



Health and Community Services  
Complaints Commission

# Annual Report

## 2023/24



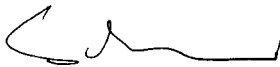
## Twenty-Sixth Annual Report (2023/24)

The Honourable Marie-Claire Boothby 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 2024.

Yours sincerely



**Stephen Dunham**

Commissioner  
12 March 2025

# Glossary of Terms

<b>Act</b>	<i>Health and Community Services Complaints Act 1998 (NT)</i>
<b>AGD</b>	Department of the Attorney-General and Justice
<b>Ahpra</b>	Australian Health Practitioner Regulation Agency
<b>ASCC</b>	Alice Springs Correctional Centre
<b>CARHS</b>	Central Australia Regional Health Service
<b>COAG</b>	Council of Australian Governments
<b>Commission</b>	Health and Community Services Complaints Commission
<b>Complaint</b>	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.
<b>CPV</b>	Community Visitor Program
<b>DCC</b>	Darwin Correctional Centre
<b>Enquiry</b>	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.
<b>GP</b>	General Practitioner / General Practice.
<b>HCSCC</b>	Health and Community Services Complaints Commission
<b>ICT</b>	Information and Communications Technology
<b>National Law</b>	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.
<b>NDIS</b>	National Disability Insurance Scheme
<b>Notification</b>	A report of concern about the health, conduct or performance of a registered health practitioner
<b>NTCS</b>	Northern Territory Correctional Services
<b>NT Government</b>	Northern Territory Government
<b>NT Health</b>	Northern Territory Department of Health
<b>PPHCS</b>	Prison Primary Health Care Service
<b>PRH</b>	Palmerston Regional Hospital
<b>RACGP</b>	Royal Australian College of General Practitioners
<b>RDH</b>	Royal Darwin Hospital
<b>Review Committee</b>	The Health and Community Services Complaints Review Committee established pursuant to Part 9 of the Act
<b>TERHS</b>	Top End Regional Health Service

# Table of Contents

<b>Glossary of Terms .....</b>	<b>2</b>	<b>Investigations .....</b>	<b>24</b>
<b>Figures.....</b>	<b>4</b>	Two investigations completed in 2023/24.....	24
<b>Tables.....</b>	<b>5</b>	<b>Policy role.....</b>	<b>24</b>
<b>Commissioner's Report .....</b>	<b>6</b>	National Code of Conduct for Health Care Workers .....	24
Emerging or strategic issues of importance ...	7	<b>The Year ahead: 2024/25.....</b>	<b>25</b>
<b>2023/24 at a Glance .....</b>	<b>10</b>	Finalising investigations .....	25
Key deliverables.....	10	Updating policy and procedure .....	25
Enquiries.....	10	Updating community engagement resources .....	25
Complaints .....	10	National Code of Conduct for Unregistered Health Practitioners .....	25
Community engagement.....	11	<b>Chapter 3: Promote Capacity and Improve Systems.....</b>	<b>26</b>
<b>Chapter 1: The Commission .....</b>	<b>12</b>	<b>Achievements 2023/24.....</b>	<b>26</b>
Our Vision .....	12	Coaching.....	26
Our Values.....	12	Management by the most appropriate complaints body .....	26
Our Mission .....	12	Complainants identifying as Aboriginal and Torres Strait Islander peoples.....	27
Our Strategic Objectives .....	12	Prison Primary Health Care Service (PPHCS) .....	28
Our History.....	13	Prescribed provider reports.....	28
Our Functions .....	13	<b>The Year ahead: 2024/25.....</b>	<b>29</b>
Our Team.....	13	Records archiving project .....	29
<b>Chapter 2: Quality Complaints Management ..</b>	<b>14</b>	Access to the Commission website.....	29
<b>Achievements 2023/24.....</b>	<b>14</b>	Updating the Commission's website .....	29
Monitoring quality improvement.....	14	<b>Chapter 4: Governance and Resource Management .....</b>	<b>30</b>
Quality Improvement outcomes recorded .....	14	<b>Health and Community Services Complaints Review Committee.....</b>	<b>30</b>
<b>Enquiries.....</b>	<b>15</b>	<b>Achievements 2023/24.....</b>	<b>30</b>
Proportion of complaints handled as enquiries .....	15	<b>The Year ahead: 2024/25.....</b>	<b>31</b>
Increase in enquiries received and closed	16	The Commission remains a learning organisation .....	31
Person-centred approach to enquiries .....	18		
Referring back .....	18		
<b>Complaints.....</b>	<b>18</b>		
Timelines .....	19		
Commissioner's decision.....	21		
Consultations with Ahpra .....	23		
<b>Conciliations.....</b>	<b>23</b>		

**Appendix 1 A: Performance** ..... 32

**Enquiries / informal complaints** .....32

        Issues raised in enquiries ..... 33

**Complaints**.....34

        Time taken to finalise complaints ..... 35

        Location of services complained about ...**36**

        How are complaints received? ..... 37

        What services are complained about? ..... 37

        What issues are complained about?..... 37

        Outcomes of issues complained about..... 44

## Figures

**Figure 1:** ..... 16  
Number of complaints and enquiries received  
2019/20 – 2023/24

**Figure 2:** ..... 16  
Number of complaints and enquiries closed  
2019/20 – 2023/24

**Figure 3:** ..... 17  
Average time to finalise enquiries (days)  
2019/20 – 2023/24

**Figure 4:** ..... 19  
Time taken to finalise complaints (average days)  
2019/20 – 2023/24 .....20

**Figure 5:** ..... 20  
Time taken to assess complaints (average days)  
2019/20 – 2023/24

**Figure 6:** ..... 27  
Aboriginal and Torres Strait Islander peoples  
complaints and enquiries received 2023/24

**Figure 7:** ..... 32  
Enquiries received and closed  
2020/21 – 2023/24

**Figure 8:** ..... 33  
Issues raised in enquiries closed 2023/24

**Figure 9:** ..... 34  
Complaints received and closed  
2019/20 – 2023/24

**Figure 10:** ..... 35  
Percentage complaints closed and timeframes  
2022/23 and 2023/24

**Figure 11:** ..... 36  
Location of services 2023/24

**Figure 12:** ..... 37  
Issues raised in complaints closed 2023/24

**Figure 13:** ..... 44  
Outcomes of issues raised in complaints closed  
2023/24

## Tables

<b>Table 1:</b> ..... 10	<b>Table 14:</b> ..... 39
Key deliverables 2021/22 – 2023/24	Complaints about consent 2019/20 – 2023/24
<b>Table 2:</b> ..... 13	<b>Table 15:</b> ..... 39
Organisational structure and staffing as at 30 June 2024	Complaints about discharge and transfers 2019/20 – 2023/24
<b>Table 3:</b> ..... 17	<b>Table 16:</b> ..... 39
Categories and percentage enquiry outcomes all issues 2021/22 – 2023/24	Complaints about environment & management of facility 2019/20 – 2023/24
<b>Table 4:</b> ..... 21	<b>Table 17:</b> ..... 40
Reasons for closure – Issues closed 2021/22 – 2023/24	Complaints about fees, costs & rebates 2019/20 – 2023/24
<b>Table 5:</b> ..... 22	<b>Table 18:</b> ..... 40
Reason for no further action – Issues closed 2021/22 – 2023/24	Complaints about grievance procedures 2019/20 – 2023/24
<b>Table 6:</b> ..... 26	<b>Table 19:</b> ..... 40
Aged, disability and mental health services complaints 2020/21 – 2023/24	Complaints about medical records 2019/20 – 2023/24
<b>Table 7:</b> ..... 27	<b>Table 20:</b> ..... 41
Aged, disability and mental health service enquiries 2020/21 – 2023/24	Complaints about medication 2019/20 – 2023/24
<b>Table 8:</b> ..... 28	<b>Table 21:</b> ..... 41
Number and proportion of enquiries about PPHCS 2019/20 – 2023/24	Complaints about professional conduct 2019/20 – 2023/24
<b>Table 9:</b> ..... 29	<b>Table 22:</b> ..... 42
Website access 2019/20 – 2023/24	Complaints about reports/certificates 2019/20 – 2023/24
<b>Table 10:</b> ..... 32	<b>Table 23:</b> ..... 42
Providers subject of enquiries 2019/20 – 2023/24	Complaints about service planning and delivery 2019/20 – 2023/24
<b>Table 11:</b> ..... 38	<b>Table 24:</b> ..... 43
Complaints about access 2019/20 – 2023/24	Complaints about treatment 2019/20 – 2023/24
<b>Table 12:</b> ..... 38	
Complaints about carers charter 2019/20 – 2023/24	
<b>Table 13:</b> ..... 38	
Complaints about communication & information 2019/20 – 2023/24	

# Commissioner's Report



Stephen Dunham  
Commissioner

**In my 2019 Annual Report, in anticipation of my lapsing appointment I reflected on my 5-year term as Commissioner, little expecting that I would be offered reappointment for a further 5 years. My report at that time was upbeat and identified a number of imminent challenges and changes.**

My 10-year term will come to an end on 11 June 2025, and thus this will be my last report as Commissioner. An election is due in coming months and there remains a compelling need for the Commission's circumstances to be more widely understood in order to face future challenges. Some of the challenges identified 5 years ago still remain and for obvious reasons have been exacerbated.

