Submission No. 003
Received 1 August 2016

Submission of the Australian Lawyers Alliance

to the

Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee of the Queensland Parliament

on the Inquiry into the performance of the Queensland Health Ombudsman's functions pursuant to section 179 of the Health Ombudsman Act 2013

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WHO WE ARE

The Australian Lawyers Alliance ("ALA") is a national association of lawyers, academics and other professionals dedicated to protecting and promoting justice, freedom and the rights of the individual.

We estimate that our 1,500 members represent up to 200,000 people each year in Australia. We promote access to justice and equality before the law for all individuals regardless of their wealth, position, gender, age, race or religious belief. The ALA started in 1994 as the Australian Plaintiff Lawyers Association, when a small group of personal injury lawyers decided to pool their knowledge and resources to secure better outcomes for their clients – victims of negligence.

The ALA is represented in every state and territory in Australia. More information about us is available on our website.

OUR STANDING TO COMMENT

The ALA is well placed to provide commentary to the Committee.

Members of the ALA regularly advise clients all over the country that have been caused injury or disability by the wrongdoing of another.

Our members advise clients of their rights under current state based and federal schemes, including motor accident legislation, workers compensation schemes and Comcare. Our members also advise in cases of medical negligence, product liability and other areas of tort.

Our members also often contribute to law reform in a range of host jurisdictions in relation to compensation, existing schemes and their practical impact on our clients. Many of our members are also legal specialists in their field. We are happy to provide further comment on a range of topics for the Committee.

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INTRODUCTION – A BETTER MODEL?

Prior to the implementation of the *Health Ombudsman Act 2013* (Qld) (the "Act") successive inquiries and reports into the previous health complaints management system had highlighted that there were "*fundamental deficiencies*" in the system including "*unjustified delays to serious allegations*" and "*confused roles*" within the health complaints management system[1]. It was intended that the Act would address these deficiencies. The Act provides for comprehensive deadlines to be met, the aim being to ensure that complaints are dealt with expeditiously and to ensure that answers can be sought as a priority for concerned patients and their families.

Notwithstanding the initial improvements made with meeting time limits by the Office of the Health Ombudsman (OHO) in its infancy, the statistics unfortunately now show that the new regulatory model has failed to improve compliance with mandated time periods and there remains confusion in relation to the health complaints management system.

The Health Ombudsman's failure to improve compliance with time limits is best illustrated by the data relating to the assessment of complaints and the time taken for investigations to be completed, which prior to the operation of the Health Ombudsman, was the responsibility of the Health Quality and Complaints Commission and the Australian Health Practitioner Regulation Agency ("AHPRA").

The Health Practitioner Regulation National Law (Queensland) ("the National Law") required assessments of complaints to be made by AHPRA 60 days after receipt of a notification. However, only 40% of the 190 notifications opened in the year ending

[1] See the explanatory notes of the *Health Ombudsman Bill 2013*

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30 June 2011 and 52% of the 90 notifications opened in the year ending 30 June 2012 met this standard[2]. Comparatively, under the Health Ombudsman, only 45% of assessments conducted in the 2015-2016 financial year[3] were completed within 60 days.

Another example is the failure to improve the time taken to finalise investigations. Of the investigations completed by AHPRA for complaints received between 1 July 2010 and 30 June 2012, only 13 or 4.05% of investigations took longer than 12 months to complete[4]. Comparatively, with the OHO, 55 or 42.97% of investigations took longer than 12 months to complete[5].

GENERAL TRANSPARENCY AND COMMUNICATION WITH COMPLAINANTS

One of the main objects of the Act is to "*maintain confidence in the management of complaints*". Section 17 of the Act requires complainants to be provided with a progress report every 3 months or whenever relevant action is taken. The ALA has received anecdotal evidence that this is occurring regularly.

The OHO publishes comprehensive data on a monthly, quarterly and annual basis on its website. The ALA considers that this is a significant positive step in providing transparency into the health complaints management system in Queensland. There does not appear to be any requirement for this information to be made publicly available and the ALA would welcome any amendments to the Act that would require this data to continue to be published on the OHO's website.

[2] Data obtained from the Chesterman Report
[3] Analysis based on data released from June 2015-May 2016.
[4] Data obtained from the Chesterman Report
[5] Analysis based on data released from July 2015-May 2016.

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Additionally, the ALA considers that the current data that is available could be enhanced by the OHO publishing statistics detailing:

- The number of requests for information made and the timeframes in which these requests are processed;
- The entire time taken for a complaint to be finalised by the OHO;
- The length of time taken after 60 days for assessments to be concluded; and
- The length of time taken after 12 months for investigations to be concluded; and
- The length of time taken from the date of the complaint to the date the Health Ombudsman takes either immediate registration action and/or issues an interim prohibition order.

