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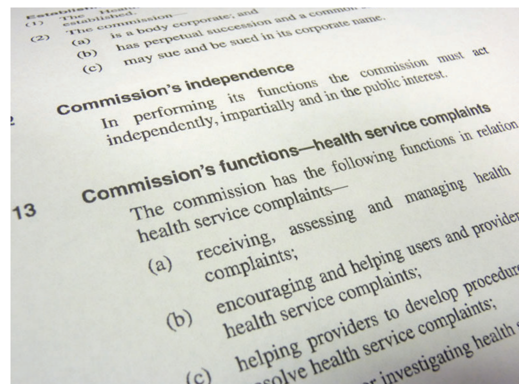

Oversight of the Health Quality and Complaints Commission

Report No. 21

Health and Community Services Committee

April 2013

Parliamentary Committees

QUEENSLAND PARLIAMENT

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Health and Community Services Committee

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Acknowledgements

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Abbreviations

AHMAC	Australian Health Ministers’ Advisory Council
AHPRA	Australian Health Practitioner Regulation Agency
CALD	Culturally and linguistically diverse
HCSC	Health and Community Services Committee
HDC	Health and Disabilities Committee
HQCC	Health Quality and Complaints Commission
the Act	*Health Quality and Complaints Commission Act 2006*

Recommendations and committee comments

Recommendation 1 8

The committee recommends that the Health Quality and Complaints Commission measure and report on the timeliness of conciliation closure as the time between the date a decision is made to conciliate a complaint and the date the conciliation is closed.

Recommendation 2 9

The committee recommends that, in light of HQCC's decision not to conciliate claims for damages – elements of which HQCC identified as causes of delay in conciliation, the HQCC:

- review its current performance target of completing 60 per cent of conciliations within 12 months, and
- consider a performance target which aims to close a higher proportion of conciliations within 12 months, or to close conciliations in a period of less than 12 months.

Committee comment 10

The committee notes that despite a reduced number of complaints referred for investigation in 2011–12 and more investigators, the time taken to complete investigations increased, contrary to the HQCC's expectations. The committee remains concerned about the length of time taken to complete investigations. The increased period for completion of investigations in 2011–12 is of significant concern to the committee.

The committee will continue to monitor the number and type of complaints that are investigated, and the time taken to complete investigations, as the new investigation prioritisation criteria are applied and new processes for management of investigations are implemented.

Committee comment 12

The committee would be concerned if the identification of delays in an HQCC investigation caused by another organisation or individual led to the HQCC reducing its performance target for the timeliness of investigations.

Committee comment 13

The committee will continue to monitor the number and type of complaints that are devolved to health providers, and the outcomes of those complaints.

Recommendation 3 15

The committee recommends that the HQCC:

- publish corrected data on issues in complaints for 2010–11 and 2011–12 in its Annual Report for 2012–2013, and
- ensure that the data remains comparable over time so that trends in complaint issues can be identified.

Committee comment 18

The committee will continue to monitor developments in national safety and quality standards for health services and the standards made by the HQCC, including transition arrangements and HQCC resourcing.

Committee comment 19

The committee notes the HQCC's expansion of its monitoring of reportable events and suggests that the HQCC include in its Annual Reports the results relevant to safety and quality in health services and the HQCC resources allocated to this work.

Committee comment 20

In 2011, the HQCC agreed to provide the former HDC with six-monthly updates on the engagement strategies implemented and the nature of complaints received from each of the different CALD communities. Six-monthly reporting will continue for this committee. Reporting on CALD enquiries and complaints is now also reflected in the HQCC's annual reporting.

Committee comment 21

The committee will continue to monitor client satisfaction with the HQCC's complaint service and the outcomes of the HQCC's improvement action plan.

Committee comment 22

The former HDC recommended that the staffing of the HQCC, including staff retention and turnover rates and the proportion of permanent and temporary staff, continue to be monitored. The committee notes the inconsistency in the reporting of retention and separation data for 2010–11 between Annual Reports.

Committee comment 24

The committee commends the HQCC for some improvements to reporting in response to the former HDC's recommendations about the provision of clear, consistent and transparent information about complaints in its Annual Report.

The committee, however, notes that further work is required to ensure that the HQCC's reporting is clear, consistent and transparent. In particular, the committee considers that more consistent and transparent reporting on the total time for management of complaints to completion (including any time awaiting allocation) and other performance measures is required. Other areas for improvement include the issues raised in complaints, and ensuring this data is comparable over time.

The committee suggests that the HQCC should use the refining of its complaints and investigations case management system as an opportunity to improve the usefulness of the data captured, as well as its presentation. The HQCC should also ensure that its ability to consider data trends over time is not compromised by changes to data capture, making arrangements for historical data to be re-categorised if necessary to ensure comparability across years.

Committee comment 25

The committee notes that meaningful reporting of performance measures requires improvement, in particular for the conciliation process, and that information on the time taken to manage complaints should be more comprehensive.

Chair’s foreword

The Health and Community Services Committee was established in May 2012 as one of seven portfolio committees. It has responsibility for oversight of the Health Quality and Complaints Commission (HQCC) under the Standing Rules and Orders of the Legislative Assembly. Between July 2011 and April 2012, this responsibility was undertaken by the former Health and Disabilities Committee.

This is the first report by the Health and Community Services Committee on oversight of the HQCC under Standing Order 194A, which requires to committee to monitor and report on the HQCC’s performance of its functions.

The Health Quality and Complaints Commission’s main functions under the *Health Quality and Complaints Commission Act 2006* are in making and reporting on health service standards, and in managing health complaints.

Generally it appears that the HQCC has made reasonable effort and achieved good progress in making and reporting on health service quality standards. Recently, primary responsibility for making standards and reporting on compliance has been transferred to the Australian Commission for Safety and Quality in Healthcare (ACSQHC). The HQCC has continued to monitor compliance with three standards which the ACSQHC has not adopted.

The committee has some concerns, as did the former parliamentary committee, with the HQCC’s reporting of its effort in complaint management. It is important to ensure that complaint management is timely and contributes to continuous improvement in health care services. I also consider it important that the HQCC’s reporting is consistent, so that its achievement can be accurately measured. Some of the concerns raised in this report are being addressed by the HQCC. The committee will continue to monitor the HQCC’s action on those issues as part of its ongoing oversight.

I thank the Commissioner, Adjunct Professor Russell Stitz, and the Chief Executive Officer of the HQCC, Mrs Cheryl Herbert, for their ongoing participation in the committee’s oversight of the HQCC.

I would also like to recognise the work undertaken in 2012 with respect to oversight of the HQCC by the former chair of the committee, Mr Peter Dowling MP, Member for Redlands and former members of the committee, Mr Aaron Dillaway MP, Member for Bulimba, Mrs Desley Scott MP, Member for Woodridge and Mr Michael Trout MP, Member for Barron River.

Thanks also to my committee colleagues and to the secretariat and Hansard staff for assisting the committee in its work.

Trevor Ruthenberg MP

Chair

1 Introduction

1.1 Role of the committee

The Health and Community Services Committee (the committee) has oversight responsibility for the Health Quality and Complaints Commission (HQCC) under the *Parliament of Queensland Act 2001* and the Standing Rules and Orders of the Legislative Assembly. Standing Order 194A describes the committee's functions:

> If a portfolio committee is allocated oversight responsibility for an entity under Schedule 6, and there are no statutory provisions outlining the committee's oversight of the entity, the portfolio committee will have the following functions with respect to that entity -
>
> (a) to monitor and review the performance by the entity of the entity's functions;
>
> (b) to report to the Legislative Assembly on any matter concerning the entity, the entity's functions or the performance of the entity's functions that the committee considers should be drawn to the Legislative Assembly's attention;
>
> (c) to examine the annual report of the entity tabled in the Legislative Assembly and, if appropriate, to comment on any aspect of the report; and
>
> (d) to report to the Legislative Assembly any changes to the functions, structures and procedures of the entity that the committee considers desirable for the more effective operation of the entity or the Act which establishes the entity.[1]

1.2 Committee oversight of the Health Quality and Complaints Commission

This is the committee's first report on its oversight of the HQCC. The former Health and Disabilities Committee (HDC) reported to the Legislative Assembly on its oversight of the HQCC in February 2012, shortly before the 53rd Parliament was dissolved. The former committee recommended that a future committee examine and monitor a number of issues that had come to the attention of the HDC, but which it did not have time to fully explore. The HDC's recommendations to a future committee are summarised in Appendix B, along with its recommendations to the HQCC about its Annual Reports.

