Health and Community Services
COMPLAINTS COMMISSION

Annual Report
2015-16

Health and Community Services
COMPLAINTS COMMISSION

Eighteenth Annual Report (2015/16)

The Honourable Natasha Fyles MLA
Minister for Health
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 2016.

Yours sincerely

Stephen Dunham
Commissioner

4 October 2016

Glossary

AHPRA	Australian Health Practitioner Regulation Agency
AMSANT	Aboriginal Medical Services Alliance Northern Territory
ATSI	Aboriginal and Torres Strait Islander
CAHS	Central Australian Health Service
CALD	Culturally and Linguistically Diverse
COAG	Council of Australian Governments
CVP	Community Visitor Program
DCLS	Darwin Community Legal Service
DoH	Department of Health
ED	Emergency Department
GP	General Practitioner / General Practice
HCE	Health Complaints Entity
HCSCC	Health and Community Services Complaints Commission
IdA	Integrated Disability Action
ISP	Individual Support Plan
NAAJA	North Australian Aboriginal Justice Agency
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NDS	National Disability Service
NTMS	Northern Territory Mental Health Service
OoD	Office of Disability
OPG	Office of the Public Guardian
PHS	Prison Health Service
PPHCS	Prison Primary Health Care Service
TEHS	Top End Health Service

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Case Studies

Case studies are used in this Annual Report as examples to illustrate our work during 2015/16. Please note that they have been de-identified; location, gender, names and in some cases outcomes are altered to protect the confidentiality of people who have entrusted the HCSCC with their complaint.

Figures

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COMISSIONER'S REPORT

The 2015/16 year marks the first full year of my 5 year appointment and sees a year of change, challenges and opportunities. It also marks the threshold of a period of continuing predictable change and growth.

I believe that the speed of change in any organisation can be assessed by an analysis of the trends over past years, subject to some confidence about the historical reporting data. The Commission has now been operating with the same legislative base, the same staffing levels and reasonable comparability in its statistical data for over 18 years. Five of the last ten years have seen the Commission as a stand-alone independent entity, with this report the sixth. Any prospective analysis using historic data with these constants can claim to be an accurate critique.

Importantly, such a "look back" can identify the nexus between changes to practice and impact on workload. Thus, this report, in addition to reporting on the 2015-16 year will attempt to understand and to some extent, anticipate the coming year's challenges. Of equal importance is critical monitoring of trends in other jurisdictions which have implemented policies and practices which will shortly feature as part of the Commission's core business.

It is worth noting that growth in workload has been accompanied by the budget allocation for the Commission reducing each year over the last 4 years to a cumulative cut of 4.2%. This, along with increased costs and an eroded dollar value (estimated to be about 6.0%) means that stark options face the Commission in future years if the declining budgets continue. Resources (and particularly the lack thereof) have the direct impact on the Commission's ability to act independently. Put simply, while the Commission's independence is guaranteed by statute, the inability to fully perform its statutory obligations due to inadequate resources directly erodes its independent status. This has been identified as the biggest risk faced by the Commission.

Fundamentally the Act mandates the Commission's direction which can be distilled into three absolute though interlinked priorities:

- Resolution of complaints
- Promotion of rights
- Improvements in services

There is little doubt that the pressing and urgent work of direct complaints resolution can result in a lesser priority for the other two imperatives, particularly in the face of increasing numbers of contacts with the Commission, and static staffing levels.

A full day workshop involving all of the Commission's staff analysed this matter and developed a comprehensive strategic forward plan to address predictable future workload and challenges. A primary motivation in the Commission's work is to establish a complaints system that "*leads to improvements in health services and community services*". Thus as advocates for change, the Commission must also embrace change to its own systems and processes to ensure continuous improvement, adherence to charter and effective use of the taxpayer's dollar. The Commission will identify and meet the changes expected to arise over the next few years and I thank all of the staff for their enthusiastic and thoughtful contributions to the strategic forward plan.

The rationing of resources is something that previous Commissioners have grappled with. That is, the imperative of direct complaints resolution has acted to reduce efforts to:

- increase emphasis on resolving complaints by way of better systems among providers;
- promote consumer rights; and
- ensure services are improved as a result of good complaints handling.

Inevitably, the important work of directly handling the enquiries and complaints which come to the Commission will fully consume the entire capacity of its workforce unless significant changes to practice are instituted.

A number of strategies have been trialled during the 2015-16 year, and each has been shown to be effective.

- "Push back" of complaints
- Emphasis on speedy resolution at the enquiry stage and for matters involving registered providers
- Capability building in providers' responses to complaints
- Sharper focus of matters under investigation
- Better front end analysis of jurisdictional issues with HCSCC and AHPRA
- Increased participation with stakeholders, particularly those service providers with a history of high complaint levels
- Opportunistic involvement with community events
- Focus on addressing the high levels of contacts from the Darwin Correctional Precinct
- More complaints being resolved by conciliation
- Analysis of work practices in interstate jurisdictions
- Comprehensive review of all complaints systems and rewrite of procedure manual
- Reallocation of workload among staff
- Modify Resolve and "paper free" initiatives
- The employment of additional resources using the Disability Employment Program auspiced by the Office of the Commissioner for Public Employment
- Surveys to ascertain the views and experience of stakeholders

Each of these will be further discussed in this report.

Finally, I must thank those many people who have generously and patiently inducted me into the workings and ways of the Commission, particularly the Deputy Commissioner Judy Clisby. Judy's clinical background, extensive experience in the work of the Commission, enthusiasm and innovative approaches to challenges feature in all of the new initiatives implemented this year.

The Commission is a small office where staff are motivated, highly collaborative and dependent upon each other to achieve the results which are amply demonstrated in this report. I am obliged to record my thanks for the work of each of them. Two of the three Senior Investigation Officers, (Laura Berta and Anne Lade) left during the year along with the Administration/Resolution Officer (Linzi Hamlyn). Each of these officers left on promotion and I am aware of the respect external agencies have for those staff who have "done time" with the Commission. I share this respect. While of course this is a source of pride, it also is a predictable feature of the continuing turnover of staff in the Commission.

Stephen Dunham
Commissioner

2015/16 at a Glance

Key Deliverables

Table 1: Key Deliverables 2014/15 – 2015/16

Key Deliverables	2014/15	2015/16
Enquiries and complaints received	608	621
Enquiries and complaints closed	618	647
Complaints resolved within 180 days	84%	85%

Enquiries

- More enquiries were closed (453) than were received (436).
- Time taken to finalise enquiries has almost doubled since 2014/15 from 6.63 days to 13.04. While this still falls within the internal Key Performance Indicator of 14 days, this will be a focus for 2016/17.
- 68% Enquiries were closed within 14 days.

Complaints

- 185 complaints received and 466 issues assessed in 2015/16.
- More complaints were closed (194) than were received (185).
- The proportion of complaints closed within 180 days remained relatively constant in comparison with 2014/15 (benchmark is 80%). However, 58% complaints were closed within 60 days compared with 41% in 2014/15, and there was a 25% increase in matters closed under 30 days.
- The average time taken to finalise complaints has decreased from 132 days in 2014/15 to 99 days in 2015/16, largely due to the changes in consultation with the Australian Health Practitioner Agency (AHPRA).
- Consultation process with National Boards changed so that in effect AHPRA and the HCSCC act as a single entry point for health complaints in the NT.

Resolution Focus

- Increased number of conciliations (22 in 2015/16).
- Higher proportion of complaints resolved at enquiry stage (70% compared with 67% in 2014/15.
- Training in customer relations and complaint handling developed.
- Guidelines for developing complaint resolution policies and procedures completed and available on the HCSCC website.

Service Improvement

- Six Investigations completed.
- 47 recommendations involving 8 distinct service providers were monitored. 15 recommendations were closed.
- Quality improvement was recorded as an outcome on 38 occasions.

Community Engagement

- Worked with Top End Prison Primary Health Care Service to introduce an internal complaints system.
- Engaged in a national trial with Victoria and Western Australia to improve consistency in the consultation process between Health Complaints Entities and AHPRA.
- Engaged in 70 separate community visits / community events in 2015/16.

Chapter 1: The HCSCC

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 HCSCC is guided by the following values:

Accessibility
Accountability
Fairness
Innovation
Person-centredness
Professionalism

Our History

The Health and Community Services Complaints Commission (HCSCC) was established in 1998 with the passage of the *Health and Community Services Complaints Act*. It sat with the Ombudsman's Office until 2010 when the HCSCC became a stand-alone entity with an independent Commissioner.

The HCSCC 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 *Health and Community Services Complaints 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 s3 of the *Health and Community Services Complaints Act* include:

- Encouraging and assisting users and providers to resolve complaints directly
- 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 Strategic Objectives

1. Quality Complaints Management
2. Promote capacity
3. Improve Systems
4. Advise government
5. Educate the NT community
6. Governance and Resources Management

Our Team

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

The organisational structure of the HCSCC is as follows:

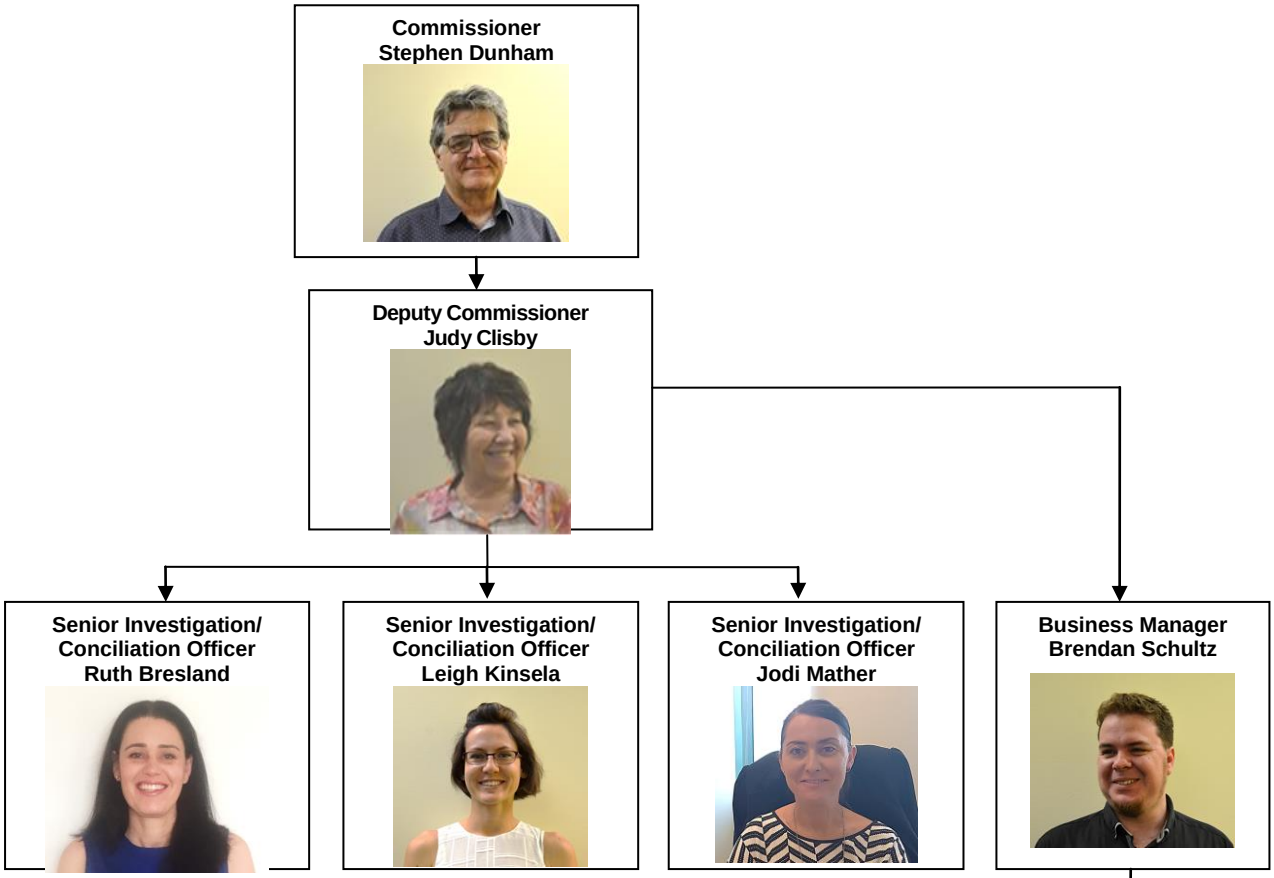


Table 2: Staffing Profile as at 30 June 2016

Position Level	Male	Female	Total
Commissioner (ECO2)	1	0	1
Deputy Commissioner (ECO1)	0	1	1
Administrative Officer 7 (AO7)	0	3	3
Administrative Officer 6 (AO6)	0.5	0	0.5
Administrative Officer 4 (AO4)	0	1	1
Administration Support Officer 1 (AO1)		0.14	0.14
Total	**1.5**	**5.14**	**6.64**

Chapter 2: Quality Complaints Management

ACHIEVEMENTS 2015/16

Changes to Consultation Process HCSCC and AHPRA

Section 68 of the *Health and Community Services Complaints Act* ('the Act') requires the HCSCC to notify the relevant Board when a complaint concerns a provider who is registered with a National Board, with s68(1) requiring the Commissioner to consult in relation to how the complaint will be managed. This consultation occurs through interface with the Australian Health Practitioner Regulation Agency (AHPRA), the administrative arm of the Boards.

