Health and Community Services
Complaints Commission

Annual Report
2022/23

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HCSCC

Health and Community Services Complaints Commission

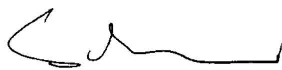
Twenty-Fifth Annual Report (2022/23)

The Honourable Chanston (Chansey) James Paech MLA
Attorney General and Minister for Justice
Parliament House
DARWIN NT 0800

Dear Minister

In accordance with the requirements of section 19(1) of the *Health and Community Services Complaints Act*, I am pleased to present the Annual Report of the Health and Community Services Complaints Commission for the year ending 30 June 2023.

Yours sincerely



Stephen Dunham

Commissioner

9 May 2024

Glossary of Terms

AGD	Department of Attorney General and Justice
Ahpra	Australian Health Practitioner Regulation Agency
ASCC	Alice Springs Correctional Centre
CARHS	Central Australia Regional Health Service
COAG	Council of Australian Governments
Commission	Health and Community Services Complaints Commission
Complaint	Unless otherwise specified, complaints include matters received by the HCSCC which were managed via its formal processes and notifications to Ahpra which were consulted on. The term complaint may also be used more broadly to include enquiries.
CPV	Community Visitor Program
DCC	Darwin Correctional Centre
Enquiry	A grievance managed via the HCSCC's informal complaints process. An enquiry may progress to a complaint or be resolved informally and expeditiously pursuant to s86 of the Act.
GP	General Practitioner / General Practice.
National Law	The Act, adopted in each state and territory, setting out the provisions of the Health Practitioner Regulation National Law. The National Law has been adopted by the parliament of each state or territory through adopting legislation. The National Law is generally consistent in all states and territories.
Notification	A report of concern about the health, conduct or performance of a registered health practitioner
NT Health	Northern Territory Department of Health
NDIS	National Disability Insurance Scheme
NTCS	Northern Territory Correctional Services
PPHCS	Prison Primary Health Care Service
Review Committee	The Health and Community Services Review Committee established pursuant to Part 9 of the Act
RACGP	Royal Australian College of General Practitioners
RDH	Royal Darwin Hospital
TERHS	Top End Regional Health Service

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Commissioner's Report

In preparing this report I toyed with the notion of resubmitting my report from last year (2021-22) from March 2023.

Many of the issues and problems facing the Commission remain, although in keeping with the general maxim on untreated malaises, the problems have been exacerbated. The lack of several 'ounces of prevention' in previous years now requires some significant 'pounds of cure' if the Commission is to perform optimally or at least allow me '...to properly perform...(my)... functions...' as mandated at s14(1) of the Act. **Frankly, I am surprised that the Commission has been provided its lowest allocation since it commenced as an independent standalone body in 2011. The workload has increased exponentially in this time, with continuing cost cutting and efficiency measures instituted to maintain viability.**

This report is a deliberately brief description of the exercise of my powers and the performance of my functions during the year.

While this report will be submitted later than I would have liked, it is neither overdue nor tardy given the statutory requirement to report '...as soon as is practicable at the end of each financial year'. I have deliberately accorded the preparation of the report a low priority given the urgent and pressing nature of other work. I have favoured the work related to the several hundred people involved in complaints and enquiries over the few who may read this report. The resolution of complaints and system improvements remain high priorities for the Commission and are afforded more emphasis and resource allocation.

In a nutshell:

- Resources continue to be curtailed as reported over the last several years since 2014-15

  Reduction in $ terms:
  1.205 – 1.019* = $185k
  15.5% reduction

  Reduction factoring in inflation:
  $1.205 in 2014 equates to $1.446 in 2022
  (20.0% over 8 years to 2022 @ 2.3 pa
  SOURCE: Reserve Bank of Australia)

  Thus

  1.446 – 1.019 = $427k
  42% reduction

  Workload increases
  698 – 608 = 90
  14.8% increase

  *This is the lowest allocation in the life of the Commission since it became an independent entity in 2010-11

- **The Health and Community Services Complaints Review Committee** was inoperative during the financial year with a number of complainants dissatisfied with the Commission's processes and seeking to have a review of their complaints. The lack of priority given to action to appoint new members to the Committee following the lapse of the previous committee's appointments is indicative of the lethargy in support provided by the Department.
- **The Review of the Act** which is overdue by decades was due to be completed some time ago. By letter of 7 July 2021, the then Minister, the Honourable Selina Uibo advised me that she had directed the Department of Attorney General and Justice to conduct a desktop review of the Act and to seek my views and those of the Committee on that review. An ambitious target of 31 December 2021 was set for the finalisation of the review. I have no advice on the progress of this matter.
- **Curtailment of activities** continues to impact on the capacity of the Commission. The Budget is insufficient for the Commission's outgoings and as previously advised, this would appear to be a breach of the *Fiscal Integrity and Transparency Act* and the Under Treasurer's certification in Budget Paper 2. It also sees the Chief Executive Officer of the Department of Attorney General and Justice in breach of s14(1) of the Act. In addition to the aforementioned lethargy I consider this casual disregard for the Commission's capacity to do its work and CEO non-adherence to statutory duties to be indicators of neglect. I am faced with the only option to ensure that the Commission remains within budget is staff reductions. No other unit in the Department can demonstrate staff reductions of this magnitude against increasing workload.
- In the coming year, it appears that all Australian jurisdictions with the exception of the NT will have instituted a ***Code of conduct for Health Care Providers***, as decided at the COAG Health Ministers' meeting in 2015. This gap in the national approach to regulating this sector is potentially a source of problems in this jurisdiction and perhaps nationally. I have referenced this matter in previous annual reports and will not expand further on it here, suffice to say, again, that operationalising this code is not possible with current resourcing.

The Commission is blessed with the calibre and commitment of its staff and their unwavering focus on the objectives set by the Act.

I am grateful too for the support of my interstate colleagues.

2022/23 at a Glance

Key deliverables

Table 1: Key deliverables 2020/21 – 2022/23

Key deliverables	2021/20	2021/22	2022/23
Enquiries and Complaints Received	650	732	**698**
Enquiries and Complaints Closed	644	772	**702**
Percentage of complaints Resolved within 180 days	75%	75%	**87%**
Percent of Enquiries and Complaints closed / Enquiries and Complaints Received	99%	105%	**101%**

Enquiries

- A slightly increased number of enquiries received in 2022/23 (648 in 2022/23 compared with 640 in 2021/22, 525 in 2020/21, and 604 in 2019/20).
- An increased proportion of total complaints and enquiries were handled at enquiry level (93% in 2022/23, compared with 87% in 2021/22, 81% in 2020/21, and 78% in 2019/20).
- A slightly increased number of enquiries were closed in 2022/23 (649 in 2022/23 compared with 645 in 2021/22, and 515 in 2020/21). This is due to the Commission's practice of managing an increasing proportion of cases informally at enquiry level.
- The average number of days taken to finalise enquiries decreased to 7.9 days, compared with 8.89 days in 2021/22, 9.75 days in 2020/21, and 9.55 days in 2019/20.

Complaints

- 50 complaints were received, a significant decrease on the 92 complaints in 2021/22 and 125 complaints received in 2020/21. This reflects the Commission's practice noted above, of managing an increasing proportion of cases informally as enquiries, rather than through its formal complaints process.
- 53 complaints were closed, a significant decrease on the 127, closed in 2021/22, and 128 complaints closed in 2020/21.
- 87% of complaints were closed within 180 days, which was an increase from 75% in 2021/22 and 75% in 2010/21. The benchmark for closure of complaints within 180 days is 80%.
- Of matters formally assessed in 2022/23, the KPI of 80% assessed within 60 days was not met. 50% of complaints were assessed within 60 days, which is a decrease on 68% in 2021/22, and increase from 39% in 2020/21. The KPI of assessment within 60 days derives from s27 of the Act, and has never been a realistic target. Engagement with complainants and clarification of complaint issues takes time, and NT Health requires a minimum of four weeks to provide a written response to a complaint. Complainants also require time to review responses and may have further queries, which makes it difficult to meet the 60 day KPI. The Commission's practice of managing a higher proportion of complaints informally (as enquiries) also leads to an increase in the average complexity of complaints managed formally, and may increase timeframes.

Community engagement

The Commission hosted stalls at the Seniors Expos in Darwin and Katherine and the All Abilities Expo in Darwin, and presented at a CALD Community Leaders Forum. It also attended meetings with Ahpra and the Acting Executive Director Top End Region NT Health and the Department of Aged and Health Care. It attended events including the Disability Strategy Launch, visits to DCC, the Youthworx Digital and Connect Launch and the Inclusion Australia NT office opening. Community engagement was otherwise severely curtailed due to resources already being stretched and a focus on website development.

Whilst the significant majority of complainants contact the Commission either by phone or via its website, some people either prefer to visit the office in person or need to do so due to special needs. Complainants are welcome to visit the Commission in person and there is a wheelchair accessible front counter.

Chapter 1: The Commission

Our Vision

High quality, responsive, person centred health, disability and aged care services throughout the Territory.

Our Mission

Independent, just, fair and accessible complaints systems which promote the rights of service users and contribute to safety and quality improvement in health, disability and aged care services in the NT.

Our Values

The Commission is guided by the following values:

- Accessibility
- Accountability
- Fairness
- Innovation
- Person-centred
- Professionalism

Our Strategic Objectives

1. Provide a quality, accessible and transparent complaints assessment, resolution and investigation service.
2. Promote the capacity of the health, disability and aged services sectors to resolve complaints directly with service users.
3. Analyse complaints to identify causes, detect trends and contribute to systemic improvement.
4. Provide independent advice to government on matters affecting health, disability and aged care services in the Territory.
5. Operate the office in accordance with good governance and resource management practices.

