts or substances removed or obtained during a health procedure. This includes the right to consent or refuse consent to the storage, preservation or use of these body parts or substances.

2) In non-emergency situations, providers have a responsibility to seek informed consent from users before providing care and treatment by:
   a) seeking consent specific to the care and treatment proposed, rather than a generalised consent;
   b) discussing the material risks, complications or outcomes associated with each care or treatment option;
   c) ensuring the user understands the material risks, complications or outcomes of choosing or refusing a care or treatment option;
   d) where relevant, explaining the legal duties imposed on providers which prevent users from refusing a type of care or treatment, such as those imposed by the *Mental Health and Related Services Act* and the *Notifiable Diseases Act;*
   e) providing users with appropriate opportunities to consider their options before making a decision;
   f) informing users they can change their decision if they wish;
   g) accepting the user's decision; and

h) documenting the user's consent, including the issues discussed and the information provided to the user in reaching this decision.

3) Providers have a right to treat without the user's consent where:
   a) treatment is provided in a life threatening emergency or to remove the threat of permanent disability and it is impossible to obtain the consent of the user or the user's personal representative; or
   b) treatment is authorised or required under Territory or Commonwealth legislation.

4) Where a provider reasonably considers that a user has diminished capacity to consent, the user still has a right to give informed consent to a level appropriate to their capacity.

5) Where a provider considers a user lacks the capacity to give informed consent, a provider must, except under specific legal circumstances, seek consent from a person who has obtained that legal capacity under the Adult Guardianship Act or other relevant legislation.

PRINCIPLE 4: PERSONAL INFORMATION

1) Users have a right to information about their health, care and treatment. However, they do not have an automatic right of access to their care or treatment records.

2) Providers may prevent users from accessing their records where:
   a) legislative provisions restrict the right to access information; or
   b) the provider has reasonable grounds to consider access to the information would be prejudicial to the user's physical or mental health.

3) Providers have a responsibility to protect the confidentiality and privacy of users by:
   a) ensuring that the user's information held by them is not made available to a third party unless:
      - the user gives written authorisation for the release;
      - subject to subpoena or pursuant to legislation; or
      - it is essential to the provision of good care and treatment and the provider obtains the user's consent. This may take the form of consent to share information between a treating team.

   b) providing appropriate surroundings to enable confidential consultations and discussions to take place;
   c) having policies and procedures in place, including policies relating to the storage of information, and ensuring all staff are aware of these;
   d) communicating with the user and other providers involved in their care and treatment in an appropriate manner and environment.

PRINCIPLE 5: THE RELATIONSHIP BETWEEN USER AND PROVIDER

1) Both users and providers have a responsibility to treat each other with respect and consideration.

2) Providers have a responsibility to:
   a) make clear the standards of behaviour and language acceptable in the relationship between user and provider;

b) make clear the circumstances under which they will restrict or withdraw the services they provide;
c) advise users if and why they are unable to provide a service the user has requested; and
d) subject to those responsibilities regarding emergency treatment, remove, or seek the removal of any person whose behaviour is considered dangerous to the provider or service users.

3) Users have a responsibility to ensure they do not endanger or deliberately put the safety of the provider or other service users at risk. This responsibility is extended to the user's family members, friends, carers and advocates in their interactions with the provider.

4) Providers have a right to be able to provide care and treatment free from intimidation, coercion, harassment, exploitation, abuse and assault.

PRINCIPLE 6: INVOLVEMENT OF FAMILY, FRIENDS, CARERS AND ADVOCATES

1) Users have a right to:
a) involve their family, friends, carer or advocate in their care and treatment;
b) withhold information from family members, friends and carers on their care and treatment, or request the provider do so;
c) seek help from an advocate if required.

2) Providers have a responsibility to:
a) respect the role family members, friends, carers and advocates may have in the user's care and treatment, and the user's right to withhold information from them; and
b) recognise the carer's knowledge of the user and of the impact care and treatment options may have on the user's health and well-being.

PRINCIPLE 7: RESEARCH, EXPERIMENTS AND TEACHING EXERCISES

1) Providers have a responsibility to:
a) inform users if the care or treatment offered to them is experimental or part of a teaching or research exercise, of its functions and aims, and of their avenues for complaint;
b) inform users they can withdraw from the research, experiment or teaching exercise at any stage; and
c) accept the user's refusal to take part in research, experiments and teaching exercises.

PRINCIPLE 8: COMPLAINTS AND FEEDBACK

1) Providers have a responsibility to:
a) provide a mechanism for users to give feedback or make complaints about their care and treatment;
b) inform users of the complaint process and of how to make a complaint;
c) ensure that complaints are dealt with in an open, fair, effective and prompt manner, and without reprisal or penalty; and
d) provide users with information about external complaint resolution mechanisms and advocates.

2) Users and providers have a responsibility to be fair, truthful and accurate when making or responding to a complaint.

CONTACTING THE COMMISSION

Service users who believe their rights have been breached are encouraged to talk or write to the person or organisation who has provided the service. Complaints may also be made directly to the Commission.
The Commission can be contacted at

The Health and Community
Services Complaints Commission
GPO Box 1344
DARWIN NT 0810

Facsimile: (08) 8999 1828
Free call: 1800 806 380.