This report is informed by: evidence given by representatives of the HQCC at a public hearing on 1 August 2012 and at a Budget Estimates hearing on 17 October 2012, the HQCC's 6 July 2012 response to pre-hearing questions on notice, and 20 December 2012 response to the committee's request for information and comment;[2] HQCC Annual Reports, *Annual Health Check 2011*, and other HQCC special reports;[3] and the *Organisational Review Report 2011*.[4]

This report contains comments on the issues raised by the former HDC, provides an overview of the HQCC's performance of its functions, and comments on the HQCC's *Annual Report 2011–12.*

After examination of the *Annual Report 2011–12*, the committee asked the HQCC for further information and comment about issues including the time taken to conciliate and investigate complaints, staffing expenditure, client satisfaction with timeliness of complaint resolution, analysis of the increase in complaint numbers according to the complaint issues, and the HQCC's target for client satisfaction with the outcome of complaint services.[2]

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[1] Legislative Assembly of Queensland, Standing Rules and Orders of the Legislative Assembly, SO 194A

[2] Responses to questions from the committee, and transcripts of the committee's public and Budget Estimates hearings are published on the committee's webpage at www.parliament.qld.gov.au/hcsc

[3] All available from the HQCC website at: http://www.hqcc.qld.gov.au/Resources/Pages/Reports.aspx

[4] Available from the former Health and Disabilities Committee's website at: http://www.parliament.qld.gov.au/documents/committees/HDC/2011/HQCC-oversight/111220-OrgReviewRpt.pdf

1.3 Functions of the Health Quality and Complaints Commission

The HQCC is an independent statutory body which replaced the Health Rights Commission in 2006 following recommendations of the 2005 Forster Review.[5] The *Health Quality and Complaints Commission Act 2006* (the Act) sets out the functions of the HQCC in four categories: health service complaints, quality of health services, provision of information and 'other' functions, which include investigating or inquiring into matters and suggesting ways to improve health services. The HQCC's statutory functions are reproduced in Appendix A.

5 *Queensland Health Systems Review*, Final Report, September 2005, available from the HQCC's website at: http://www.hqcc.qld.gov.au/About-Us/Documents/Report%20-%20Queensland%20Health%20Services%20Review%20-%20Forster%20-%20Final%20-%20September%202005.pdf

2 Health service complaint processes

The Act provides for the ways the HQCC must deal with health service complaints. Complaints must generally be confirmed in writing by the complainant. The ways a complaint may be dealt with are summarised below and shown diagrammatically in Figure 1 on page 4.

Direct resolution: Complainants are encouraged to contact the health provider directly. The complainant is encouraged to make a written complaint to the HQCC if it is not resolved directly with the health provider.

Early resolution: The Act enables the HQCC to do what is reasonable to facilitate resolution of a complaint, instead of immediately assessing it, if there is a reasonable likelihood the HQCC may be able to facilitate early resolution (section 52). The HQCC gives the health provider a copy of the complaint and asks them to comment and provide relevant information. Serious complaints, e.g. those involving claims of sexual misconduct, are not suitable for early resolution.[6] If the complaint remains unresolved after 30 days, it must be assessed (section 53).[7]

Assessment: A health service complaint must be assessed within 60 days, or 90 days if complex (section 58). A complaint about a registered provider must be the subject of consultation with the relevant registration board (section 57). After assessment of a complaint, the HQCC decides (sections 59–66) whether to:

- take no further action (e.g. the complaint may have been resolved or further action may not be warranted)
- conciliate the complaint
- investigate the complaint
- refer the complaint to a registration board or another body.

Conciliation: Voluntary conciliation is privileged and confidential (sections 82–83) and a forum to resolve complaints by open and direct discussion and negotiation. Independent clinical opinions may be obtained if relevant.[8] The HQCC (non-statutory) performance target is to close 60 per cent of conciliations within 12 months.

Investigation: HQCC has broad powers to investigate health providers, including powers to require information or attendance. An investigation may be about a complaint that is considered serious, about possible systemic issues, or referred by an agency such as the Coroner. In addition, the Minister may direct that a matter be investigated. The HQCC (non-statutory) performance target is to close 70 per cent of investigations within 12 months.

Referral to registration board: The HQCC must consult with the relevant registration board about complaints about registered health providers (e.g. doctors). A complaint may be referred to the relevant state[9] or national health professional registration board, and must be referred if it is in the public interest to do so.

Referral to another entity: After assessment, or as a result of investigation, the HQCC may refer a complaint or issue to another entity.

Devolution: In 2012, the HQCC introduced devolution of some complaints to a health provider when issues which the HQCC believes are best managed by the provider remain outstanding after assessment. The health provider is expected to report back to the HQCC.

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6 HQCC, *Resolving your complaint*, Fact sheet, May 2011, p.1, accessed 30 October 2012 from http://www.hqcc.qld.gov.au/Complaints/Documents/Fact-sheet-online-consumers-resolving-your-complaint.pdf

7 Section references are to the *Health Quality and Complaints Commission Act 2006*, available from http://www.legislation.qld.gov.au/LEGISLTN/ACTS/2006/06AC025.pdf

8 HQCC, *Conciliating your complaint*, Fact sheet, June 2012, p.1, accessed 30 October 2012 from http://www.hqcc.qld.gov.au/Resources/Documents/Fact-sheet-online-consumers-2-page-conciliating-your-complaint.pdf

9 There are two state registration boards: the Dental Technicians Board of Queensland and the Speech Pathologists Board of Queensland. The Health Practitioner Registration and Other Legislation Amendment Bill 2012, passed by the Legislative Assembly on 21 March 2013, will remove the requirement for state registration of these professions.

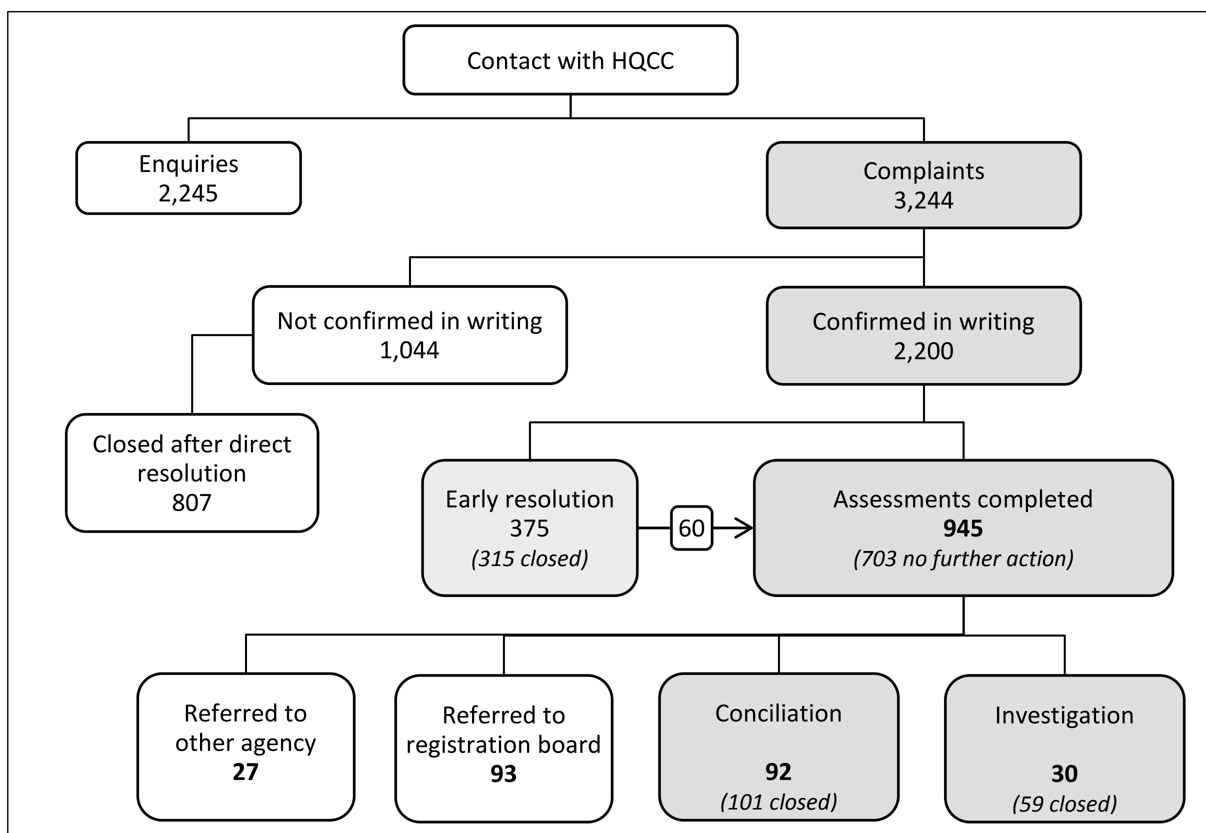
3 Number of complaints received 2011–12

During 2011–12, the HQCC reports that it received 3,244 complaints about health services. This total includes oral complaints that were not confirmed in writing. The total complaints received increased by 28 per cent (719) compared to 2010–11. Oral complaints that were not confirmed in writing increased from 850 in 2010–11 to 1,044 or 32 per cent of complaints, in 2011–12. Unless an oral complaint is of "sufficient severity and detail" for the HQCC to consider initiating its own action, complaints not confirmed in writing are closed.[10] The HQCC received 2,200 written complaints in 2011–12, compared to 1,675 in 2010–11.

The HQCC states that it keeps records of oral complaints to assist in identifying "patterns of provider practice and complaint trends or more widespread system issues".[11] The HQCC indicated in oral evidence to the committee that it was concerned about the number of complaints that were not confirmed in writing.[12] The HQCC provides callers with a complaint form and reply paid envelope, and helps with the writing of a complaint if required. The HQCC intends to introduce online facilities for making a complaint in 2012–13.[13]

The HQCC also received 2,245 enquiries in 2011–12.[14] An enquiry is a matter that is not eligible to be considered a complaint.[15]

Figure 1: HQCC complaints received and closed in 2011–12



Notes: Because complaints still open at the beginning of 2011–12 are not included in the figures above, it is not possible to reconcile complaints received with complaints closed.
Nine additional matters were referred to the HQCC for investigation in 2011–12 from other agencies.