Health and Community Services Complaints Commission

Our History

The Health and Community Services Complaints Commission (Commission) was established in 1998 with the passage of the *Health and Community Services Complaints Act* (the Act). It sat with the Ombudsman's Office until 2010 when the Commission became a stand-alone entity with an independent Commissioner. The Commission was set up to provide an independent, just, fair and accessible mechanism for the resolution of complaints between users and providers of health, disability and aged services. The focus of the Act is on the resolution of complaints, the improvement of services and the promotion of the rights and responsibilities of both service users and providers.

Our Functions

The Commissioner's powers and functions as set out in section 3 of the Act include:

- encouraging and assisting users and providers to resolve complaints directly with each other;
- leading to improved services and promoting rights and responsibilities;
- providing information, advice and reports to Boards, service users, the Minister and the Legislative Assembly ;
- consulting with providers, organisations and users of health and community services; and
- enabling users and providers to contribute to the review and improvement of health services and community services.

Our Team

The Commission receives support from the Department of Attorney-General and Justice in areas such as human resources, finance, procurement, record management, office accommodation and information technology. The Commission is co-located with the Office of the Children's Commissioner.

Table 2: Organisational structure and staffing as at 30 June 2023

Commissioner	Stephen Dunham
Deputy Commissioner	Ruth Brisbane
Senior Investigation/ Conciliation Officer	Sean Goff
Senior Investigation/ Conciliation Officer	unfunded
A/Investigation/ Conciliation Officer	Kiarna Murray
Office Manager (50% position)	Rebecca Byers
Administration/ Resolution Officer	vacant

Chapter 2:
Quality Complaints Management

ACHIEVEMENTS 2022/23

Monitoring quality improvement

The Commission has three primary functions; the promotion of service quality, the promotion of the rights and responsibilities of service users and service providers, and the resolution of complaints.

Two separate mechanisms are employed to promote quality improvement. The first is to encourage service providers to reflect on the issues which led to a complaint or enquiry, and to improve service quality to reduce the likelihood of other, similar complaints. These outcomes are recorded on Resolve, the Commission's complaint management system. The Commissioner making suggestions for quality improvement when closing a complaint achieves the second mechanism. To determine the effectiveness of its focus on quality, the Commission decided to monitor quality improvements made through complaints in 2022/23.

Quality Improvement outcomes recorded

In 2022/23, the Commission recorded 18 (compared with 32 in 2021/22) quality improvement outcomes from complaints and enquiries across health, disability and aged care services. Examples of these quality improvements include:

- Policy update to include clearer steps to ending a therapeutic relationship with a patient
- A space with greater privacy identified to be used for intimate procedures
- Closer supervision of patients in early pregnancy
- Improved documentation of special personal care needs
- A reminder to all staff of health and disability providers to ensure the Manager is notified immediately of any customer complaints
- Updated billing terms and conditions to improve clarity and transparency by a service offering psychological counselling
- Availability of long sleeve apparel to prisoners for sun protection including custodial facilities and work camps

The Commission is unable to provide further without divulging the identity of the service providers and/or service users.

Enquiries

Increasing proportion of complaints handled as enquiries

The Commission has continued its focus on resolving matters at the lowest level possible by managing an increasing proportion of matters referred to it as an enquiry. The term 'enquiries' is used to refer to matters dealt with informally. In 2022/23, 93% (compared with 87% in 2021/22) of the 698 matters received were managed as an enquiry.

Some serious matters can be handled informally, and some are handled this way when a prompt outcome is desirable. Factors that are considered when deciding whether to handle a matter informally include whether the issue is current, complexity, risk and the maintenance of relationships.

Increase in enquiries received and closed

Figure 1: Number of complaints and enquiries received 2018/19 – 2022/23

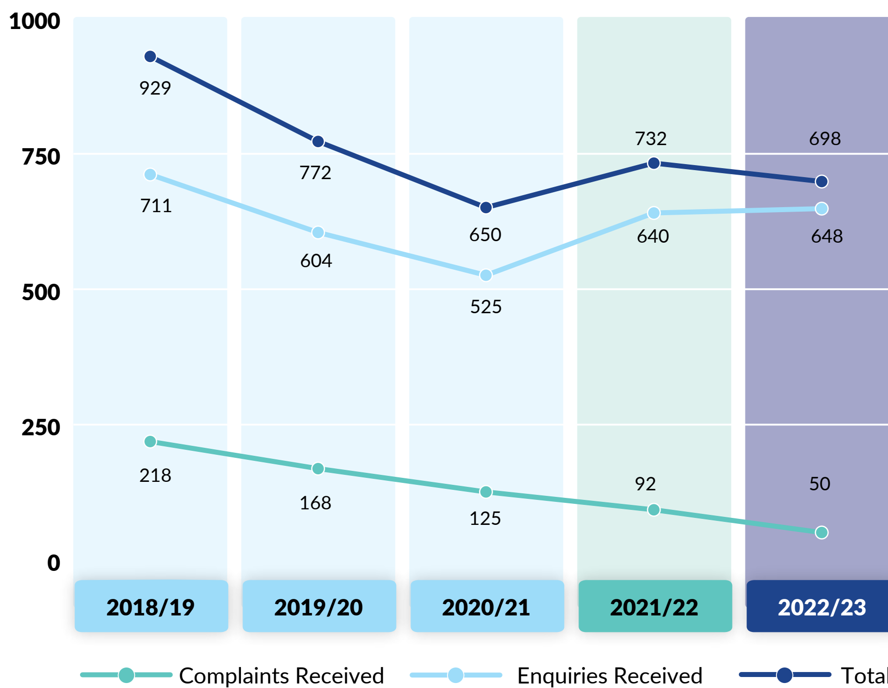


Figure 1 depicts in 2022/23, 648 enquiries were received, an increase of 1% on the 640 received in 2021/22. Our aim is to close enquiries within 14 days. In 2022/23, this goal was achieved in 84% of matters (an increase from the 82% recorded in 2021/22).

Figure 2: Number of complaints and enquiries closed 2018/19 – 2022/23

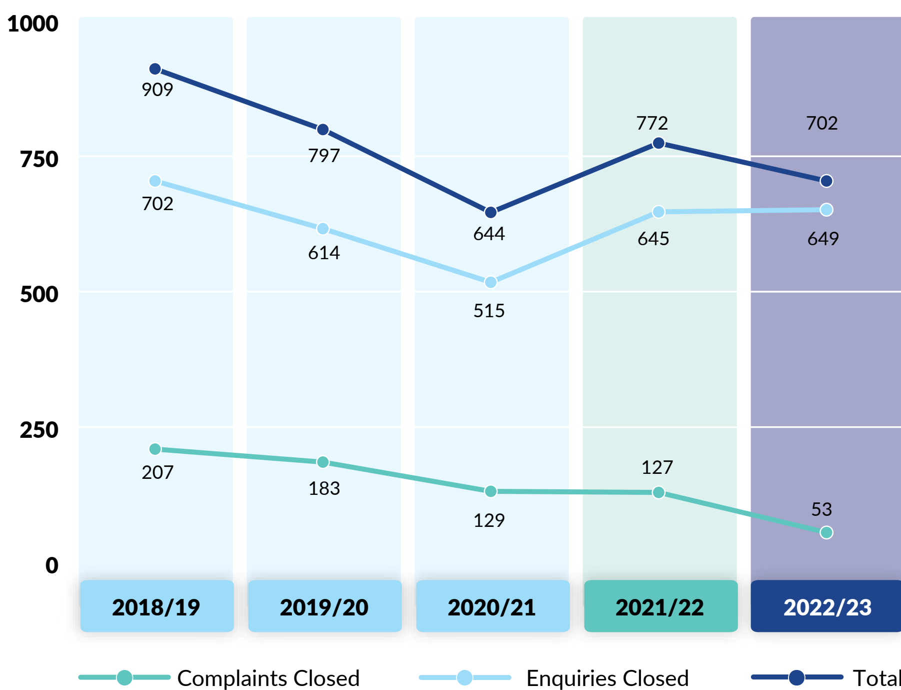


Figure 2 depicts the number of complaints and enquiries closed from 2018/19 until 2022/23. The numbers of complaints fell between 2018/19 and 2020/21, rose for the period 2021/22 and fell again in 2022/23. The earlier drop is believed to have been a result of COVID-19, and the more recent drop a result of the Commission's reduced capacity to carry out community engagement. Part of the purpose of community engagement is to ensure service users are aware of their right to make a complaint and how to do so. It follows that a lower number of complaints will be made in an environment where community engagement has been restricted.

When assessing enquiries, Commission staff may handle several separate issues in the one file. For example, a service user might complain about the billing practice of their GP. If they complain to the Practice Manager about these billing practices and are unhappy with the response and the way it was delivered, they might also complain about the way their complaint was handled. Thus, there would be one enquiry, but two issues.