11.3 List of Submissions to the Review

No	Date	Respondent Details
1	21/07/03	Bethia Wilson Commissioner Health Services Commissioner 30th floor, 570 Bourke Street MELBOURNE VIC 3000 (Via email)
2	14/08/03	Jennifer Prince Under Treasurer NT Treasury GPO Box 1974 DARWIN NT 0801
3	25/08/03	Dr David Welch Stuart Park Surgery and Darwin After Hours Medical Service 1 / 5 Westralia Street STUART PARK NT 0820
4	26/08/03	Deb Hall Advocate Aged & Disability Rights Team DCLS GPO Box 3180 DARWIN NT 0801 (Via email)
5	28/08/03	Deafness Association of NT Shop 14 Casuarina Plaza CASUARINA NT 0810 (Via email)
6	29/08/03	Ms B Gray 8 Rounsevell Street ALICE SPRINGS NT 0870 (original received by Minister 25/08/03)
7	29/08/03	Dr David Welch Stuart Park Surgery and Darwin After Hours Medical Service 1 / 5 Westralia Street STUART PARK NT 0820 (original received by Minister 25/08/03)
8	29/08/03	Petros Markou East Point Day Surgery Centre PO Box 1000 PARAP NT 0804
9	29/08/03	Robyn Thompson Director, Office of Senior Territorians, (on behalf of Seniors Advisory Council to the Chief Minister)(Via Email)
10	29/08/03	Carolyn Wilson Director HPLA GPO Box DARWIN NT 0801 (Submission on behalf of all Prof Boards except Medical Board)
11	01/09/03	Colin Hardaker Seniors Advisory Council to the Chief Minister TENNANT CREEK NT 0860 (Submission forwarded by Robyn Thompson, Director, Office of Senior

		Territorians)
12	01/09/03	Robyn Hopcroft Director of Health Complaints Health Complaints Unit GPO Box 960K HOBART TASMANIA (Via email)
13	02/09/03	Vicki Langley (Via email)
14	05/09/03	Mary Johnson President Integrated disAbility Action PO Box 645 NIGHTCLIFF NT 0814 (Via email)
15	09/09/03	Jean Young-Smith 3/2 Darter Court LEANYER NT 0812
16	09/09/03	Naomi Brennan Ruby Gaea Centre PO Box 42082, Casuarina NT 42081 (Via email)
17	09/09/03	NTCOSS PO Box 1128 Nightcliff 0824
18	11/09/03	Robyn Cahill Executive Director Australian Medical Association (NT) PO Box 41046 CASUARINA NT 0811
19	12/09/03	Wayne Gorst Admin. Branch Manager Central Australian Aboriginal Congress PO Box 1604 ALICE SPRINGS NT 0871 (Via Email)
20	11/9/03	Miwatj Aboriginal Corporation, Miwatj Legal Aid Service, CWA, Nhulunbuy C/- PO Box 519 NHULUNBUY 0881
21	17/09/03	Kez Hall Danila Dilba PO Box DARWIN NT 0801
22	19/09/03	Review Committee Health and Community Services Complaints Act GPO Box 1344 DARWIN NT 0801
23	19/09/03	Robert Griew CEO Department of Health and Community Services PO Box 40596 CASUARINA NT 0801
24	19/09/03	Peter Boyce Health and Community Services Complaints Commissioner GPO Box 1344 DARWIN NT 0801

11.4 CUSTOMER SATISFACTION SURVEYS

Since the 2001/2002 Financial Year, the Commission has sought feedback from providers and complainants as to their satisfaction with the complaints process. Customer Satisfaction Survey forms are usually sent to both complainants and providers after the complaint process is complete.

In 2001/2002, a total of 42 Customer Satisfaction surveys were returned, 26 from providers and 20 from complainants. 163 files were closed during the year.

In 2002/2003 a total of 70 Customer Satisfaction Surveys were returned, 38 from providers and 32 from complainants. 108 files were closed during the year.

Satisfaction with Complaint Outcomes.

The first section of the survey seeks to measure the level of satisfaction with the ***outcome*** of a complaint.

Of the **provider** responses:

- 2001/2002 4% were not satisfied, 50% were satisfied, 46% were very satisfied
- 2002/2003 8% were not satisfied, 54% were satisfied, 38% were very satisfied

Of the **complainant** responses:

- 2001/2002 45% were not satisfied, 45% were satisfied, 10% were very satisfied
- 2002/2003 47% were not satisfied, 33% were satisfied, 20% were very satisfied

The following Graphs depict the provider and complainant outcome satisfaction over a period of two financial years.

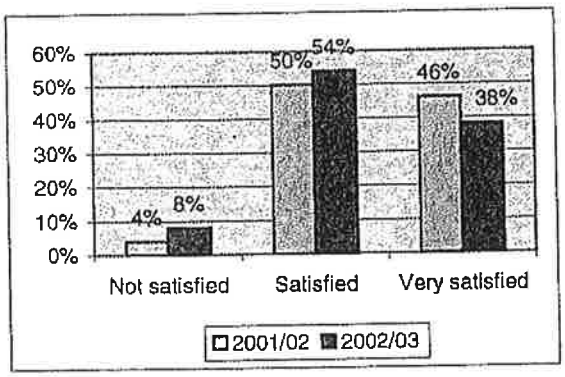


Table 1: **Provider** outcome satisfaction satisfaction

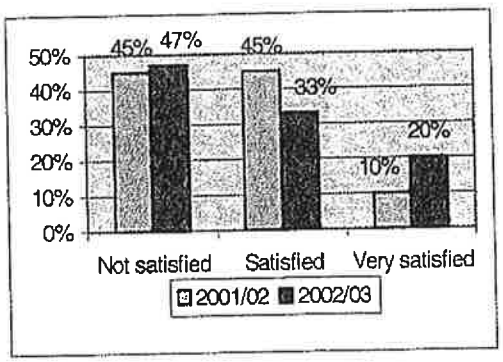


Table 2: **Complainant** outcome

Providers and complainants were asked how clear were the reasons given for the complaint *outcome*.

Of the **provider** responses:

- 2001/2002 0% indicated not clear, 54% clear, 42% very clear.
- 2002/2003 5% indicated not clear, 60% clear, 35% very clear.