Source: Drawn from data in *HQCC Annual Report 2011–12*

10 HQCC, *Annual Report 2011–12*, 2012, p.23
11 HQCC, *Annual Report 2011–12*, p.23
12 Cheryl Herbert, CEO HQCC, *HQCC Public Hearing Transcript*, 1 August 2012, p.3
13 Herbert, *Public Hearing Transcript*, 2012, p.3
14 HQCC, *Annual Report 2011–12*, p.22
15 HQCC, *Annual Report 2011–12*, p.22

4 How complaints were managed 2011–12

4.1 Timeliness of complaint management

The committee has concerns about the time taken to complete investigation and conciliation of complaints, which are discussed in later sections. In this context, the committee sought to understand the time taken from receipt of a complaint to its completion, from the perspective of a complainant or health provider. The committee acknowledges that some complaints may be addressed promptly through 'direct resolution' and 'early resolution', and others that are conciliated or investigated may take considerably longer.

The committee notes that the Annual Report 2011–12 includes information about the number of complaints closed in each phase of complaint management. The number of complaints in conciliation and investigation carried over from the preceding year is reported; however, the number carried forward in the 'early resolution' and 'assessment' phases is not reported. This adds to the challenges in understanding overall timeliness of complaint management. The committee will seek further information from the HQCC to better understand the timeliness of complaint processes for complainants and health providers.

4.2 Direct resolution

The HQCC encourages direct resolution of less serious oral complaints. In 2011–12, direct resolution was suggested for 807 complaints compared to 454 in 2010–11, an increase from 18 per cent of complaints to 25 per cent. The HQCC advises complainants to formalise their complaint in writing if direct resolution is not successful.[16]

4.3 Complaint triage

The HQCC piloted a new complaint triage process from May to October 2011 and formally established a triage team in a new Resolution Services Unit in March 2012. Senior triage officers make the preliminary assessment of complaint severity and decide the best course of action. After the trial, triage officer positions were increased from two to five, with recruitment finalised by the end of 2011–12.[17]

4.4 Early resolution

The HQCC attempted early resolution of 375 complaints in 2011–12 compared to 278 in 2010–11. This increase reflected a change in focus following the implementation of the recommendations of the HQCC's 2011 organisational review. Early resolution was satisfactory in the HQCC's view in 315 complaints, and the remaining 60 complaints were assessed.[18]

The HQCC reported that 91 per cent of the complaints resolved through early resolution were closed within 30 days. The HQCC notes that the decrease in resolution of cases within 30 days from 95 per cent in 2010–11 was due to the transition of the early resolution function within the HQCC and the increase in the number of cases managed in early resolution.[19]

4.5 Assessment of complaints

If a complaint is not suitable for 'early resolution', or is not resolved, it is assessed. The Act provides that assessment should be completed within 60 days, or up to 90 days if the complaint is complex, more time is needed to provide information to the HQCC, or the complaint can be resolved in that

[16] HQCC, *Annual Report 2011–12*, p.23
[17] HQCC, *Annual Report 2011–12*, p.31
[18] HQCC, *Annual Report 2011–12*, p.23
[19] HQCC, *Annual Report 2011–12*, p.23

time. The HQCC reports that 93 per cent of complaints were assessed in the legislated timeframe in 2011–12, up from 90 per cent of complaints in 2010–11 and 86 per cent in 2009–10.[20]

During 2011–12, 945 complaints were assessed during and 703 (74 per cent of those assessed) were closed and categorised as no further action required after assessment. This was an increase on 493 (or 66 per cent of all complaints received) closed with no further action in 2010–11.[21] The outcome of assessment of complaints is shown in Table 1.

Table 1: Complaints assessed by HQCC 2011–12

Outcome of assessment / action	No.	Percentage of assessments
Closed, no further action	703	74.4
Referred to conciliation	92	9.7
Referred to investigation	30	3.2
Referred to registration boards	93	9.8
Referred to other agencies	27	2.9
Total complaints assessed	**945**	

Source: HQCC, *Annual Report 2011–12*, p.24

4.6 Conciliation of complaints

4.6.1 Complaints conciliated

In 2011–12, 92 complaints were accepted for conciliation, 101 were closed, and 92 remained open at 30 June 2012.[22]

The HQCC reported that 61 per cent of conciliations closed were successful in 2011–12, down from 71 per cent in 2010–11. Nearly half of successful outcomes resulted in the provision of an explanation of the events surrounding the complaint. There was a financial settlement in 19 cases.[23]

4.6.2 Review of conciliation process

The HQCC's conciliation process was reviewed in 2010–11 by an external consultant. The former HDC recommended that this committee examine the review recommendations and progress in their implementation. The recommendations aimed to improve conciliation processes, timeliness and effectiveness, and client understanding. The HQCC's *Annual Report 2011–12* details the HQCC's action on the review recommendations, most of which were accepted and implemented. In general, those recommendations not accepted and implemented related to obtaining independent clinical opinions and advice.[24]

4.6.3 Timeliness of conciliation

The HQCC reports that 59 per cent of conciliation cases were closed within 12 months in 2011–12, unchanged from 2010–11 and slightly below the HQCC's conciliation timeliness performance target for 2011–12 of 60 per cent of cases closed within 12 months.[25]

The average time to complete conciliation in 2011–12 was 422 days, an increase on 2010–11 (354 days).

[20] HQCC, *Annual Report 2011–12*, p.24 and HQCC, *Annual Report 2010-11*, 2011, p.40 'Complaints received/closed'
[21] HQCC, *Annual Report 2011–12*, p.24 and HQCC, *Annual Report 2010-11*, p.40 'Outcome of complaint intake and assessment'
[22] HQCC, *Annual Report 2011–12*, p.24
[23] HQCC, *Annual Report 2011–12*, p.25
[24] HQCC, *Annual Report 2011–12*, pp.32–33
[25] HQCC, *Annual Report 2011–12*, p.24

The increase in time to complete conciliation occurred despite the HQCC's review of its conciliation process and implementation of new procedures in 2011–12, and an expectation that the proportion of conciliation cases closed within 12 months would increase during 2011–12.[26] The HQCC advised the committee that implementation of review recommendations had resulted in conciliation process improvements. The HQCC stated that "the changes have yet to significantly improve conciliation timeframes".[27]

The committee will continue to monitor the timeliness of conciliation.

4.6.4 Causes of delay in conciliation

The committee sought the HQCC's comments on the time taken to complete conciliations. The HQCC advised it had re-examined the reasons for delays in conciliation and identified delay points as:

- sourcing independent clinical opinions and the time taken by clinicians to provide those opinions
- obtaining complainant and provider input on the questions to be posed to the independent clinicians
- the time taken by complainants to submit a claim for compensation
- delays when parties decide to engage or consult with legal counsel
- the need for complainants to undergo medical assessment to establish compensation value
- periods when a party is too unwell to engage in conciliation, and
- the time taken to negotiate compensation (damages) and finalise deeds of release.[28]

The HQCC advised the committee it had already implemented strategies to address delays in obtaining expert clinical opinions and obtaining feedback on questions to be posed to the expert.[29]

The HQCC advised that, in addition to remedies such as provision of an explanation or apology or agreement to a change in policy, process or practice, the conciliation process "supports the resolution of disputes involving a range of financial settlements". Not all financial settlements include compensation for damages. A financial settlement may be a refund, fee waiver, reimbursement of fees, payment of out-of-pocket expenses, and/or reparative treatment costs. Where financial remedies other than damages are sought, an independent clinical opinion is often not required and issues are simpler to resolve in conciliation.[30] A complaint that involves negotiation of a claim for compensation, where one or more parties may engage legal representation, can take considerably longer than the 12 month target to resolve.[31]

4.6.5 HQCC will cease conciliation of claims for damages

The HQCC advised the committee that the commission decided in November 2012 to cease conciliating for the purpose of financial compensation (damages) as, in its view, those cases would be better dealt with through the courts. Conciliation of complaints will focus on cases "where there is an opportunity to achieve resolution and healthcare improvement in a timely manner".[32] The HQCC will seek to involve the parties in conciliation directly, rather than through legal representatives, and will limit conciliation to a proposed maximum timeframe of 12 months, with extension only in extenuating circumstances.[33]

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26 HQCC, *Annual Report 2010–11*, p.13

27 HQCC, *Correspondence – Response to questions of 3 December 2012*, 20 December 2012, p.5, available from http://www.parliament.qld.gov.au/documents/committees/HCSC/2012/HQCC/corr-20Dec2012.pdf

28 HQCC, *Response to questions of 3 December 2012*, p.5

29 HQCC, *Response to questions of 3 December 2012*, p.6

30 HQCC, *Response to questions of 3 December 2012*, p.6

31 HQCC, *Response to questions of 3 December 2012*, p.6

32 HQCC, *Response to questions of 3 December 2012*, p.6

33 HQCC, *Response to questions of 3 December 2012*, p.6

The committee notes that the Act contemplates that conciliation may be used for negotiation of a financial settlement or other compensation (section 76(5)), but that the Act does not specify that conciliation must be available for this purpose. The committee also notes that 19 complaints closed in 2011–12 resulted in a financial payment.[34]

4.6.6 Performance measurement of timeliness of conciliation

The committee sought clarification from the HQCC of its *Annual Report 2011–12* data about conciliation timeliness. One part of the Annual Report states that 53 per cent of conciliations were closed within 12 months in 2011–12,[35] compared to the 59 per cent reported as its performance against service standards elsewhere in the report.[36]

The HQCC advised the committee that the timeliness of conciliation closure of 59 per cent was calculated “based on the date of the conciliator’s first written contact with the complainant and healthcare provider”, while the conciliation closure of 53 per cent within 12 months was calculated “based on the date conciliation cases were allocated to a conciliator for management”. The HQCC stated that the reported rate of 53 per cent of conciliations closed within 12 months includes “the time taken by conciliators to familiarise themselves with complaint files and draft case management plans before they contact the parties”.[37] The HQCC also advised the committee that:

> *To ensure consistency and transparency, in future annual reports and in the service delivery statements, the HQCC will report conciliation closure timeframes based on the date conciliation cases were allocated to a conciliator*.[38]

The committee considers that the time taken for conciliation should be measured from immediately after a decision is made at the end of assessment to conciliate the complaint until the complaint is closed. In the committee’s view, it is important to measure timeliness in a way that is consistent with a complainant’s or respondent’s experience of complaint management. The time measured should, therefore, include any waiting period between a decision to conciliate and allocation to a conciliator, and any time taken for conciliator familiarisation and planning for the conciliation.