## Emerging or strategic issues of importance

- > **National Disability Insurance Scheme (NDIS)** – the NDIS is a national scheme for funding people with disabilities which was sequentially rolled out over a year, with full coverage achieved on 1 July 2018. The HCSCC continues to be fundamental in ensuring consumer safeguards and can receive complaints from “non-participants”, the people who are unable to access the National Disability Insurance Agency (NDIA) system. Interestingly this is the major portion of people with disabilities.
- > **Processes for dealing with complaints against registered providers** – the Australian Health Practitioner Regulation Agency (Ahpra) is a national authority which registers and oversees 16 health professions, such as medical practitioners, nurses, dentists, physiotherapists and pharmacists. Its statutory base is the *Health Practitioner Regulation National Law Act 2009* (Qld) which is referenced in the NT Act. The two agencies have significant functional and legislative overlap. The relationship has benefited from changes to practices over the last few years to ensure that the collaborative actions between the Commission and Ahpra are more effective and efficient.
- > **The reductions to funding of the HCSCC over recent years coupled with increases to workload will necessitate curtailment of current functions** – a number of options to contain activities to remain within allocation are under consideration. One live option is to reduce staffing levels. Currently the Commission has deliberately left a position vacant due to the inadequacy of its appropriation to fully fund salaries of all staff. Such action fetters the HCSCC's independence, introduces lengthy delays in processing complaints and lessens the adherence to statutory requirements.
- > **Community engagement** – the Act requires the HCSCC to promote the rights of users of health services and community services; and encourage an awareness of the rights and responsibilities of users and providers of health services and community services. This work has not received the priority it deserves in recent years and is the probable cause of the under representation of complaints from some sectors and particularly the disability sector. A number of strategies are now in place to address this statutory obligation and it is recognised that such actions will have a direct nexus with increasing complaints received by the HCSCC. The Commission's new website is expected to increase community awareness of the Commission's role.

- > **Impetus for further national change** – there has been widespread high level focus on both aged and disability sectors arising from Commonwealth and state reviews and Royal Commissions, two of which have reported, but the NT has yet to respond to the recommendations (the Royal Commission into Aged Care Quality and the Royal Commission into Safety and the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability). Media reporting and the publicising of cases of fraught circumstances of aged and disabled people has garnered community opprobrium and momentum for change. It can be reasonably expected that changes to policy, practice, funding and regulatory oversight will feature as recommendations of the Royal Commissions. Some of these changes may fall within the HCSCC's jurisdiction.
- > **Health and Community Services Complaints Review Committee**

Part 9 of the Act establishes and describes the work of the Health and Community Services Complaints Review Committee (the Committee). This Committee can '*...review the conduct of a complaint*'...but does not allow it to '*...review a finding, recommendation or other decision of the Commissioner*'. A number of complainants have expressed dissatisfaction with some of the Commission's findings over recent years with some intending to pursue matters via the Committee. Possibly 10 such matters will make applications for review and a number of these have also ventilated their grievances with various Ministers, the media and other parties. Part of the growing disquiet with this group has its origins in the extended time to establish a new Committee following the lapse of the terms for the members of the previous Committee. The newly appointed Committee has been slow to undertake its work and some applications for review are now quite aged, approaching two years. This work is arm's length from the Commission for obvious reasons but there appears no resolution on the matters queued up.

- › **Unregistered Providers** – at the COAG Health Council meeting of 17 April 2015, Health Ministers released the *Final Report: A National Code of Conduct for Health Care Workers* and agreed that jurisdictions should examine the implementation of the code regulation regime, how it should apply and implications for each jurisdiction. Essentially, this code would apply to the health practitioners (such as masseurs, doulas and hypnotists) who are not registered by one of the 15 National Boards which comprise Ahpra, (for instance nurses, medical practitioner and dentists). The Department of Health is currently preparing a draft Bill which would establish a code regulation scheme in the NT, with the model largely based on that which currently operates in South Australia. All Australian jurisdictions are active participants in the national code with the NT the sole outlier. The work associated with this policy is significant and the NT will be unable to effectively participate in the absence of additional resources.
- › **Review of the Act** – the Act commenced in 1998 and is required to be reviewed at two years following its commencement and every five years thereafter (section 106 of the Act refers). Thus it should have been subjected to five reviews. It has only been formally reviewed on one occasion (in 2004) with the review findings not being accepted or made public for reasons unknown. The Act requires at s106(3): *The Minister must cause a copy of the report to be tabled in the Legislative Assembly as soon as practicable after it is received.* In lieu of this, in 2021. Nearly two decades late, the previous Minister directed that the review be publicly available on the AGD website. It can no longer be accessed as it appears to have been removed for reasons unknown by persons unknown.

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. I am unaware of progress with this matter. This Ministerial direction has also disappeared from the AGD website.

While still functional, the Act would benefit from review involving stakeholders.

The Commission is staffed by experienced and intelligent staff who are energetic and impartial in their work. All take an oath in relation to this and all adhere to this without fail. I thank them and am confident that the Commission will continue to function at a high level following my departure next year.

# 2023/24 at a Glance

## Key deliverables

**Table 1: Key deliverables 2021/22 – 2023/24**

Key deliverables	2021/22	2022/23	2023/24
Enquiries and Complaints Received	732	698	<b>759</b>
Enquiries and Complaints Closed	772	702	<b>756</b>
Percentage of complaints Resolved within 180 days (includes Ahpra notifications)	75%	87%	<b>95%</b>
Percentage of Enquiries and Complaints closed / Enquiries and Complaints Received	105%	101%	<b>100%</b>

### Enquiries

- An increased number of enquiries were received in 2023/24 (649 in 2023/24 compared with 648 in 2022/23, 640 in 2021/22, and 525 in 2020/21).
- A decreased proportion of total complaints and enquiries were handled at enquiry level (86% in 2023/24, compared with 93% in 2022/23, 87% in 2021/22, and 81% in 2020/21).
- A slightly decreased number of enquiries were closed in 2023/24 (647 in 2023/24 compared with 649 in 2022/23, and 645 in 2021/22).
- The average number of days taken to finalise enquiries increased to 8.9 days, compared with 7.9 days in 2022/23, 8.89 days in 2021/22, and 9.75 days in 2020/21.

### Complaints

- 110 complaints were received, a significant increase on the 50 complaints in 2022/23 and 92 complaints in 2021/22. This is substantially due to an increasing number of notifications consulted on with Ahpra, noting that the category complaints also includes Ahpra notifications.

- 109 complaints were closed, a significant increase on the 53, closed in 2022/23, and a decrease from 127 complaints closed in 2021/22.
- 95% of complaints were closed within 180 days, which was an increase from 87% in 2022/23 and 75% in 2021/22. The benchmark for closure of complaints within 180 days is 80%.
- Of the complaints and Ahpra notifications which proceeded to formal assessment by the Commission in 2023/24, the KPI of 80% assessed within 60 days was not met. 25% of complaints were assessed within 60 days, which is a decrease on 50% in 2022/23, and 68% in 2021/22. 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.



ABOVE: Acting Commissioner Ruth Brisbane with (L-R) Anti-Discrimination Commissioner Jeswynn Yogaratnam, Federal Disability Minister Hon Bill Shorten, NT Disability Minister Hon Ngaree Ah Kit, Adult Guardian Beth Walker and Manager Community Visitor Program Susan Burns, 24 August 2023



ABOVE: Senior Investigation and Conciliation Officer Sean Goff hosting the Commission's stall at the All Abilities Expo Alice Springs, 23 November 2023

## Community engagement

The Commission hosted stalls at the Seniors Expos in Darwin and Katherine, the All Abilities Expos in Darwin, Katherine and Alice Springs, and the Welcome to the Top End Defence Expo.

It also attended meetings with Ahpra, the Acting Executive Director Top End Region NT Health, the Regional Executive Director Central Australia Region NT Health, the Chief Psychiatrist, the NT Health Consumer Engagement Team, the Nursing and Midwifery and Pharmacy Boards and the Aged Care Quality and Safety Commission. The Commission also participated in a consultation meeting with the Hon Bill Shorten, Minister for the National Disability Insurance Scheme, the Hon Ngaree Ah Kit, Northern Territory Minister for Disability and other independent NT offices.