Of the **complainant** responses:

- 2001/2002 25 % indicated not clear, 70% clear, 5% very clear.
- 2002/2003 20% indicated not clear, 70% clear, 10% very clear.

Satisfaction with the Complaint Process

The second section of the survey seeks to measure satisfaction with the complaints ***process*** (ie the handling of the complaint by the Commission.)

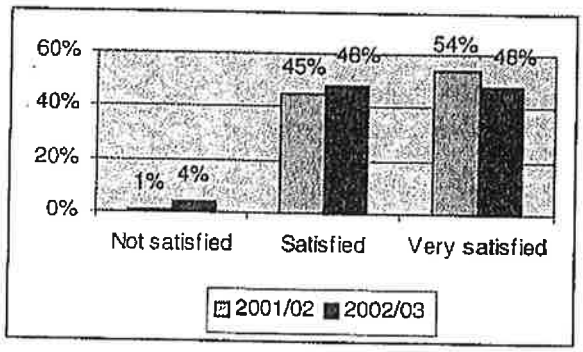
Overall, Provider satisfaction with complaint process was:

- 2001/2002 not satisfied (0%), satisfied (45%), very satisfied (54%)
- 2002/2003 not satisfied (4%), satisfied (48%), very satisfied (48%)

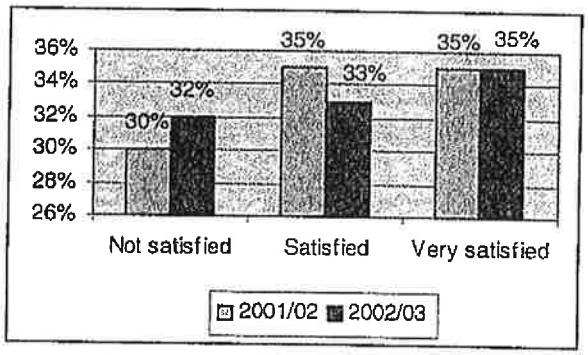
Overall, Complainant satisfaction with the complaint process was:

- 2001/2002 not satisfied (30%), satisfied (35%), very satisfied (35%).
- 2002/2003 not satisfied (32%), satisfied (32%), very satisfied (35%).

The following Graphs depict the provider and complainant process satisfaction over a period of two financial years.



Provider satisfaction: *Complaint Process*
Complaint Process



Complainant satisfaction:

The survey includes a number of questions relating to key elements of the complaints handling process.

Providers found they could contact Commission staff:
- 2001/2002 not easily (0%), easily (54%), very easily (46%).
- 2002/2003 not easily (0%), easily (62%), very easily (38%).

Complainants found they could contact Commission staff:
- 2001/2002 not easily (15%), easily (40%), very easily (45%)
- 2002/2003 not easily (13%), easily (47%), very easily (40%)

Providers found that the Commission responded to letters and phone calls:
- 2001/2002 not promptly (0%), promptly (54%), very promptly (46%)
- 2002/2003 not promptly (6%), promptly (53%), very prompt (41%)

Complainants found that the Commission responded to letters and phone calls:

- 2001/2002 not promptly (15%), promptly (35%), very promptly (50%).
- 2002/2003 not promptly (10%), promptly (37%), very promptly (53%).

Providers found Commission staff to have been:
- 2001/2002 polite (42%), very polite (58%)
- 2002/2003 polite (50%), very polite (50%)

Complainants found Commission staff to have been:
- 2001/2002 not polite (0%), polite (40%), very polite (55%)
- 2002/2003 not polite (6%), polite (32%), very polite (62%).

Providers found Commission staff listened:
- 2001/2002 not well (0%), well (42%), very well (54%).
- 2002/2003 not well (3%), well (47%), very well (50%).

Complainants found Commission staff listened:
- 2001/2002 not well (0%), well (35%), very well (60%).
- 2002/2003 not well (10%), well (32%), very well (58%).

Providers found Commission staff explained the Commission's processes and role:
- 2001/2002 not clearly (4%), clearly (46%), very clearly (50%).
- 2002/2003 not clearly (4%), clearly (46%), very clearly (50%).

Complainants found Commission staff explained the Commission's processes and role:
- 2001/2002 Not clearly (15%), clearly (40%), very clearly (45%)
- 2002/2003 Not clearly (13%), clearly (47%), very clearly (40%)

Providers found that Commission staff kept them informed of the progress of the complaint:
- 2001/2002 not well (12%), well (35%), very well (54%).
- 2002/2003 not well (15%), well (41%), very well (44%).

Complainants found that Commission staff kept them informed of the progress of the complaint:
- 2001/2002 not well (15%), well (30%), very well (55%).
- 2002/2003 not well (13%), well (35%), very well (52%).

Commentary and Analysis

There has been a significant difference between providers and complainants on the degree of satisfaction with the *outcomes* from complaints. Whereas less than 10% of providers claim not to be satisfied with complaint outcomes, more than 40% of complainants were not satisfied with the outcomes of their complaint.

A similar pattern is evident on degree of satisfaction on the complaint process. Again, a much higher proportion of providers were satisfied with the complaint process when compared with complainant satisfaction levels. Over the two year period, more than 95% of providers were "satisfied" to "very satisfied" with the whole process of complaints resolution, whereas approximately 30% of complainants said they were "not satisfied" with the complaints process.

However, given the relatively high levels of complainant dissatisfaction with the complaints process, it is interesting to note that complainants consistently rated specific elements of the complaints handling process positively. Although complainants overwhelmingly endorsed Commission staff as being easily contactable, responding promptly to letters and phone calls, polite, good listeners and good at explaining Commission roles and processes, more than 30% of complainant respondents said that they were "not satisfied" with the complaint process.