Table 3: Categories and percentage enquiry outcomes all issues 2020/21 – 2022/23

	2020/21		2021/22		2022/23	
Enquiry Outcomes	**No**	**%**	**No**	**%**	**No**	**%**
Enquiry - information provided	184	24	183	21	**279**	**24**
Enquiry - referred back	285	37	341	38	**441**	**38**
Enquiry - resolved	65	8	97	11	**85**	**7**
Enquiry - other	27	4	48	5	**151**	**13**
Enquiry - referred elsewhere	142	18	127	14	**137**	**12**
Enquiry - referred to HCSCC complaints process	72	9	100	11	**68**	**6**
Total	**775**	**100**	**896**	**100**	**1161**	**100**

Figure 3: Average time to finalise enquiries (days) 2018/19 – 2022/23

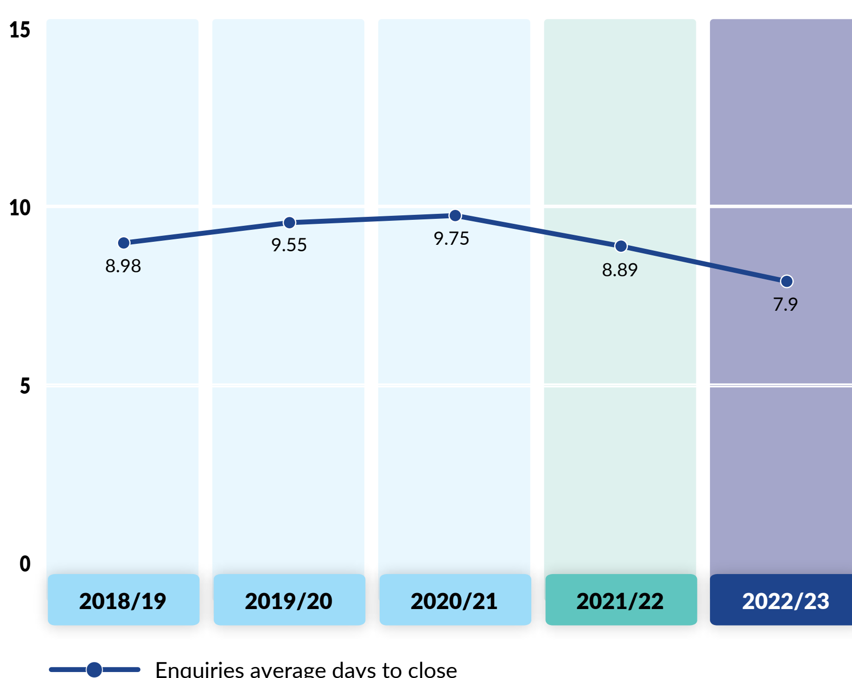


Figure 3 depicts the average time taken to close enquiries for the past five years. This decreased to 7.9 days in 2022/23 compared with 8.89 days in 2021/22 and 9.75 days in 2020/21.

Person-centred approach to enquiries

A person-centred approach requires that Commission staff are aware of the impact of a situation on all parties to a complaint.

Referring back

The Commission has continued referring complaints back for direct resolution. Where a complainant has not attempted to resolve a complaint directly with a service provider, Commission staff will forward the complaint to the provider for a direct response and close the file. Complainants are invited to recontact the Commission if the response they receive does not resolve their complaint. Where a complaint is more serious, the Commission may also request that a copy of the response be provided to the Commission.

Complaints

If a concern cannot be, or is not suitable to be resolved at enquiry level, it is dealt with as a complaint. Commission processes for assessing and resolving complaints have gradually changed over time, so that while a formal structure is retained, there is also the flexibility to adapt processes to fit the needs of individual parties and circumstances. With every complaint, staff of the Commission will consider how it might best be resolved, keeping in mind the goal of resolving all complaints as informally and quickly as possible.

Complaint numbers each year comprise complaints received by the Commission and notifications received by Ahpra. In 2022/23, the Commission closed 53 complaints (29 received by the Commission and 24 received by Ahpra). Every complaint contains at least one complaint issue, with some large and complex complaints containing many more. The number of complaint issues will therefore always be greater than the number of complaints. In 2022/23, outcomes were recorded for 106 issues in the 53 matters finalised. This is less than the 288[1] issues assessed in 2021/22.

1 2021/22 was reported incorrectly as 382 issues assessed, see appendix one for details.

Timelines

In 2022/23, 87% of complaints were closed within 180 days, which exceeds the KPI of 80% complaints closed in this period and is a significant improvement on results of 75% in 2021/22. This is attributable to staffing changes and is a testament to the hard work of the two staff at Investigator and Senior Investigator levels.

Figure 4: Time taken to finalise complaints (average days) 2018/19 – 2022/23

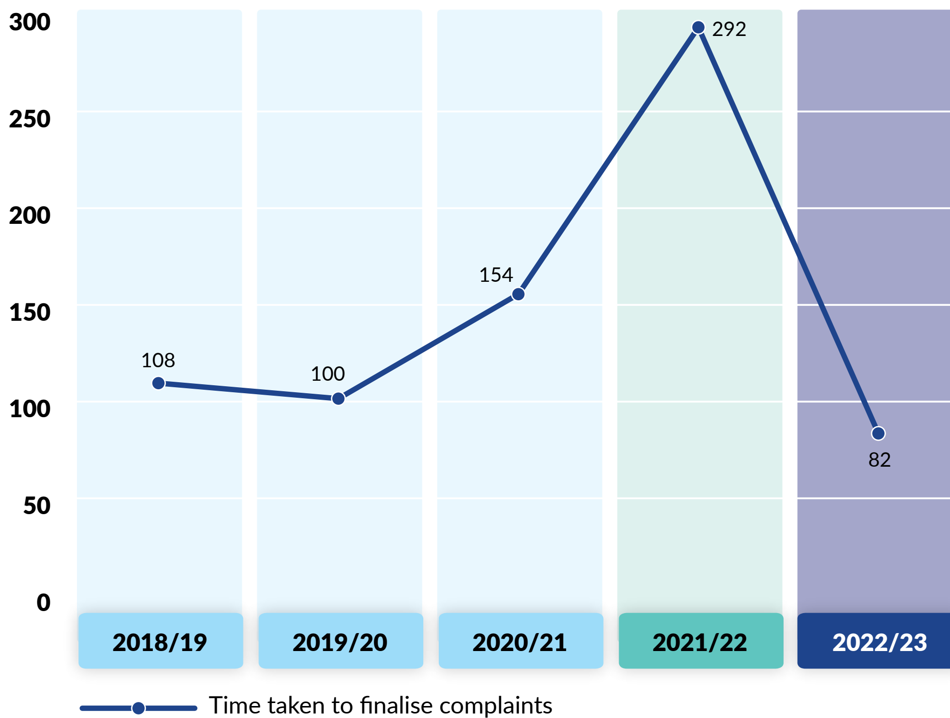
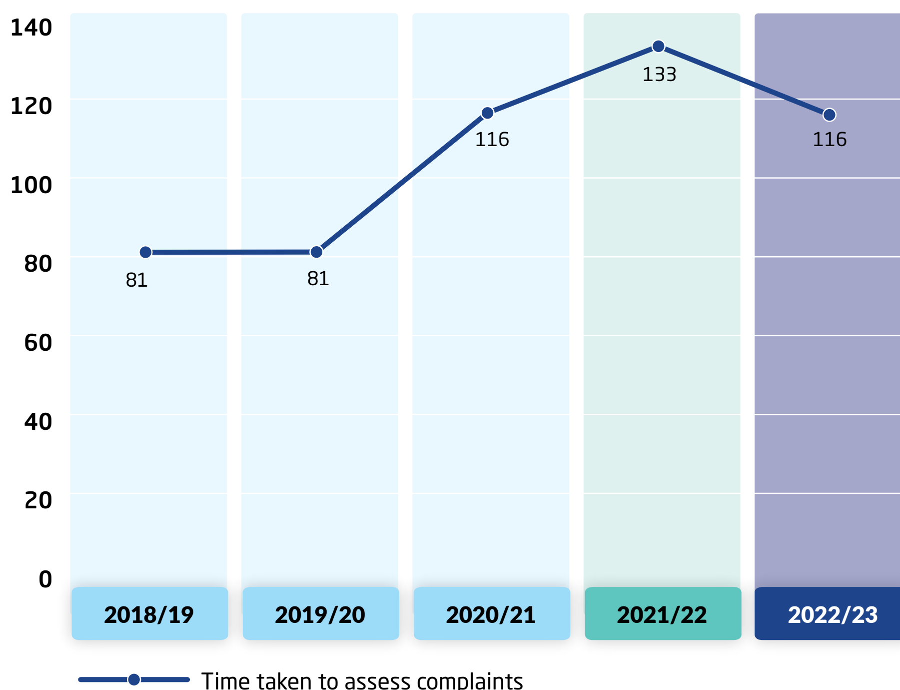


Figure 5: Time taken to assess complaints (average days) 2018/19 – 2022/23[2]



In 2022/23, 50% of complaints (which also includes Ahpra notifications) were assessed within 60 days as required by section 27(1) of the Act. This fell below the Commission's KPI of 80% although improved compared with 40%[3] achieved in 2021/22. The average number of days taken to finalise complaints improved very significantly from 292 days in 2021/22 down to 82 days in 2022/23. This can be attributed to prompt consultation between Ahpra and the Commission to determine which body will manage the complaint or notification and staffing changes which have improved efficiency in the management of complaints.

A number of factors can impinge on timeliness. They include complexities in the complaint itself, and complexities which arise during the assessment of a complaint. Cases where a complainant is suffering from physical or mental illness which delays or complicates communication, or a provider requires significant additional time to provide a response due to staffing issues. There are also often delays over Christmas when organisations (including the Commission) are short staffed.

2 Figure 5 excludes notifications which were retained by Ahpra at consultation and therefore did not proceed to assessment by the Commission. This explains why average days to assess (figure 5) is greater than time to finalise (figure 4).

3 2021/22 was reported incorrectly as 68% of complaints assessed within 60 days.

Commissioner's decision

Section 27 of the *Health and Community Services Complaints Act*, requires the Commissioner to make one of four decisions after assessing a complaint. The Commissioner can refer a matter to conciliation, refer a registered provider to a National Registration Board, take no further action under section 30 of the Act or investigate the complaint. If a matter is not suitable for conciliation and if there is no registered provider (or if a complaint about a registered provider was referred to Ahpra for assessment), the Commissioner is left with two options; refer the matter to investigation or take no further action. A matter is referred to investigation only if it meets requirements set out in section 48 of the Act; that is if there appears to be a significant issue of public health or safety or public interest; or a significant question as to the practices and procedures of a service provider. Investigations are resource intensive, and for this reason, a very small proportion of matters are managed this way.