Recommendation 1

The committee recommends that the Health Quality and Complaints Commission measure and report on the timeliness of conciliation closure as the time between the date a decision is made to conciliate a complaint and the date the conciliation is closed.

4.6.7 Performance target for timeliness of conciliation

The HQCC reduced its conciliation timeliness performance target from 75 per cent of cases closed within 12 months in 2010–11 to 60 per cent in 2011–12. The 2010–11 Annual Report stated this acknowledged that “… conciliation timeframes will always be impacted by various factors outside of our control…”

In light of the HQCC decision to cease conciliating claims for damages, elements of which the HQCC identified as sources of delay in conciliation, the committee considers that the HQCC should review its performance target for the timeliness of conciliation.

34 HQCC, *Annual Report 2010–11*, p.25
35 HQCC, *Annual Report 2010–11*, p.24 Table ‘Timeliness of conciliations closed’
36 HQCC, *Annual Report 2010–11*, p.16
37 HQCC, *Response to questions of 3 December 2012*, p.5
38 HQCC, *Response to questions of 3 December 2012*, p.5

Recommendation 2

The committee recommends that, in light of HQCC's decision not to conciliate claims for damages – elements of which HQCC identified as causes of delay in conciliation, the HQCC:

- review its current performance target of completing 60 per cent of conciliations within 12 months, and
- consider a performance target which aims to close a higher proportion of conciliations within 12 months, or to close conciliations in a period of less than 12 months.

4.7 Investigation of complaints

4.7.1 Criteria for deciding to investigate a complaint

The timeliness of investigations was another issue the former HDC recommended this committee consider. Against a backdrop of public and committee concern about the time taken to complete investigations, the HQCC advised the former HDC in late 2011 that it had considered new draft criteria for commencing an investigation, which were implemented from January 2012.

Criteria for commencing an investigation aimed to focus HQCC resources on investigating the most serious complaints that are likely to result in safety and quality improvement recommendations which impact on multiple healthcare providers.[39] The HQCC advised the former HDC in September 2011 that it expected the time taken to finalise investigations to reduce, in response to a reduced caseload and increased investigation staffing.[40] In oral evidence to the committee in August 2012, the HQCC advised that "previously when we had assessments that went over time we moved some of those more complex cases into investigations, but it is not appropriate".[41]

4.7.2 Cases investigated

The new criteria for commencing an investigation appeared to significantly reduce the number of cases accepted for investigation in 2011–12. The Annual Report states that 39 complaints were accepted for investigation during 2011–12 and 70 cases continued from 2010–11.[42] During 2011–12, 59 investigations were closed during 2011–12, compared to 70 in the previous year.[43]

The HQCC reported that the majority of complaints accepted for investigation in 2011–12 were health quality complaints.[44] In contrast, the majority of investigations commenced in 2010–11 were health service complaints, made by a consumer or on their behalf. The HQCC notes that this change may be the result of the application of the new investigation acceptance criteria.[45]

4.7.3 Timeliness of investigations

As noted above, the timeliness of investigations and the number of investigation staff was considered by the former HDC in its oversight of the HQCC during 2011. The HQCC's *Annual Report 2011–12* includes data on the timeliness of investigations closed in 2009–10, 2010–11 and 2011–12 (see Table 2).

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39 Cheryl Herbert, CEO HQCC, *HQCC Hearing Transcript*, 7 September 2011, p.12 and also HQCC, *Response to request for information*, 23 November 2011, available from http://www.parliament.qld.gov.au/documents/committees/hdc/2011/hqcc-oversight/111123-hqcc-resptorequest.pdf

40 HQCC, *Annual Report 2011–12*, p.25

41 Herbert, *Hearing Transcript,* 2012, p.6

42 HQCC, *Annual Report 2011–12*, p.25

43 HQCC, *Annual Report 2011–12*, p.23

44 'health quality complaints' are made by someone other than a consumer or their representative, e.g. a staff member might complain about hygiene standards in a hospital; the Minister may complain about a serious issue.

45 HQCC, *Annual Report 2011–12*, p.25

Table 2: Timeliness of investigations closed

	2009–10	2010–11	2011–12
Less than 6 months	35	41	9
6–12 months	14	7	16
12–18 months	6	10	13
18–24 months	2	5	11
24–30 months	4	7	7
30–36 months			0
36–42 months			1
42–48 months			0
48–54 months			2
Total	**61**	**70**	**59**

Source: HQCC, *Annual Report 2011–12*, p.26

In 2011–12, 42 per cent of the 59 investigations closed were completed within 12 months. In contrast, 69 per cent of those complaints closed in 2011–12 were completed within 12 months. The HQCC's Annual Report indicates that 34 of the 44 investigations open at 30 June 2012 had already been open for more than 12 months.[46]

The HQCC's Annual Report states that the three longest running cases closed in 2011–12 took over three years to investigate, were complex matters involving other jurisdictions, and required the HQCC to wait on external processes to be completed before continuing the HQCC investigation.[47]

4.7.4 Reduction in timeliness of investigations

The committee notes that new investigation acceptance criteria significantly reduced the number of investigations accepted in 2011–12 to 39, compared to 83 in 2010–11, and that investigation staff increased from eight to 12.[48] The Annual Report states that the decrease in investigations completed within 12 months was because the HQCC focussed on finalising more complex, lengthy investigations in 2011–12.[49]

Improved closure times might have been expected with a reduced number of new investigations and a 50 per cent increase in investigation staff, notwithstanding the focus on closing long-running investigations.

Committee comment

The committee notes that despite a reduced number of complaints referred for investigation in 2011–12 and more investigators, the time taken to complete investigations increased, contrary to the HQCC's expectations. The committee remains concerned about the length of time taken to complete investigations. The increased period for completion of investigations in 2011–12 is of significant concern to the committee.

The committee will continue to monitor the number and type of complaints that are investigated, and the time taken to complete investigations, as the new investigation prioritisation criteria are applied and new processes for management of investigations are implemented.

[46] HQCC, *Annual Report 2011–12*, p.26
[47] HQCC, *Annual Report 2011–12*, p.26
[48] HQCC, *Annual Report 2011–12*, p.25
[49] HQCC, *Annual Report 2011–12*, p.26

4.7.5 *Review of investigation process*

At its public hearing in August 2012, the committee asked the HQCC why more investigations had not been closed within 12 months and was advised that a KPMG report of a review of investigation processes was expected shortly.[50] In December 2012, the committee sought further comment from the HQCC on its investigation performance during 2011–12 and details of the KPMG review.

The KPMG review was to consider the effectiveness and efficiency of the HQCC investigation process, benchmark it and identify any improvement opportunities. The HQCC's investigation process was benchmarked against the Australian Government Investigations Standard. The HQCC advised the committee in December 2012 that it had implemented a review recommendation to establish an oversight group, called an Investigation Management Team in the review report, through which all complaints referred for investigation are considered for acceptance and prioritisation against specific criteria. The HQCC also advised that the development of investigation prioritisation criteria was underway.[51] The oversight group, comprising the managers of the complaint triage, early resolution, assessment, conciliation and investigation teams, together with the CEO and Commissioner was established in October 2012.[52]

The committee notes that the Australian Government Investigations Standard (AGIS), against which the HQCC investigation process was benchmarked, is described as "… the minimum standard for (Australian Government) agencies conducting investigations relating to the programs and legislation they administer."[53] The AGIS does not consider the timeliness of investigations. The review report noted that the former HDC made observations about the timeliness of HQCC investigations, but made no recommendations about the timeliness of investigations.[54]

4.7.6 *Performance target for timeliness of investigations*

The HQCC advised the committee in December 2012 that improving the timeliness of its investigations is a priority. It also advised that in 2013 it would revisit its performance target of completing 70 per cent of investigations within 12 months, "in recognition of the delays to investigation which are outside the HQCC's control".[55]

The HQCC stated that "delays outside the HQCC's control can significantly impact investigation timeframes", including:

- over 30 witness and health provider statements may be required, and may be the responsibility of a small legal team or single hospital lawyer; extensions to the HQCC's four-week deadline for statements are granted if health providers make every effort but are unable to meet the HQCC deadline
- delays in gathering information can occur when a health provider has moved overseas
- identifying suitably qualified independent clinical experts can be delayed, and delays occurs in experts providing an opinion due to other commitments
- delays awaiting information from external sources, e.g. other investigative agencies
- legal challenges to investigation, or
- health providers seek additional time to make a submission about adverse comment proposed to be included in a report.[56]

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[50] Herbert, *Hearing Transcript*, 2012, p.6

[51] KPMG report provided as attachment to HQCC, *Response to questions of 3 December 2012*, p.3

[52] HQCC, *Response to questions of 3 December 2012*, p.8

[53] *Australian Government Investigation Standards* 2011, Australian Government, p.iii, accessed 13 March 2013 from http://www.ag.gov.au/RightsAndProtections/FOI/Documents/AGIS%202011.pdf

[54] KPMG report, p.8

[55] HQCC, *Response to questions of 3 December 2012*, p.7

[56] HQCC, *Response to questions of 3 December 2012*, p.7

The committee acknowledges the difficulties the HQCC experiences which it advises are outside its control, however the committee does not consider that this necessarily justifies lowering the HQCC performance target for completion of investigations. The committee will continue to monitor this issue.