Prior to 2015/16, if a complaint received about a registered provider indicated that there was no immediate safety risk to the public, the HCSCC would assess the complaint and then consult with the Board regarding whether to refer the complaint or to take no further action on it. Generally, the HCSCC would take 60 days to assess the complaint and the consultation process taking on average a further 30 days. This meant that any complaint process involving a registered provider would take at least three months to finalise, and longer if the complaint outcome involved action by the Board.

In 2015/16, along with Victoria and Western Australia, the NT participated in a trial of the consultation process to improve speed and consistency of decision-making between jurisdictions. AHPRA and the HCSCC in the NT agreed to consult weekly about complaints received by the HCSCC and notifications received by AHPRA to decide the agency best suited to manage the matter. Decisions could include referral of the complaint to the Board, retention of the matter by the HCSCC or splitting the complaint, with some issues investigated by the Board and some by the HCSCC. As a result, there is now in effect a single door for receipt of complaints and notifications involving providers registered with a Board and working in the NT.

Case Study 1 – Complaint split between the Board and the HCSCC

Sally attended a hospital with wounds from an accident at home. After treatment in ED, Sally was discharged, with a view to her returning to the hospital outpatients for assistance managing her wounds.

Sally's wounds became so seriously infected that Sally was admitted to hospital for treatment. She believed that this occurred because Tom, the nurse tasked with dressing the wounds in outpatients, did not observe proper infection control procedures and did not advise Sally what she should do at home to avoid infection.

While in hospital, Sally stated that other nursing staff were unprofessional in the way they treated her. One nurse in particular, Jane, told Sally that it was her fault that she was injured and that her wounds had become infected. Sally was unwell at the time, and found this extremely upsetting.

The HCSCC consulted with AHPRA regarding the agency best suited to manage this complaint. It was agreed that the complaint about Tom would be managed by the Nursing Board because the complaint raised serious concerns about clinical practice (noting that this was a referral for assessment, and not a finding). The complaint about Jane was retained by the HCSCC for resolution, as was the more general complaint about quality of infection control.

Reduced Time Taken to Finalise Complaints

In 2015/16 the average time taken to finalise complaints[1] (where complaints include complaints received by the HCSCC and notifications received by AHPRA subject to consultation with HCSCC) reduced from an average 132 days in 2014/15 to 99 days. This is largely due to two factors, an overall reduction in time taken to assess complaints involving registered providers and a reduction in time to consult on outcomes of notifications received by AHPRA.

Figure 1: Time Taken to Finalise Complaints 2011/12 – 2015/16 (Average Days)

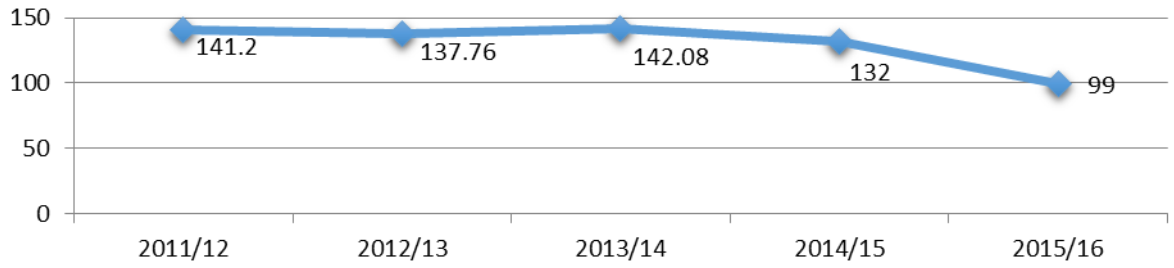
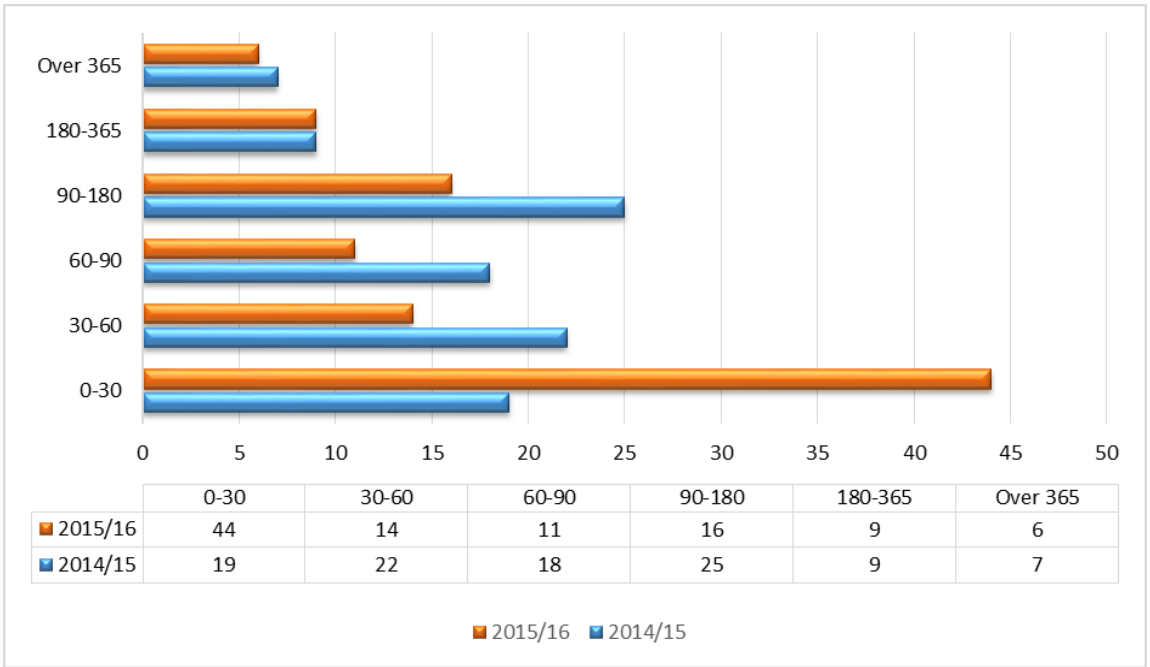


Figure 2 illustrates the vastly increased proportion of matters closed within 30 days (44% 2015/16 compared with 19% 2014/15). It demonstrates that 58% complaints were closed within 60 days in 2015/16 compared with 41 % in 2014/15.

Figure 2: Percentage Complaints Closed and Time Frames 2014/15 and 2015/16



	0-30	30-60	60-90	90-180	180-365	Over 365
2015/16	44	14	11	16	9	6
2014/15	19	22	18	25	9	7

In 2015/16 85% of complaints were closed within 180 days, marginally more than the 84% closed within 180 days in 2014/15. The benchmark for closure within 180 days is 80%.

[1] 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.

High Proportion of Matters Resolved

Anyone can approach the HCSCC to discuss a complaint or possible complaint about a health, disability, or aged service.

25% of All Enquiries Resolved

The most informal way of dealing with complaints is through our enquiry, or informal complaint system. The aim of the enquiry system is to assist parties to resolve their concerns in the most timely and informal way possible. Whenever a complaint is received, it is assessed to determine whether it can be resolved informally. In many cases we are able to assist the service user to raise their concerns directly with the service provider without further involvement from us. In other cases, we may make contact with the provider and facilitate the resolution in that way.

For the first time in 2015/16, outcomes from enquiries were recorded as below, enabling the HCSCC to quickly determine how the enquiry was handled and its outcome. As can be seen from the table below, 25% of all enquiries were resolved with HCSCC help.

Case Study 2 – Vaccination not Processed

Carmen phoned the HCSCC complaining that her Centrelink Child Care Rebate had been cancelled because records of her daughter's vaccination at the local GP Centre had not been processed by Centrelink. As a result, five months later, Carmen was paying full child care fees. Carmen had already tried to resolved the complaint with her GP, without success.

The HCSCC contacted the clinic nurse who confirmed that the child had received her vaccination, and that the record had been sent to the Communicable Disease Centre (CDC). The HCSCC then spoke to the Manager of the CDC to find out whether a record of the vaccination had been received. The record had been received, but not processed due to a backlog. It was processed that day and the child care rebate reinstated.

Table 3: Categories and Percentage Enquiry Outcomes 2015/16

	Number	Percentage
Enquiry - complaint form sent	42	10
Enquiry - complaint made	8	2
Enquiry - information provided	224	51
Enquiry - referred back	53	12
Enquiry - resolved	109	25
TOTAL	436	100

Rate of Complaints Resolved Maintained

If a concern cannot be resolved at enquiry level, it is dealt with as a complaint. This is a more formal process in which information is gathered with a view to deciding whether further action is necessary in relation to the concerns raised. In many cases the answers to relevant questions or outcomes that the person making the complaint wants can be obtained during this initial process and no further action is needed.

Our complaints numbers each year comprise complaints received by the HCSCC and notifications received by AHPRA subject to consultation by the two agencies. In 2015/16, the HCSCC closed 194 complaints, 114 of which were complaints received by the HCSCC. Every complaint contains at least one complaint issue, with some large and complex complaints containing many more. Thus the number of complaint issues will always be greater than the number of complaints. In 2015/16 outcomes were recorded for 466 issues in the 194 matters finalised as set out in the table below.

Case Study 3 – Complaint Resolved in Assessment

A legal organisation lodged a complaint on behalf of a client regarding a lengthy wait for provision of a medical report required to support an application for priority housing. The complaint addressed the Health Service's failure to provide the report in a timely fashion, along with a failure to recognise the significant impact of this delay.

The complaint was resolved by providing the report, offering an apology for the delay and putting improvements in place to ensure that this would not recur.

Table 4: Reasons for Closure: Issues Closed 2015/16

Reason for closure	Number
Conciliation complete	55
Dealt with by Board pursuant to MOU	184
Investigation complete	10
No further action	206
Referred to other entity	11
Total	466

Table 5: Reason for No Further Action Issues Closed 2015/16

Reason for No Further Action	
No basis for complaint to HCSCC	1
Complaint over 2 years old	1
Failure to reasonably resolve with provider	13
Further investigation unnecessary &/or unjustified	99
Complaint lacks substance	16
Complaint is resolved	42
Complaint determined by a court, tribunal or board	3
Frivolous/vexatious	1
Required information not received	10
Complaint has been withdrawn	20
Total	206

It is not unusual for the HCSCC to take no further action in relation to a complaint (see Table 5 above), however that may be for a variety of reasons, including the fact that a complaint has resolved through the process. In 2015/16, 42, or 9% of all complaint issues were resolved during assessment compared with 16% in 2014/15.

In 2015/16, an increased proportion of issues were resolved at conciliation (12% compared with 4% in 2014/15). If issues resolved at assessment and in conciliation are considered together, 21% of all issues were resolved in 2015/16, maintaining the resolution rate of 21% of all issues achieved in 2014/15.