There are several possible reasons for this apparent discrepancy:

1. Almost 50% of complainant respondents also indicated that they were not satisfied with the *outcome* of a complaint. It is possible that their impressions of the processes undertaken by the Commission in managing the complaint were influenced by their dissatisfaction with the outcomes. Overwhelmingly positive feedback from complainants on the individual elements of complaints handling may also support this possibility.
2. Commission records show that a high proportion of complaints were not substantiated during the period in question. (2001/2002 X% of complaints, 2002/2003 52% of complaints). Again, the "failure" to substantiate a complaint could contribute to complainant concerns about process, irrespective of the quality of the actual process.
3. Complainants who are dissatisfied with complaint outcomes may have been more inclined to complete the survey to voice their dissatisfaction.

However, even taking into account the relatively high proportion of complainants not satisfied with both the outcomes and process from complaints, the *majority* of both complainants and providers were satisfied or very satisfied with the services provided by the Commission.

Any complaint process is highly contested, and can cause high levels of anxiety, defensiveness and frustration between the relevant parties.

Given this context, the generally positive nature of most of the feedback provided in Customer Satisfaction Survey could be said to endorse the independence, justness and fairness of the complaints management system which has been established under the Act.

11.5 SERVICE IMPROVEMENT OUTCOMES FROM 3 COMPLAINTS

Case Study 1: Improved guardianship arrangements:

The Commission was asked to enquire into a complaint against a residential care facility in which it was alleged that a woman with a severe intellectual disability was being kept in seclusion and cared for in an unsatisfactory manner.

Enquiries revealed that the woman had a long history of having difficulties finding satisfactory accommodation. In order to prevent her having to either be physically or chemically restrained in a mental health institution, it had been decided that she reside in a purpose built room attached to a rural residence owned by the provider. The provider explained the extent of the consultation, review and documentation that occurred in relation to deciding on the most suitable care for the woman. The provider also invited the Commission to meet with their staff to discuss the complaint and to visit the residence to inspect the accommodation.

The Commission could not find any evidence to support the issues raised in the complaint, however enquiries did reveal that the woman had no adult guardian and that no application for such a guardian had been made.

While the Commission had no desire to interfere or breakdown the important relationship between staff and the woman, the Commission was concerned that from a long term perspective, the issue of guardianship for the woman did need to be properly considered and resolved. Particularly given that she was an adult, her parents were not legal guardians and neither was the provider. It was felt that should the woman's health physically deteriorate or her needs change in the future, the issues could become quite problematic and the provider would be very exposed.

Subsequently the Commission recommended to the provider that they have a legal guardian appointed for the woman so that decisions concerning her well-being could be made with legal authority.

The provider agreed to implement the recommendation and in addition advised that, on their own initiative, they would be seeking adult guardians for a small number of other clients who were in similar circumstances.

Whilst no action was taken on the issues associated with the initial complaint, enquiries by the Commission in this case led to important changes being implemented which will enhance the quality of care and decision making for persons at risk by providing for an independent guardian to protect the interests of the person in care.

Case Study 2: Improved Procedures in relation to Informed Consent and Notification of Aboriginal Families

The complainant's father (now deceased) was an inpatient in a public hospital. He was operated on for a gangrenous foot, had a stroke and subsequently died in the intensive care unit of the hospital. The complainant stated that:

- the family was not informed adequately that the deceased was going to have an operation;
- the family were not made aware of the nature of the operation;

- the deceased spoke and understood very little English;
- the deceased would not have been able to give valid consent to the operation because he would not have understood the nature and consequence of the operation if an explanation was given in English;
- the family had no opportunity to visit the deceased before the operation; and
- the hospital staff ignored relatives wishes because they were Aboriginal.

A detailed response from the provider was forwarded to the complainant. The complaint was referred to the hospital's ethics committee for their comment and suggestions. The ethic committee made recommendations in relation to the issues of informed consent and the requirement of notification of 'family' in relation to Aboriginal patients in hospitals. These recommendations were agreed to by the Commission and reinforced with the provider.

Issues Identified: Consent not Informed, Inadequate Information on Diagnosis, Prognosis, Treatment or Operation and Inadequate Interpreter Services. **Complaint Objectives:** Seek Explanation and Obtain Apology. **Outcomes Achieved:** Explanation Provided and Policy Changed.

Case study 3: Improved management of renal/diabetes patients and to prescribing and recording practices

A complaint was lodged with the Commission by an Aboriginal Advocacy body on behalf of the sister of a deceased person. The sister complained that her brother attended a public hospital but was not admitted. A few days later he again attended and was admitted and released on the same day. He was admitted again the next day and died 24 hours later.

On inquiring about her brother's death, she was advised by attending doctors that her brother had died of "*old age*". Her brother had only recently celebrated his 37th birthday.

The complainant's main concerns were:
1. Her brother's initial discharge from the hospital was premature, particularly in light of his readmission the next day.
2. An inappropriate diagnosis was made of the deceased medical condition.
3. The deceased was given the wrong medication or an inadequate explanation of the medication, and the drugs prescribed were "*knocking him around*".

The complainant sought an explanation of the events leading to her brother's death and an assurance that any treatment issues identified would be addressed for the benefit of future patients.

Background

This initial complaint led to the Commission undertaking two related but separate investigations. These were:
1. Investigation into the care and treatment provided to the complainant's brother by the public hospital concerned; and
2. Investigation into the manner in which drugs were dispensed, prescribed and recorded for the deceased person by the Aboriginal health service.

In addition to the above investigations, the circumstances surrounding the death of the complainant's brother, together with the circumstances surrounding the death of another person the subject of a separate complaint, lead to the instigation of a further investigation by the Commission into the manner the public hospitals concerned reported deaths to the Northern Territory Coroner.