Visits were conducted to Royal Darwin Hospital, Darwin Private Hospital, Alice Springs Hospital and the health clinic at Alice Springs Correctional Centre. Information sessions in relation to the role of the Commission were provided to the executive leadership team at Palmerston Regional Hospital and staff at Katherine Hospital. The Commission also hosted the Australian and New Zealand Health Commissioner's Conference.



ABOVE: Commissioner Stephen Dunham hosting the Commission's stall at the Seniors Expo in Alice Springs, 22 August 2023



LEFT: Acting Commissioner Ruth Brisbane hosting the Commission's stall visited by NT Disability Minister Hon Ngaree Ah Kit, at the All Abilities Expo Katherine, 6 October 2023

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 2024**

<b>Commissioner</b>	Stephen Dunham
<b>Deputy Commissioner</b>	Ruth Brisbane
<b>Senior Investigation/ Conciliation Officer</b>	vacant
<b>Senior Investigation/ Conciliation Officer</b>	unfunded
<b>A/Investigation/ Conciliation Officer</b>	Kiarna Murray
<b>Office Manager (.5 EFT)</b>	Rebecca Byers
<b>A/Administration/ Resolution Officer</b>	Tatyana Slavova

# Chapter 2: Quality Complaints Management

## ACHIEVEMENTS 2023/24

### 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 monitored quality improvements made through complaints in 2023/24.

### Quality Improvement outcomes recorded

In 2023/24, the Commission recorded 21 (compared with 18 in 2022/23) quality improvement outcomes from complaints and enquiries across health, disability and aged care services. Examples of these quality improvements include:

- › Introduction of a Dietary Requirements Request Form outlining the requirements for a low fibre diet for a period of three days for prisoners undergoing colonoscopy
- › Establishment of a Consumer Feedback Taskforce to tackle issues related to delayed or inadequate responses to consumer complaints
- › Review of the role of the Patient Advocate
- › Provision of education to pharmacists in relation to the maximum quantity of a schedule 8 medication permitted to be dispensed on a single occasion
- › Approval for prisoners to access natural medications/vitamins if these are self-funded
- › A treating team was reminded to consult with a ward Pharmacist after admission medicines were not continuously administered during a hospital admission
- › Provision of education to nursing staff after a small number were found to be un-spiking and re-using flush bags
- › An incident report was entered to facilitate review and improvement of risk assessment and follow up following discharge of mental health patients
- › Northern Territory Correctional Services conducted a review of all CCTV cameras to check alignment and function after a camera which would have provided evidence to assist resolution of a complaint was found to be incorrectly aligned

## Enquiries

### Proportion of complaints handled as enquiries

The Commission has continued its focus on resolving matters at the lowest level possible by managing matters referred to it as an enquiry wherever possible. The term 'enquiries' is used to refer to matters dealt with informally. In 2023/24, 86% (compared with 93% in 2022/23) of the 759 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. In 2023/24 some matters needed to be managed formally due to failure by service providers to respond to attempts to resolve issues informally.

## Increase in enquiries received and closed

Figure 1: Number of complaints and enquiries received 2019/20 – 2023/24

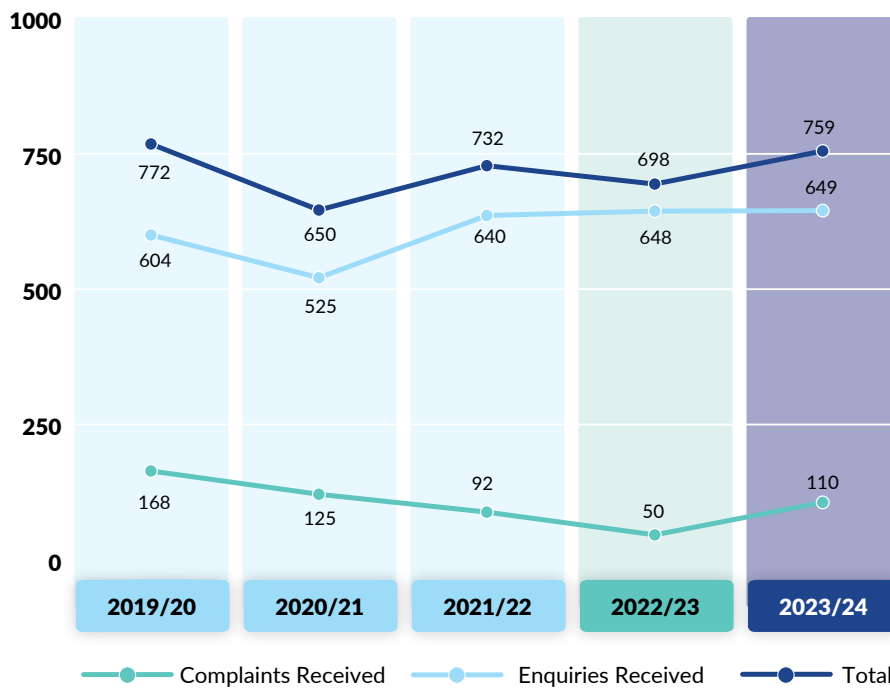


Figure 1 depicts in 2023/24, 649 enquiries were received, an increase of 1% on the 648 received in 2022/23. Our aim is to close enquiries within 14 days. In 2023/24, this goal was achieved in 80% of matters (a decrease from the 84% recorded in 2022/23).

Figure 2: Number of complaints and enquiries closed 2019/20 – 2023/24

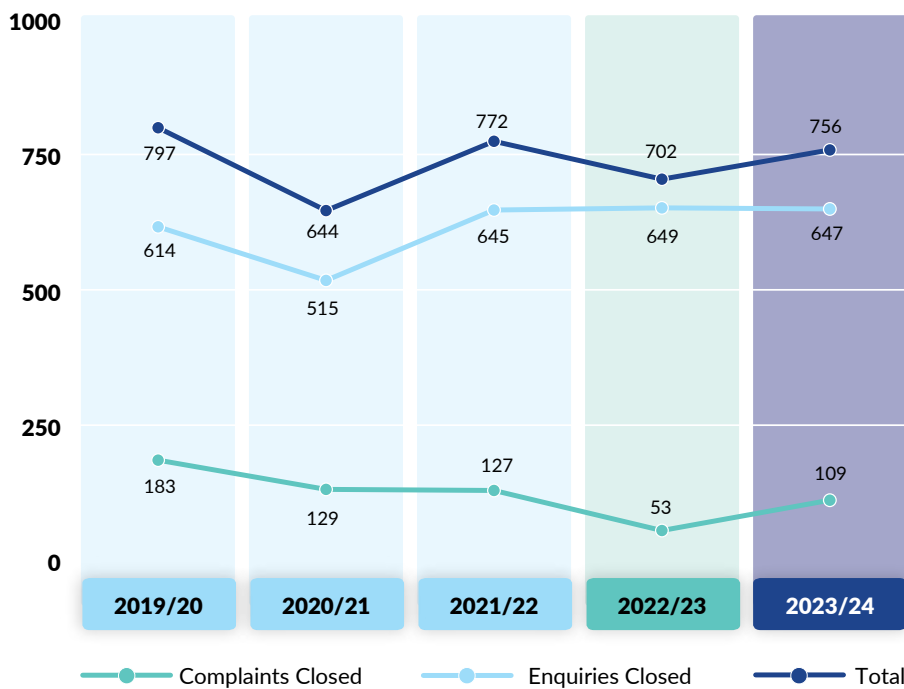


Figure 2 depicts the number of complaints and enquiries closed from 2019/20 until 2023/24. The number of enquiries closed has remained reasonably constant between 2021/22 and 2023/24, increasing following the period of 2020/21. The earlier drop is believed to have been a result of COVID-19.