NON-COMPLIANCE WITH DEADLINES

A central feature of the Act is the provision of comprehensive deadlines to be met when dealing with complaints. Unfortunately, in most instances, the OHO is failing to meet the prescribed time limits, and this can often be distressing for patients and their families seeking answers.

The Act requires that an assessment must be completed within 30 days[6]. In certain circumstances, an extra 30 days is allowed for the Health Ombudsman to complete an assessment[7]. Analysis of the statistics shows that 926 or 55.09% of matters referred to assessment took longer than the 60 day mandated period[8]. Of these 926 matters, no data has been provided to indicate how long the assessments took once

[6] See section 49(1) of the Act
[7] See section 49(2) of the Act
[8] Analysis based on data released from July 2015-May 2016

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60 days had elapsed. We have received anecdotal evidence from our members that some assessments are taking 12 months to complete.

The ALA believes that in the interests of efficiency and transparency, the current assessment process requires clearer boundaries to prevent it from becoming a quasi-investigation. For example, our members have advised that many assessment decisions indicate that significant evidence has been gathered from various sources, there is a detailed analysis of this evidence and clinical advice has been sourced. To this end, it is suggested that clear legislative guidance or procedures, milestones or steps be established during the assessment period to ensure that the assessment phase is essentially a short triage process. If a decision regarding a complaint is unable to be made within 60 days then it should automatically be referred for investigation or to AHPRA.

Similarly, section 85(1) of the Act requires the Health Ombudsman to complete an investigation as "*quickly as is reasonable*" and, in any case within 12 months. Section 85(2) allows the Health Ombudsman the ability to extend the due date for the finalisation of an investigation. Analysis of the statistics shows that of the 126 investigations finalised between July 2015 and May 2016: 8.74% were finalised within 3 months; 13.49% were finalised between 3 and 6 months; 13.49% were finalised between 6 and 9 months; 20.63% were finalised between 9 and 12 months and 43.65% were finalised after 12 months. Of these 55 investigations that took longer than 12 months to finalise, no data has been provided to indicate how long the investigations took once 12 months elapsed.

The data published by the OHO in May 2016 suggests that there are 292 open investigations. Of the open matters, 40.05% have been open for longer than 12 months. Given only 126 investigations were finalised between July 2016 and May

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2015, the ALA holds grave concerns about the OHO's ability to finalise investigations expeditiously and within the legislated timeframes.

Finally, since its inception, only 19 matters have been referred to the Director of Proceedings for disciplinary action. To date, there has only been one successful outcome in QCAT with disciplinary action taken.

The ALA is concerned that the OHO is failing to reach the prescribed deadlines at a variety of different stages of a complaint. Moreover, the ALA believes that the failure to meet certain time limits is unjust for both complainants and practitioners, with timely resolution of complaints in the best interests of all parties. The ALA notes that in the 2014-15 financial year, the Health Ombudsman reportedly spent approximately $380,000.00 under budget. Therefore, the ALA would welcome any review into the resourcing and staffing arrangements of the Health Ombudsman.

UNREALISTIC TIME PERIOD FOR SUBMISSIONS

Section 54(1) of the Act allows the Health Ombudsman to request information by giving notice to the complainant, relevant health service provider or any other person. The information should be provided in a reasonable time, "*but must not be more than 14 days after the notice is given*"[9].

The ALA considers that this time limit is impractical, given that this short time period does not account for the fact that many practitioners store files offsite or that some individuals may be on leave or have left their employment. The ALA would welcome any legislative amendments that would allow a reasonable extension to these time periods to better account for commercial realities and personal circumstances.

[9] Section 54(2)

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DUPLICATION OF WORK AND RESOURCES

Prior to the Act, a criticism of the complaints system was that there was confusion in relation to the roles of the health complaint management entities. Unfortunately, the ALA believes that the Act has done little to alleviate these issues and greater delineation of the role of both the Health Ombudsman and AHPRA is required.

There is a high volume of matters (736 or 28.23%) being referred to AHPRA from the OHO following the assessment process compared to matters being referred for investigation following the assessment process (65 or 2.49%)[10]. Additionally, 47 or 37.30% of completed investigations were also referred to AHPRA[11].

The ALA is concerned that the reported statistics indicate there may be a large duplication of the work conducted by both AHPRA and the Health Ombudsman. It would appear that any complaint referred to AHPRA from the OHO, undergoes its own assessment process. AHPRA also has the ability to conduct its own investigation. Therefore, even though a matter has been assessed, or even an investigation conducted by OHO, this work may be duplicated when the matter is referred to AHPRA.

