UnitingCare Health

166 Baroona Road
Rosalie QLD 4064

PO Box 1996
MILTON QLD 4064

Phone: 3511 4808
Facsimile: 3367 1956
Email: richard.royle@uchealth.com.au

ABN: 87 842 457 440

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Ms Sheridan Groth
Research Director
Health Quality and Complaints Commission
Select Committee
Parliament House, George Street
BRISBANE QLD 4000

Dear Ms Groth

Thank you for the opportunity to provide a submission to The Queensland Parliamentary Health Quality and Complaints Commission Select Committee's review of the performance of the Health Quality and Complaints Commission and the *Health Quality and Complaints Commission Act 2006*.

Following is UnitingCare Health's submission that addresses a number of concerns identified as a large provider of private health services in Queensland.

The performance of the Health Quality and Complaints Commission and the operation of the *Health Quality and Complaints Commission Act 2006* in relation to:

Policies, procedures and systems to resolve complaints in a timely and responsive manner.

UnitingCare Health supports the requirement, in accordance with the legislation, for independent investigation of complaints regarding health care delivery, but further to recent experience, has significant concerns that in implementing this requirement the Health Quality and Complaints Commission has not established processes for the rigorous application of standards which ensure the quality of the investigative process and analysis of evidence.

These concerns stem from UnitingCare Health's recent experience of the investigation process where, further to legal review of the report by a well respected Barrister and Solicitor, a number of disturbing issues were identified, including:

a) The inconsistent process by which the investigation was conducted, including the logical analysis of the evidence and the presentation of the findings, such that there is poor confidence in the rigour of the process.
b) Inconsistencies between independent expert evidence and evidence of fact and the investigators' findings.
c) Unsigned and undated statements referenced as evidence.
d) Retrospective application of a standard in 2007 to 2005 without analysis of the differences in processes or available evidence within this two year period.

For the investigation of complaints to lead to improvement in safety and quality for patient care, investigations should be robust and ensure both patient and health care provider confidence in the process. UnitingCare Health believes this warrants further review, with recency of practice a recommended key requirement within the team undertaking the investigation.

Compounding this concern was the distribution of the draft report in accordance with Part 3, Section 87, 88 and 89 and Part 3, Section 91 of the *Health Quality and Complaints Commission Act 2006* to the Chief Health Officer and other organizations, without the organization having an opportunity of reply and to identify and address errors of fact.

UnitingCare Health acknowledges, and agrees with, the need for distribution of the report to organizations or agencies subject to adverse findings. However, natural justice principles should underpin the investigative and reporting process and except where there is an immediate concern for patient safety, the health care provider's right to reply before distribution to licensing and registration bodies should be protected within the legislation.

In accordance with the identified terms of the Select Committee, specific details of the investigation have not been provided. However, I would be happy to discuss these further and provide confidential documentary evidence to support these concerns.

Strategies to proactively engage providers and other entities about the quality of health services, including the making of standards and quality improvement processes.

UnitingCare Health supports the principle of introducing standards which might lead to improvements in patient safety. The level of consultation with the initial seven standards introduced, however, was insufficient particularly with engaging clinicians where medical management of patients was core to the standards being considered. As an example, communication by one UnitingCare Health hospital with members of their Medical Advisory Committee identified that the Executive of the Australian and New Zealand Cardiac Society, the preeminent body for cardiac services in Australia, had not been consulted regarding the development of the AMI management standard. To proactively engage all health care providers in improving quality of health care, consultation prior to the development of standards should be undertaken with the relevant Clinical Colleges and all other key stakeholders before the drafting of these standards. It is well recognised that engagement of key stakeholders such as Clinical Colleges is critical to the development of appropriate quality standards and the successful implementation of a quality improvement process. Such engagement of the Colleges, in our opinion, was not undertaken at the appropriate time nor in the depth that was optimal.

The consultation that was undertaken lacked detailed information to assess where the standards would give rise to process, implementation and resourcing impacts on providers. Also, there are already extensive quality improvement systems in place in the private sector, including ones which require private sector providers to report results and outcomes to licensing and accreditation bodies. A more comprehensive consultation process prior to the drafting of these standards would have resulted in the duplication of quality systems not occurring. Reference was made in the draft to issues being further defined in the "implementation guide" with the guide not released. The complete information was not released until the education sessions for the standards which were held during the week of 25 June 2007, the week prior to their 1 July 2007 commencement date.

The education sessions provided were scheduled during school holidays and at the same time as the annual Adverse Events Conference in Melbourne, a key conference aimed at improving patient safety. As a result, a number of key UCH positions, such as the UnitingCare Health Quality and Risk Managers, were unable to attend these education sessions.

In addition to this, the education sessions offered were in Brisbane, with a one day regional education program identified to be provided. This has yet to occur for the Fraser Coast area, despite the standards having been implemented.

For the standards to be applied consistently by all health service providers, appropriate opportunities for education should be provided, with a reasonable lead time before standards are implemented. The training should be consistent for both regional and metropolitan facilities.

I would be happy to meet with you and discuss these issues further should it be required.

Yours sincerely

RICHARD ROYLE
Chief Executive Officer