

# **Oversight of the Health Quality and Complaints Commission**

**Report No. 44**

**Health and Community Services Committee**

**April 2014**

## Health and Community Services Committee

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### Acknowledgements

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## Contents

<b>Chair’s Foreword</b>	<b>v</b>
<b>1 Introduction</b>	<b>1</b>
1.1 Role of the committee	1
1.2 Committee oversight of the Health Quality and Complaints Commission	1
1.3 Functions of the Health Quality and Complaints Commission	1
1.4 New arrangements for a Health Service Complaints Management System	2
<b>2 Health service complaint processes</b>	<b>3</b>
<b>3 Number of complaints received 2012-13</b>	<b>4</b>
<b>4 How complaints were managed 2012-13</b>	<b>6</b>
4.1 Timeliness of complaint management	6
4.2 Direct resolution	6
4.3 Complaint triage	6
4.4 Early resolution	7
4.5 Assessment of complaints	7
4.6 Conciliation of complaints	8
4.6.1 <i>Complaints conciliated</i>	8
4.6.2 <i>Performance measurement of timeliness of conciliation</i>	9
4.6.3 <i>Timeliness of conciliation</i>	9
4.6.4 <i>Performance target for timeliness of conciliation</i>	10
4.6.5 <i>Causes of delay in conciliation</i>	10
4.7 Investigation of complaints	11
4.7.1 <i>Complaints investigated</i>	11
4.7.2 <i>Increased completion of investigations</i>	11
4.7.3 <i>Delays in investigation and strategies implemented</i>	12
4.7.4 <i>Timeliness of investigations</i>	13
4.7.5 <i>Performance target for timeliness of investigations</i>	13
4.8 Referral and devolution of complaints	14
4.8.1 <i>Referral to registration boards and other agencies</i>	14
4.8.2 <i>Devolution to health providers</i>	15
4.9 Review of HQCC decisions	16
<b>5 What were complaints about?</b>	<b>16</b>
<b>6 Who were complaints about?</b>	<b>17</b>
6.1 Hospitals and other health organisations	17
6.2 Individual health providers	17
6.3 Unregistered health providers	17
<b>7 Health service quality and standards</b>	<b>18</b>
7.1 Introduction of national standards	18
7.2 HQCC standards and reporting	19
7.3 Reportable event monitoring and analysis	19
7.4 Monitoring quality improvement	20
<b>8 HQCC clients and stakeholders</b>	<b>20</b>
8.1 Awareness of the HQCC	20

8.1.1	<i>Complaints from people from culturally and linguistically diverse communities</i>	21
8.1.2	<i>Complaints from Aboriginal and Torres Strait Islander people</i>	21
8.2	Improvements in provision of information about complaint progress	21
8.3	Satisfaction with HQCC complaint management	21
<b>9</b>	<b>HQCC staffing and resourcing</b>	<b>22</b>
9.1	Staffing	22
9.2	Resourcing	22
<b>10</b>	<b>HQCC Reporting</b>	<b>22</b>
10.1	Annual Report 2012-13	22
10.2	Performance reporting	23
10.3	Other reports	23
	<b>Appendices</b>	<b>25</b>

## Figure

Figure 1: HQCC complaints received and closed in 2012-13	5
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## Tables

Table 1: Complaints assessed by HQCC 2012-13	8
Table 2: Timeliness of investigations closed	13

## Abbreviations

ACSQHC	Australian Commission on Safety and Quality in Healthcare
the Act	Health Quality and Complaints Commission Act 2006
AHMAC	Australian Health Ministers Advisory Council
AHPRA	Australian Health Practitioner Regulation Agency
AQAR	Annual Quality and Activity Return
the committee	Health and Community Services Committee
HDC	(former) Health and Disabilities Committee
HQCC	Health Quality and Complaints Commission
KPI	key performance indicator
MBQ	(former) Medical Board of Queensland
QBMBA	Queensland Board of the Medical Board of Australia

## 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.

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

The HQCC'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.

In February 2013, the Government launched the *Blueprint for better healthcare in Queensland*. The Blueprint included plans to introduce legislation to re-design the health complaints system in Queensland. As part of those reforms to the system for managing complaints about health services, the *Health Quality and Complaints Commission Act 2006* will be repealed and the HQCC will cease to exist on 30 June 2014. The HQCC will be replaced by a new Health Ombudsman, who will provide a single point for people to make health service complaints under the *Health Ombudsman Act 2013*.