The Commissioner consistently decides to take no further action with a significant proportion of complaint issues. In 2022/23, the Commissioner decided to take no further action with 65% of complaint issues, being an increase on the 56% recorded in 2021/22. Complaints are not referred to conciliation unless the Commission is confident parties will behave in an appropriate manner and conciliation offers the prospect of resolution. The planning and holding of a conciliation requires the allocation of significant staff resources by the Commission and the provider. One complaint was referred to conciliation in the 2022/23 period. One investigation was completed during the 2022/23 period and two were in progress.

In 2022/23, 9% of complaints were closed with no further action because they were resolved, compared with 19% in 2021/22 being a significant decrease. One likely explanation for this is that as fewer complaints are managed formally (as a complaint rather than enquiry) the complexity and seriousness of those complaints increases as does the likelihood of them being intractable. In such cases a complainant may have been provided with an explanation and apology, and system improvement may have also occurred, however the complainant may not consider the issue resolved.

Table 4: Reasons for closure - Issues closed 2020/21 – 2022/23

Reason for Closure	**2020/21**	**2021/22**	**2022/23**
Conciliation complete	2	0	**1**
Dealt with by Board	90	63	**25**
Investigation Complete	9	4	**1**
Referred to Board	8	10	**3**
No further action	121	145	**70**
Referred to other entity	20	2	**8**
Total	**250**	**224**	**108**

Table 5 below demonstrates that the primary reason for no further action was that further investigation was unnecessary and/or unjustified. The number of issues closed due to the issue being resolved dropped from 28 to 5. This likely to be partly due to a decreasing number of complaints being managed formally (increased management as an enquiry) and the higher complexity, seriousness and intractability of those complaints. For example, where a complaint relates to care provided to a subsequently deceased relative, the grief associated with the perspective of the complainant may overshadow a valid clinical explanation. In other cases a service may have acknowledged deficits in case and implemented systemic improvements in which case further investigation may be unnecessary or unjustified. An issue is only recorded as resolved if it is considered resolved by the complainant.

Complainant cooperation and engagement is essential to the Commission's process, and when a file is closed due to required information not being provided by a complainant, they are advised that they may recontact the Commission should they wish to reengage in the future subject to the two year limitation period.

Table 5: Reason for no further action - Issues closed 2020/21 – 2022/23

Reason for No Further Action	2020/21	2021/22	2022/23
No basis for complaint /Out of Jurisdiction	2	7	**2**
Complaint over 2 years old	0	0	**7**
Failure to reasonably resolve with provider	5	5	**1**
Further investigation unnecessary and/or unjustified	68	89	**42**
Complaint lacks substance	0	0	**0**
Complaint is resolved	26	28	**5**
Complaint determined by a court, tribunal or board	3	0	**0**
Civil proceedings commenced	1	0	**0**
Required information not received	8	10	**5**
Complaint has been withdrawn	8	6	**8**
Total	**121**	**145**	**70**

Consultations with Ahpra

Section 68 of the Act states that if the Commission receives a complaint about someone classified as one of the health professions which comprise registered providers, the Commissioner must notify the relevant Board as soon as practicable after the complaint is received. Similarly, section 150(1) of the *Health Practitioner Regulation National Law Act 2009* (National Law) provides that if the subject matter of a notification received by Ahpra falls within the jurisdiction of the local health complaints entity, the National Board must notify the health complaints entity accordingly.

The requirements of these two pieces of legislation are met through consultation between the Commission and Ahpra. Through these consultations, a joint decision is made regarding the agency best suited to manage complaints and notifications about registered providers.

As a result of these consultations, the Commission referred 3 complaints about registered providers to the relevant Board for assessment in 2022/23.

Notifications received by Ahpra may be also be referred to the Commission for management. In 2022/23, this occurred on four occasions when the complaint was generally about lower risk behaviour and the outcomes sought could be better achieved in the Commission's jurisdiction.

Conciliations

One option available to the Commission to assist parties to resolve complaints is conciliation. Conciliation is a form of alternate dispute resolution in which parties come together to discuss the issues of complaint in a confidential environment with the aim of settling the dispute. It is a voluntary, flexible process. Its purpose is to act as an alternative to medico-legal processes, often resulting in explanations provided to parties, along with apologies where appropriate. In many cases, agreements reached through conciliation can lead to improvements in services, even resolving issues that are assessed as potentially affecting public safety and avoiding a time consuming and costly investigation. In 2022/23, one matter was referred to conciliation.

Investigations

One investigation completed in 2022/23

The Commissioner may decide to investigate a complaint, or series of complaints, which raise significant issues of public health or safety, or public interest. Investigation is a formal process during which the Commissioner may interview people involved and obtain documents.

One of the main aims of an investigation is to look into systemic issues and identify areas for service improvement. At the conclusion of an investigation, the Commissioner will make findings and may make recommendations for action or change. Where a recommendation is made, the party concerned will be advised of the recommendations and reasons for the decision. The provider is then required to advise the Commissioner of action to be taken to comply with the recommendation and the Commission monitors implementation of the recommendations to ensure that undertakings are

met and improvements made. An investigation is a major body of work and is difficult for Investigation/Conciliation Officers to complete when there are competing priorities such as responding to enquiries and complaints. In 2022/23 the Commission left one Investigator/ Conciliator position vacant due to inability to fund it following budget cuts. The threshold for referral to investigation has been raised as a result, as staff struggle to carry investigations in addition to large numbers of incoming complaints. In 2022/23, the Commission finalised one investigation and there were two in progress.

Policy role

National Code of Conduct for unregistered health practitioners

In April 2015, Australian Health Ministers issued a Communique announcing their intention to give effect to a code regulation regime for all health care workers not registered under the National Registration and Accreditation Scheme for health practitioners. The National Code of Conduct sets standards for expected conduct and practice for unregistered health workers to be implemented consistently in each State and Territory. A Code regime has been implemented in Queensland, New South Wales, Victoria, South Australia, Western Australia and the Australian Capital Territory. The National Code of Conduct has been passed by parliament in Tasmania, but not yet received proclamation. The Northern Territory has a draft Bill which would establish a code regulation scheme, with the model largely based on that which currently operates in South Australia. The National Code has not yet been enacted in the Northern Territory.

Essentially, this code would apply to the health practitioners (such as masseurs, personal care attendants, social workers and some therapists) who are not registered by one of the 15 National Boards which comprise Ahpra, (for instance nurses, medical practitioners and dentists). The various occupations covered by this code are also commonly those which provide services to people with disabilities.

Once introduced, the Commission is expected to have authority to issue orders prohibiting unregistered health and community service providers from practising in a way which is unsafe, limit scope of practice or prohibit practice altogether. This will strengthen the capacity of the Commission to ensure the safety of service users.

In the coming year, it appears that all Australian jurisdictions with the exception of the NT will have instituted a *Code of conduct for Health Care Providers*, as decided at the COAG Health Ministers' meeting in 2015. This gap in the national approach to regulating this sector is potentially a source of problems in this jurisdiction and perhaps nationally. The Commissioner has referenced this matter in previous annual reports and it will not be expanded further here, suffice to say, again, that operationalising this code is not possible with current resourcing.

THE YEAR AHEAD: 2023/24

The team meets annually to decide on priorities for the upcoming year within the constraints of the Strategic Plan. Factors which determine priorities for the coming year include the core business of the Commission, outcomes of the Commission's performance indicators, and the policy environment in which the Commission operates.

Finalising investigations

One investigation was completed in 2022/23. The Commission has substantially raised its threshold for referral to investigation as a result of budget cuts which have reduced current Conciliators/Investigators from three to two. There are two investigations on foot and it is expected that at least one of these will be completed in 2023/24.

Updating policy

The Commission planned to update the investigations section in the Policy and Procedures Manual. The Deputy Commissioner and Resolution Officer did not complete this due to resourcing issues and a redirection of focus to redevelopment of the website. Updating the Investigations section of the Policy and Procedures Manual is a large task and remains a focus.

The Office Manager and Resolution Officer continued the process of developing a procedure manual for the numerous tasks which make up their roles. Whilst this was not completed, very substantial progress was made given the large amount of work involved in this task. Completion is impacted by the Office Manager position being half time. The procedure manual for the numerous tasks carried out by the Resolution Officer and Officer Manager is expected to be finalised in the 2023/24 financial year.

Improving accessibility

In 2022/23 the Commission intended to undertake consultation and develop a strategy to raise awareness of the Commission's role and improve accessibility amongst Indigenous service users. The Commission has not previously recorded which service users are Indigenous, however intends to commence recording this data in 2023/24. Development of consultation and strategy to more effectively engage with Indigenous service users was not achieved in 2022/23 due to competing priorities and budget restraints, and remains a focus for 2023/24.

National Code of conduct for unregistered health practitioners

The National Code of conduct is operational in Queensland, New South Wales, Victoria, South Australia, Western Australia and the Australian Capital Territory. The National Code of Conduct has been passed by parliament in Tasmania, but not yet received proclamation.

Legislative change to enable implementation of the regime has not yet been passed in the Northern Territory.

Chapter 3: Promote Capacity and Improve Systems

ACHIEVEMENTS 2022/23

Coaching

When approached with a complaint, the Commission will always determine whether the service user has made a reasonable attempt to resolve the complaint first. If not, the complainant will generally be asked to try to resolve their complaint directly with the service provider. The Commission's experience is that people who contact the Commission with a complaint are often quite happy to try to resolve their complaint this way, but do not do so because they don't quite know how to go about it. Commission staff will coach service users in how to go about making a complaint.

Coaching is also provided to service providers at enquiry stage to assist with direct resolution of matters and when a complaint is being assessed with a view to skills learned being adaptable to future complaints.