Case Study 4: Complaint not Resolved. Referred to Investigation

Noelene complained about the care provided to her adult daughter Mary who has impaired decision-making capacity and impaired mobility. Noelene complained about discharge planning, stating that the hospital had discharged Mary without first organising the equipment needed so that Noelene could manage her at home (including a wheelchair). Noelene had complained directly to the service, however was unhappy with the response she had received which she described as offensive and irrelevant to her concerns.

The HCSCC found that there had been inadequate planning in relation to Mary's discharge from hospital and in particular, there had been no physiotherapy assessment of her mobility. Further, the hospital advised the HCSCC that it was assessed no wheelchair or equipment was required despite observation by staff in the Medical Record that Mary could only walk 5-10 metres unassisted. The officer conducting the assessment noted that distance from the ward to the foyer was much further than 10 metres.

Secondly, the HCSCC found that the hospital's response did not recognise the distress and difficulty experienced by Noelene and her daughter Mary following discharge and generally did not respond in a patient centred manner.

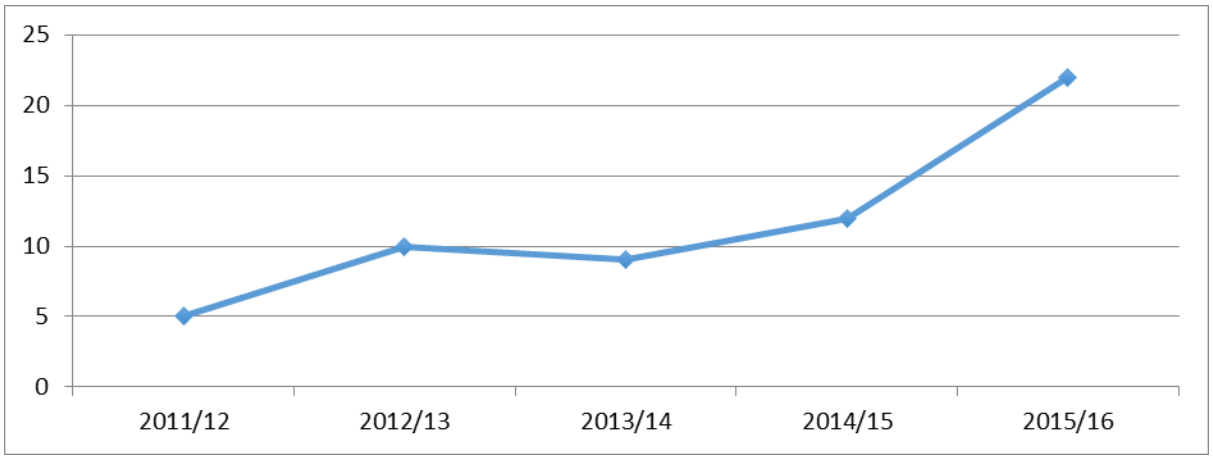
This complaint resulted in two investigations: discharge planning in the hospital involved and complaints handling. Both investigations are currently underway.

Increase in Number of Matters Conciliated

Another option for the HCSCC to assist parties 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 in which parties are encouraged to discuss issues frankly and openly. It can be used as an alternative to medico-legal processes, or a forum for communication resulting often in explanations being provided to parties, along with apologies where appropriate. In some cases agreements reached through conciliation can lead to improvements in services.

In 2015/16, 22 complaints were finalised in conciliation compared with a record 12 in 2014/16. Of these, 13 complaints were resolved in conciliation, three (3) were terminated with complainants deciding to seek outcomes by litigation, three (3) were terminated after subsequently being assessed as not suitable for conciliation, two (2) complainants withdrew their complaint and one (1) matter was resolved outside of the conciliation process.

Figure 3: Number of Complaints Conciliated 2011/12 – 2015/16



Case Study 5 – Community Conciliation

A complaint was received from Joe, a respected elder in a remote community. Joe told the HCSCC that the community was unhappy with the way the staff at the local Health Centre Complaint had dealt with Miriam's medical emergency, and that Miriam had to travel to Darwin for medical follow up as a result. Miriam, her family and the entire community had lost faith in the health centre. They were seeking service improvement as an outcome from the complaint.

The complaint was referred to conciliation. The Community Justice Centre mentored HCSCC staff to ensure that they would approach the conciliation in a culturally appropriate way. The conciliation took place over two days. On the first day, Joe introduced staff to family and community members, taking the full day to work out what would be discussed at conciliation, who would be present and when. The conciliation conference took place on the second day, with firstly family present and then community members. It was a flexible process, with the complaint resolved at conciliation with agreement as to service improvements that would take place in

Case Study 6 – Explanation Resolves Complaint at Early Conciliation

Janice complained about the way she was dealt with by a remote clinic when she was injured out bush. While she was satisfied with the quality of clinical care received, Janice was unhappy that she had to attend the clinic some 200kms away for treatment and that clinic staff did not meet her half way with an ambulance. Janice also believed the practitioner had not been at all caring when she finally arrived at the clinic.

The Manager of the Clinic, who had no experience of conciliation with the HCSCC, was initially reluctant to participate, however she eventually agreed to resolve the complaint this way and to attend the conciliation with Eva, the clinician involved on the night Janice was injured. At conciliation, Eva explained the reasons for her decision to meet Janice half way with an ambulance, and Janice realised on the basis of the explanation that the decision was reasonable. Both parties recognised that the way they related to each other on the night was based on misunderstanding, and apologised.

Case Study 7 – Complaints about Disability Services Referred to Early Conciliation

Andy cares for his son Michael who has a profound disability requiring considerable support. Andy contacted the HCSCC with concerns about the quality of the service provided to Michael, complaining that staff often failed to turn up for scheduled visits as well as inconsistent rostering of staff. Andy complained that the Office of Disability, despite repeated complaints about the quality of service, did not follow through with the service provider to ensure that an appropriate service was provided. Andy also complained that the OoD did not give him any say in how his son's funding would be administered or flexible options for short term respite.

The Commissioner will often refer complaints such as this one to conciliation immediately with the goal of repairing or maintaining the relationship with the service provider. In this case, two conciliations were conducted, firstly with the service provider and secondly with the Office of Disability. While both complaints were resolved at conciliation, the decision had already been made to transfer to an alternate provider.

Six Investigations Completed in 2015/16

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 seize 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 and required to advise the Commissioner of action to be taken to comply with the recommendation. If the Commissioner is not satisfied that appropriate steps have been taken in relation to a recommendation, the Commissioner may provide the Minister with a copy of the report and it will then be tabled in Parliament.

The HCSCC the monitors implementation of the recommendations to ensure that undertakings are met and improvements made.

An investigation is a major body of work, difficult for Investigation/Conciliation Officers to complete when there are competing priorities such as responding to enquiries and complaints. In 2015/16, there was a substantial focus on completing investigations, with six completed. The case study below describes an investigation tabled in Parliament 17 March 2016.

Case Study 8- Investigation Women Prisoners' Access to Health Services

In mid 2014 Ms A contacted the HCSCC complaining that she had been unable to see a doctor at the Prison Health Service (PHS) despite repeated requests. She reported that she had been suffering dizzy spells and headaches, urinating multiple times per night and had sore and swollen legs. She was pregnant when she was admitted to prison, however the blood test which would have confirmed her pregnancy status was lost and never followed up. Eventually after many complaints and contacts with the HCSCC, Ms A saw a doctor. She was then taken to the Royal Darwin Hospital and found to be 8 months pregnant. Up until this time, she had received no antenatal care and was taking a medication contraindicated during pregnancy.

A second complaint was received from Ms B in early 2015. Ms B reported that from early 2014 she had complained of pain to her right wrist and shoulder and requested medical attention. Four months after reporting the pain, she was x-rayed and found to have a wrist fracture. She continued to be in pain, alleging that she did not receive proper treatment after the fracture was diagnosed.

These complaints were referred directly for investigation under Part 7 of the Act on the basis of the seriousness of the allegations and the systemic issues raised. The complaints were consistent with the large proportion of complaints received by HCSCC about the PHS, which raised similar concerns about: the management of medical request forms; triage processes; waiting periods; communication with patients; access to specialist medical services; and medical follow-up and recall systems.

The HCSCC found that the PHS failed to provide an adequate health care service to Ms A by failing to follow up pathology results for her pregnancy test; failing to exercise due care and skill in responding to Ms A's requests for medical assistance; failing to provide adequate antenatal care to Ms A and her unborn child; and by administering a medication to Ms A which could have been harmful to her and her unborn child.

In relation to Ms B, the HCSCC found that the PHS failed to provide an adequate health care service to Ms B by failing to diagnose her wrist fracture; failing to provide adequate treatment for her wrist injury; and failing to coordinate Ms B's treatment of her wrist injury.

In relation to systemic issues with the quality of care provided by the PHS, the HCSCC found that PHS did not have satisfactory systems in place for the management of requests for medical assistance; satisfactory clinical follow up procedures were not in place; adequate processes to coordinate services with Corrections were not in place; adequate processes to coordinate external services were not in place; the service was not meeting its responsibility to communicate with patients about their health care; and there were substantial failings in access to women's health at PHS.

Recommendations to address issues identified in the report are currently being implemented by PHS (now known as the Prison Primary Healthcare

High Satisfaction with HCSCC Staff

When closing a complaint, the HCSCC surveys all parties to the complaint by post or email. In 2015/16, responses were received from 20 complainants and 13 service providers. The average response to each question is set out in the table below. "Strongly Agree" with the statement scores 5 and "Strongly Disagree" scores 1, so that the closer the score is to '5', the higher the level of satisfaction.

Table 6 Survey Responses 2015/16

Survey Statements	Complainant	Provider
HCSCC staff were polite	4.40	4.54
HCSCC staff listened to what I had to say	4.25	4.23
HCSCC staff understood what I had to say	4.35	4.08
HCSCC staff kept me informed of the progress of the complaint	4.20	4.08
HCSCC staff responded promptly to my enquiries	4.25	4.31
I had a clear understanding of what I could reasonably expect from making my complaint	4.15	N/A
The HCSCC officer explained the complaint process so I understood the next steps	4.25	N/A
I could understand letters and emails sent by the HCSCC	4.45	4.46
I could understand information given over the phone	4.45	4.46
My views were taken seriously	3.95	3.62
I understand the reasons for the decision	3.60	4.38
The decisions took all available information into account	3.75	3.77
The decisions took all points of view into account	3.70	3.69
The length of time to finalise the complaint was reasonable	4.00	3.38
I am satisfied with the way the complaint was handled	4.00	3.62
I am satisfied with the outcome of the complaint	3.40	4.15
I would use the HCSCC's services again	4.05	3.46

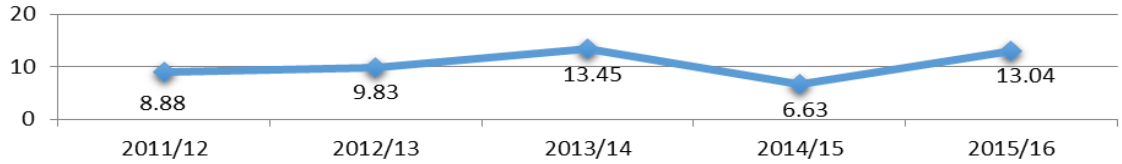
People who are very satisfied with the HCSCC complaints process and those who are very dissatisfied appear more likely to respond to the survey. HCSCC staff are therefore to be commended for the high value placed on their work. Survey results show that there is still room for improvement in the areas of managing expectations with respect to complaint outcomes and ensuring that all parties to a complaint understand reasons for decisions.

THE YEAR AHEAD: 2016/17

Improve Time Lines for Managing Enquiries

The benchmark set for finalisation of enquiries is 10 business, or 14 calendar days. As can be seen from Figure 5 below, average time taken to manage enquiries in 2015/16 was 13.04 calendar days compared with a record 6.63 days in 2014/15 (Note that one matter was removed when calculating average days to finalise enquiries as it was inappropriately recorded as having been received in July 2014 and remaining open for 12 months. Two other enquiries open for 12 months because they were from detainees at the Baxter Detention Centre and the HCSCC had difficulty contacting representatives from the Medical Service were not excluded.). In 2015/16, the HCSCC will focus on reducing the time taken to finalise enquiries.