A summary of each of the two related investigations undertaken by the Commission and the recommendations made as a result of those investigations follows.

Investigation into the care and treatment provided to the complainant's brother by the public hospital concerned

Conduct of the Investigation

The investigation was carried out through accessing the patient's medical records, and obtaining written statements from staff at the hospital. In addition, an expert report was sought on the care and treatment provided to the patient.

Following receipt of the expert's report and medical records, additional information was sought from the Aboriginal medical service. Independent assistance was also sought from a medical practitioner with respect to the medical records and information provided by the Aboriginal medical service.

A Discussion Paper, detailing the results of the information obtained from the investigation, was provided to both the complainant and the hospital and comments were received.

The additional comments received from the hospital were again provided to the expert for his further opinion.

Issues Considered

The Commission investigated the following issues:

- the alleged failure by the hospital to admit or treat the patient at his initial presentation;
- the patient's diagnosis, and the appropriateness of the medication prescribed to treat his condition; and
- the treatment of the patient following his admission to the hospital until the time of his death.

Conclusions Reached by the Commission

1. There was no basis for the allegation that the hospital failed to admit or treat the patient when he first presented.
2. The care and treatment provided to the patient by the hospital fell below an acceptable standard in relation to the ongoing treatment of his chronic medical conditions, and in particular, the medication prescribed, and the steps taken to monitor his condition.
3. The current guidelines set by the Head of Nephrology Services within the Department of Health and Community Services for the ongoing management of cases involving diabetes and chronic renal disease needed to be independently and externally assessed as they may have contributed to a death that otherwise may have been avoided.
4. The Aboriginal medical service may have continued to administer a particular drug to the patient without appropriate prescription or authority to do so and in

circumstances where such medication may have been contraindicated by the patient's medical condition.
5. A specific investigation into the issues associated with the Aboriginal medical service be reported on separately.
6. The care and treatment provided by the hospital to the patient during his last admission fell below an acceptable standard.

The relationship and sharing of information between the hospital and the Aboriginal medical service and the managing of patients needs to be greatly improved.

Recommendations Made

As a result of undertaking this investigation I recommended that:

1. The hospital consider and provide to both the Commission and the complainant, a response to the conclusions reached by the Commission in the report, specifically how the hospital will ensure they will not happen again.
2. The current guidelines for the ongoing management of Aboriginal patients suffering from multiple chronic conditions such as diabetes and renal failure, set by the Head of Nephrology Services, be independently and externally assessed to ensure they equate with an acceptable, reasonable and appropriate standard of care.
3. Specialist training be implemented for hospital staff on the treatment of multiple chronic illnesses such as diabetes and renal impairment, including monitoring protocols and appropriate medication.
4. The hospital review its policies and procedures in relation to the processing and communication of pathology results, particularly in urgent cases.
5. Training for hospital staff be undertaken in relation to the medico-legal implications of clinical record keeping.
6. The hospital and the Aboriginal medical service implement demonstrable steps / activities to improve communication in relation to, and shared management of, patients with chronic illness being treated by both agencies.

The Department of Health and Community Services Response

The Department responded to the recommendations by stating that:

1. They had recently appointed a Specialist Outreach Physician and as part of the duties of this position, the Specialist would be assessing the management of patients with multiple chronic diseases and ensuring that ongoing management equates with acceptable, reasonable and appropriate standards of care.
2. Specialist training for hospital staff for the treatment of multiple chronic diseases is now part of orientation practices, as well as ongoing staff education opportunities. Written guidelines are also being given to all doctors working in the district as part of their orientation. In addition, a Chronic Disease Unit had recently been established using additional Commonwealth resources and this Unit would provide specialist training and advice to all staff in the District.
3. As part of the hospital's Accreditation Program, a critical examination of policies and procedures in relation to the following will occur:
   - treatment of preventable chronic diseases;
   - administration of medication;
   - communication of patient information on admission and discharge of patients;
   - appropriate use of pathology and radiology services, including management of urgent request; and
   - clinical record keeping, including medico-legal aspects.
4. Departmental wide workshops were being held which, amongst other things, examined medico-legal issues, including clinical record keeping.

5. The hospital participated in a number of initiatives designed to improve the working relationship with the Aboriginal medical service. These included:
   - weekly medical education meetings where all doctors in the town are invited;
   - a list of the creatinine results of patients being shared between the hospital and the Aboriginal health service;
   - the hospital providing all relevant information for inpatients whose ongoing care was to be undertaken by the independent Aboriginal health service; and
   - regular meetings between the managers of both services being conducted.

The manner in which drugs were dispensed, prescribed and recorded for the deceased person by an Aboriginal health service

The investigation by the Commission into the above complaint about the care and treatment of a person by a public hospital revealed that there may have been a significant issue of public health and safety relating to the manner in which drugs were dispensed, prescribed and recorded for the person, the subject of the complaint, by an independent Aboriginal health service.

Background

The expert's report in relation to the care and treatment provided by the hospital raised some significant issues in relation to the provision of the patient's medication. As a result the Commission undertook an analysis of the hospital and the Aboriginal medical service medical records relating to the patient. This identified a number of issues relating to the care and treatment provided to the patient by the medical service that were of concern to the Commission.

A formal investigation was then undertaken into:

1. The manner in which the medical service dispensed, prescribed and recorded drugs; and
2. The following specific issues:
   a. Was the patient provided with a certain drug following his release from the hospital
   b. Was there a current medication order to supply the particular drug?