Management by the most appropriate complaints body

Table 6 below details the number of complaints about disability services, mental health services and aged care services over the past five years, which were managed formally. Contacts about aged services are consistently low because almost all aged care complaints are managed by the Aged Care Quality and Safety Commission. In 2022/23, the Commission managed one complaint about a disability service through its formal complaints process. The NDIS Quality and Safeguards Commission is responsible for managing complaints from participants who receive services from NDIS funded service providers. The Commission is able to receive complaints about services for people with a disability irrespective of funding source. In practice, the Commission refers complaints about NDIS funded services to the NDIS Quality and Safeguards Commission.

Table 6: Aged, disability and mental health services complaints 2019/20 – 2022/23

Provider Type	2019/20	2020/21	2021/22	2022/23
Disability Services	0	0	1	**1**
Mental Health Services	24	14	7	**7**
Aged Services	2	1	2	**0**
Total	**26**	**15**	**10**	**8**

The data in **Table 7** below demonstrates that low numbers of enquiries were received about disability and aged care services. This is because the NDIS Quality and Safeguards Commission is responsible for managing complaints from participants who receive services from NDIS funded service providers and the Commonwealth Aged Care Quality and Safety Commission manages most complaints about aged care services. The Commission dealt with seven complaints and 74 enquiries about mental health services. Many people with grievances about mental health services choose to lodge their complaint with the Community Visitor Program (CVP).

Table 7: Aged, disability and mental health service enquiries 2019/20 – 2022/23

Provider Type	2019/20	2020/21	2021/22	2022/23
Disability Services	18	11	15	**17**
Mental Health Services	42	23	55	**74**
Aged Services	17	8	11	**13**
Total	**77**	**42**	**81**	**104**

Prison Primary Health Care Service (PPHCS)

Prisoners at Darwin Correctional Centre (DCC) and Alice Springs Correctional Centre (ASCC) are able to contact the Commission to raise concerns about the health services they receive via an unmonitored phone line. In 2022/23, 192 enquiries (including 37 enquiries about the health care service at ASCC and the balance at DCC) were received.

Table 8: Number and proportion of enquiries about PPHCS 2018/19 – 2022/23

Year	Number	Proportion of all enquiries
2018/19	156	22%
2019/20	171	28%
2020/21	161	31%
2021/22	153	24%
2022/23	**192**	**30%**

Table 8 above details the number of contacts from prisoners. TERHS and CARHS have processes enabling prisoners to lodge complaints about the prison health clinics directly with the service. Prisoners complete a feedback form available on the prison block and are provided with a response. If no response is received, or the response does not resolve the concern, the prisoner may lodge a complaint by phone with the Commission. This process of direct resolution initially resulted in a continuing drop in the proportion of enquiries received from prisoners. However the proportion rose from 24% in 2021/22 to 30% in 2022/23.

Prescribed provider reports

Providers prescribed in Schedule 7 of the *Health and Community Services Complaints Regulations* (the Regulations), in accordance with section 99 of the Act, are required to provide details of complaints received during the financial year by a date determined by the Commissioner. Prescribed providers for this purpose as set out in Schedule 7 of the Regulations are:

- Anyinginyi Congress Aboriginal Corporation
- Central Australian Aboriginal Congress Incorporated
- Danila Dilba Biluru Butji Binnilutlum Medical Service Aboriginal Corporation
- Miwatj Health Aboriginal Corporation
- Wurli Wurlinjang Aboriginal Health Service
- Darwin Private Hospital Pty. Ltd.
- Northern Territory Health Services (now NT Health)

The organisations required to lodge provider returns under the Act made up the largest provider organisations when the Act was passed in 1998. Neither the prescribed provider list, nor any other aspect of the Act has been updated since its introduction. As a result, important organisations are missing from this list. They include the Katherine West Health Board, Sunrise Health Service and a number of large disability organisations.

In 2022/23 details of complaints received by prescribed provider organisations were not requested by the Commissioner. The rationale for this was that the prescribed provider list is no-longer representative of large providers in the Territory, which restricts the usefulness of the data. The Commission is also conscious of the pressures faced by health and community services providers, and does not wish to add to this unnecessarily. The Act is currently under review and it is expected that deficits in this section of the Act will be addressed when the Act is amended.

THE YEAR AHEAD 2023/24

Maintain work with disability sector

In the coming year, the Commission will continue to work with the NDIS Quality and Safeguards Commission to increase participation from the disability sector in complaints processes, ensuring that there will be 'no wrong door' and that any person contacting either Commission will be referred to the agency best able to manage the complaint.

Access to the Commission website

Anyone can access the Commission through its website at hcscc.nt.gov.au. The website has links to our on-line complaint form, information that includes the latest Annual Report and brochures, complaints handling training, the Guide to Complaints Resolution and our legislation. Website access increased 6% in 2022/23 when compared with the year 2021/22.

Updating the Commission's website

Updating the Commission's website was commenced during the 2020/21 financial year and was almost complete at the end of 2022/23. The website needs to be replaced as it does not meet NT Government website requirements and requires updating. This very large task is being coordinated and managed by the Office Manager and Deputy Commissioner.

Updating information and handouts

A review of all Commission templates and handouts commenced in 2020/21 and is ongoing. This process includes updating information about all the Commission's functions, including conciliation handouts to ensure they are accurate and user friendly. Information sheets and outcome letters will be reviewed to ensure that reasons for decisions can be easily understood.

Ongoing coaching of complainants and service providers

Resolving complaints requires some skill and willingness by service providers and service users. As stated earlier in this report, Commission staff, when referring a complainant back to resolve their complaint at point of service, will when possible provide coaching to assist this process. Coaching addresses the best person to contact with their issue and how to prepare for this contact (for example, being clear about the complaint and what they hope to achieve from it). Similarly, service providers can contact the Commission for advice on how to manage existing or potential complaints.

There is already helpful information on the Commission's website to assist parties when they are making a complaint or responding to complaints. This information has been reviewed as part of the website update.

Table 9: Website access 2017/18 – 2022/23

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Total visits	5072	6155	6066	6277	6651	**7019**

Chapter 4: Governance and Resource Management

Health and Community Services Complaints Review Committee

Sections 78-84 of the Act set out the establishment, role and functions of the HCSCC Review Committee. Section 79 sets out its powers and functions as follows: to review the conduct of a complaint to determine whether procedures were followed and to make recommendations to the Commissioner; to monitor the operation of the Act and make recommendations to the Commissioner; and to advise the Commissioner and Minister on the operation of the Act and Regulations.

When a complaint is closed, all parties to a complaint (with the exception of NT Health) are informed in writing of the right to have the conduct of the complaint reviewed by the HCSCC Review Committee established under Section 78 of the Act.

During 2022/23 there was no HCSCC Review Committee in place. The term of the previous committee lapsed in March 2022 and as at 30 June 2023 the Minister had not appointed a new committee. During the period where there was no Review Committee in place, a number of requests for review were lodged via the committee email inbox for action on appointment of the new committee.

ACHIEVEMENTS 2022/23

The year 2021/22 has been a challenging but rewarding one for the Commission. Reversion of the Office Manager position in the previous financial year (which provides vital support to the Deputy Commissioner in particular) back to half time from full time continues to have a significant impact. One Senior Investigator/Conciliator position has been left vacant due to inability to fund it from the Commission's budget. The need to prioritise complaints handling has increased pressure on the remaining two Investigators/Conciliators and severely curtailed capacity to undertake project work, investigations and conciliations. Redevelopment of the Commission's non-compliant website which has been underway for the previous few years is almost complete and will be a vast improvement. The Commission has also taken this opportunity to rebrand. The Commission continued to work effectively with service users and providers in conducting its core business.

THE YEAR AHEAD 2023/24

The Commission remains a learning organisation

The Commission offers a quality service by ensuring that staff are properly trained, and that they provide a consistent service that is courteous and empathetic to all parties.

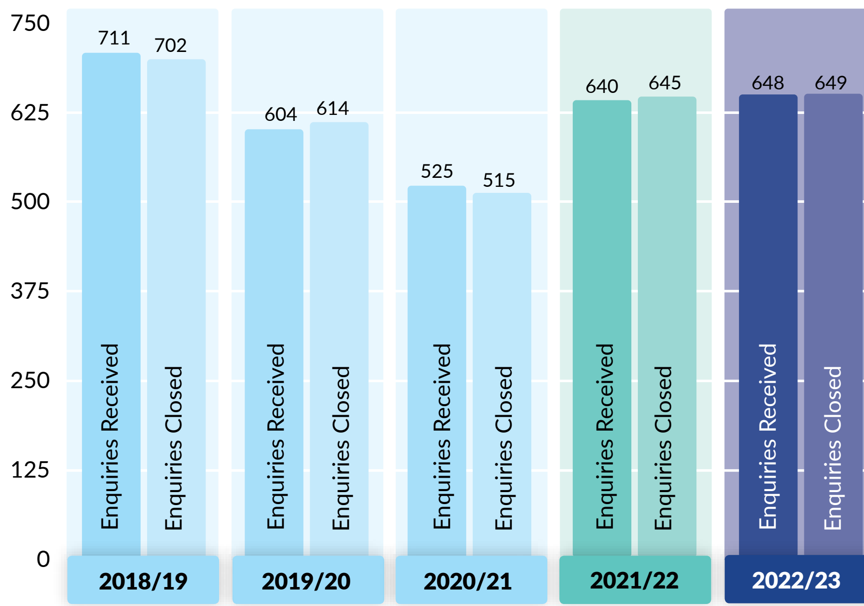
In 2022/23, staff undertook performance evaluation reviews to set work goals and identify development needs and training required. Monthly staff meetings are held at which updates can be provided in relation to the Commission's activities and discussion occurs regarding themes and emerging issues in the health, disability and aged care sectors.

Appendix 1: Performance

Enquiries / informal complaints

In 2022/23, the Commission received 648 enquiries and closed 649. This is higher than the number received and closed in 2021/22 and 2020/21.