LACK OF TRANSPARENCY REGARDING EXPERT SUBMISSIONS

Section 29 of the Act allows the Health Ombudsman to "*establish committees and panels of appropriately qualified persons to advise the health ombudsman about clinical matters or health consumer issues*". However, the ALA has received anecdotal evidence that in many complaints, expert opinion is obtained individually on an ad hoc basis.

[10] Analysis based on data released from July 2015-May 2016
[11] Analysis based on data released from July 2015-May 2016

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Section 278 of the Act stipulates that when a decision is reached, "*the reasons for the decision*" must be provided. In the experience of ALA members, whilst the reasons for the decision generally include a summary of clinical advice that has been provided, it often does not include the information that was provided to the expert, the questions or issues the expert was asked to comment, the actual advice provided by the clinician nor the qualifications of the expert. This lack of transparency means that complainants may have difficulty assessing what weight should be placed on the expert advice. Whilst the ALA is unsure whether this is the case, it presumes that in order to comply with the principles of natural justice, the health practitioner would be provided with a copy of the clinical advice. This would mean that the complainant and health service providers are provided with differing levels of information. Furthermore, this approach would mean that there is inevitably a different standard of advice provided on each matter, in a different format, which would cause additional resources to be wasted.

The ALA would welcome legislative amendments that would require clinical advice on each matter to be provided in a uniform way. A relatively straight forward amendment to the Act would be to require the compulsory establishment of medical expert committees by the Health Ombudsman.. The ALA also believes that legislative amendments should be made to section 278 of the Act requiring the information or material provided to the clinician, the questions the clinician is asked, the qualifications of the clinician and a copy of any clinical advice received to be provided to the parties to accompany the reasons for decision.

FAIRER CONCILIATION OUTCOMES

Section 135 of the Act provides that the purpose of conciliating a health service complaint is to allow the parties to "*settle the complaint in a reasonable way*". In some instances, the Act contemplates that conciliation may only be for the purposes of

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"*arranging a financial settlement or other compensation with the complainant*"[12]. While the ALA believes that conciliations for this purpose are important, there is a lack of clarity regarding what may be arranged as part of conciliated compensation.

The OHO's website states that compensation agreed upon during a conciliation is "*limited to out of pocket expenses and/or corrective treatment costs*". The ALA believes that this information does not align with the Act, which at no point limits what compensation may be agreed upon in conciliation. The ALA believes that to avoid any misapprehension of what outcomes may be achieved through conciliation, the Act should be amended to clearly specify what losses may be compensated.

In particular, the ALA believes that in a limited number of cases complainants should have the right to seek a small amount of compensation for pain and suffering as part of any compensation agreed upon in a conciliated agreement. This is because in these cases, this may be the only economical way for complainants to receive some form of compensation from the health care provider for possible negligent treatment. It is noted that the Tasmanian Health Complaints Commissioner has made a number of comments about the importance of publically funded hospitals and services engaging in conciliation in a meaningful manner to try and avoid litigation[13]. It would appear from the data published by the Tasmanian Health Complaints Commissioner, that the Tasmanian system allows for compensation to be paid to the complainant in addition to out of pocket expenses[14].

[12] See section 140(6) of the Act
[13] See http://www.healthcomplaints.tas.gov.au/__data/assets/pdf_file/0004/331897/Health_Complaints_Commissioner_Annual_Report_2014-15.pdf
[14] See http://www.healthcomplaints.tas.gov.au/__data/assets/pdf_file/0004/331897/Health_Complaints_Commissioner_Annual_Report_2014-15.pdf

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CONCLUSION AND RECOMMENDATIONS

The ALA supports the intention of the Act and the mandated timeframes, indeed such a mechanism has an important role to play in providing patients and their families, as well as any other members of the public who may have concerns, with a means for lodging such complaints and seeking further answers. It is vital however for this to occur effectively, and for patient safety concerns to be promptly and thoroughly addressed, that the mandated timeframes are complied with to ensure health care complaints are dealt with expeditiously. Further examination should occur to identify reasons why the mandated timeframes are unable to be complied with and whether any further resources or systematic changes can be made to address this.

The ALA supports the intention of the Act to establish a single entity complaints management system but believes that clearer delineation should be made in relation to the following areas:

- the triage or assessment process: to ensure that this process is completed quickly without it becoming a quasi-investigation; and
- referral of matters to AHPRA: to ensure that there is consistency in the type of complaints that are referred to AHPRA or remain at OHO and that there is no duplication of resources (ie., if a matter has been assessed by OHO then the same process should not be undertaken by AHPRA).

The ALA is encouraged by the transparency displayed by the OHO to date and considers that this transparency can be enhanced by the disclosure of additional information.