Figure 4: Time Taken to Finalise Enquiries (Days) 2011/12 - 2015/16



Continue to Improve Complaints Processes

The Business Plan 2016/17 highlights two areas for ongoing improvement in the way the HCSCC manages complaints. Firstly, when it is not possible to resolve a complaint, staff will use the *Code of Health Rights and Responsibilities* as an objective set of standards against which to measure complaints about practice. This will provide the opportunity to advise service providers about improvements they can make in the quality of service delivery in the event that practice is not assessed as being up to the standard contained in the Code. It will also act as a professional development tool, preparing HCSCC staff to assess the standard of individual named providers not registered with a National Board against the Code of Conduct for Health Practitioners (see below).

Parties to complaints are often apprehensive about the conciliation process conducted by the HCSCC. Accordingly, in 2015/16, information prepared for parties to complaints will be reviewed with a view to making it more comprehensive and user friendly.

Introduce Code of Conduct for Health Practitioners

In a Communique dated 14 April 2015, Australian Health Ministers announced the implementation of a nationally consistent Code of Conduct for health practitioners ('Code of Conduct'). The Code will strengthen health complaints mechanisms with respect to health practitioners who are not subject to regulation under the National Registration Scheme, applying to practitioners such as counsellors, social workers, paramedics and massage therapists. The regime will allow for the issuing of prohibition orders, a nationally accessible web based register of prohibition orders along with mutual recognition of state and territory issued prohibition orders. The introduction of the scheme will be overseen by the Australian Health Ministers' Advisory Council (AHMAC).

In 2015/16, the HCSCC worked with the Department of Health (DoH) and the Department of Attorney General and Justice (AGD) to decide on how changes in legislation could be implemented in the NT. In 2016/17 amendments to the Act will be drafted and the Commissioner and Deputy Commissioner will continue to contribute to the National Working Party established to introduce a nationally consistent Code of Conduct. The HCSCC is also represented on a national working party to develop uniform reporting to the Council of Australian Governments (COAG).

Chapter 3: Promote Capacity

ACHIEVEMENTS 2015/16

Service Providers able to Resolve Directly

Enquiries

When receiving a phone call, staff will ask the caller if they have tried to resolve their matter directly with the provider. This is required under s26((a) and s30(1)(d) of the *Act*. If they have not done so, HCSCC staff will speak to enquirers to find out whether there are barriers to direct resolution. If there are no barriers, the enquirer will be invited to try to resolve their matter with the service provider, with information provided as to how they might go about doing this. This process is recorded as "Enquiry referred back" on the Resolve database.

In 2015/16, resolve records of enquiry outcomes show that 53 enquiries (12% of all enquiries received) were referred back to the provider for direct resolution. It is apparent that this underestimates the number of matters referred back as prison enquiries are almost all referred back. It is likely that this is recorded inconsistently between staff, with some staff recording "information provided" as the outcome when a matter is referred back for direct resolution. It should be noted that "information provided" is recorded as the outcome of 224, or 51% of all enquiries received. Work is already being undertaken in 2016/17 to improve consistency between staff in the way outcomes from enquiries are recorded.

<u>Prison Primary Health Care Service</u>

Prisoners at Darwin (Holtze) and Alice Springs Correctional Centres are able to contact the HCSCC to raise concerns about services via a dedicated, secure phone line. Very few complaints or enquiries are received from prisoners in Alice Springs (39 enquiries in 2015/16).

Prior to 2015/16, the Prison Primary Health Care Service (PPHCS) in the Holtze facility had no mechanism for managing internal complaints. With support from the HCSCC, this has been a focus for the service in 2015/16. There are two arms to this improvement – a new system for communicating with prisoners and the development of an internal complaints

procedure. The medical request form used by prisoners who have a health issue which they want followed up has a section on the bottom which allows for prisoners to compliment staff, and also to make a complaint should they wish to do so. The PPHCS has undertaken to follow up any complaints made by prisoners within 5 days of the complaint being received.

The majority of the issues raised by prisoners from Holtze are now referred back to the PPHCS to be resolved in accordance with agreed protocols. The HCSCC will contact the health service if the prisoner informs us that s/he has already tried to resolve the complaint internally or if the issue being raised by the prisoner appears urgent. The HCSCC maintains a record of "return enquiries" from the Holtze PPHCS, that is, instances where a prisoner has been already been referred back to the Prison Primary Health Care Service to resolve their matter directly. In 2015/16, 149 approaches were received from prisoners. Forty three (43) contacted the HCSCC after being directed back to the PPHCS for direct resolution. Table 8 below details the number of contacts from prisoners. With the return enquiries removed (see note 2) there was a slight reduction of prisoner enquiries as a proportion of all enquiries. Statistics of contacts from prisoners will continue to be monitored and analysed for trends in 2015/16.

Table 7: Number and Proportion Enquiries about PHS 2012/13 – 2015/16

Year	Number	Proportion of all Enquiries
2012/13	89	23%
2013/14	146	32%
2014/15	154	38%
2015/16	149	34%

Complaints

Section 30(1)(d) of the *Act* provides that the Commissioner must take no further action in a complaint if satisfied that "...without good reason or cause", reasonable steps have not been taken to resolve the complaint with the provider.

When received, all complaints are tested to determine whether adequate attempts have been made to resolve the complaint directly with the provider. All complaints lodged by a legal agency acting on behalf of a client are now referred back for direct resolution unless a genuine attempt has been made to resolve the complaint before bringing it to the HCSCC. When the complainant is not represented, an officer from the HCSCC will contact the complainant to discuss any attempts made to resolve the complaint and to provide contact details and any help needed to go back and resolve the matter directly.

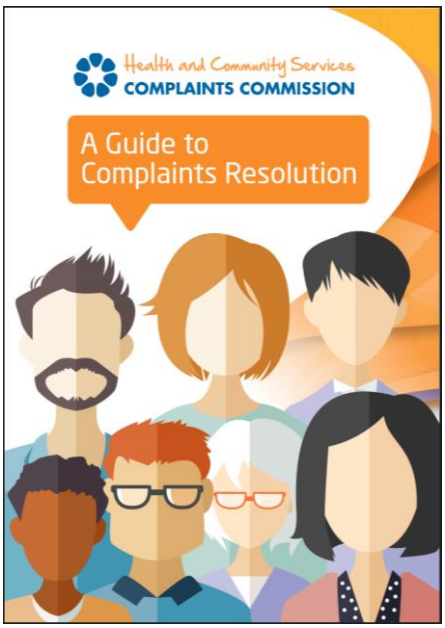
Training Developed

Two training programs to assist service providers manage complaints were completed in 2015/16. The first program, Communications Skills and Complaints, provides training for staff firstly on how to avoid complaints through developing strong customer service skills; secondly how to recognise dissatisfaction and intervene early, and finally how to manage low level complaints informally.

The second training programme deals with the same continuum, from customer service to complaints handling, however it provides information on how to manage complaints informally and formally. The program contains information to assist managers deal with staff who are the subject of complaints, as well as tips and resources for complaint resolution.

Ruth Bresland was instrumental in developing the training programme in conjunction with a specialist Education Consultant. HCSCC cannot routinely deliver the training without additional resources however the Consultant who worked with HCSCC staff to develop the training is able to deliver it on a fee for service basis. By the end of June 2016, Top End Health Service (TEHS) had commenced rolling out the training to its staff in primary and tertiary health care settings.

Guide to Complaints Resolution Available



The Guide to Complaints Resolution provides the information necessary for organisations to develop complaints policies, procedures and practices. Six principles essential to a quality complaints resolution system, drawn from complaints handling literature and from HCSCC experience are identified and explained in the Guide. These principles, and suggestions as to how they might be put into practice, are consistent with the *National Standards for Disability Services*, the *Code of Health Rights and Responsibilities* and Schedule 8 of the Act – *Internal Complaints Procedures.*

THE YEAR AHEAD 2016/17

Safeguards with the Introduction of the NDIS

In July 2014, the Commonwealth, State and Territory governments began consultations to inform the development of a Consultation Regulatory Impact Statement to seek community input on the development of a national disability safeguards and quality framework. Australian Commissioners identified the minimum safeguards which should form part of a national quality and safeguards framework for people with disability under the National Disability Insurance Scheme (NDIS). To date several of these essential components identified by Commissioners two years ago do not exist in the Northern Territory. Considerable work to ensure satisfactory rollout of the scheme is required in coming months.

On 5 May 2016, the Commonwealth and Territory governments signed an agreement for the full rollout of the NDIS in the Northern Territory, to commence on 1 July 2016 with

full rollout complete by July 2019. It was agreed that the Northern Territory would be responsible for quality and safeguarding arrangements through the transition period.

Table 1 in Schedule F of the Bilateral Agreement specifies that the HCSCC will be responsible for complaints and monitoring critical incident reporting. At the time the agreement was signed, the HCSCC had asked for an additional two staff through the transition period to work with communities, people with disabilities and their carers and families and with disability service providers to build capacity in complaints management. If the HCSCC is to be responsible for monitoring critical incident reporting as set out in the Bilateral Agreement, HCSCC capacity will need to be further enhanced. The Act may also require amendment to cover circumstances where such action by the Commission is not in response to a complaint and is thus considered an "own motion" investigation. At the time of writing this Annual Report, no provision has been made to the HCSCC to assist it carry out its role during transition, and refinement of the bilateral agreement is continuing.

In 2016/17, the HCSCC will develop a project plan to ensure that complaints mechanisms are available and accessible to people receiving services funded by the NDIS, develop a business case for additional short term funding, and dependent on the outcome, work to provide a complaints resolution /investigation service during transition.

Prescribed Providers

Section 99 of the Act states that a "prescribed provider" must lodge a return to the Commissioner particularising complaints received from the HCSCC and complaints received directly by the organisation,

Schedule 7 of the Health and Community Services Complaints Regulations prescribes the following organisations as those required to report under the Act: the 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; and Wurli Wurlinjang Aboriginal Health Service.

The list of health providers required to report to the HCSCC is well out of date. Not only are there many more health service providers which should be included in this list (for example Katherine West Health Board), but the public service provider has undergone several transitions since 1998, now organised under three separate but interlinked entities: DoH, TEHS and CAHS.

No returns have been lodged for the past two years as the information provided cannot be meaningful for reasons set out above.

Given the roll out of the NDIS from 1 July this year, it is important that consideration is given as to whether disability service providers should be prescribed under the Act. Importantly, to do so will mean an additional layer of safeguards for Territorians receiving services under the NDIS.

As set out in Chapter 4 of this Annual Report, the HCSCC will seek the views of government regarding how to best employ this form of regulation.

Chapter 4: Advise Government

ACHIEVEMENTS 2015/16

Omnibus submission

On 24 February the Commissioner and Deputy briefed the Minister by way of an omnibus submission on a suite of issues relating to the Commission and its future direction. The meeting raised a number of issues and nominated several potential amendments to the *Health and Community Services Complaints Act*.

Potential amendments to the *Health and Community Services Complaints Act*

1. Total review as required by s106

Section 106 requires as follows:

106 Review of operations of Act

(1) The Minister must cause a review and report to be made on the operation of this Act as soon as practicable after the expiration of 2 years after the commencement of this Act and then at intervals not longer than 5 years.

(2) The report must contain recommendations as to whether amendments to this Act or the Regulations are necessary or desirable.

(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

This requirement is significantly in default with the 1998 Act subject to 4 scheduled reviews, only one of which has occurred. A comprehensive review was undertaken with a team commissioned in late 2002. Following a call for submissions, extensive consultation and 15 months of work, a 172 page report made 78 recommendations, none of which were made public for reasons unknown. Many of these recommendations have been overtaken, lack current relevance or have become practice by other means. With the exception of minor procedural matters and the amendment to recognise new instrumentalities such as the Children's Commissioner for example, the Act remains largely unchanged from its introduction in 1998 and should be reviewed following the general election due in August this year.

2. Unregistered providers and "own motion" powers

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. They further agreed to the development of a common web portal and a nationally consistent suite of explanatory materials to support the National Code and for thiswork to be led by the Australian Health Complaints Commissioners.

On 30 July 2015, the Health Workforce Principal Committee agreed for Victoria to take the lead in coordinating the implementation of those aspects of the National Code regime which require coordinated national action. These include:

- A common web portal for the National Register of prohibition orders
- Nationally consistent explanatory materials
- A common framework for data collection and reporting
- Annual performance reporting to Ministers; and
- Policy resource to assist jurisdictions implementing a code regime for the first time.