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 2021/22 – 2023/24**

Enquiry Outcomes	2021/22		2022/23		2023/24	
	No	%	No	%	No	%
Enquiry – information provided	183	20%	279	24%	192	20%
Enquiry – referred back	341	38%	441	38%	399	41%
Enquiry – resolved	97	11%	85	7%	75	8%
Enquiry – other	48	5%	151	13%	94	10%
Enquiry – referred elsewhere	127	14%	137	12%	119	12%
Enquiry – referred to HCSCC complaints process	100	11%	68	6%	90	9%
Enquiry – quality change	4	0%	10	1%	6	1%
<b>Total</b>	<b>900</b>	<b>100%</b>	<b>1171</b>	<b>100%</b>	<b>975</b>	<b>100%</b>

**Figure 3: Average time to finalise enquiries (days) 2019/20 – 2023/24**

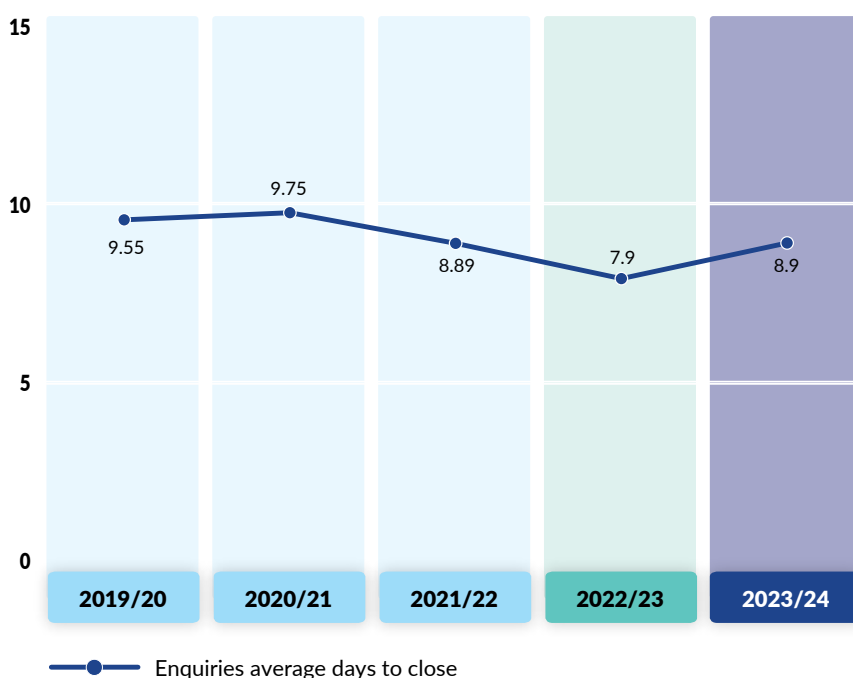


Figure 3 depicts the average time taken to close enquiries for the past five years. This increased to 8.9 days in 2023/24 compared with 7.9 days in 2022/23 and equalling 8.89 days in 2021/22. Variation in time taken to close enquiries can be influenced by external factors, most notably the timeframe in which services provide an informal response to a concern.

## 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

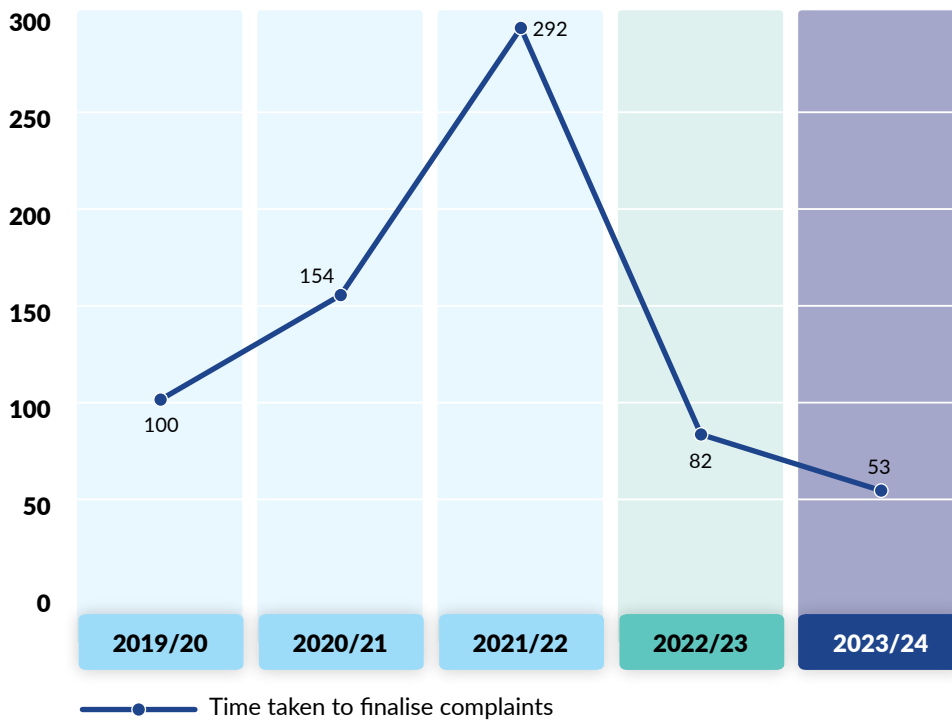
If a concern cannot be or is not suitable to be resolved at enquiry level, it is dealt with as a complaint. Commission processes for assessing and resolving complaints have gradually changed over time, so that while a formal structure is retained, there is also the flexibility to adapt processes to fit 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 2023/24, the Commission closed 109 complaints (40 received by the Commission and 69 received by Ahpra), an increase compared to 53 (20 received by the Commission and 24 received by Ahpra), in 2022/23. 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 2023/24, outcomes were recorded for 213 issues in the 109 matters finalised. This is significantly greater than the 106 issues assessed in 2022/23.

## Timelines

In 2023/24, 95% 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 87% in 2022/23 and 75% in 2021/22.

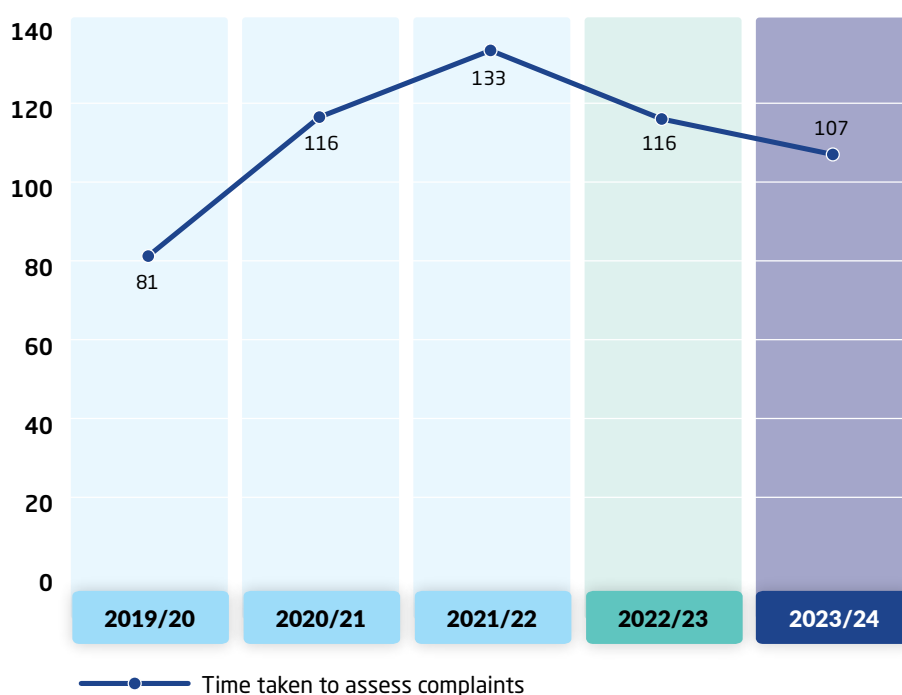
**Figure 4: Time taken to finalise complaints (average days) 2019/20 – 2023/24**



**Figure 4** depicts the average number of days taken to finalise complaints. This decreased for the second year in a row from 82 days in 2022/23 down to 53 days in 2023/24. This can be attributed to an increase in the number of consultations between Ahpra and the Commission where the outcome is for the complaint or notification to be managed by Ahpra. At the point of consultation, if the issue is retained by Ahpra, the Commission's file is closed.

In 2023/24, 24% of complaints (which also includes Ahpra notifications) were assessed within 60 days as required by section 27(1) of the Act. This fell well below the Commission’s KPI of 80%, and is a significant decrease compared with 50% achieved in 2022/23. This KPI has never been a realistic target and should be reviewed when review of the Act occurs.

**Figure 5: Time taken to assess complaints (average days) 2019/20 – 2023/24<sup>1</sup>**



**Figure 5** depicts the average time taken to assess complaints for the past five years. The number of days fell to 107 in 2023/24 compared with 116 days in 2022/23 and 133 days in 2021/22.

A number of factors can impinge on timeliness. They include complexities in the complaint itself, complexities which arise during the assessment of a complaint and the time lapse between the occasion of care and the lodgement of the 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 are also factors. There are also often delays over Christmas when organisations (including the Commission) are short staffed.

<sup>1</sup> 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).

## 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 2023/24, the Commissioner decided to take no further action with 58% of complaint issues, being a decrease on the 65% recorded in 2022/23.

**Table 4: Reasons for closure – Issues closed 2021/22 – 2023/24**

Reason for Closure	2021/22	2022/23	2023/24
Conciliation complete	0	1	0
Dealt with by Board	63	25	75
Investigation Complete	4	1	2
Referred to Board	10	3	9
No further action	145	70	124
Referred to other entity	2	8	3
<b>Total</b>	<b>224</b>	<b>108</b>	<b>213</b>

**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 increased from 5 in 2022/23 (5 being an outlier and not representative of usual data compared to 28 in 2021/22) to 27 in 2023/24. This is consistent with the increase in number of complaints and Ahpra notifications closed in 2023/24 compared to 2022/23.