Figure 6: Enquiries received and closed 2018/19 – 2022/23



Although the majority of enquiries do not become formal complaints, they represent a substantial proportion of the Commission's workload.

Public providers accounted for 66% of the providers about whom enquiries were received in 2022/23, which is only very slightly lower compared to 65% received in 2021/22.

Table 10: Providers subject of enquiries 2018/19 – 2022/23[4]

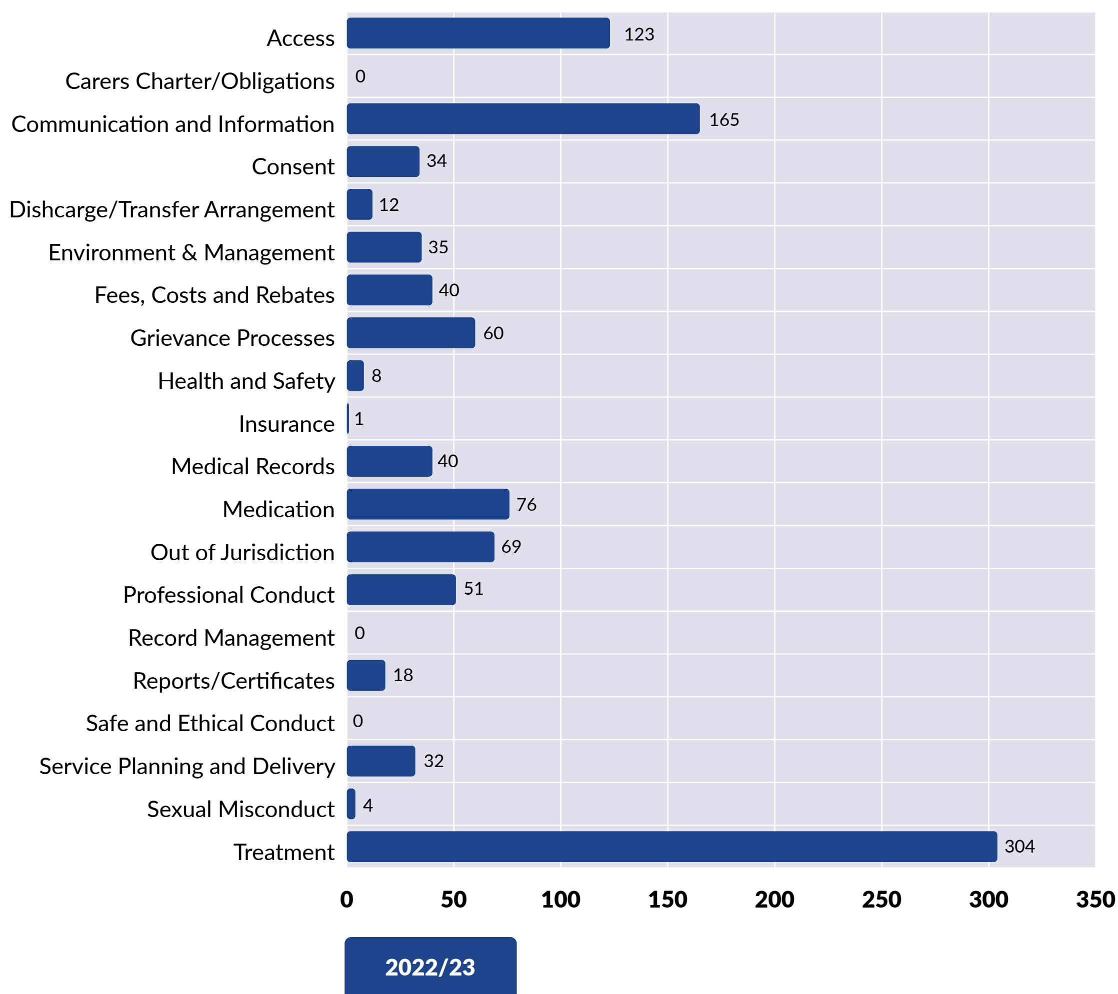
Providers	2018/19	2019/20	2020/21	2021/22	2022/23
Private	207	180	183	257	**258**
Public	559	468	392	478	**514**
Total	**766**	**648**	**575**	**735**	**772**

4 Table 11 includes all providers within each case and multiple service providers can be included within the one enquiry. This explains why the number of service providers is greater than the number enquires received.

Issues raised in enquiries

Often more than one issue is raised per enquiry, 1072 issues were dealt with when assisting with the 648 enquiries received. The most common issues raised and dealt with through our enquiry process were standard of treatment, access to services, communication and information, and medication. Sixty-nine issues were out of jurisdiction. Out of jurisdiction enquiries include contacts from prisoners where it is assessed that the issue relates to correctional rather than health issues, enquiries about environmental health issues and people seeking general information. The Commission has a 'no wrong door' policy, and ensures that every enquiry receives some consideration, ensuring that the caller is provided with the information needed.

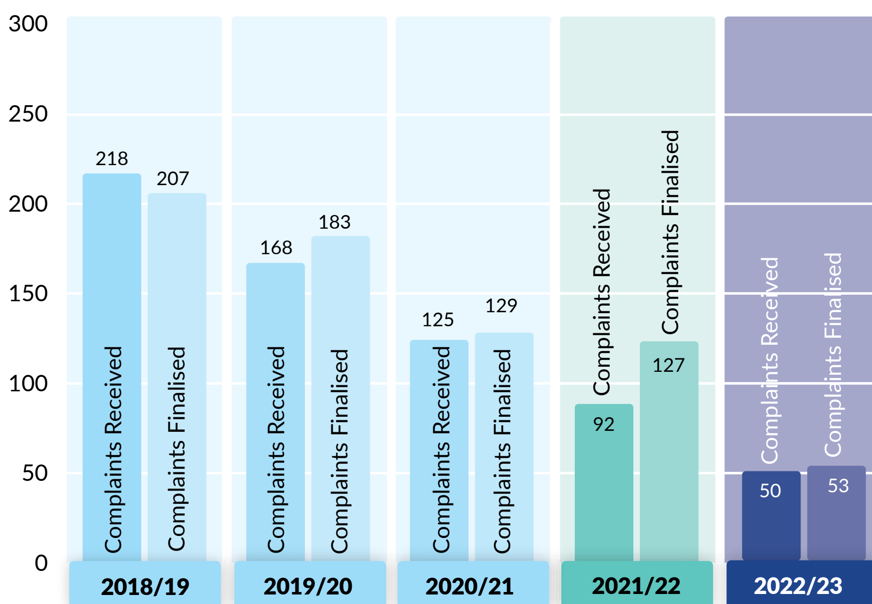
Figure 7: Issues raised in enquiries closed 2022/23



Complaints

Fifty new complaints were received in 2022/23, representing a 46% decrease on the number received in the previous year. This significant decrease reflects the Commission's approach of increasingly managing complaints informally as enquiries where proper consideration of the matter permits.

Figure 8: Complaints received and closed 2018/19 – 2022/23

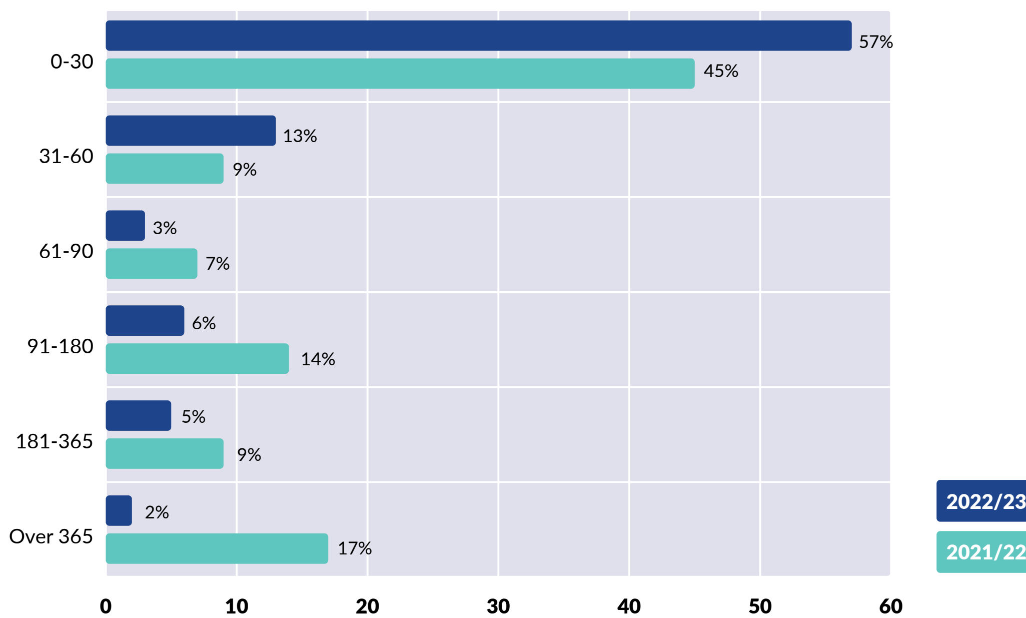


Time taken to finalise complaints

The average time taken to finalise complaints[5] (where complaints include complaints received by the Commission and notifications received by Ahpra subject to consultation with Commission) decreased from an average 292 days in 2021/22 to 85 days in 2022/23. This is partly due to greater efficiency as fewer complaints are managed formally. This result can also be attributed to staffing changes during the 2022/23 year and is a testament to the hard work of current staff.

5 Time taken to finalise complaints is measured from the date it is entered on Resolve to the date it is closed, and may include additional actions including investigations and conciliations.