Committee comment

The committee would be concerned if the identification of delays in an HQCC investigation caused by another organisation or individual led to the HQCC reducing its performance target for the timeliness of investigations.

4.7.7 Investigation outcomes and cost

In 2011–12, the HQCC made or endorsed recommendations in 27 of the 59 investigations closed, and made 158 recommendations for improvement.[57] The HQCC performance target is to make recommendations in 75 per cent of its investigations. Forty-six per cent of investigations made recommendations for improvement. The HQCC reported that it expects that new investigation acceptance criteria will increase the percentage of investigations which result in recommendations and for 2012–13 has set a higher target of 80 per cent.[58]

The HQCC reported that 72 per cent of the investigation recommendations made to health providers and due to be completed in 2011–12 were fully implemented within agreed timeframes,[59] and that it met its performance targets about timely implementation by health providers of recommendations from investigations and quality monitoring.

The HQCC advised the former HDC that the average cost of an investigation conducted during 2010–11 was $28,041.[60] As the HDC had no information about how this figure was derived it recommended that the current committee seek further information. In answer to the committee's request, the HQCC advised that the average cost per investigation was calculated as total labour and non-labour costs in a year, divided by the number of investigations closed in that year. This average cost does not include the costs incurred at stages of the complaint management process prior to the complaint becoming an investigation.[61]

4.8 Referral and devolution of complaints

4.8.1 Referral to registration boards and other agencies

The Act provides for some complaints about registered providers to be referred, after consultation, to state registration boards,[62] and to national registration boards (through the Australian Health Practitioner Regulation Agency – AHPRA) under the *Health Practitioner Regulation National Law Act 2009* (Qld). Complaints may also be referred to other agencies, for example the Ombudsman.

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57 HQCC, *Annual Report 2011–12*, p.27

58 HQCC, *Annual Report 2011–12*, p.11

59 HQCC, *Annual Report 2011–12*, p.27

60 HQCC, *Response to questions of 3 December 2012*

61 HQCC, *Questions on Notice and Responses to pre-hearing questions*, 6 July 2012

62 There are two state registration boards: the Dental Technicians Board of Queensland and the Speech Pathologists Board of Queensland. The Health Practitioner Registration and Other Legislation Amendment Bill 2012, passed by the Legislative Assembly on 21 March 2013, will remove the requirement for state registration of these professions.

During 2011–12, 93 complaints (10 per cent of all complaints received) were referred to health practitioner registration boards, and 27 (3 per cent) were referred to other agencies.[63] The HQCC did not report how many cases referred to registration boards, AHPRA or other agencies it was continuing to monitor.

4.8.2 Devolution to health providers

The HQCC's 2011 *Organisational Review Report* stated that devolution of complaints to health providers, with oversight by the HQCC would:

> *… be employed when issues remain outstanding following assessment which the HQCC believes are best managed by the healthcare provider. The HQCC will make greater use of section 20 of the HQCC Act – the duty of a provider to establish, maintain and implement reasonable processes to improve the quality of health services – to oversight local investigation of outstanding complaint issues and monitor action plan implementation.*[64]

During 2011–12, the HQCC formalised its use of devolution as an alternative approach. Under devolution, the HQCC refers the issue to the healthcare provider to conduct an initial internal review and report back. A dedicated devolution officer in the HQCC manages the process.[65]

Between March and June 2012, the HQCC devolved seven complaints to health care providers. The HQCC indicates that the complaints devolved involved "multiple systemic issues to be addressed by providers" and that not all were of a clinical nature. At the time of the HQCC Annual Report, none had been finalised.[66]

Committee comment

The committee will continue to monitor the number and type of complaints that are devolved to health providers, and the outcomes of those complaints.

[63] HQCC, *Annual Report 2011–12*, p.24
[64] HQCC, *Organisational Review Report*, 20 December 2011, p.9
[65] HQCC, *Annual Report 2011–12*, p.33
[66] HQCC, *Annual Report 2011–12*, p.33

5 What were complaints about?

The HQCC reports on the issues people complain about. In its *Annual Report 2011–12* the HQCC reported increases across all categories of complaint issue and notable increases in the number of complaints about medication, professional conduct and access to health services.[67]

In light of the 28 per cent increase in complaints received, the committee was interested in identifying possible reasons underlying the increase in complaints between 2010–11 and 2011–12 and sought clarification of the Annual Report data about issues in complaints and whether it was comparable across years.

The HQCC advised the committee that there was an error in the Annual Report data about complaints by issue. The HQCC provided corrected data, which is presented in summary categories of the issues in Table 3. More detailed corrected data was also provided, in line with the issue categories on page 38 of the *Annual Report 2011–12*.[68]

Table 3: Corrected data for complaints by issue category

Complaint issue category	2010–11	2011–12
Treatment	1,751	2,464
Communication and information	437	830
Professional conduct	290	460
Medication	192	397
Access	115	289
Fees and costs	93	179
Medical records	34	115
Discharge and transfer arrangements	48	109
Environment/management of facilities	56	103
Consent	37	95
Reports/certificates	39	57
Grievance processes	11	25
Enquiry service only	4	3
Total	3,107*	5,126*

* As complaints may include more than one issue, the total number of issues is greater than the reported total number of complaints received.
Source: *Response to questions of 3 December 2012*, p.10

During 2011–12, 2,464 complaints (48 per cent) were about treatment, compared to 56 per cent in 2010–11. The majority of those complaints were about inadequate treatment, unexpected treatment outcomes or complications and diagnosis.

The next most common complaint category was communication and information. In 2011–12, 830 complaints (16 per cent) were about communication and information, which is relatively consistent with past years. In over half (58 per cent) of the complaints about communication and information, the main issue was the attitude or manner of health professionals.

67 HQCC, *Annual Report 2011–12*, p.36
68 HQCC, *Response to questions of 3 December 2012*, pp.11–12

In its advice to the committee, the HQCC advised that the significant increase in the number of issues of complaint recorded in 2011–12 was likely to be due in part to the implementation of the new complaint triage process,[69] which is described in section 4.3 above.

The committee notes that data on the issues in complaints reported in the HQCC's *Annual Report 2011–12* were not correct and that the HQCC has provided the committee with corrected data. Consideration of the categories of issues in complaints over time may be important in understanding trends in healthcare safety and quality issues. The committee will continue to monitor the number of complaints received by issue category.

Recommendation 3

The committee recommends that the HQCC:

- publish corrected data on issues in complaints for 2010–11 and 2011–12 in its Annual Report for 2012–2013, and
- ensure that the data remains comparable over time so that trends in complaint issues can be identified.

[69] HQCC, *Response to questions of 3 December 2012*, p.10

6 Who were complaints about?

6.1 Hospitals and other health organisations

In 2011–12, 1,775 complaints were about health organisations such as hospitals, medical centres, and aged care facilities. Public hospitals were the most commonly complained about health organisation, being the subject of 1,102 (63 per cent) of complaints about health organisations in 2011–12.[70] This increase in the percentage of health organisation complaints received about public hospitals is a return to the level of 2008–09 after decreases in the percentage in 2010–11 and 2009–10.[71] To put this in context, the Annual Report noted that, “on any given day at Queensland Health 8,466 people receive admitted care in acute public hospitals, and 30,521 non-admitted patient services, including emergency services, are provided in public hospitals”. There was also a significant increase in the number of complaints about health services provided by correctional facilities, up from 12 to 85 in 2011–12. [72]

6.2 Individual health providers

Doctors accounted for 68 per cent of complaints (862) about individual health providers, and dental practitioners (including dental therapists, dental hygienists, oral health therapists and dental prosthetists) accounted for 17 per cent (216). Unregistered or alternative practitioners were the subject of 10 per cent of complaints about individuals. Nine other professions made up the remaining five per cent of complaints (59) received about individuals in 2011–12. At 68 per cent, there was a decrease in the percentage of individual health provider complaints that were about doctors in 2011–12, down from 72 per cent 2010–11 and 78 per cent in 2009–10. [73]

6.3 Unregistered health providers

Unregistered providers include professions such as counsellors, dieticians and naturopaths. The number of complaints against unregistered providers was not separately reported in 2010–11, and the HDC recommended more detailed reporting. In 2011–12, the HQCC reported it received 127 complaints about alternative or unregistered health providers.

The HQCC response to complaints about unregistered providers depends on the issues raised. It may include referral to the Therapeutic Goods Administration, trade practices or AHPRA (if an unregistered person claims to be registered).[74]

On behalf of State, Territory and Commonwealth Health Ministers, the Australian Health Ministers Advisory Council (AHMAC) is considering the regulatory or other means to protect the public from unregistered health providers who fail to observe minimum standards of professional conduct.[75] Consultation on regulatory options was undertaken by AHMAC in 2011; no outcomes had been publicly reported at the time this report was prepared.