In 2023/24, 22% of complaints were closed with no further action because they were resolved, compared with 9% in 2022/23 being a significant increase. The 9% in 2022/23 was an anomaly, with higher percentages in previous years.

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 2021/22 – 2023/24**

Reason for No Further Action	2021/22	2022/23	2023/24
No basis for complaint /Out of Jurisdiction	7	2	2
Complaint over 2 years old	0	7	0
Failure to reasonably resolve with provider	5	1	20
Further investigation unnecessary and/or unjustified	89	42	66
Complaint lacks substance	0	0	2
Complaint is resolved	28	5	27
Complaint determined by a court, tribunal or board	0	0	0
Civil proceedings commenced	0	0	0
Required information not received	10	5	3
Complaint has been withdrawn	6	8	4
<b>Total</b>	<b>145</b>	<b>70</b>	<b>124</b>

## 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 15 complaints about registered providers to the relevant Board for assessment in 2023/24.

Notifications received by Ahpra may be also be referred to the Commission for management. In 2023/24, this occurred on 15 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. 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. In 2023/24, no matters referred to conciliation. The Department of Health has adopted a policy of not engaging in conciliation where financial compensation is sought. While this decision is entirely legal insofar as the Act is concerned, the Commission has some concerns about it conforming with the NT Government's Model Litigant policy.

## Investigations

### Two investigations completed in 2023/24

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 2023/24 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 2023/24, 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 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: 2024/25

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 2023/24. 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 2024/25.

### Updating policy and procedure

The Office Manager and Resolution/Administration Officer implemented a number of transitions in government systems for the Commission. Controls in relation to access by NT Government support services to the Commission's complaints database were also strengthened.

### Updating community engagement resources

In 2023/24 the Commission updated content and redesigned the Commission's information brochure. In 2024/25 it intends developing an easy read brochure, a brochure for prisoners and a poster. The Commission has also decided to establish a social media presence.

### National Code of Conduct for Health Care Workers

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.

The Commission is considering changes which will need to be made to its complaints database to accommodate the National Code of Conduct for Health Care Workers. It has found two bodies of work are required. First, is the need to register interstate prohibition orders. This is required whether or not the Code is implemented in the NT, as it will enable prohibition orders made in other jurisdictions to be entered onto the Commission's complaints database so that where a practitioner subject of a prohibition order in another jurisdiction subsequently has a complaint lodged about them in the NT, Commission staff will be alerted. The other body of work requires changes to the complaints workflow in the event the Code is implemented in the NT and to institute 'own motion' powers.

# Chapter 3: Promote Capacity and Improve Systems

## ACHIEVEMENTS 2023/24

### 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 2023/24, 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 2020/21 – 2023/24**

Provider Type	2020/21	2021/22	2022/23	2023/24
Disability Services	0	1	1	3
Mental Health Services	14	7	7	21
Aged Services	1	2	0	0
<b>Total</b>	<b>15</b>	<b>10</b>	<b>8</b>	<b>24</b>

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 21 complaints and 93 enquiries about mental health services in 2023/24, an increase from the seven complaints and 74 enquiries in 2022/23. Many people with grievances about mental health services choose to lodge their complaint with the Community Visitor Program (CVP).

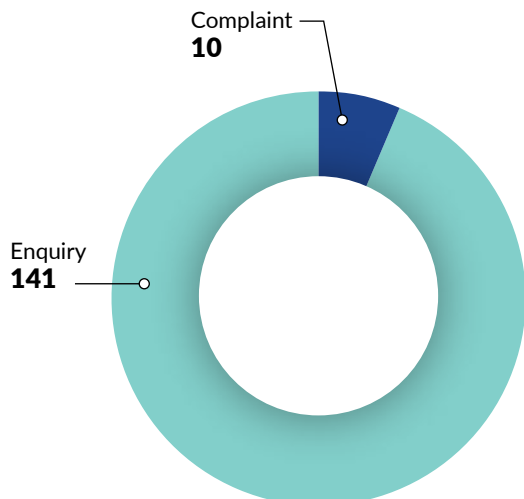
**Table 7: Aged, disability and mental health service enquiries 2020/21 – 2023/24**

Provider Type	2020/21	2021/22	2022/23	2023/24
Disability Services	11	15	17	17
Mental Health Services	23	55	74	93
Aged Services	8	11	13	13
<b>Total</b>	<b>42</b>	<b>81</b>	<b>104</b>	<b>123</b>

### Complainants identifying as Aboriginal and Torres Strait Islander peoples

The Commission commenced collecting data regarding the number of complainants who identify as Aboriginal and Torres Strait Islander peoples in 2023/24.

**Figure 6: Aboriginal and Torres Strait Islander peoples complaints and enquiries received 2023/24**



**Figure 6** depicts 151 complainants identified as Aboriginal and Torres Strait Islander peoples of the 759 complainants and enquires received in 2023/24. Proportionally representing 22% of total enquiries, 9% of total complaints, and 20% of the total complainants and enquires received in 2023/24.

## 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 2023/24, 190 enquiries (including 40 enquiries about the health care service at ASCC and the balance at DCC) were received.

**Table 8: Number and proportion of enquiries about PPHCS 2019/20 – 2023/24**

Year	Number	Proportion of all enquiries
2019/20	171	28%
2020/21	161	31%
2021/22	153	24%
2022/23	192	30%
2023/24	190	29%

**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 drop in the proportion of enquiries received from prisoners. However the proportion rose from 24% in 2021/22 to 30% in 2022/23 and was 29% in 2023/24.

## 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
- > Darwin Private Hospital Pty Ltd
- > Miwatj Health Aboriginal Corporation
- > Northern Territory Health Services (now NT Health)
- > Wurli Wurlinjang Aboriginal Health Service

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 all disability organisations.

In 2023/24 details of complaints received by prescribed provider organisations were not requested by the Commissioner which is his prerogative. 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: 2024/25

### Records archiving project

In the coming year, the Commission intends to undertake an audit of its aged hard copy case files against retention schedules and sort these to enable destruction and storage as applicable. The Commission has been largely paper free since the introduction of its current complaints database Resolve in 2015.

### Access to the Commission website

Anyone can access the Commission through its website at [hcsc.nt.gov.au](https://hcsc.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, a Guide to Complaints Resolution and a link to our legislation. Table 9 details that website access increased 20% in 2023/24 when compared with the year 2022/23.

### Updating the Commission’s website

Updating the Commission’s website was commenced during the 2020/21 financial year and was completed in 2023/24. The website needed to be replaced to meet NT Government ICT policies and standards. This very large task that included rebranding was coordinated and managed by the Deputy Commissioner and Office Manager.

**Table 9: Website access 2019/20 – 2023/24**

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
<b>Total visits</b>	6155	6066	6277	6651	7019	<b>8475</b>

# 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.

At 30 June 2023, the HCSCC Review Committee comprised:

**Ms Suzi Kapetas**

Chairperson

**Ms Carley Plume**

Provider Representative

**Mr Michael Fallon**

Provider Representative

**Mr Mark Coffey PSM**

User Representative

**Mr Patrick Stephensen**

User Representative

## ACHIEVEMENTS 2023/24

The year 2023/24 has been a challenging but rewarding one for the Commission. The HCSCC is the only independent Commission without a full-time Office Manager, and whilst the part-time (0.5EFT) nature of this position suits the current incumbent, the workload requires a full-time position. I wish to thank Mrs Rebecca Byers who provides invaluable support to the office, often working extended hours.

One Senior Investigation/Conciliation Officer 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 has required that the Deputy Commissioner also carry a caseload of complaints and investigations. Redevelopment of the Commission's non-compliant website which has been underway for the previous few years is now complete and is 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: 2024/25

### **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 2023/24, 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 A: Performance

## Enquiries / informal complaints

In 2023/24, the Commission received 649 enquiries and closed 647. This is consistent with enquiries received and closed in 2022/23, 2021/22, and 2020/21.

**Figure 7: Enquiries received and closed 2020/21 – 2023/24**



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 2023/24, which was equal to the percentage in 2022/23.