Figure 9: Percentage complaints closed and timeframes 2021/22 and 2022/23

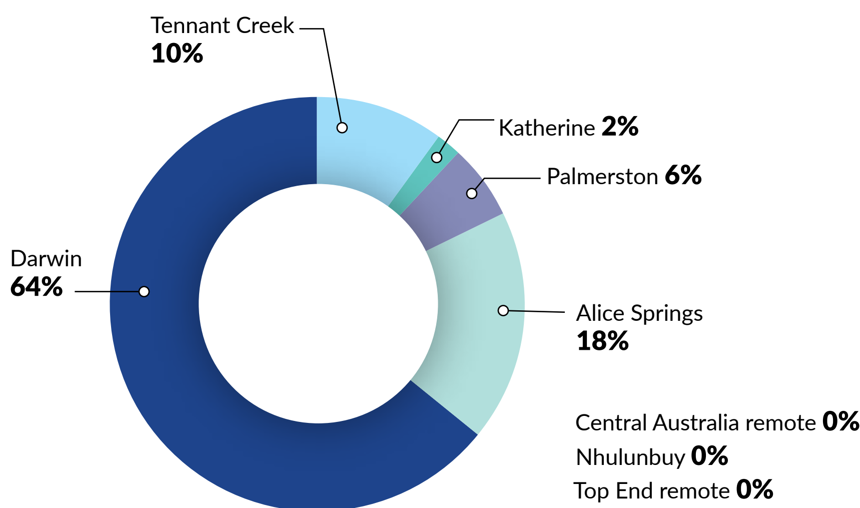


In 2022/23, 87% of complaints were closed within 180 days. The benchmark for closure within 180 days is 80%.

Location of services complained about

As expected, the majority of services subject to a complaint were located in Darwin (64%), a slight increase from 59% 2021/22. The percentage of complaints received about services in Alice Springs and Palmerston remained the same for 2022/23 when compared with 2021/22 being 18% and 6% respectively.

Figure 10: Location of services 2022/23



How are complaints received?

Where the complaint is made by phone, the complainant may asked to confirm it in writing. Where a complainant is unable to confirm a complaint in writing, the Commission may assist them to reduce it to writing and provide a copy to the complainant.

In 2022/23, of the 27 complaints (that is complaints received and subsequently managed formally) made directly to the Commission, 66% of complainants approached the Commission by electronic means (4% by email and 62% via the Commission website), 19% by phone and 15% were received by mail.

What services are complained about?

For the purpose of this report, organisational and individual providers are counted only once in each complaint even though there may be multiple issues against each; however, the same provider may be involved in several complaints and in this sense is counted several times.

In 2022/23, there were a total of 143 providers involved in the 50 complaints[6] received by the Commission. Of these, 74 (52%) were public providers and 69 (48%) were private.

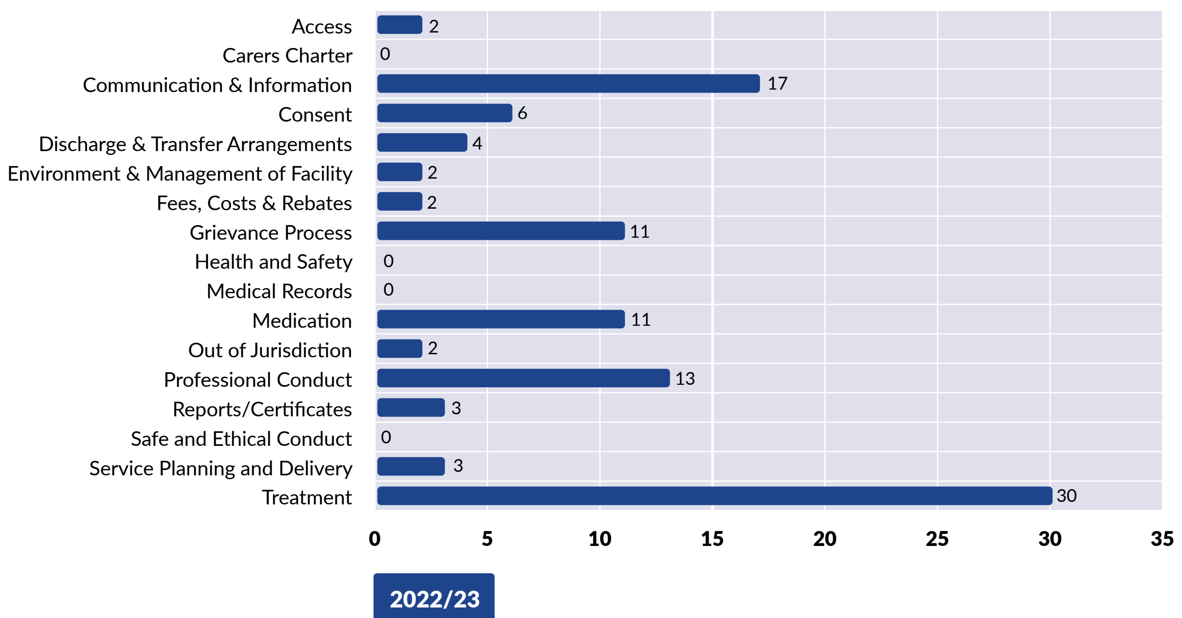
What issues are complained about?

Each issue described in individual complaints received by the Commission is recorded for reporting purposes, with some complaints raising more than one issue. Issue categories are used relatively consistently across Australia to allow for comparison. In 2022/23, a total of 106 issues were assessed.

Issues are recorded against all complaints received by the Commission, including Ahpra notifications. This method of reporting allows for a more complete picture of the types of issues complained about in the NT.

The top three issues of treatment, communication and professional conduct, remain consistent year on year. Serious conduct matters are generally dealt with by the National Health Practitioner Boards.

Figure 11: Issues raised in complaints closed 2022/23



6 Comprising complaints received by the Commission managed formally and notifications received by Ahpra.

A further breakdown of each of the categories of complaint issue and a comparison with previous years can be found below. The breakdown does not include the six issues assessed as out of jurisdiction.

In 2021/22 data relating to complaint issues and its subcategories was reported incorrectly. The figure below provides the correct data in the complaints column correlating to the data fixes in tables 12-25 in the following section.

2021/22	Complaints	Ahpra	Total #
Treatment	100	14	**114**
Service Planning and Delivery	6	1	**7**
Safe and Ethical Conduct	0	0	**0**
Reports/Certificates	2	2	**4**
Professional Conduct	27	26	**53**
Out of Jurisdiction	13	8	**21**
Medication	14	8	**22**
Medical Records	4	0	**4**
Health and Safety	1	0	**1**
Grievance Process	19	2	**20**
Fees, Costs & Rebates	1	0	**1**
Environment & Management of Facility	10	1	**11**
Discharge & Transfer Arrangements	6	0	**6**
Consent	25	9	**34**
Communication & Information	46	18	**64**
Claims to Cure or Treat	0	0	**0**
Carers Charter	0	0	**0**
Access	14	6	**20**
Total	**288**	**94**	**382**

Table 11: Complaints about access 2018/19 – 2022/23

ACCESS	2018/19	2019/20	2020/21	2021/22[7]	2022/23
Access to facility	1	0	7	1	**1**
Access to subsidies	3	2	2	1	**0**
Refusal to admit or treat	5	3	3	5	**1**
Service availability	5	7	4	2	**0**
Waiting list	1	0	1	5	**0**
Total	**15**	**12**	**17**	**14**	**2**

Issues relating to access made up 2% of all issues raised in complaints in 2022/23. Concerns about access to services, however, comprised 11% of all enquiry issues, largely due to the high proportion of contacts from prisoners and waiting lists for outpatient appointments.

7 As previously noted, this subcategory was reported incorrectly in the 2021/22 report

Table 12: Complaints about carers charter 2018/19 – 2022/23

CARERS CHARTER	2018/19	2019/20	2020/21	2021/22	2022/23
Obligations to carers not met	0	0	1	0	**0**
Total	**0**	**0**	**1**	**0**	**0**

This issue is included because section 23(1)(k) of the Act specifically refers to service provider obligations to meet the expectations of the NT Carers Charter as set out in the Regulations to the *Carers Recognition Act*.

Table 13: Complaints about communication & information 2018/19 – 2022/23

COMMUNICATION & INFORMATION	2018/19	2019/20	2020/21	2021/22[8]	2022/23
Attitude and manner	24	36	26	22	**12**
Inadequate information provided	17	23	19	17	**5**
Incorrect/misleading information provided	5	4	9	6	**0**
Special needs not accommodated	4	5	3	1	**0**
Total	**50**	**68**	**57**	**46**	**17**

Issues relating to communication and information made up 16% of all issues complained about, remaining the same as the previous financial year.

Table 14: Complaints about consent 2018/19 – 2022/23

CONSENT	2018/19	2019/20	2020/21	2021/22[9]	2022/23
Consent not obtained or inadequate	7	4	4	22	**4**
Involuntary admission or treatment	0	3	3	2	**2**
Uninformed consent	3	1	1	1	**0**
Total	**10**	**8**	**8**	**25**	**6**

Issues relating to consent constituted 6% of all issues complained about in 2022/23. This is a decrease when compared with 9% in 2021/22.

8 ibid

9 As previously noted, this subcategory was erroneous in the 2021/22 report

Table 15: Complaints about discharge and transfers 2018/19 – 2022/23

DISCHARGE & TRANSFERS	2018/19	2019/20	2020/21	2021/22	2022/23
Delay	1	0	0	1	**0**
Inadequate discharge	9	5	4	4	**4**
Mode of transport	1	1	3	1	**0**
Patient not reviewed	1	0	2	0	**0**
Total	**12**	**6**	**9**	**6**	**4**

4% of issues raised in 2022/23 related to discharge and transfer arrangements. This is a slight increase from 2% in the previous financial year.