Drafting Instructions are well advanced and following further refinement and consultation with Victoria, will be the subject of a Cabinet Submission.

The necessity for the Commissioner to have "own motion" powers will be a central component of the regulation of unregistered providers. Such power is currently not available to the Commissioner. The current legislation drafting instructions envisage own motion powers and its use will be quarantined to those matters relating to the new provisions relating to unregistered providers, pending decisions when the entire Act is reviewed.

3. Current Review capability.

Part 9 of the Act provides (in part) as follows:

Health and Community Services Complaints Review Committee

78 Establishment of Committee

(1) The Health and Community Services Complaints Review Committee is established.

(2) The Committee consists of 5 persons appointed by the Minister….

79 Powers and functions of Committee

(1) The functions of the Committee are as follows:

(a) to review the conduct of a complaint to determine whether the procedures and processes for responding to the complaint were followed and, as it thinks fit, to make recommendations to the Commissioner in respect of the conduct of the complaint;

(b) to monitor the operation of this Act and make recommendations to the Commissioner in respect of any aspect of the procedures and processes for responding to complaints;

(c) to advise the Commissioner and the Minister, as appropriate, on the operation of this Act and the Regulations.

(2) Subsection (1) does not authorise the Committee:

(a) to investigate a complaint; or

(b) to review a decision of the Commissioner to investigate, not to investigate, or to discontinue investigation of, a complaint; or

(c) to review a finding, recommendation or other decision of the Commissioner, or of any other person, in relation to a particular investigation or complaint.

(3) The Committee has power to do all things necessary or convenient to be done in connection with the performance of its functions...

There are a number of issues which could be canvassed in the review of the entire Act in relation to review capability. These include the effectiveness of a review process which does not allow review of a complaint, finding, decision or recommendation of the Commission (see s79(2)). Additionally, the Review Committee has power to monitor the Act and make recommendations but has not done so in relation to deficiencies in the Act. The incoming Committee has adopted this power into its work program.

There is also some potential for criticism of an appeal avenue which finds deficiency in the Commissioner's "conduct of a complaint" and thence makes recommendations to the Commissioner, the original decision maker.

4. <u>Prescribed providers ss99 and 100</u>

Sections 99 and 100 of the Act provide;

99 Returns by providers

(1) A prescribed provider must lodge with the Commissioner, not later than the date determined by the Commissioner, a return containing the particulars that the Commissioner requires concerning:

(a) all complaints that the provider was notified of by the Commissioner during the financial year; and

(b) all complaints that the provider received during the financial year; and

(c) any action taken during the financial year in response to, or as a result of receiving, a complaint mentioned in paragraph (a) or (b) or such a complaint received during a previous financial year.

Maximum penalty: 40 penalty units.

(2) In subsection (1), a reference to a complaint received by a provider includes:

(a) a complaint received by a provider in relation to a health service or community service, whether or not the same or a similar complaint has been made to the Commissioner; and

(b) a complaint in respect of which the Commissioner, if the complaint had been made to him or her, would not have entertained.

100 Internal complaints procedures

A prescribed provider must implement the internal complaints procedures as set out in the Regulations.

Maximum penalty: 40 penalty units.

The intention of the original legislators appears clear. While the objective of the Act at 3(a)(i) charges the Commission with providing

"... an independent, just, fair and accessible mechanism for resolving complaints between users and providers of health services and community services",

3(a)(ii) tasks the Commission with establishing a complaints system that:

"...encourages and assists users and providers to resolve complaints directly with each other"

This has been a major emphasis of the Commission over the course of the year. That is, an assumption that larger organisations with robust fair complaints mechanisms will handle routine matters in the first instance, in lieu of the Commission.

The most obvious example is with the Prison Health Service (PHS). Prisoners previously accounted for approximately 38% of complaint enquiries. (See table 7). Most complaints justified and valid, and most were minor in nature and quickly resolvable at enquiry stage as evidenced by PHS formal complaints only comprising 2% of all complaints. Importantly, many complaints provided sound indicators of service deficiencies and should have been used to inform and improve processes and practice. Significant work has seen better complaints systems instituted at the point of service. The TEHS PHS has now introduced a complaint system and there is palpable goodwill between the Commission, the Department of Health and the Department of Corrections in this regard and an MOU between the two Departments was signed. An investigation involving complaints from prisoners titled *Investigation into the Prison Health Service at Darwin Correctional Centre* was tabled in the Parliament on 26 February 2016

The current approach is adaptable to other providers with high complaints profiles.

There appears little doubt that the original legislators sought to ensure a continuing oversight of these internal systems by the Commission to maintain confidence that they were embedded in operations, robust and fair. The original list of prescribed providers reflects the period of the Act's commencement and is seriously deficient in terms of the span of providers in the health sector today. Essentially it comprises the Aboriginal health services in each of the regions, the then Department of Northern Territory Health Services and the Darwin Private Hospital. In the intervening period, numerous private providers and several new Aboriginal health providers have emerged. The list contains no providers of services for aged people or people with a disability.

In order to move effectively manage the complaints workload of the Commission and give priority to the legislative requirement to encourage and assist users and providers to resolve complaints directly with each other s99 and 100 will become an emphasis of the Commission.

S104 requires the development of a Code for prescribed providers which outlines the procedures they must implement. This Code is circa 2000, and while reasonable is not optimal in terms of contemporary complaints practice and would benefit from review and updating.

This matter will be resubmitted for specific Ministerial direction and endorsement in coming months

5. <u>Relationship with AHPRA/Boards</u>

During the biannual meeting of Health Complaints Entities Commissioners (HCEs), AHPRA and Boards in October 2015 there were wide-ranging discussions about the Snowball Report which had been tabled and publically released at the August 2015 Ministers' meeting.

The Northern Territory along with Victoria and Western Australia undertook a three month trial to improve complaints handling involving the Commissions and AHPRA along the lines recommended by Mr Snowball. Essentially this requires either of the parties to cease involvement in a complaint with an assumption that the "handling" entity's processes will be sufficiently robust to satisfy the legislative and other requirements of the "relinquishing" entity.

Efficiencies are now evident and further expanded on page 7.

6. Legislative charter and priorities (Objectives s3)

The Act at s3 states:

3 Objectives

The objectives of this Act are:

(a) to establish a health and community services complaints system that:

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

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

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

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

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

(b) to set out the powers and functions of the Commissioner; and

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

This charter is well understood and a valid and potent response to concerns about safety, quality improvement and consumer participation within the health, disability and aged sectors in the Northern Territory. However, it is obvious that the objectives are derived from a circa 1990 perspective and they do not comprehensively cover the field. A further issue of concern is the lack of demonstrable progress with 3(a) (ii), (iii), (iv) and (v) and the lack of updating and alteration to the Code of Health and Community Rights and Responsibilities.

The major deficits in a comprehensive response to complaints handling discussed with the Minister were:

- The lack of effective advocacy for vulnerable groups
- Significant underrepresentation of certain groups in the Commission's statistical complaints profile
- Lack of choice of provider including circumstances where there is a complete absence of service provision
- Inadequate analysis of the impact of national policies on the Northern Territory.
- Tardiness evident in developing robust health complaints process in providers with high client loads and sufficient capability to complete this task
- Ensuring that complaints have led to service improvement.

Discussions with the Minister

Discussions with the Minister were also held regarding:

- the NDIS, and funding requirements for the Commission.
- Tabling of the prison investigation on 26 February 2016 *Investigation into the Prison Health Service at Darwin Correctional Centre*
- Appointments to the Review Committee

THE YEAR AHEAD 2016/17

The current business plan requires the Commissioner to offer face to face briefings with all Members of the Legislative Assembly. This will be undertaken as a routine regular matter following the general elections due in August 2016.

Chapter 5: Educate the Community

ACHIEVEMENTS 2015/16

HCSCC Staff Involved in 70 Community Visits/Events

Key functions of the HCSCC, in addition to the investigation and resolution of complaints, include promotion of the rights and responsibilities of service users and providers, promotion of effective complaints systems, and provision of information, education and advice about the *Health and Community Services Complaints Act*, the Code and complaint resolution.

As set out in Appendix 2 to this report, in 2015/16 the HCSCC was involved in 70 community visits / events, comprising contact with more than 1800 people. In 2015/16, there was a focus on providing information about the HCSCC to people receiving disability services as well as to providers of disability services.

In addition to the face-to-face work that was undertaken, the HCSCC continues to distribute brochures and posters to a range of health and disability organisations in the NT.

Brendan Schultz and Linzi Hamlyn at the Disability Awareness Festival 2015

Stephen Dunham and Judy Clisby visit staff of Somerville NT in Katherine

Engagement with AHPRA and the Boards

The HCSCC works closely with AHPRA and the National Boards as partners in managing health complaints in the Territory. In 2015/16, the Commissioner met with four National Boards: the NT Medical Board, the NT Nursing and Midwifery Board, the NT Dental Board and the Podiatry Board. In addition, as outlined earlier in the report, the Commissioner was a member of a working group trialling consultation processes between the Boards and Health Complaints Entities, the outcomes of which include new Information and Referral Protocols. A pamphlet for users of health services which describes the roles of the Boards and Health Complaints Entities will be published in 2016/17.

In the picture above, the Commissioner is addressing a stakeholder breakfast hosted by AHPRA on 21 June 2016.

Hosted Australia's Biggest Morning Tea 26 May 2016

Activities aimed at providing education about the rights and responsibilities of service users and service providers, as well as the role and function of the HCSCC generally include attendance at community events, visiting agencies and presenting at community forums.

The HCSCC decided to try to reach a different group of people in 2015/16 by hosting a "Biggest Morning Tea" function, and inviting everybody working in NT House and Charles Darwin Centre as well as key stakeholders from Top End Health Service and AHPRA.

In addition to being able to offer a great morning tea along with information about the HCSCC, the team raised $601.20 to contribute to cancer research and to services for people with cancer.

Increased visits to HCSCC Website

Anyone can access the HCSCC through the website at www.hcscc.nt.gov.au. The website has links to our on-line complaint form, information which includes the latest Annual Report and brochures, complaints handling training, the Guide to Complaints Resolution and our legislation. By accessing the website, it is possible to find answers to questions without the need to contact the HCSCC directly.

Table 8: Website Access 2011/12 – 2015/16

Year	2011/12	2012/13	2013/14	2014/15	2015/16
Total Visits	3157	2956	3802	4056	6185

Twenty eight percent (28%) of complaints were received from the website 2015/16 compared with 21% in 2014/15 and 15% in 2013/14. This is to be expected in today's computer savvy environment and is a cause of the Commission's greater focus on this communication.

THE YEAR AHEAD 2016/17

Improve Accessibility to the HCSCC for People with Disability

Table 9 below tracks the number of complaints received about disability services, mental health services and aged care services over the past five years. The failure to increase the proportion of complaints about disability services over this time, despite the focus by the HCSCC, indicates the importance of further concentration of our efforts, particularly in light of the NDIS (see page 20 of this report).

In 2016/17, information about the rights of users of disability services, the HCSCC complaints process and a revised complaint form will be developed as part of a package of initiatives to improve accessibility to the HCSCC for people with disability and their carers, families and support people. Staff will also visit the work sites of providers throughout the year to improve community participation and awareness of the Commission's role..

Table 9: Aged and Disability Services Complaints 2011/12 – 2015/16

Provider Type	2011/12	2012/13	2013/14	2014/15	2015/16
Disability Services	4	6	8	9	4
Mental Health Services	1	1	14	18	3
Aged Services	1	1	1	1	3
Total	6	8	23	28	10

Disability Expo

As part of increasing involvement with the disability sector, the HCSCC will work with key non-government disability service providers and the peak organisation, the National Disability Service, to organise an annual Disability Expo. The first expo will be designed to focus on readiness for the full rollout of the NDIS by empowering people with disability, their carers and families to choose the right service provider for them. It will give service providers the opportunity to market their services.

It is envisaged that future expos will be held late in August each year to coincide with the Disability Awareness Festival. While this expo will have a narrow focus, plans for future annual expos are to display a broad range of information about services designed to enhance the lives of people with disability, including in areas such as work, money, education, human rights, life skills and recreation.