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[70] HQCC, *Annual Report 2011–12*, p.39

[71] HQCC, *Annual Report 2008–09*, p.27

[72] HQCC, *Annual Report 2011–12*, p.39

[73] HQCC, *Annual Report 2011–12*, p.40

[74] Herbert, *Hearing Transcript*, 2011, p.12

[75] Australian Health Ministers Advisory Council (AHMAC), *Options for regulation of unregistered health practitioners*, Consultation paper, 2011, p.5, available from: http://www.ahmac.gov.au/cms_documents/Consultation%20Paper%20-%20Options%20for%20Regulation%20of%20Unregistered%20Health%20Practitioners.pdf

7 Health service quality and standards

7.1 HQCC standards and reporting

The HQCC's statutory functions include making standards about the quality of health services, and monitoring and reporting on health service providers' compliance with standards. The HQCC made nine standards in 2007, which were updated in July 2010. The standards apply to public and licensed private hospitals and day hospitals. Standards compliance is self-assessed and reported to the HQCC.

All 224 acute hospitals and day hospitals in Queensland reported against the revised standards for the period July 2010 to June 2011.[76] On average, compliance with the standards reported by hospitals in September 2011 was 87 per cent, down from 93 per cent in June 2010. The HQCC stated that this fall in compliance was likely to be due to the expanded scope of some of the revised standards, which had "raised the bar".[77] The HQCC anticipated that the next reporting period would see 100 per cent compliance achieved.[78]

The HQCC published *Standards of care: A report on Queensland acute and day hospital self-assessed compliance* in December 2012. It covered the period July 2011 to June 2012 and indicates that self-reported compliance averaged across the standards increased by 5 per cent in 2012 to 92 per cent, almost returning to the 2010 level, although not the 100 per cent anticipated.[79]

Compliance with most individual standards increased in 2012. Compliance with the *Credentialing and scope of clinical practice* standard was very high; hospitals reported that 99.5 per cent of all doctors were credentialed. Reported compliance with the *Hand hygiene* standard increased to 72 per cent but remains below the target of 75 per cent compliance.[80]

Seven per cent of Queensland hospitals reported that they did not meet all the criteria for the *Complaints management* standard. The HQCC notes that complainant satisfaction declined between 2011 and 2012 and that this decline was mainly in public hospitals. Hospitals continue to find the *Management of acute myocardial infarction on or following discharge or transfer* standard and the *Reducing the risk of venous thromboembolism* standard challenging to comply with.[81]

7.2 Introduction of national standards

As part of national health reforms, governments have agreed to the introduction of national standards for health providers. The Australian Commission on Safety and Quality in Healthcare (ACSQHC) was created as a statutory body in July 2011 under the *National Health and Hospitals Network Act 2011*. Its statutory functions include making standards, promoting quality improvement and monitoring the implementation of standards.

Ten national standards were endorsed by Australian Health Ministers in September 2011 and health services were required to be accredited against them by 1 January 2013. Until January 2013, health providers that were due for accreditation could choose to be accredited against their accrediting organisation's standards (e.g. Australian General Practice Accreditation Ltd or Australian Council for Healthcare Standards) or the national standards.

[76] HQCC, *Annual Report 2011–12*, p.56
[77] HQCC, *Annual Report 2011–12*, p.57
[78] HQCC, *Annual Report 2011–12*, p.56
[79] HQCC, *Standards of care: A report on Queensland acute and day hospital self-assessed compliance with healthcare standards*, 2012, p.6, available from: http://www.hqcc.qld.gov.au/Resources/Documents/Report-Standards-of-care-Queensland-acute-and-day-hospital-self-assessed-compliance-with-healthcare-standards-10-Dec-2012.pdf
[80] HQCC, *Standards of care*, pp.7 & 8
[81] HQCC, *Standards of care*, pp.7 & 8

Until the national standards are fully implemented in 2013, the HQCC is maintaining its reporting against the existing Queensland healthcare standards.[82] There was considerable overlap of six of the existing Queensland standards with the national standards, and those six standards were retired on 31 December 2012. The HQCC will continue to require providers to report against three clinical standards not covered by the new national standards:

- *Review of hospital related deaths*
- *Management of acute myocardial infarction on and following discharge or transfer standard*, and
- *Reducing the risk of venous thromboembolism*.[83]

The HQCC will review the need for these three standards by December 2014, or earlier if required.[84]

Full implementation of national safety and quality standards for health services in 2013 will result in a reduced role for the HQCC in making standards and monitoring and reporting on the compliance of health services. The HQCC reviewed its operations and staffing in 2011 and 2012 and moved resources from its standards function to complaint management.

Committee comment

The committee will continue to monitor developments in national safety and quality standards for health services and the standards made by the HQCC, including transition arrangements and HQCC resourcing.

7.3 Review of root cause analysis

Under the *Hospital and Health Boards Act 2011*, the commissioning authority for a root cause analysis of a 'reportable event'[85] (or the Chief Health Officer) must give a root cause analysis report to the HQCC. The HQCC noted in 2011 that the number of root cause analysis reports received was reducing as health care providers chose other processes to examine reportable events.

A root cause analysis is a systematic process to review a reportable event to identify the factors that contributed to the event and any remedial measures that could prevent a recurrence of a similar event. It does not include investigation of the professional competence of a person in relation to the event or identifying who is to blame.

It is open to health care providers to adopt other forms of analysis or investigative techniques in response to reportable events, the reports of which are not required to be released to the HQCC.[86] The HQCC estimated that it received root cause analysis reports on about half of reportable events and that this was likely to decline further.[87] The trend of analysing reportable events in ways other than root cause analysis is most noticeable in the public sector.[88]

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[82] HQCC, *Response to questions on notice*, 1 September 2011, p.7

[83] HQCC, *Annual Report 2011–12*, p.63

[84] HQCC, *Standards of care*, p.9

[85] 'reportable event' is defined in section 29 of the Hospital and Health Boards Regulation 2012 and section 36A of the *Ambulance Service Act 1991*. A reportable event is an unforeseen and serious event resulting in unexpected death or patient harm. It includes events such as maternal death, death associated with incorrect medication, retention of an instrument during surgery, death or damage to a person from intravenous gas embolism. Accessed 18 March 2013 from http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/H/HHNR12.pdf

[86] HQCC, *Expanded reportable events monitoring – Fast Facts*, accessed 19 November 2012 from http://www.hqcc.qld.gov.au/Quality/Pages/Reportable-events-monitoring-fast-facts.aspx

[87] HQCC, *Annual Report 2011–12*, p.63 and *Fast Facts*

[88] HQCC, *Annual Report 2011–12*, p.59

Reportable events monitoring applies to public sector health service facilities, private health facilities and the Queensland Ambulance Service.[89]

The HQCC monitors the implementation of recommendations from root cause analysis until it is satisfied that safety and quality concerns have been addressed. It also monitors timeframes for implementing recommendations, as a timely response to adverse events is critical to reducing the risk of harm to patients.

The HQCC decided in 2012 to expand its approach to reportable events monitoring, to monitor all reportable events, not only those for which a root cause analysis is conducted. The HQCC seeks to ensure that it captures information on all reportable events, not only those for which a root cause analysis is selected as the review methodology.[90] In early 2012, the HQCC consulted with health care stakeholders and the Office of the State Coroner about expanding its monitoring of reportable events to include reports on the outcome of coronial investigations and other complaints and reportable event data. The HQCC reported that it would require reports on all reportable events that occur in public and private health facilities and during the provision of ambulance services from 1 July 2012.[91]

Committee comment

The committee notes the HQCC's expansion of its monitoring of reportable events and suggests that the HQCC include in its Annual Reports the results relevant to safety and quality in health services and the HQCC resources allocated to this work.

[89] HQCC, *Expanded reportable events monitoring*
[90] HQCC, *Expanded reportable events monitoring*
[91] HQCC, *Annual Report 2011–12*, p.64

8 Information to clients and stakeholders

8.1 Awareness of the HQCC

8.1.1 Reporting on complaints received from special needs groups

The HDC was concerned about the under-representation of complainants from culturally and linguistically diverse (CALD) communities and people of Aboriginal or Torres Strait Islander background,[92] and sought information from the HQCC. In its *Annual Report 2011–12*, the HQCC reported on the complaints received from people born overseas and on the preferred language of complainants, and continued to report on complaints received from Aboriginal and Torres Strait Islander people.

8.1.2 Complaints from people from culturally and linguistically diverse communities

In 2011–12, 12.7 per cent of complainants were born overseas (including those born in English-speaking countries), up from 8.8 per cent in 2010–11 and 5.7 per cent in 2009–10.[93] In comparison, in 2011, 20.5 per cent of Queensland's population was born overseas.[94] Fewer than one per cent of complaints in 2011–12 were made by complainants whose preferred language was not English.