Table 16: Complaints about environment & management of facility 2018/19 – 2022/23

ENVIRONMENT & MANAGEMENT	2018/19	2019/20	2020/21	2021/22[10]	2022/23
Administrative processes	6	2	3	2	**1**
Cleanliness/hygiene of facility	2	1	4	1	**0**
Physical environment of facility	4	4	1	0	**0**
Staffing and rostering	0	1	0	1	**0**
Statutory obligations/ accreditation standards not met	4	6	2	4	**1**
Resources	0	0	1	2	**0**
Workforce issues/Staff related issues	5	3	2	0	**0**
Total	**21**	**17**	**13**	**10**	**2**

Complaints in this category relate to administration rather than the care/treatment component of the service. These issues made up 2% of all issues raised in complaints, which is a slight decrease from 3% in the previous financial year.

Table 17: Complaints about fees, costs & rebates 2018/19 – 2022/23

FEES, COSTS & REBATES	2018/19	2019/20	2020/21	2021/22	2022/23
Billing practices	7	5	3	0	**2**
Cost of treatment	0	2	4	1	**0**
Financial consent	1	1	0	0	**0**
Total	**8**	**8**	**7**	**1**	**2**

Issues relating to cost of service constituted 2% of issues in complaints in 2022/23.

10 Ibid

Table 18: Complaints about grievance procedures 2018/19 – 2022/23

GRIEVANCE	2018/19	2019/20	2020/21	2021/22[11]	2022/23
Inadequate/no response to complaint	15	11	16	17	**9**
Information about complaint procedure not provided	1	0	0	0	**0**
Reprisal/retaliation as a result of complaint lodged	1	0	0	1	**2**
Total	**17**	**11**	**16**	**18**	**11**

Issues related to grievance procedures and complaint handling made up 10% of all issues complained about.

Table 19: Complaints about medical records 2018/19 – 2022/23

MEDICAL RECORDS	2018/19	2019/20	2020/21	2021/22	2022/23
Access to/transfer of records	4	2	2	3	**0**
Record keeping	8	4	11	1	**0**
Record management	0	1	0	0	**0**
Total	**12**	**7**	**13**	**4**	**0**

The medical records category includes complaints about errors and inadequacies in medical records. There were no issues about medical records complained about in 2022/23 which were managed formally as complaints. The Commission is more likely to manage such complaints informally and may refer complaints that are only about records to the relevant information specialist: the Office of the Information Commissioner in the NT for public records, or the Australian Office of the Information Commissioner for private records (such as those held by GPs).

Table 20: Complaints about medication 2018/19 – 2022/23

MEDICATION	2018/19	2019/20	2020/21	2021/22[12]	2022/23
Administering medication	7	1	15	4	**4**
Dispensing medication	8	1	6	3	**4**
Prescribing medication	11	5	9	6	**1**
Supply/security/storage of medication	2	3	2	1	**2**
Total	**28**	**10**	**32**	**14**	**11**

Medication related concerns made up 10% of all issues in 2022/23. In addition, the Commission handled 76 complaints (7% of all enquiries) about medication at enquiry level. Many of these complaints were about access to opiate replacement therapy by prisoners prior to release.

11 Ibid
12 Ibid

Table 21: Complaints about professional conduct 2018/19 – 2022/23

PROFESSIONAL CONDUCT	2018/19	2019/20	2020/21	2021/22[13]	2022/23
Annual declaration not complete	1	0	0	0	**0**
Assault	5	3	2	1	**2**
Boundary violation	4	5	2	3	**2**
Breach of condition	2	2	0	2	**1**
Breach of guideline/law	20	2	4	5	**1**
Competence	13	16	20	5	**4**
Discriminatory conduct	2	0	2	1	**1**
Emergency treatment not provided	2	0	0	1	**0**
Financial fraud	0	0	0	0	**0**
Illegal practice	1	2	4	0	**0**
Impairment	0	2	2	1	**1**
Inappropriate disclosure of information	7	8	12	1	**1**
Misrepresentation of qualifications	1	0	2	0	**0**
Sexual misconduct	0	5	6	7	**0**
Total	**58**	**45**	**56**	**27**	**13**

Issues relating to professional conduct made up around 12% of all issues complained about. Many of these matters are dealt with by the relevant Board after consultation has occurred as required by the *Health Practitioner Regulation National Law Act* and the *Health and Community Services Complaints Act*.

Table 22: Complaints about reports/certificates 2018/19 – 2022/23

REPORTS/CERTIFICATES	2018/19	2019/20	2020/21	2021/22[14]	2022/23
Accuracy of report/certificate	2	5	1	1	**3**
Costs of reports/certificates	0	0	0	0	**0**
Inadequate/no consultation	0	0	0	0	**0**
Refusal to provide reports/ certificates	1	0	0	1	**0**
Report written with inadequate or no consultation	1	1	0	0	**0**
Timeliness of report/certificate	0	0	0	0	**0**
Total	**4**	**6**	**1**	**2**	**3**

Complaints about reports and certificates made up 3% of issues in complaints in 2022/23. The Commission has no jurisdiction in relation to the process of writing, or the content of, a health status report as per Schedule 2, Part 2 of the *Health and Community Services Complaints Regulations*.

13 Ibid
14 Ibid

Table 23: Complaints about service planning and delivery 2018/19 – 2022/23

SERVICE PLANNING AND DELIVERY	2018/19	2019/20	2020/21	2021/22[15]	2022/23
Decision making/choice	2	1	3	0	**0**
Individual needs/person centred planning	5	2	3	4	**2**
Privacy and dignity of service user		1	4	2	**1**
Total	**7**	**4**	**10**	**6**	**3**

3% of issues assessed on 2022/23 related to service planning and delivery.

Table 24: Complaints about treatment 2018/19 – 2022/23

TREATMENT	2018/19	2019/20	2020/21	2021/22[16]	2022/23
Attendance	0	1	0	0	**0**
Coordination of treatment	16	9	15	12	**0**
Delay in treatment	12	15	9	8	**2**
Diagnosis	23	17	16	11	**2**
Excessive treatment	1	1	2	0	**0**
Experimental treatment	0	1	3	0	**0**
Inadequate care	16	11	18	5	**5**
Inadequate consultation	11	4	0	4	**2**
Inadequate prosthetic device	0	0	0	0	**0**
Inadequate treatment	39	64	25	30	**6**
Infection control	2	3	2	1	**1**
No/inadequate referral	4	5	9	6	**1**
Public/Private election	1	0	0	1	**0**
Rough & painful treatment	1	3	5	3	**3**
Unexpected treatment outcome/complications	15	14	20	7	**6**
Withdrawal of treatment	0	0	1	1	**1**
Wrong/inappropriate treatment	7	9	13	10	**1**
Total	**148**	**157**	**138**	**100**	**30**

Issues relating to treatment constituted 28% of all issues in complaints closed in 2022/23, a decrease from 35% in 2021/22. Inadequate treatment and unexpected treatment outcome/complications are identified as the most prevalent concerns within this category.

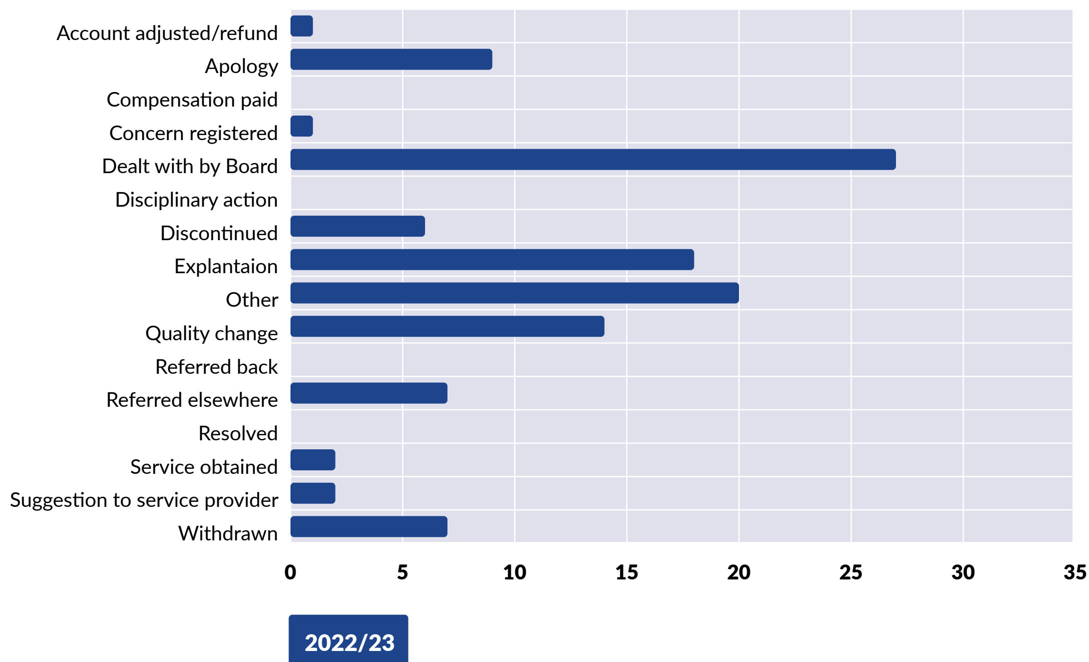
15 Ibid

16 Ibid

Outcomes of issues complained about

When complaints are finalised, the outcome of each issue identified in the complaint is recorded. The outcome of notifications received by Ahpra and managed within that jurisdiction are not included in the outcomes below, apart from recording that the issue was dealt with by the Board.

Figure 12: Outcomes of issues raised in complaints closed 2022/23



The most common outcome from issues closed by the Commission was an explanation (16%) and dealt with by the relevant Board (24%). 12% of matters resulted in a quality improvement and 12% were referred elsewhere. An apology was an outcome of 8% of issues.

Health and Community Services
Complaints Commission

For more information about the HCSCC, including more information about how to resolve complaints, how to make a complaint or how to respond to a complaint, please contact the HCSCC or visit our website.

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