Improvements to the website

The increasing proportion of electronic delivery of complaints and increasing numbers of visits to the HCSCC website require that the website is updated and maintained. In particular, resources developed by the HCSCC to assist service providers with complaints resolution

Chapter 6: Governance & 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 Department of Health entities) are informed in writing of the right to have the conduct of the complaint reviewed. Very few choose to do so, however one request was received in early December 2015.

Appointments of members of the Review Committee were due to be renewed in early 2016, and due to resignations from the Committee, at the time the request was lodged there were insufficient members to constitute the committee.

The HCSCC Review Committee, appointed early April 2016, is comprised of:

Mr Andrew George – Chairperson
Dr Joanne Seiler – Provider Representative
Ms Karyn Cook – Provider Representative
Ms Kiah Hanson – User Representative
Mr Robert Kendrick - User Representative

L-R: Joanne Seiler, Andrew George, Karyn Cook, Robert Kendrick, Kiah Hanson

ACHIEVEMENTS 2015/16

Internal Functional Review

In 2015/16, the HCSCC reviewed workflows using lean management principles (see below), and also reviewed the role of the three investigation /conciliation officer positions to determine whether specialisation of staff would lead to efficiencies in the way the HCSCC conducts its business. In the past twelve months, the HCSCC trialled recruiting staff with specialist rather than generic skills.

As a result, staff now possess specialist complaint resolution investigation / report writing and conciliation expertise. We found that due to the small size of the team, all staff need some generic skills; that is they need to be able to perform outside of their specialist function. Each specialist staff member now mentors other staff in their area of expertise, with the outcome improved quality of service.

Re-worked Resolve Workflows

When first introduced, Resolve workflows were designed to mirror every step of the complaint process. While this was useful initially, it did add unnecessarily to staff workload with a number of unnecessary steps. Resolve was tasked with changing workflows to simplify them in a manner agreed to by staff after extensive consultation. Changes were implemented during the early part of the financial year.

Since then, major changes to the consultation process with AHPRA meant that further changes needed to be made to the workflows on Resolve.

Brendan Schultz, half time Business Manager with the HCSCC adapted Resolve to implement these additional, quite complex changes. His understanding of the HCSCC complaints and enquiry process, along with his technical skills and knowledge mean that Brendan makes a valuable contribution to the complaints handling team.

All Complaints Workflows Reviewed

Workflows for all complaints received by the HCSCC were reviewed and updated in 2015/16 to manage increasing staff workloads by ensuring that HCSCC processes are as “lean” as possible; and to account for changes to AHPRA Consultation processes.

Flow charts with accompanying checklists were developed to cover all contingencies when a complaint is received by the HCSCC. The result is a comprehensive portfolio of documented complaints processes which enable fast, individual yet consistent management of complaints received by the HCSCC.

This was a large body of work as it resulted in a comprehensive update to the HCSCC Policies and Procedure Manual.

THE YEAR AHEAD 2016/17

Update Resolve Manual

Resolve provided a comprehensive, albeit generic manual when it was first introduced in 2014. This was adapted with an additional chapter setting out how HCSCC staff should use the database for complaints. It set out business rules for how records should be kept on resolve as well as recording conventions to ensure consistency between staff.

In 2016/17, the Resolve Manual will be updated to reflect the changes that have occurred with the HCSCC complaints process.

Paper Free Complaints System

In 2015/16, work completed to reduce unnecessary steps in the HCSCC complaints process, setting out new workflows and then mirroring these workflows in the Resolve database system has meant that HCSCC complaints can now be managed only by use of Resolve, ie paper free. Plans are in place to commence a paper free office with all complaints, enquiries and AHPRA notifications received from 1 July 2016 to be managed electronically.

Work towards a Paper Free Office

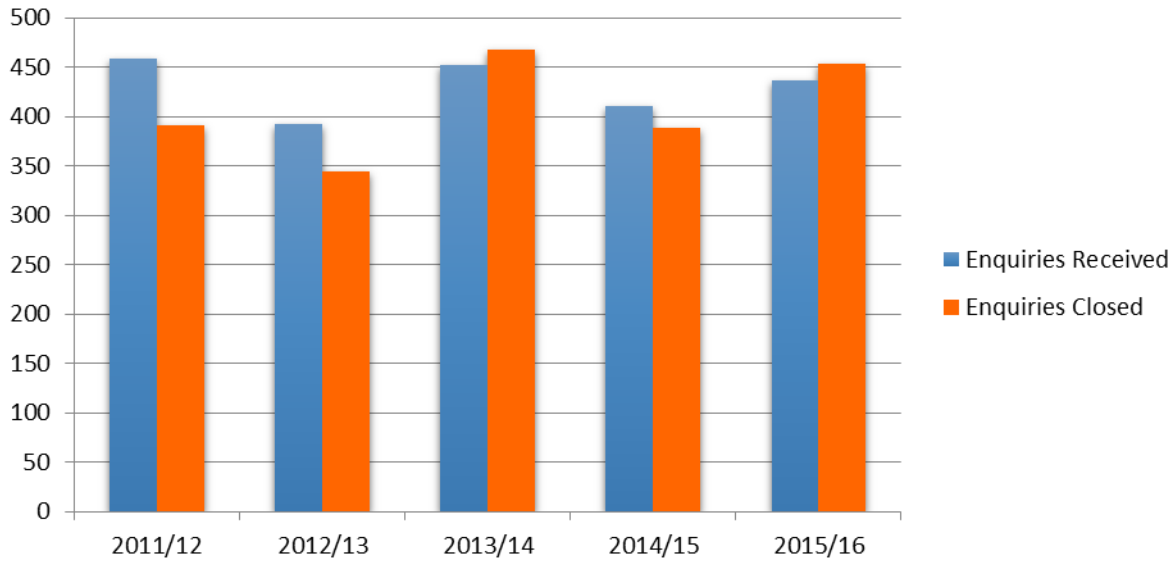
The HCSCC plans to commence being entirely paper free from 1 July 2017 using TRIM as the database to manage all files other than complaint files. Tasks in 2016/17 include a review of administrative policies and procedures; training staff on how to use TRIM; reviewing and updating existing TRIM files; and reviewing current files kept on the HCSCC drive to ensure they, and the way they are organised, are compatible with TRIM thesaurus terms.

Appendix 1: Performance

Enquiries / Informal Complaints

In 2015/16, the HCSCC managed 436 enquiries.

Figure 5: Enquiries Received and Closed 2011/12 – 2015/16



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

Public providers accounted for 84% of the enquiries received 2015/16, in line with an increasing trend over the past two years of a higher proportion of enquiries about the public system.

Table 10: Providers Subject of Enquiries 2011/12 – 2015/16

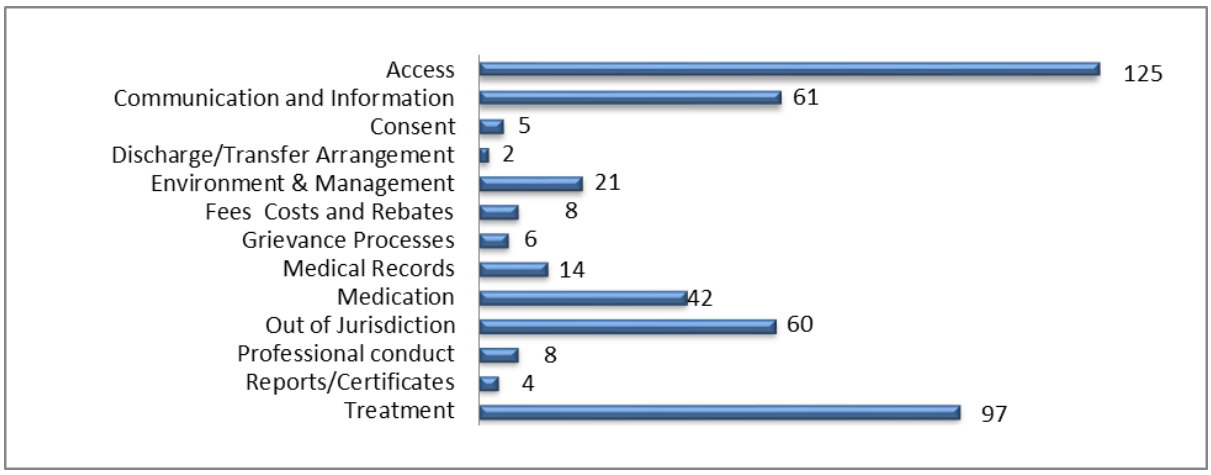
Providers	2011/12	2012/13	2013/14	2014/15	2015/16
Private	232	198	163	95	75
Public	226	195	289	315	381
Total	458	393	452	410	456[2]

[2] Some enquiries may involve more than one issue and more than one provider. For this reason, there are more providers than there are enquiries See note below, only one issue is counted per enquiry.

Issues Raised in Enquiries

As with previous years, the most common issues raised and dealt through our enquiry process were access to services, standard of treatment and communication. Sixty enquiries were considered and found to be out of jurisdiction.

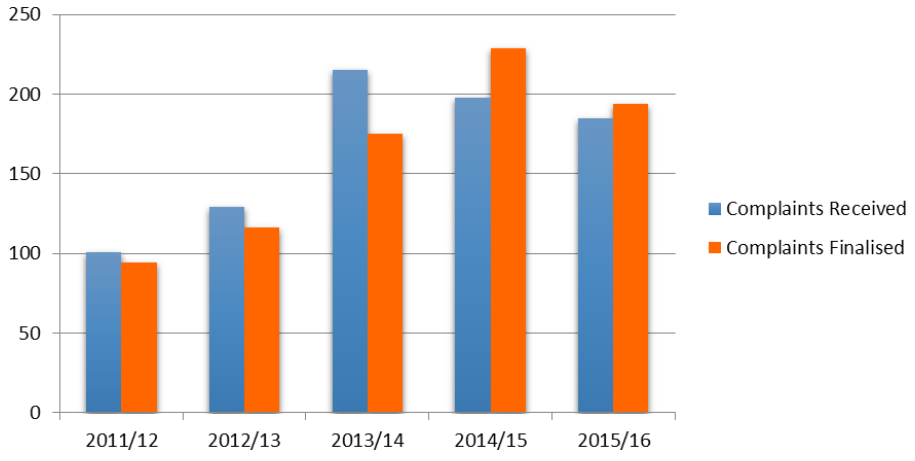
Figure 6: Issues Raised in Enquiries Closed 2015/16[3]



Complaints

One hundred and eighty five (185) new complaints were received in 2015/16. While the total number of complaints decreased in 2015/16, the total number of matters handled by the HCSCC increased. The downward trend in complaints since 2013/14 may represent a greater proportion of complaints handled as enquiries. Complaint numbers may also be affected by the changeover to Resolve as multiple providers can be recorded and managed on any one complaint file. Prior to the introduction of Resolve, a complaint about two organisational providers would be recorded as two separate complaints (as they are in interstate jurisdictions), whereas now it is likely to be recorded as one complaint. As in 2014/15, more complaints were finalised (194) than were received.