Conduct of the Investigation

The investigation was carried out by:

- accessing the patient's medical records from both the hospital and the medical service;
- obtaining an expert opinion;
- examining the content of the expert report prepared for the complaint against the hospital which provided details of the care and treatment received by the patient;
- obtaining a response from the medical service to a Discussion Paper that identified issues raised in the expert reports;
- obtaining a further response from the experts to the reply by the medical service; and
- obtaining a further expert opinion from the GP Advisor, Royal Australian College of General Practice. All the above information and reports were provided to this expert who was asked to report on the following specific issues:
  - The manner in which the medical service dispensed, prescribed and recorded drugs.
  - Was there a current medication order to supply the particular drug to the deceased?

- Was the deceased at any time dispensed the particular drug without an authorised prescription to do so.
- What authority, if any, does a Discharge Summary have to allow for the continual prescribing of a medication?

Conclusions reached by the Commission

Following a complete examination and analysis of the medical service's medical records and the expert opinions received, I was able to conclude the following:

1. The manner in which the medical service dispensed, prescribed and recorded drugs during the period in question was not of an appropriate standard and that it did attract the severe disapproval of the independent expert and the Royal Australian College of General Practice.
2. The patient was regularly provided with a particular drug by the medical service following his release from the hospital.
3. Prior to the patient's admittance into hospital, there was no current medication order for the medical service to provide the patient with the particular drug.
4. The patient was dispensed the drug without an authorised prescription.
5. The medical service used the hospital discharge summary for a purpose it was not authorised or intended for.
6. Health Workers at the medical service made a number of errors in dispensing medication to the patient and failed to note the medical records as to what they dispensed.
7. There was no monitoring or auditing by the doctors of the medical records at the medical service to ensure that errors were not made and the patient was being managed and treated to a reasonable standard.
8. The poor standard of record management reflected in this patient's case was most likely of a systemic nature.
9. The death should have been reported to the NT Coroner. The issues surrounding this non-reporting of the death were subsequently investigated (with another case) and reported on separately.

Current Situation

On a positive note, I must also record that in the medical service's response to the expert opinions they advised that since the time in question they had introduced the following improvements with regard to drug management procedures and protocols:

- The introduction of a computerised patient information and recall system.
- In-house blister (Webster) packaging for approximately eighty (80) patients. The prescriptions for these patients are now held on the computer that is used for Webster labelling. The filling process includes a double check by Health Workers and the Pharmacist or Doctor.
- Employment of a Pharmacist to assist with the heavy burden of Webster packaging and other drug management issues.
- Increasing use of Medical Director software to record patient's current medication and automatically check for drug reactions. This system is being progressively implemented.
- Regular attendance at Doctor level at the hospital discharge planning meetings has assisted in communication flow between the medical service and the hospital. In addition, doctors from both services attend weekly clinical update meetings, with frequent presentations on the management of renal and other chronic disease issues.
- The medical service has been funded by the National Prescribing Service to undertake research investigating some of the issues of poor medication compliance, and attempt to address them.

- All policies and procedures are being revised within the organisation and this includes the development of further specific and clear policies regarding issues of drug management.

I was pleased that the medical service had been proactive in making these changes and I was sure they would go some way to improving what was in my view a very poor standard of record management. However, I still made a number of significant recommendations

Recommendations

As a result of undertaking this investigation I recommended that:

1. The medical service agree to enter into the Commission's conciliation process with the complainant to reach an agreed outcome in relation to the following findings:
   A) the substandard manner in which the medical service dispensed, prescribed and recorded drugs in relation to the care and treatment of the patient; and
   B) the failure of the medical service to dispense, prescribe and record the patient's medications to an acceptable standard which was a contributing factor to his death.
2. The medical service implement a records management system that meets the standards set by the Royal Australian College of General Practitioners. In implementing such a system, they consult with and gain the endorsement of RACGP. In making this recommendation I appreciated that some of the changes already made by the medical service may have been to the appropriate standard.
3. The medical service arrange for ongoing independent random audits to be taken of their medical records to ensure their medical case management system continually meets the RACGP standard.
4. A copy of all available information and documents resulting from this investigation be provided to the following professional registration boards so that they may take action as they consider appropriate in relation to the professional conduct of the various health professionals involved from medical service in the care and treatment of the patient:
   - Medical Board;
   - Nursing Board; and
   - Aboriginal Health Worker Board
5. The medical service and the hospital continue to implement demonstrable steps/activities to improve communication in relation to, and shared management of, patients with chronic illness being treated by both agencies.

I was also concerned that some or all of my findings in relation to the independent Aboriginal medical service may also have been applicable to other independently run health services throughout the Northern Territory. Because of the significance of the findings in relation to medical records management and the possible effect this could have if not to an appropriate standard, in accordance with the Act, I also provided a copy of this report to the following:

- Department of Health and Aged Care;
- Aboriginal Medical Service Alliance of the Northern Territory;
- Department of Health and Community Services; and
- The Minister for Health and Community Services.

Response to Recommendations from the Medical Service

In response to the recommendations made by the Commission, the health service advised on the actions they had taken and intended to take in order to comply with the recommendations. These were:

1. The medical service agreed to enter into the Commission's conciliation process in order to reach an agreed outcome with the complainant in relation to the concerns raised in the report.
2. The medical service agreed to implement a records management system that complied with the standards set by the Royal Australian College of General Practitioners (RACGP). In doing so they would consult with RACGP during the process and gain their agreement at its conclusion.
3. The medical service would arrange for regular independent audits of their medical records system to ensure that it continually meets the RACGP Standard.
4. The medical service stated they were committed to improving communication with the public hospital regarding any mutual client's care and management. The current procedures would be strengthened to ensure this objective was met; including the following;
   - Clinical staff will regularly attend the regular discharge planning meetings currently held at the public hospital;
   - Where appropriate, the medical service and the public hospital will continue to participate in Clinical Case Conferences and the development of Care Management Plans for individual clients;
   - Clinical staff from both organisations will continue to attend regular (usually weekly) Continuing Medical Education meetings, where general principles for management of chronic diseases are a frequent topic; and
   - The medical service will carefully review each discharge summary, paying particular attention to any medication changes and ensure these are appropriately actioned. A regular audit process will be developed in conjunction with the public hospital to review both the quality and timeliness of discharge summaries, and the stringency of their review by the medical service.