**Table 10: Providers subject of enquiries 2019/20 – 2023/24<sup>2</sup>**

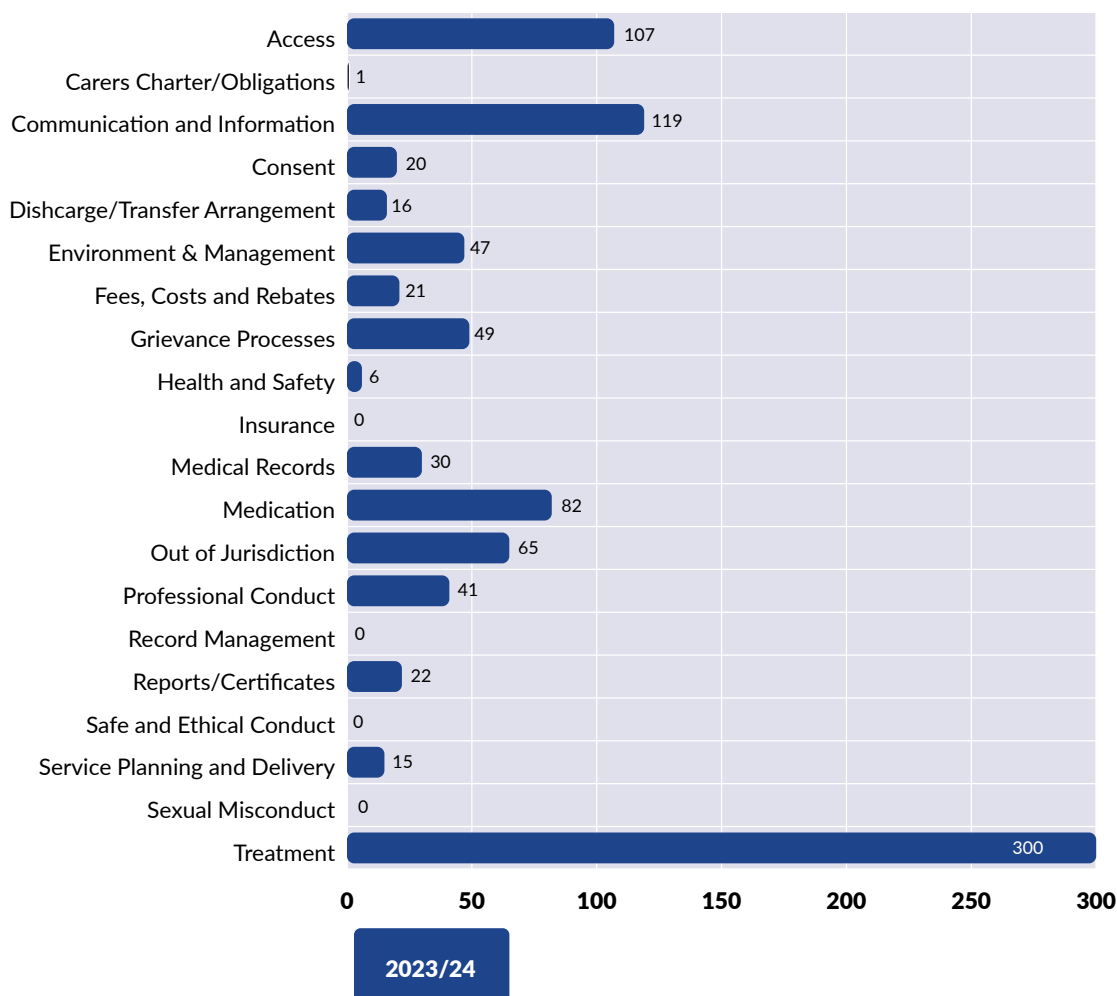
Providers	2019/20	2020/21	2021/22	2022/23	2023/24
Private	180	183	257	258	261
Public	468	392	478	514	508
<b>Total</b>	<b>648</b>	<b>575</b>	<b>735</b>	<b>772</b>	<b>769</b>

<sup>2</sup> Table 10 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 enquiries received.

## Issues raised in enquiries

Often more than one issue is raised per enquiry, 941 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, communication and information, access to services, communication and information, and medication. Sixty-five 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.

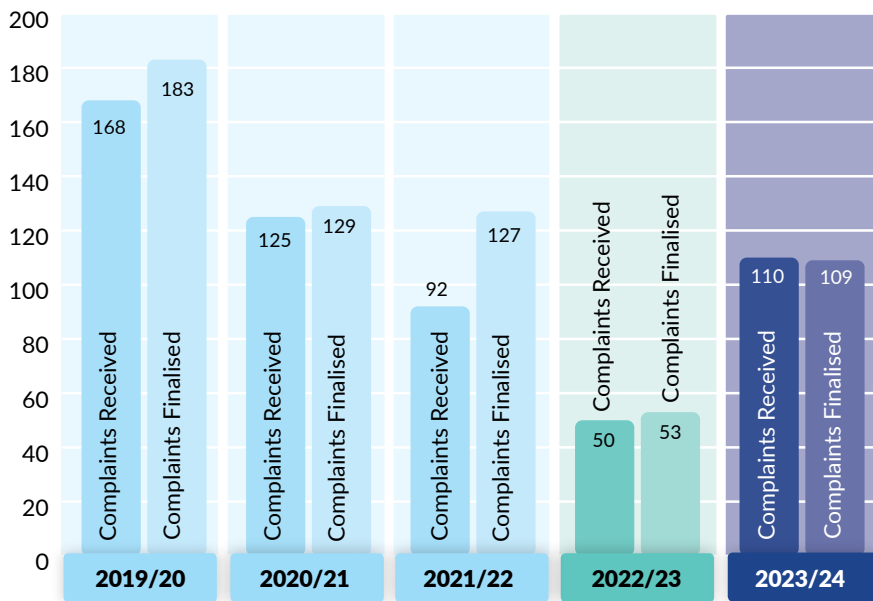
**Figure 8: Issues raised in enquiries closed 2023/24**



## Complaints

110 new complaints were received in 2023/24, representing a 120% increase on the number received in the previous year. The primary reason for this significant increase is that notifications received by Ahpra and which are subject to consultation with the Commission increased dramatically from 24 in 2022/23 to 69 in 2023/24. As is demonstrated below in figure 9, complaint numbers in 2022/23 also appear to be an anomaly, being significantly lower than previous years.

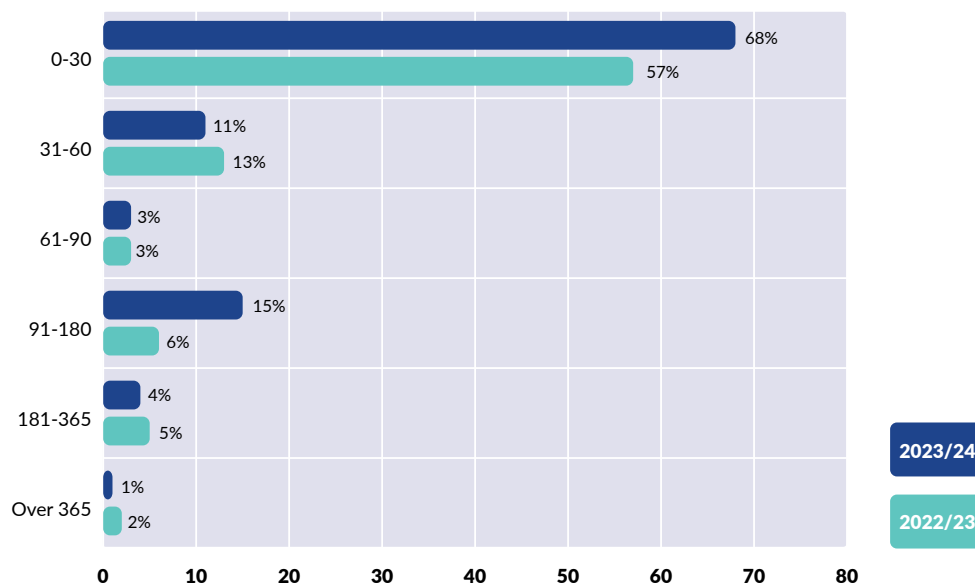
**Figure 9: Complaints received and closed 2019/20 – 2023/24**



## Time taken to finalise complaints

The average time taken to finalise complaints<sup>3</sup> (where complaints include complaints received by the Commission and notifications received by Ahpra subject to consultation with Commission) decreased from an average 85 days in 2022/23 to 53 in 2023/24. This is a result of complaints data including an increased volume of Ahpra notifications consulted on. Where at consultation the outcome is for a complaint or notification to be managed by Ahpra, the Commission's file is closed.

**Figure 10: Percentage complaints closed and timeframes 2022/23 and 2023/24**



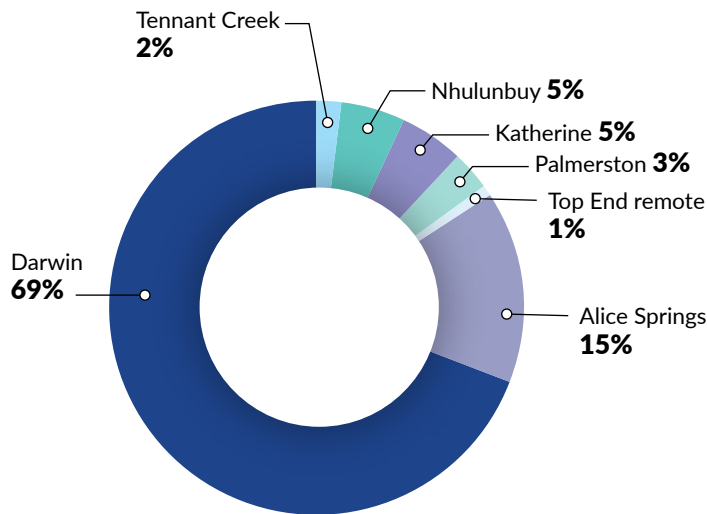
In 2023/24, 95% of complaints were closed within 180 days, an increase on 87% in 2022/23. The benchmark for closure within 180 days is 80%.