8.1.3 Complaints from Aboriginal and Torres Strait Islander people

Complaints made by Aboriginal and Torres Strait Islander people increased from 74 in 2010–11 to 104 in 2011–12. In 2011–12, 4.4 per cent of complaints and 3.6 per cent of enquiries were made by Aboriginal and Torres Strait Islander people, a small increase on 2010–11.[95] The proportion of complaints is slightly higher than the proportion of Aboriginal and Torres Strait Islander people in Queensland (3.6 per cent)[96] but it is important to note that Aboriginal and Torres Strait Islander people "… have higher rates of hospitalisation and higher prevalence rates for many health conditions compared to other Australians".[97]

Committee comment

In 2011, the HQCC agreed to provide the former HDC with six-monthly updates on the engagement strategies implemented and the nature of complaints received from each of the different CALD communities. Six-monthly reporting will continue for this committee. Reporting on CALD enquiries and complaints is now also reflected in the HQCC's annual reporting.

92 Herbert, *Hearing Transcript*, 2011, p.5
93 HQCC, *Annual* Report *2011–12*, p.44 and HQCC, *Response to request for information*, 11 November 2011, p.6
94 Queensland Treasury and Trade, *Census 2011: Diversity in Queensland*, accessed 19 November 2012 from http://www.oesr.qld.gov.au/products/bulletins/diversity-qld-c11/diversity-qld-c11.pdf
95 HQCC, *Annual* Report *2011–12*, p.43
96 ABS Census 2011, accessed 21 November 2012 from http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/2075.0main+features32011
97 HQCC, *Annual Report 2011–12*, p.43

8.2 Satisfaction with HQCC complaint management

The HQCC surveys complainants and health providers when complaints are closed to seek feedback about satisfaction levels and whether expectations were met during early resolution, assessment and conciliation.[98] In 2011–12, 233 clients responded to the client satisfaction survey. The HQCC's target is 75 per cent satisfaction with the complaint service, and 60 per cent satisfaction with complaint outcomes.[99]

The percentage of parties satisfied with the timeliness of the complaint service was only 61 per cent in 2011–12, significantly below the target of 75 per cent and down compared to 2010–11. The percentage of parties satisfied with the complaint outcome was also below target at 54 per cent. The decrease in client satisfaction with the complaint service, particularly with regard to the timeliness of complaint resolution, is of concern to the committee. [100]

In its Annual Report, the HQCC states that it developed an action plan to improve the timeliness of its service, staff communication, and the frequency and quality of information provided to clients throughout the complaint process.[101] The HQCC states that client expectations around timeframes can sometimes be unrealistic; however it also recognises that the time taken to manage complaints affects client satisfaction.[102]

The HQCC will implement a range of measures to improve the timeliness of complaint management, including the redirection of staff to early resolution roles to assist more complainants and providers to resolve issues informally.[103]

The HQCC advised the committee that high demand in 2012 for complaint management meant that the time before complaint allocation to a case officer (where there was no potential risk to the complainant) had increased. Complaints were on a waiting list for allocation of up to eight weeks. The HQCC advised the committee that it will enhance its complaint case management system in 2013 to enable reporting on complaint allocation waiting times.[104]

Committee comment

The committee will continue to monitor client satisfaction with the HQCC's complaint service and the outcomes of the HQCC's improvement action plan.

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98 HQCC, *Annual Report 2010–11*, p.42
99 HQCC, *Annual Report 2011–12*, p.12
100 HQCC, *Annual Report 2011–12*, p.16 and *Annual Report 2010–11*, p.17
101 HQCC, *Annual Report 2011–12*, pp.12 & 29
102 HQCC, *Annual Report 2011–12*, p.12
103 HQCC, *Response to questions of 3 December 2012*, p.10
104 HQCC, *Response to questions of 3 December 2012*, p.19

9 HQCC staffing and resourcing

9.1 Staffing

The former HDC recommended that this committee examine HQCC staffing, including the HQCC's reported need for additional staff. The HDC had concerns about the proportion of temporary staff and turnover rates.

At 30 June 2012, the HQCC had a permanent staff establishment of 70.4 with two permanent positions vacant. Of the 68.4 actual staff at 30 June 2012, 88 per cent (60) were permanent employees and 12 per cent (8) were temporary, down from 15 per cent at 30 June 2011.[105] Seven permanent and nine temporary staff were recruited by the HQCC during 2011–12.[106]

The HQCC now reports positions by function (for example, complaint management or community engagement) rather than by business unit as in previous Annual Reports. Following the HQCC's internal organisational review in 2011, human resources were realigned to enable the HQCC to better achieve its strategic objectives. At 30 June 2012, 60.5 per cent of staff were deployed in complaint management which includes triage, early resolution, assessment, conciliation, investigation and complaint support.[107]

The HQCC did not participate in the Queensland Government voluntary separation program introduced in January 2011.[108] The HQCC's permanent retention rate was 87.9 per cent in 2011–12. The permanent separation rate was 5.46 per cent. The *Annual Report 2011–12* data on retention and separation in 2010–11 differs from the data in the *Annual Report 2010–11*. A significant difference is in the permanent separation rate (14 per cent separation rate in 2010–11 reported previously, in contrast to 0.2 per cent in 2010–11 in the 2011–12 Annual Report).[109]

The HQCC's cultural survey of its staff each year measures 'staff engagement', which fell to 22 per cent in 2011–12 from 50 per cent in 2010–11. The HQCC notes this probably reflected the significant organisational change undertaken in 2012. The percentage of staff 'engaged' is a strategic performance indicator for 2012–13, with a performance target set at 60 per cent of staff identified by the cultural survey as engaged.[110]

Committee comment

The former HDC recommended that the staffing of the HQCC, including staff retention and turnover rates and the proportion of permanent and temporary staff, continue to be monitored. The committee notes the inconsistency in the reporting of retention and separation data for 2010–11 between Annual Reports.[111]

105 HQCC, *Annual Report 2011–12*, p.69
106 HQCC, *Annual Report 2011–12*, p.68
107 HQCC, *Annual Report 2011–12*, p.69
108 HQCC, *Annual Report 2011–12*, p.73
109 See HQCC, *Annual Report 2010–11*, p.79 in comparison to HQCC, *Annual Report 2011–12*, p.73
110 HQCC, *Annual Report 2011–12*, p.74
111 HQCC, *Annual Report 2011–12*, p.68

9.2 Resourcing

The HQCC's Annual Report for 2011–12 indicated that employee expenses increased significantly (by $994,243) over 2010–11 expenditure. Of this increase, $627,362 was reported as 'wages and salaries' in the Notes to the Financial Statements for 2011–12. The HQCC advised the committee that a number of additional temporary staff were engaged in complaint assessment, investigation and conciliation over 2011–12 to address increasing caseloads, as well as cover long-term staff absences where the staff member continued to receive full pay.[112]

The HQCC received $10.078 million in grants in 2011–12 – $180,000 more than initially budgeted to cover its enterprise bargaining agreement. The HQCC's Budget allocation for 2012–13 is $10.170 million. An increase of $40,000 has been provided for co-location rent expenses, and a further increase of $12,000 added to the funding for the transition of the new payroll and finance system.[113]

[112] HQCC, *Response to questions of 3 December 2012*, p.8

[113] Queensland Government, *State Budget 2012–13 – Service Delivery Statements – Qld Health*, pp.183 & 186

10 HQCC Reporting

10.1 Annual Report 2011–12

The former HDC noted some apparent inconsistencies in data reporting in the HQCC *Annual Report 2010–11*. It recommended that the HQCC ensure that future Annual Reports give information about complaints and performance in a clear, consistent and transparent way (see Appendix B for the recommendation).

The HQCC *Annual Report 2011–12* was tabled in Parliament on 28 September 2012. The committee considers that the *Annual Report 2011–12* complies with the Queensland Government's *Annual report requirements for Queensland Government agencies*.[114]

In some respects, the presentation of data has been improved in response to recommendations made by the former HDC in 2012. The number of complaints closed after 'direct resolution', 'early resolution', or because they were 'not confirmed in writing' are now reported separately. Information about the number of people from other cultural backgrounds who make complaints and the gender of complainants is reported.

Data provided on the number of complaints about each practitioner type is now more clearly reported, with the addition of a category for unregistered providers and a note on the number of complaints where information about the practitioner type has not been received.

The committee, however, has identified some issues relating to the accuracy and consistency of data presented in the *Annual Report 2011–12*. For example, the HQCC provided corrected data on the issues in complaints in response to the committee's request for clarification (see section 5) and the reporting of the performance measure for conciliation timeliness was not transparent (section 4.6.6).

The HQCC indicated that in 2012–13 it will refine its complaints and investigations case management system to improve data capture.[115]

Committee comment

The committee commends the HQCC for some improvements to reporting in response to the former HDC's recommendations about the provision of clear, consistent and transparent information about complaints in its Annual Report.

The committee, however, notes that further work is required to ensure that the HQCC's reporting is clear, consistent and transparent. In particular, the committee considers that more consistent and transparent reporting on the total time for management of complaints to completion (including any time awaiting allocation) and other performance measures is required. Other areas for improvement include the issues raised in complaints, and ensuring this data is comparable over time.

The committee suggests that the HQCC should use the refining of its complaints and investigations case management system as an opportunity to improve the usefulness of the data captured, as well as its presentation. The HQCC should also ensure that its ability to consider data trends over time is not compromised by changes to data capture, making arrangements for historical data to be re-categorised if necessary to ensure comparability across years.