The medical service concluded by stating that they intend to hold regular meetings to inform their staff of the issues and ensure progress is sustained towards implementing the recommendations.

11.6 Definition of Community Services

It is proposed that regulations under the Act be amended to include the following definition of "community services".

"**Community Services**" means *those services which assist or support members of the community in personal functioning as individuals or as members of the wider community* including:

- **Personal and social support services:** eg information advice and referral, individual and family support, independent and community living support, domiciliary support, employment services specifically for people with a disability;
- **Child care and pre-schools services:** ie provision of care by persons other than parents under the supervision of a paid coordinator in a group setting or another home; eg centre –based day care, family day-care, occasional child care, before and after school hours care, vacation care, pre-schools.
- **Residential care and accommodation support services:** ie services which assist people who are disadvantaged to access suitable housing and accommodation, crisis accommodation, or special purpose accommodation.
- **Financial and material assistance services:** ie services that are designed to enhance personal functioning and to facilitate access to community services through the provision of emergency, or immediate financial assistance and material goods, and transport. Eg financial assistance, provision of equipment or goods during crises or disaster, Taxi Subsidy Scheme.
- **Policy or service development support services:** ie services which aim to articulate and promote improved social policies and practices eg development of public policy submissions, training, volunteer development, etc.

The following services are specifically excluded from the definition of community services:

- Baby sitting;
- Long term housing assistance such as public housing;
- Income support services such as social security, pensions, benefits and rental assistance;
- Services which provide protection from physical, sexual or emotional harm or physical neglect through statutory intervention;
- Concession relief activities including concessions on taxation, transport (not including the Taxi Subsidy Scheme), water and energy, municipal rates etc;
- Training, vocational rehabilitation and employment services which assist people who are disadvantaged in the labour market by providing training, job search skills, help in finding work, and rehabilitation. Employment services specifically for people with a disability are **not** excluded;
- Services involving correctional or rehabilitative supervision and protection of public safety through corrective arrangements and advice to courts and parole boards.

A "**Community service provider**" means *any person or body which provides, funds or monitors community services.* This includes:

- The Commonwealth Department of Family and Children's Services or any other relevant Commonwealth Government Department or agency;
- The NT Department of Health and Community Services or any other relevant NT Government Department or agency;
- Local Government authorities;

- Non-Government organisations which provide relevant community services whether for profit or not-for-profit, including:
  - Client/consumer representative organisations
  - Service provider representative organisations
  - Service provider organisations
  - Self-help groups
  - Indigenous organisations
  - Other specific community organisations
  - Commercial for profit organisations which provide community services;

Unpaid volunteers, helpers or family members providing relevant community services are included in the definition of community service provider.

12 TABLES

12.1 Health Complaints Acts in Victoria, Queensland and WA

Element	Victoria	Queensland	Western Australia
Purpose and Objectives	The Victorian Health Services Commission is governed by *the Health Services (Conciliation and Review) Act 1987.* Section 1, of the Act lists its purposes as: *(a) to provide an independent and accessible review system for users of health services: and* *(b) a means for reviewing and improving the quality of health service provision; and* *(c) to set out the functions and powers of the Health Services Commissioner.* The Act's objectives are to set up a health services review system that will enable users to have their complaints resolved, encourage providers to follow guiding principles, and lead to improvements in quality of health care.	The Queensland Health Rights Commission was established in 1992 by the *Health Rights Commission Act 1991 (Qld).s (7)* The Act provides "*for independent review and conciliation with respect to services provided by health service providers to health service users and for improvements to those services*". (Long title) The Act's objectives are to bring about improvements to health services through establishing an accessible, independent complaints facility. The objectives also require the development of a Code of Health Rights and Responsibilities, and the establishment of the Health Rights Advisory Council. (Part 3)	In Western Australia (WA) the Office of Health Review is established by the *Health Services (Conciliation and Review) Act 1995.* The Act establishes *"an agency as a readily accessible means of having complaints about the provision of health services reviewed, conciliated and dealt with in confidence and for related purposes."* (Long title) . The Act does not set out objectives. The functions and powers of the Director as set out in Section 10 do not give any particular prominence to any particular function.
Coverage	The Act covers government and non-government health and community health services, and services provided in the alternative health care field. (p3)	Health services covered under the Act are listed in Schedule 1. They include standard health services, provided by both registered and non-registered providers. Some services are specifically declared not to be health services. These include services provided under Workcover and Workplace Health and Safety Acts. The Act does not cover most community services, unless provided as part of a health service.	Originally established to enquire into health complaints, the Office's functions were expanded in 1999 to include inquiries into complaints about disability services. However, disability services complaints are handled under the separate *Disability Services Act 1993.*