<sup>3</sup> 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.

## Location of services complained about

As expected, the majority of services subject to a complaint were located in Darwin (69%), a slight increase from 64% 2022/23. The percentage of complaints received about services in Alice Springs and Palmerston decreased to 15% and 3% in 2023/24 when compared with 18% and 6% respectively in 2022/23. Tennant Creek complaints decreased to 2% in 2023/24 when compared to 10% in 2022/23, while Katherine and Nhulunbuy complaints both increased to 5% in 2023/24 from 2% and zero in 2022/23 respectively.

**Figure 11: Location of services 2023/24**



## How are complaints received?

Where the complaint is made by phone, the complainant may be asked to confirm it in writing. Where a complainant is unable to confirm a complaint in writing, the Commission may assist them to render it into writing.

In 2023/24, of the 39 complaints (that is complaints received and subsequently managed formally) made directly to the Commission, 48% of complainants approached the Commission by electronic means (10% by email and 38% via the Commission website), 38% by phone and 5% were received by mail.

## What services are complained about?

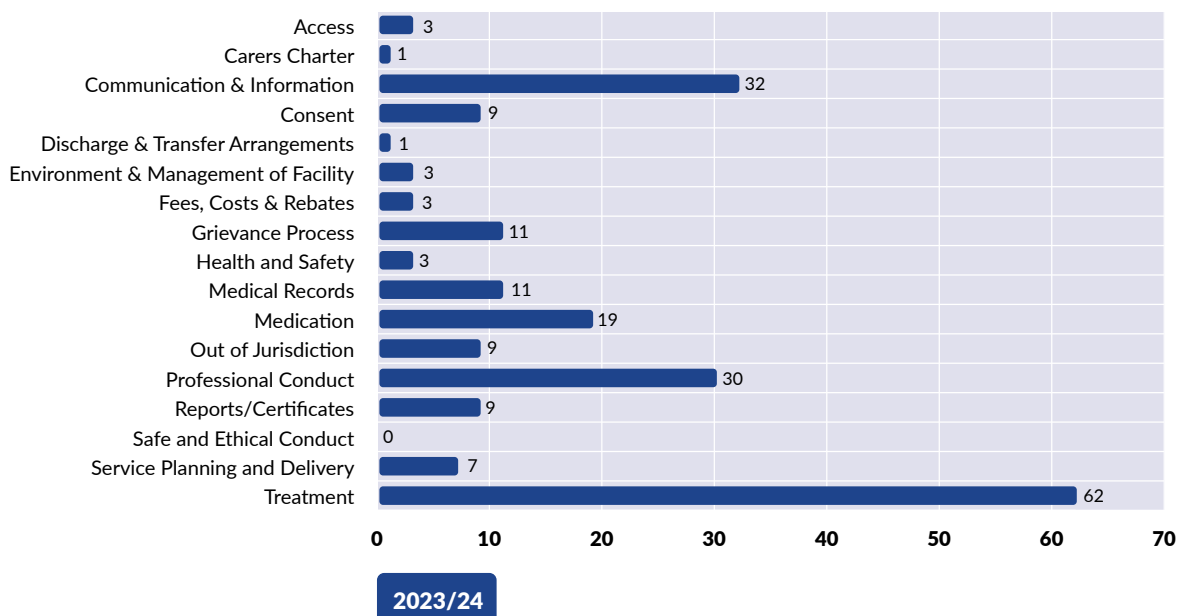
For the purpose of this report, organisational and individual providers are counted only once in each complaint even though there may be multiple issues against each; however, the same provider may be involved in several complaints and in this sense is counted several times.

In 2023/24, there were a total of 153 providers subject of the 110 complaints<sup>4</sup> received by the Commission. Of these, 98 (64%) were public providers and 55 (36%) 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 2023/24, a total of 213 issues were assessed.

**Figure 12: Issues raised in complaints closed 2023/24**



<sup>4</sup> Comprising complaints received by the Commission managed formally and notifications received by Ahpra.

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.

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 nine issues assessed as out of jurisdiction.

**Table 11: Complaints about access 2019/20 – 2023/24**

<b>ACCESS</b>	<b>2019/20</b>	<b>2020/21</b>	<b>2021/22</b>	<b>2022/23</b>	<b>2023/24</b>
Access to facility	0	7	1	1	0
Access to subsidies	2	2	1	0	1
Refusal to admit or treat	3	3	5	1	1
Service availability	7	4	2	0	1
Waiting list	0	1	5	0	0
<b>Total</b>	<b>12</b>	<b>17</b>	<b>14</b>	<b>2</b>	<b>3</b>

Issues relating to access made up 1% of all issues raised in complaints in 2023/24. Concerns about access to services, however, comprised 11% of all enquiry issues, largely due to the high proportion of contacts from prisoners. Issues relating to access to health services by prisoners often relate to the capacity of Correctional Officers to escort prisoners to the health centres within the prisons or to transport them to external appointments.

**Table 12: Complaints about carers charter 2019/20 – 2023/24**

<b>CARERS CHARTER</b>	<b>2019/20</b>	<b>2020/21</b>	<b>2021/22</b>	<b>2022/23</b>	<b>2023/24</b>
Obligations to carers not met	0	1	0	0	1
<b>Total</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>1</b>

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 2019/20 – 2023/24**

<b>COMMUNICATION &amp; INFORMATION</b>	<b>2019/20</b>	<b>2020/21</b>	<b>2021/22</b>	<b>2022/23</b>	<b>2023/24</b>
Attitude and manner	36	26	22	12	21
Inadequate information provided	23	19	17	5	4
Incorrect/misleading information provided	4	9	6	0	4
Special needs not accommodated	5	3	1	0	3
<b>Total</b>	<b>68</b>	<b>57</b>	<b>46</b>	<b>17</b>	<b>32</b>

Issues relating to communication and information made up 15% of all issues complained about. This is a slight decrease on 16% in 2022/23.

**Table 14: Complaints about consent 2019/20 – 2023/24**

CONSENT	2019/20	2020/21	2021/22	2022/23	2023/24
Consent not obtained or inadequate	4	4	22	4	5
Involuntary admission or treatment	3	3	2	2	4
Uninformed consent	1	1	1	0	0
<b>Total</b>	<b>8</b>	<b>8</b>	<b>25</b>	<b>6</b>	<b>9</b>

Issues relating to consent constituted 4% of all issues complained about in 2023/24. This is a decrease when compared with 6% in 2022/23 and 9% in 2021/22.

**Table 15: Complaints about discharge and transfers 2019/20 – 2023/24**

DISCHARGE & TRANSFERS	2019/20	2020/21	2021/22	2022/23	2023/24
Delay	0	0	1	0	0
Inadequate discharge	5	4	4	4	1
Mode of transport	1	3	1	0	0
Patient not reviewed	0	2	0	0	0
<b>Total</b>	<b>6</b>	<b>9</b>	<b>6</b>	<b>4</b>	<b>1</b>

One issue was raised in relation to discharge and transfer arrangements, a decrease when compared to four issues raised in 2022/23 and six in 2021/22.

**Table 16: Complaints about environment & management of facility 2019/20 – 2023/24**

ENVIRONMENT & MANAGEMENT	2019/20	2020/21	2021/22	2022/23	2023/24
Administrative processes	2	3	2	1	1
Cleanliness/hygiene of facility	1	4	1	0	0
Physical environment of facility	4	1	0	0	0
Staffing and rostering	1	0	1	0	0
Statutory obligations/ accreditation standards not met	6	2	4	1	1
Resources	0	1	2	0	1
Workforce issues/Staff related issues	3	2	0	0	0
<b>Total</b>	<b>17</b>	<b>13</b>	<b>10</b>	<b>2</b>	<b>3</b>

Complaints in this category relate to management of the service rather than the care/treatment component of the service. These issues made up 1% of all issues raised in complaints in 2023/24, a slight decrease on 2% in 2022/23.