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114 Available from: http://www.premiers.qld.gov.au/publications/categories/guides/annual-report-guidelines.aspx

115 HQCC, *Annual Report 2011–12*, p.52

10.2 Performance reporting

The HQCC reviews and revises its strategic plan, key performance indicators (KPIs) and targets annually. The HQCC commenced its *Strategic Plan 2011–15* on 1 July 2011. The plan included a range of new KPIs and, therefore, while performance against the key performance indicators is measured, the reporting of trends in the new indicators is not possible.[116]

The HQCC's *Strategic Plan for 2012–16* includes additional KPIs in comparison to the *Strategic Plan 2011–15*. Baselines for a number of these will be established by 30 June 2013.[117]

Committee comment

The committee notes that meaningful reporting of performance measures requires improvement, in particular for the conciliation process, and that information on the time taken to manage complaints should be more comprehensive.

10.3 Other reports

During 2011–12, the HQCC released reports on complaints about access to health services and self-assessment by acute and day hospitals of compliance with HQCC standards.[118]

The HQCC also released *Annual Health Check 2011*, a snapshot of the HQCC's work in resolving healthcare complaints and monitoring the quality of health services in Queensland.

In addition, the HQCC provided the Minister with special reports about:

- credentialing and defining the scope of clinical practice for doctors employed by Queensland Health and in licensed private acute and day hospitals, and
- investigations completed by the HQCC from 1 July to 31 December 2011.

Under section 173 of the Act, the Minister must table a special report from the HQCC in the Legislative Assembly.

In July 2012, the HQCC released the first volume of a report on the perceptions and experiences of health care in Queensland. In September 2012, it released a spotlight report on complaints about dental care.

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[116] HQCC, *Annual Report 2011–12*, p.10

[117] HQCC, *Strategic Plan 2012–16*, available from http://www.hqcc.qld.gov.au/About-Us/Documents/Plan-Strategic-Plan-2012-16-FINAL-1-July-2012.pdf

[118] HQCC reports are available from their website at: http://www.hqcc.qld.gov.au/Resources/Pages/Reports.aspx

Appendices

Appendix A – Statutory functions of the Health Quality and Complaints Commission

The HQCC's statutory functions, as set out in sections 13–16 of the *Health Quality and Complaints Commission Act 2006*, are:

Health service complaints (s.13)
The commission has the following functions in relation to health service complaints-
- (a) receiving, assessing and managing health service complaints;
- (b) encouraging and helping users and providers to resolve health service complaints;
- (c) helping providers to develop procedures to effectively resolve health service complaints;
- (d) conciliating or investigating health service complaints.

Quality of health services (s.14)
The commission has the following functions in relation to health services-
- (a) monitoring and reporting on providers' compliance with section 20(1);
- (b) making standards relating to the quality of health services;
- (c) assessing the quality of health services and processes associated with health services;
- (d) responding to health quality complaints, including by conducting investigations and inquiries;
- (e) promoting continuous quality improvement in health services;
- (f) promoting the effective coordination of reviews of health services carried out by public or other bodies;
- (g) recommending ways of improving health services;
- (h) identifying and reviewing issues arising from health complaints;
- (i) receiving, analysing and disseminating information about the quality of health services.

Information (s.15)
The commission has the following functions in relation to the provision of information-
- (a) providing information, education and advice to users, providers, the public and others relating to-
  - (i) health rights and responsibilities; and
  - (ii) procedures for resolving health service complaints;
- (b) providing information, advice and reports about health complaints to registration boards;
- (c) providing information to the public about the quality of health services, the commission standards and the commission's functions and powers.

Other functions (s.16)
The commission's functions also include the following-
- (a) suggesting ways of improving health services and of preserving and promoting health rights;
- (b) investigating or inquiring into matters under this Act;
- (c) advising and reporting to the Minister on matters relating to health services or the administration of this Act;
- (d) advertising for and nominating to the Minister persons the commission considers suitable for appointment as members of health community councils;
- (e) conducting research relating to its functions;
- (f) performing other functions conferred on the commission under an Act.

Appendix B – Recommendations of former Health and Disabilities Committee

Committee recommendations to a committee of the next Parliament with responsibility for oversight of the HQCC	Section of report
o examine the recommendations of the external review of conciliation, those which the HQCC has adopted and progress on implementation of changes to conciliation	2.6.2
o monitor the time taken to complete investigations and any changes that may be desirable	2.7.2
o examine the implementation of draft criteria for decisions to commence an investigation by the HQCC and the impact of any changes on the number and type of complaints that are examined	2.7.3
o examine the cost of an investigation and the methodology by which the average cost of $28,041 was calculated	2.7.4
o consider the HQCC's devolution of complaint issues to health providers, referred to in the HQCC Review Report	2.8.1
o continue to monitor developments in national safety and quality standards for health services and the quality standards made by the HQCC, and report to the Legislative Assembly on the implications	3.2.2
o monitor HQCC activities to make its complaint services accessible to people from CALD [culturally and linguistically diverse] communities, and the complaints received from people in those communities	4.1.1
o monitor the staffing of the HQCC, including staff retention and turnover rates and the proportion of permanent and temporary staff	5
o examine the rationale for additional staff requirement reported in the HQCC Review Report	5
o examine the HQCC Review Report and the proposed changes that arise from it and their implementation. In addition to specific recommendations noted above, those changes include proposed 'analysis', 'collation' and 'sharing' functions of the HQCC	7.4
o that the HQCC ensure that future Annual Reports give information about complaints and performance in a clear, consistent and transparent way. In particular, the committee recommends that HQCC Annual Reports include: o data about the number of complaints that are closed because they were not confirmed in writing, separately from complaints that are closed by 'direct resolution' and 'early resolution' o complete data about the type of health provider about whom complaints are made, including health providers in professions which are not registered o data about the number of complainants from culturally and linguistically diverse backgrounds o consistent performance reporting, including sufficient information to enable the achievements that are reported in percentages to be examined	8.1

Statement of Reservation

JO-ANN MILLER MP
SHADOW MINISTER FOR HEALTH, NATURAL RESOURCES AND MINES, AND HOUSING
MEMBER FOR BUNDAMBA

HEALTH AND COMMUNITY SERVICES COMMITTEE

Oversight of the Health Quality and

Complaints Commission

24 April 2013

Statement of Reservation

I wish to submit the following Statement of Reservation to Report 21 of the Health and Community Services Committee on *Oversight of the Health Quality and Complaints Commission.*

I commend the Health Quality and Complaints Commission staff, Chief Executive Officer Mrs Cheryl Herbert, and Commissioner Professor Russell Stitz for their contributions to the safety and quality of care in our health system.

Health and Community Services Committee has identified areas for improvement in the timely management of complaints, and in monitoring of standards and reportable events.

I concur broadly with the Committee's assessment of the Commission's performance however I do not believe sufficient weight has been given to barriers to achieving Key Performance Indicators created by third parties beyond the Commission's direct control. This is particularly the case for complex complaints involving multiple parties, government agencies in other jurisdictions, and where litigation for compensation is involved.

I agree that there is scope to improve the accuracy and clarity of presentation of data on trends in complaints.

My principal concern is with the adequacy and stability of staffing and resources for the Commission in the face of what is likely to be an avalanche of complaints on access to health care services and the quality and safety of these services where cuts in the state health budget have meant fewer, less qualified staff delivering models of care driven by costs cutting.

There is potential for the number of complaints to be further exacerbated by any outsourcing of services, privatisation of clinical management of our hospitals and the sale of public health assets.

The 2012-13 HQCC budget allocation of $10.170 million does not seem sufficient to ensure that a minimum staff establishment of 70 full time equivalent positions are sustained and resources are available to employ additional temporary staff as needed. There is also clear evident from the HQCC's cultural survey that current staff are under stress with the growing volume of complaints and the expectations imbedded in Key Performance Indicators.

The LNP budget in 2012 stated that the government intends to reduce health expenditure by $3 billion over the next four years. Despite claims that efficiency requirements will not impact on access to services or to their quality, this is blatantly untrue.

The government has a stated policy of sacking well over 4,000 health workers, of closing or substantially reducing non-hospital services and shifting their responsibilities to non-government organisations and federally funded service providers. These reductions in public services have been compounded by cuts to grants for non-government organisations to delivery services on behalf of the state.

Of even greater concern is this government's secret program of privatisation and outsourcing of public health services. Outsourcing of facilities management and clinical support services is well underway. Privatising of the management of our public hospitals, firstly with the new Gold Coast and Sunshine Coast university hospitals, is now openly discussed.

The public has yet to be informed about the potential scope for this privatisation agenda across our network of public hospitals. The detail of the Costello Audit report still remains a secret. The government has indicated that it will selectively release recommendations that it considers relevant. Other, less palatable recommendations are likely to be hidden from public scrutiny making a mockery of the government's claim to be open and accountable.

In health care, where profits are put before people's health care needs, the quality and safety of that care will inevitably decline. For private providers to get their minimum 6% return on capital investment, costs will be cut; meaning fewer, less qualified and experienced clinical and support staff and more rapid turnover of patients.

There is growing evidence of the decline in the quality and safety of health care standards in the United Kingdom where the LNP has sourced its ideas for privatisation of public services. Short term cost cutting will lead to a long term burden of illness and disability for the people of Queensland.

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Rightly Queenslanders will complain about the lack of access to health care caused by budget cuts and mismanagement of federal-state funding agreements. It is unclear if they will be able to complain about poorer quality of care in privatised services and whether contracts between the government and health services corporations will be open to public scrutiny or hidden behind a veil of secrecy called "Commercial in Confidence".

In either case the volume of complains to the HQCC will rise and the Commission has inadequate staff to deal with these complaints in a timely manner.

Yours sincerely

Jo-Ann Miller MP
Member for Bundamba

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