Figure 7: Complaints Received and Finalised 2011/12 – 2015/16

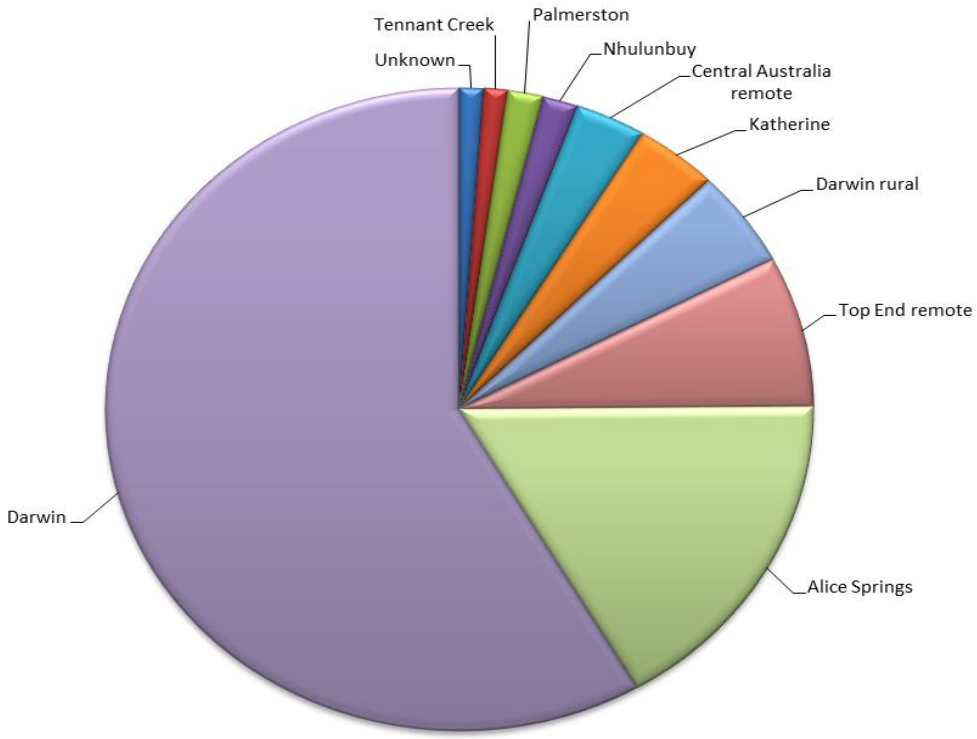


[3] Only one issue is counted for each enquiry in 2015/16 to ensure consistency between staff practice

Location of Services Complained About

As expected, the majority of services subject to a complaint are located in Darwin (58%).

Figure 8: Location of Services 2015/16



How are Complaints Received?

Where the complaint is made by phone the complainant is asked to confirm it in writing. Where a complainant is unable to confirm a complaint in writing, the HCSCC will reduce it to writing and provide a copy to the complainant as required under the Act.

In 2015/16, of the 106 complaints made directly to the HCSCC, 67% of complainants approached the HCSCC by electronic means (39% by email and 28% by the HCSCC website), 20% complaints received by mail and 8% in person. The remaining complaints were or taken by phone (5%)

In 2015/16, seventy nine (43%) of complaints originated with the relevant Practitioner Registration Board.

What Services are Complained About?

In the past, the HCSCC has reported the providers subject to complaint as one provider per complaint. This practice means that the number of providers is under-represented, as any one complaint file may involve numerous providers, including organisational providers (for example the Department of Health) and individual providers (for example medical practitioners).

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. So for example, Allan lodges a complaint about organisational provider Busy Hospital Inc. In this complaint, Allan alleges that

1. he waited too long in ED;
2. when he was admitted to the hospital he was placed in an inappropriate ward; and
3. interpreters were not used to gain his consent to treatment.

This comprises three complaint issues, however Busy Hospital Inc is counted once for this complaint. Later, Zac makes a complaint about Busy Hospital Inc. A second complaint file is opened, and Busy Hospital Inc is counted again.

In 2015/16, there were a total 243 providers involved in the 185 complaints managed by the HCSCC. 132 (54%) involved public providers and 111 (46%) private.

Figure 10 gives a breakdown of public sector complaints organised into two sections; organisational provider types and individual provider types. Twenty seven percent of all public sector complaints were about hospitals, with nurses receiving the highest number of complaints about individual practitioners (25% of all public sector complaints) followed by medical practitioners (20%).

Figure 9: Public Providers 2015/16

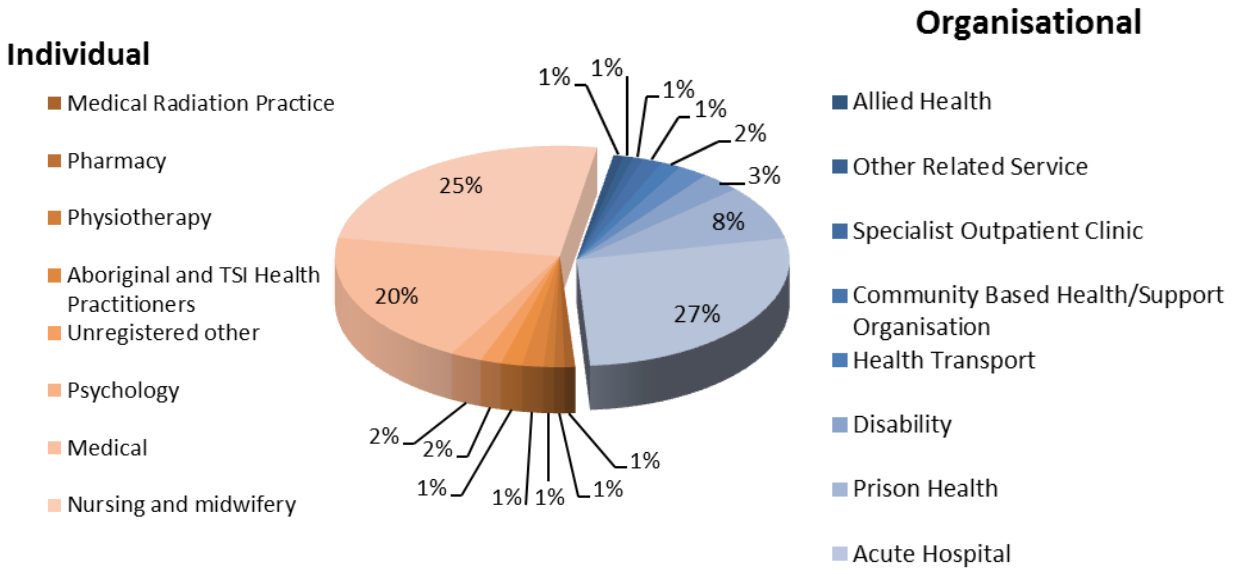


Figure 10: Private Providers 2015/16

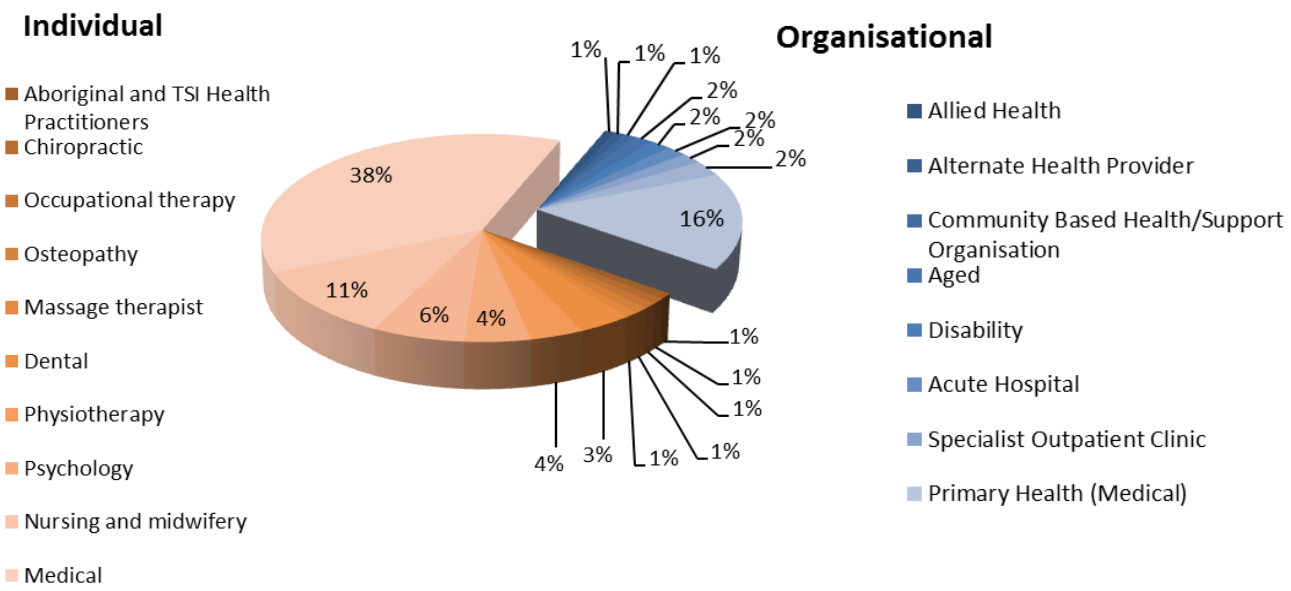
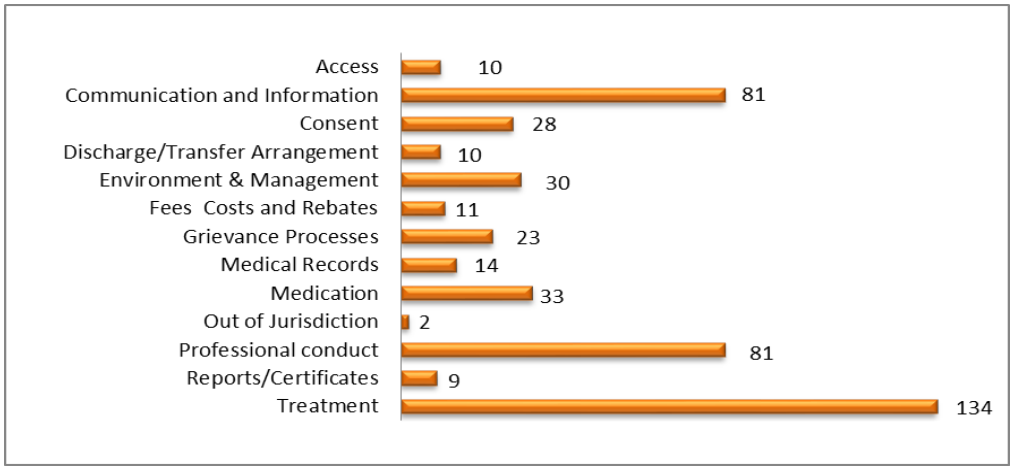


Figure 11 above shows that in the private sector, the highest number of complaints about organisations were about services offered by GP Clinics (16% of all private sector complaints), and again, medical practitioners were subject to the greatest number of private sector complaints (38%), followed by Nurses and Midwives (11%) and Psychologists (6%).

What Issues are Complained About?

Each issue described in each complaint received by the HCSCC is recorded for reporting purposes, with some complaints raising more than one issue. Issue categories are used consistently across Australia to allow for comparison. 466 issues were assessed in 2015/16.

Figure 11: Issues Raised in Complaints Closed 2015/16



Issues are recorded against all complaints received by HCSCC, including AHPRA notifications. This method of reporting allows for a more complete picture of the types of issues complained about in the Northern Territory, and is consistent with practice in most other Australian jurisdictions.

While the top three issues: treatment, communication and conduct remain consistent year on year, most conduct matters are 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.

Table 11: Complaints about Access 2011/12 – 2015/16

ACCESS	2011/12	2012/13	2013/14	2014/15	2015/16
Access to facility	0	1	0	3	0
Access to subsidies	0	1	0	2	0
Refusal to admit or treat	4	5	8	7	4
Service availability	1	6	12	9	5
Waiting list	2	3	5	2	1
Total	7	16	25	23	10

Issues relating to access made up 2% of all issues raised in complaints in 2015/16. Concerns about access to services however comprised 26% of all enquiry issues, largely due to the high proportion of contacts from prisoners.

Table 12: Complaints about Communication & Information 2011/12 – 2015/16

COMMUNICATION & INFORMATION	2011/12	2012/13	2013/14	2014/15	2015/16
Attitude and manner	12	20	38	42	41
Inadequate information provided	7	12	16	37	31
Incorrect/misleading information provided	1	2	4	12	4
Special needs not accommodated	0	4	3	6	5
Total	20	38	61	97	81

Issues relating to communication and information made up 17% of all issues complained about. This is consistent with last year's figures (19%).

Table 13: Complaints about Consent 2011/12 – 2015/16

CONSENT	2011/12	2012/13	2013/14	2014/15	2015/16
Consent not obtained or inadequate	4	3	9	17	21
Involuntary admission or treatment	2	0	2	1	3
Uninformed consent	0	1	1	1	4
Total	6	4	12	19	28

Issues relating to consent constituted 6% of all issues complained about.

Table 14: Complaints about Discharge and Transfers 2011/12 – 2015/16

DISCHARGE & TRANSFERS	2011/12	2012/13	2013/14	2014/15	2015/16
Delay	0	0	1	0	0
Inadequate discharge	0	6	3	17	9
Mode of transport	0	0	0	1	1
Patient not reviewed	0	1	1	0	0
Total	0	7	5	18	10

Two per cent of issues raised in 2015/16 related to discharge and transfer arrangements.