**Table 17: Complaints about fees, costs & rebates 2019/20 – 2023/24**

<b>FEES, COSTS &amp; REBATES</b>	<b>2019/20</b>	<b>2020/21</b>	<b>2021/22</b>	<b>2022/23</b>	<b>2023/24</b>
Billing practices	5	3	0	2	2
Cost of treatment	2	4	1	0	1
Financial consent	1	0	0	0	0
<b>Total</b>	<b>8</b>	<b>7</b>	<b>1</b>	<b>2</b>	<b>3</b>

Issues relating to cost of service constituted 1% of issues in complaints in 2023/24.

**Table 18: Complaints about grievance procedures 2019/20 – 2023/24**

<b>GRIEVANCE</b>	<b>2019/20</b>	<b>2020/21</b>	<b>2021/22</b>	<b>2022/23</b>	<b>2023/24</b>
Inadequate/no response to complaint	11	16	17	9	11
Information about complaint procedure not provided	0	0	0	0	0
Reprisal/retaliation as a result of complaint lodged	0	0	1	2	0
<b>Total</b>	<b>11</b>	<b>16</b>	<b>18</b>	<b>11</b>	<b>11</b>

Issues related to grievance procedures and complaint handling made up 5% of all issues complained about in 2023/24.

**Table 19: Complaints about medical records 2019/20 – 2023/24**

<b>MEDICAL RECORDS</b>	<b>2019/20</b>	<b>2020/21</b>	<b>2021/22</b>	<b>2022/23</b>	<b>2023/24</b>
Access to/transfer of records	2	2	3	0	2
Record keeping	4	11	1	0	9
Record management	1	0	0	0	0
<b>Total</b>	<b>7</b>	<b>13</b>	<b>4</b>	<b>0</b>	<b>11</b>

The medical records category includes complaints about errors and inadequacies in medical records. There were 11 issues about medical records complained about in 2023/24, which were managed formally as complaints, an increase when compared to no complaint issues about medical records in 2022/23. 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 2019/20 – 2023/24**

MEDICATION	2019/20	2020/21	2021/22	2022/23	2023/24
Administering medication	1	15	4	4	8
Dispensing medication	1	6	3	4	1
Prescribing medication	5	9	6	1	8
Supply/security/storage of medication	3	2	1	2	2
<b>Total</b>	<b>10</b>	<b>32</b>	<b>14</b>	<b>11</b>	<b>19</b>

Medication related concerns made up 9% of all issues in 2023/24. In addition, the Commission handled 82 complaints (9% of all enquiries) about medication at enquiry level. Many of these complaints were about access to opiate replacement therapy by prisoners prior to release.

**Table 21: Complaints about professional conduct 2019/20 – 2023/24**

PROFESSIONAL CONDUCT	2019/20	2020/21	2021/22	2022/23	2023/24
Annual declaration not complete	0	0	0	0	0
Assault	3	2	1	2	0
Boundary violation	5	2	3	2	4
Breach of condition	2	0	2	1	0
Breach of guideline/law	2	4	5	1	3
Competence	16	20	5	4	4
Discriminatory conduct	0	2	1	1	2
Emergency treatment not provided	0	0	1	0	2
Financial fraud	0	0	0	0	0
Illegal practice	2	4	0	0	0
Impairment	2	2	1	1	6
Inappropriate disclosure of information	8	12	1	1	6
Misrepresentation of qualifications	0	2	0	0	1
Sexual misconduct	5	6	7	0	2
<b>Total</b>	<b>45</b>	<b>56</b>	<b>27</b>	<b>13</b>	<b>30</b>

Issues relating to professional conduct made up around 14% 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 2019/20 – 2023/24**

REPORTS/CERTIFICATES	2019/20	2020/21	2021/22	2022/23	2023/24
Accuracy of report/certificate	5	1	1	3	4
Costs of reports/certificates	0	0	0	0	0
Inadequate/no consultation	0	0	0	0	0
Refusal to provide reports/certificates	0	0	1	0	4
Report written with inadequate or no consultation	1	0	0	0	0
Timeliness of report/certificate	0	0	0	0	1
<b>Total</b>	<b>6</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>9</b>

Complaints about reports and certificates made up 4% of issues in complaints in 2023/24. 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*.

**Table 23: Complaints about service planning and delivery 2019/20 – 2023/24**

SERVICE PLANNING AND DELIVERY	2019/20	2020/21	2021/22	2022/23	2023/24
Decision making/choice	1	3	0	0	0
Individual needs/person centred planning	2	3	4	2	3
Privacy and dignity of service user	1	4	2	1	4
<b>Total</b>	<b>4</b>	<b>10</b>	<b>6</b>	<b>3</b>	<b>7</b>

Three per cent (3%) of issues assessed in 2023/24 related to service planning and delivery.

**Table 24: Complaints about treatment 2019/20 – 2023/24**

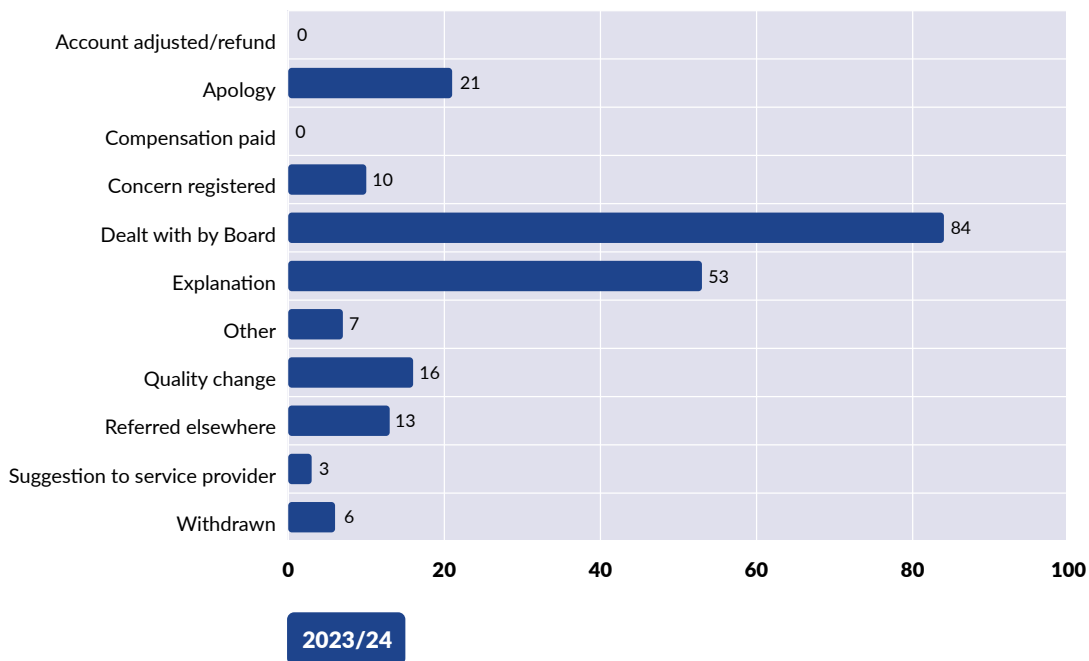
TREATMENT	2019/20	2020/21	2021/22	2022/23	2023/24
Attendance	1	0	0	0	1
Coordination of treatment	9	15	12	0	6
Delay in treatment	15	9	8	2	3
Diagnosis	17	16	11	2	2
Excessive treatment	1	2	0	0	1
Experimental treatment	1	3	0	0	0
Inadequate care	11	18	5	5	9
Inadequate consultation	4	0	4	2	2
Inadequate prosthetic device	0	0	0	0	0
Inadequate treatment	64	25	31	6	20
Infection control	3	2	1	1	1
No/inadequate referral	5	9	6	1	2
Public/Private election	0	0	1	0	0
Rough & painful treatment	3	5	3	3	0
Unexpected treatment outcome/complications	14	20	7	6	3
Withdrawal of treatment	0	1	1	1	0
Wrong/inappropriate treatment	9	13	10	1	12
<b>Total</b>	<b>157</b>	<b>138</b>	<b>100</b>	<b>30</b>	<b>62</b>

Issues relating to treatment constituted 29% of all issues in complaints closed in 2023/24, an increase from 28% in 2022/23. Inadequate treatment and unexpected treatment outcome/complications are identified as the most prevalent concerns within this category.

## 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 13: Outcomes of issues raised in complaints closed 2023/24**



The most common outcome from issues closed by the Commission was an explanation (25%) and dealt with by the relevant Board (39%). Eight percent of issues resulted in one or more a quality improvements and 6% were referred elsewhere. An apology was an outcome of 10% 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.

GPO Box 4409  
Darwin NT 0801

Level 4, NT House  
22 Mitchell St, Darwin NT 0800

**Phone:** 08 8999 1969  
**Freecall:** 1800 004 474

**Email:** [hcsc@nt.gov.au](mailto:hcsc@nt.gov.au)

**TTY:** 133 677 or 1800 555 677

**Translating and Interpreting Service (TIS):**  
131 450