Bodies established by Act	**Health Services Review Council:** a nine member council appointed by the Minister to advise the Minister on the functioning of the health complaints system and operations of the Commissioner. The Council also advises the Minister and Commissioner on issues referred to it by the Commissioner and, with Ministerial approval, refers complaint matters to the Commissioner for inquiry.	**Health Rights Commission:** consisting of the Health Rights Commissioner and officers of the Commission. **Health Rights Advisory Council**: a six member council appointed by the Minister. Broadly, the function of the council is to advise the Minister on health services complaints system and issues. The Council also advises the Commissioner in relation to complains and refers health complaints matters to the Commissioner for advice. S 41	**Office of Health Review.**
Processes under the Act	The Act preamble lists guiding principles for Victorian health service providers and users, and states that service providers should aim to satisfy these guiding principles. The Commissioner cannot usually accept a complaint about an incident that occurred more than 12 months before a complaint is made. S 19 (3) Oral complaints must be confirmed in writing unless the Commissioner is satisfied that there is good reason not to do so. S 17 The Commissioner has 28 days to determine whether to accept, reject or refer the complaint on. S 19 (7) If the complaint is unduly complex or may be "satisfactorily resolved" the Commissioner may fix a further period of 28 days. S 19 (8) The Commissioner must stop dealing with a complaint that has been withdrawn. S 15 (6) Evidence gained during conciliation is not admissible in courts or tribunals and cannot be used by the Commissioner in investigation or inquiry. S 14	The Queensland Commission endeavours to take an informal and conciliatory approach to resolution of health complaints. The Act specifically requires that proceedings are conducted with "as little formality and technicality, and with as much expedition, as practicable" S 30 (a) In handling a complaint about a non-registered provider the Commissioner may conciliate, investigate or refer the complaint to another entity . S 73 (2) The Commissioner can decide not to take action on a complaint referring to a matter that took place more than one year prior to lodging the complaint. S 79 (5) The Commissioner has discretion to extend the initial 28 day assessment period for a further 28 days, to allow the Commissioner to properly assess a complex complaint, or if it is likely that the complaint can be satisfactorily resolved. S 76 (1) & (3) Parties reaching agreement during conciliation may enter an enforceable contract. S 89	According to the Office's website, "the office operates in a spirit of cooperation with both providers and consumers of health and disability services. In the first instance we encourage complainants to make a direct approach to the service provider. Where this is not appropriate, or is unsuccessful, a complaint may then be lodged in writing to the Office." S 30 Staff can assist consumers to submit a complaint, but do not provide an advocacy service. Section 4 of the Act provides principles to guide health service providers in delivering quality care. In assessing a complaint, the Director is required to make a decision as to whether unreasonable conduct has occurred while having regard to the principles and commonly accepted professional standards. The Director must conduct a "preliminary assessment" of a complaint within 28 days to "decide whether and to what extent" to accept, reject or refer it. The Director may

	Investigations aim to decide whether the provider has acted unreasonably in relation to the guiding principles and generally accepted standards. The investigation procedure is at the Commissioner's discretion. S 19 (2) The Victorian model places an emphasis on Conciliation. Only matters not suitable for Conciliation can be referred to investigation. S 21 (1) (a)	Conciliation is privileged. S 91 However, if the person who prepared a document, and all persons named in the document consent, it can be used in other proceedings. S 91 (4) Professional mentors are to provide advice to conciliators in dispute resolution skills. S 93. The Commissioner may hold an inquiry as part of a formal investigation. An inquiry is a judicial proceeding under the Criminal Code. S 109	extend the assessment period for a further 28 days "if it is for the benefit of the person who made the complaint to do so." S 33 A complaint about an incident which occurred more than 12 months before the complaint is made would normally be rejected. S 24 If a complaint is withdrawn by the complainant, the Director must stop dealing with the complaint. S 29 In order for the Director to refer a complaint to another body (apart from Registration Boards) he / she requires the consent of the person who made the complaint. S 32.
Relationship with Boards	If, after consultation, the Commissioner considers the board has the power to deal with a complaint relating to a registered provider *"and the matter is not suitable for conciliation"*, the Commissioner must refer complaints to the relevant Board. However, if the Commissioner decides the matter is suitable for conciliation, it must refer the matter for conciliation "*without delay*". S 19 (6) &(10) Boards must provide the Commissioner with reports about complaints concerning the provision of health services by a provider. S 24	A Board may provide advice to the Commissioner in relation to complaints. The Commissioner may request Boards to provide reasonable information in its possession in relation to a complaint or registered provider and vice versa. S 128 and 129. The Commissioner may intervene in a Board's disciplinary proceedings at any time.	The Director may refer a complaint, or an element of a complaint, to a Registration Board if the Director considers the complaint unsuitable for conciliation or investigation, or if the Director deems it should be dealt with by the Board. However, complaints may only be referred to a Board after consultation with the Board, and with the written consent of the complainant. S 31
Overall Comparison with NT Act	Like the NT Act, the Victorian Act emphasises conciliation and resolution. The Victorian Commissioner's powers and functions support this approach. The principles listed in the preamble to the Act function provide a framework against which a complaint can be assessed. The principles do not include the responsibilities of consumers. The NT's Code for Health and Community Services Practice provides a similar framework, but incorporates both consumer and provider rights and responsibilities. The activities of the Victorian Commissioner are	The Queensland Act is similar to the NT Act in that it requires, if possible, the conciliation and resolution of complaints rather than a formal, more adversarial approach. The issues to be addressed in the Health Rights and Responsibilities Code to be developed in accordance with the Act do not address consumer responsibilities as included in the NT. The Queensland Act provides the Commission	The WA Act, unlike the NT Act, does not give any particular prominence to certain roles or functions of the Commissioner. For instance, the NT Act is explicit about use of conciliation where possible and appropriate.

	subject to monitoring and review by the Health Services Review Council. If asked, the Commissioner must report to the Council on any matter relating to operations under the Act. The functions of the Review Council are broader than the NT's Review Committee, which looks at administration of the Act on appeal. Unlike the NT, the Victorian Commissioner has the capacity to extend the assessment time period by a further 28 days under specified circumstances.	with more power in relation to registration boards than the NT Act.	