Table 15: Complaints about Environment & Management of Facility 2011/12 – 2015/16

ENVIRONMENT & MANAGEMENT	2011/12	2012/13	2013/14	2014/15	2015/16
Administrative processes	1	4	3	16	10
Cleanliness/hygiene of facility	2	2	0	10	5
Physical environment of facility	1	0	2	7	3
Staffing and rostering	1	2	6	3	1
Statutory obligations/accreditation standards not met	1	2	3	6	11
Total	6	10	14	42	30

Complaints in this category relate to administration rather than the care/treatment component of the service. These issues made up 6% of all issues raised in complaints, double that of last year.

Table 16: Complaints about Fees, Costs & Rebates 2011/12 – 2015/16

FEES, COSTS & REBATES	2011/12	2012/13	2013/14	2014/15	2015/16
Billing practices	0	1	7	9	11
Cost of treatment	1	0	0	0	0
Financial consent	0	1	0	1	0
Total	1	2	7	10	11

Issues relating to cost of service constituted 2% of issues in complaints finalised.

Table 17: Complaints about Grievance Procedures 2011/12 – 2015/16

GRIEVANCE	2011/12	2012/13	2013/14	2014/15	2015/16
Inadequate/no response to complaint	2	6	5	19	16
Information about complaint procedure not provided	1	1	0	2	1
Reprisal/retaliation as a result of complaint lodged	0	2	0	2	6
Total	3	9	5	23	23

Issues related to grievance procedures and complaint handling made up 5% of all issues complained about, consistent with previous years.

Table 18: Complaints about Medical Records 2011/12 – 2015/16

MEDICAL RECORDS	2011/12	2012/13	2013/14	2014/15	2015/16
Access to/transfer of records	0	0	2	7	3
Record keeping	2	6	5	7	10
Record management	0	0	1	5	1
Total	2	6	8	19	14

The medical record category includes complaints about errors and inadequacies in medical records. They accounted for 3% of all issues complained about in 2015/16.

Table 19: Complaints about Medication 2011/12 – 2015/16

MEDICATION	2011/12	2012/13	2013/14	2014/15	2015/16
Administering medication	2	5	7	7	8
Dispensing medication	0	4	3	3	11
Prescribing medication	2	6	6	9	10
Supply/security/storage of medication	2	2	3	7	4
Total	6	17	19	26	33

Medication related concerns made up 7% of all issues in 2015/16, slightly more than the 5% in 2014/15.

Table 20: Complaints about Professional Conduct 2011/12 – 2015/16

PROFESSIONAL CONDUCT	2011/12	2012/13	2013/14	2014/15	2015/16
Assault	1	2	12	6	2
Boundary violation	7	4	5	4	4
Breach of condition	0	0	2	2	1
Competence	21	20	60	53	42
Discriminatory conduct	0	2	5	2	5
Emergency treatment not provided	0	0	0	0	1
Financial fraud	5	0	1	1	3
Illegal practice	5	6	14	6	8
Impairment	1	3	1	3	1
Inappropriate disclosure of information	1	8	12	14	10
Misrepresentation of qualifications	0	1	4	0	2
Sexual misconduct	0	4	1	1	2
Total	41	50	117	92	81

Issues relating to professional conduct made up 17% of all issues complained about. The majority of these matters were dealt with by the relevant Board after consultation had occurred as required by the National Law.

Table 21: Complaints about Reports/Certificates 2011/12 – 2015/16

REPORTS/CERTIFICATES	2011/12	2012/13	2013/14	2014/15	2015/16
Accuracy of report/certificate	0	2	3	7	6
Costs of reports/certificates	0	0	0	1	0
Inadequate/no consultation	0	0	1	1	0
Refusal to provide reports/certificates	0	0	0	0	1
Report written with inadequate or no consultation	0	0	0	0	1
Timeliness of report/certificate	0	0	0	0	1
Total	0	2	4	9	9

Complaints about reports and certificates made up 2% of issues in complaints closed in 2015/16. The HCSCC has no jurisdiction over the process of writing, or the content of, a health status report.

Table 22: Complaints about Treatment 2011/12 – 2015/16

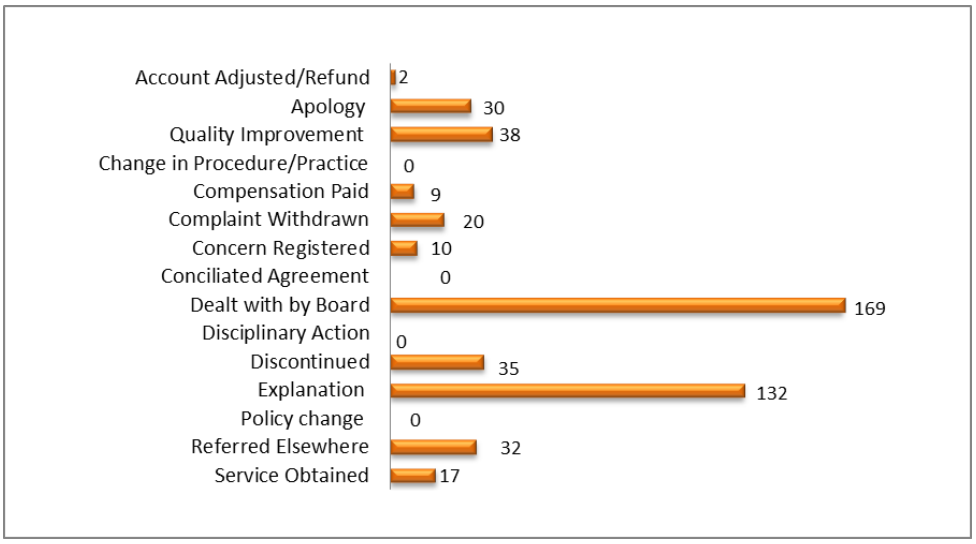
TREATMENT	2011/12	2012/13	2013/14	2014/15	2015/16
Attendance	0	0	1	1	1
Coordination of treatment	3	1	11	18	5
Delay in treatment	2	1	9	11	7
Diagnosis	12	8	12	13	19
Excessive treatment	0	3	0	3	1
Inadequate consultation	1	0	4	5	10
Inadequate treatment	9	7	17	39	54
Infection control	0	2	2	5	4
No/inappropriate referral	2	4	0	9	7
Public/Private election	0	2	0	0	3
Rough & painful treatment	0	0	1	4	4
Unexpected treatment outcome/complications	8	8	4	13	10
Withdrawal of treatment	2	3	1	4	1
Wrong/inappropriate treatment	5	2	9	13	8
Total	44	41	71	138	134

Issues relating to treatment constituted 29% of all issues in complaints closed in 2015/16, increasing from 26% in 2014/15 and 20% in 2013/14. Inadequate treatment is identified as the primary concern 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.

Figure 12: Outcomes of Issues Raised in Complaints Closed 2015/16



The most common outcome from issues closed by the HCSCC was an explanation (41%, up from 29% 2014/15). Twelve percent of matters resulted in a quality improvement of some kind and 11% were discontinued without further outcome.

Appendix 2: Community Engagement Activities 2015/16

Date	Organisation	Activity	No attendees (approx)
1/7/15	DCLS	Presentation and discussion	10
7/7/15	Meet Executive team of TEHS	Discuss RDH approach to complaints	10
10/7/15	Children's Commissioner	Child Death Review process	2
13/7/15	NT Medical Board	Explain Complaints focus and discuss Snowball report	10
28/7/15	NT Nursing and Midwifery Board	Explain Complaints focus and discuss Snowball report	10
5/8/15	IdA for Seniors Week	Know your rights presentation	40
14/8/15	NT Dental Board	Explain Complaints focus and discuss Snowball report	10
19/8/15	Seniors EXPO	Contribute with other service providers to information for seniors	300
22/8/15	AGD	Supreme Court Open Day	150
24/8/15 – 28/8/15	CAHS	Meeting with COO	
	CAMHS	Meeting with Manager and staff	4
	CVP	Meeting Manager and staff	3
	AOD	Meeting with Manager	
	Alcohol Mandatory Treatment	Meeting with Co-ordinator. Visit to facility	2
	ASH	Meeting with Manager and site visit	1
	ASCC	Meeting with senior managers Site visit	10
	Renal Clinic	Site visit	2
	AS Community Care	Site visit Flynn Drive	
	OPG AS	Meeting Manager	2
	Disability Advocacy Service	Meeting with Coordinator	4
	OoD	Introduction to Team Leader	1
31/8/15	DAF	Opening Civic Centre	75

2/9/15	DAF	Happiness and Well-being Market	
7/9/15	Batchelor Clinic	Meeting Manager	1
	Adelaide River Clinic	Meeting Manager	1
	Pine Creek Clinic	Meeting Manager	1
	Step Out	Site visit to Day program and respite house	6
	DAF event Katherine -	NT Friendship and Support	12
8/9/15	Rocky Ridge Aged Care	Site visit – Service Manager	1
	DAF Know Your Rights Red Cross Katherine	Expo and discussion	20
	KH	Site visit –Manager and, Medical Director	5
9/9/15	Kintore School	Principal – Site visit	6
	Somerville Katherine	Site visit and visit to clients' home –Coordinator	8
23-24/9/2015	Royal Commission into Institutional Responses to Child Sexual Abuse	Royal Commission Private Roundtable of Disability Services	30
1/10/15	PHS Meeting re Holtze Correctional Precinct	Improvement and modification of the PHS complaint processes	8
6/10/2015	Commonwealth Ombudsman Social Services, Indigenous and Public Interest Disclosure Branch	Discussions regarding the NDIS complaints system	3
14-16/10/2015	Australian Health and Disability Commissioners' meeting	Bi-annual meeting covering national and interjursdictional issues.	50
23/10/2015	Office of the Adult Guardian	Familiarisation and consultation	8
23/10/2015	CVP	Consultation	1
4/11/15	PHS	Presentation on HCSCC and AHPRA	20
10/11/15	NTLAC	Re new civil service	1
13/11/15	ADC and CVP	Training on mental health and conciliation	8
26/11/2016	TEHS	Consult on changes to Complaints system	10
9/12/2015	Federal Aged Care Commissioner	Meeting to advise new and changed arrangements	8
19/1/16	HCSCC SA	Code of Conduct	1
22/1/16	NTLAC	NT Law Handbook	1 Potential large audience
29/1/2016	Community function to commemorate the retirement of Dr Scattini	Attendance	350

15/2/2016	Charles Darwin University	Presentation to students undertaking Cert IV in Community Services	45
12/2/2016	Commissioner for Correctional Services Mark Payne	Discussions regarding PHS and complaint processes	2
19/02/16	Youth Inpatient Program	Information Forum TEMHS	2
25/2/2016	Commonwealth Dept of Human Services	Multicultural forum	60
02/03/2016	Disability Awareness Festival Meeting	Festival Planning	1
08/03/2016	NDS – Darwin Regional Forum	Information Forum	2
15/3/- 18/3	Commissioners Conference	Disability and Health	15
16/3/16:	Aged Care Complaints Commissioner	Exchange of letters	1
16/3/2016	RDH	Dinner with RDH staff to meet new staff/clarify processes	2
6/4/16	Independents quarterly meeting	Common issues and discussion	8
15/4/16	Privacy Commissioner Federal	Information	1
17/5/16	NDIA Regional forum Katherine	Information	40
24/5/16	HCSCC Review Committee first meeting	Information, induction, workshop	7
25/5/16	Hosting NT Cancer Council Biggest Morning Tea	Morning Tea	40
2/6/16	ANZCOG Advancing Leadership	Training course	12
2/6/16	Total Recreation	Quiz Night	80
6/6/16	Correctional Services Review team (Mr Hamburger et al)	Oral submission	6
7/6/16	Commonwealth Aged Care Complaints	Consult on new structure	4
10/6/16	RDH Quality and Safety Awards	Awards ceremony	120
20/6/16	AHPRA Management	Consultation	12
21/6/16	AHPRA Stakeholder breakfast	Consultation/presentation	60
23/6/16	Podiatry Board	Regular consultation	12

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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