The new arrangements for the health complaints system have also expanded the oversight role of the committee to include monitoring and review of the Health Ombudsman and, in relation to the health, conduct and performance of registered health practitioners in Queensland, the fourteen national registration boards and the Australian Health Practitioner Regulation Agency.

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 reporting is consistent, so that achievement can be accurately measured. The committee will be monitoring the new health complaints management system, and the Health Ombudsman, and will continue to focus on those issues as part of its ongoing oversight.

I thank the former Commissioner, Adjunct Professor Russell Stitz, the current Commissioner, Dr John Rivers, and the Chief Executive Officer of the HQCC, Adjunct Professor Cheryl Herbert, for their participation in the committee's oversight of the HQCC and their role in ensuring that Queensland's health system is safe, and I wish them well in the future.

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.<sup>1</sup>

### 1.2 Committee oversight of the Health Quality and Complaints Commission

This is the committee's second report on its oversight of the HQCC. This report provides an overview of the HQCC and its performance and comments on the HQCC's Annual Report for 2012-13.<sup>2</sup>

This report is informed by: evidence given by representatives of the HQCC at a public hearing on 22 May 2013 and at a Budget Estimates hearing on 24 July 2013, the HQCC's 14 May 2013 response to pre-hearing questions on notice, and 9 October 2013 response to the committee's request for information and comment;<sup>3</sup> HQCC Annual Reports, *Annual Health Check 2012*,<sup>4</sup> and other HQCC reports.<sup>5</sup> The Minister for Health responded to the committee's previous oversight report on the HQCC on 26 July 2013.

After examination of the *Annual Report 2012-13*, the committee asked the HQCC for further information and comment about reportable event monitoring and analysis and reporting on the devolution of complaints and outcomes.<sup>3</sup> The HQCC response of 18 March 2014 to the committee provides this information.

### 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.<sup>6</sup> The *Health Quality and Complaints Commission Act 2006* (the Act) sets out the functions of the HQCC in four categories: health service

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

2 Health Quality and Complaints Commission, Annual Report 2012-13, available from <http://www.hqcc.qld.gov.au/Resources/Documents/Annual%20report%202012-13/Report-HQCC-Annual-report-2012-13-FINAL-9-Sep-2013.pdf>

3 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](http://www.parliament.qld.gov.au/hcsc)

4 HQCC, *Annual Health Check 2012*, available from <http://www.hqcc.qld.gov.au/Resources/Documents/Reports/Annual-Health-Check-2012.pdf>

5 All available from the HQCC website at: <http://www.hqcc.qld.gov.au/Resources/Pages/Reports.aspx>

6 *Queensland Health Systems Review*, Final Report, September 2005 (the Forster Review), 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>

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.

#### 1.4 New arrangements for a Health Service Complaints Management System

Over 2012 and 2013, the outcomes of three inquiries (the Chesterman<sup>7</sup>, Hunter<sup>8</sup> and Forrester<sup>9</sup> Reports) highlighted deficiencies in the existing health complaints system in Queensland.

In February 2013, the Government launched the *Blueprint for better healthcare in Queensland*.<sup>10</sup> The Blueprint included plans to introduce legislation to re-design the health complaints system in Queensland.

The Health Ombudsman Bill 2013 was introduced into the Legislative Assembly by the Minister for Health on 4 June 2013 and was passed on 20 August 2013. The Bill will repeal the *Health Quality and Complaints Commission Act 2006*, and reform the system for managing complaints about health services in Queensland. In his introductory speech, the Minister for Health said that the new arrangements would remove the role confusion between complaints entities, and address the issue of lack of oversight of the Queensland Board of the Medical Board of Australia.<sup>11</sup>

The reforms include the creation of the statutory position of Health Ombudsman as the single agency to receive health service complaints under the *Health Ombudsman Act 2013*. The Health Ombudsman has a wider complainant management role than the current HQCC – including the ability to take *immediate action* – if necessary to protect the public, management of the most serious complaints about registered health practitioners, which are currently managed by registration boards, and referral by the Director of Proceedings to the Queensland Civil and Administrative Tribunal (QCAT). The Health Ombudsman will also be able to take disciplinary action against health practitioners who are not required to be registered under the National Scheme (non-registered health practitioners).

All health complaints will now be made to the Health Ombudsman, rather than being split between the HQCC and the national health practitioner registration boards. The new Health Ombudsman was appointed and commenced duty on 28 January 2014 and the HQCC will cease to operate on 30 June 2014.

The new arrangements for the health complaints management system have also expanded the oversight role of this committee. The new functions for the committee include monitoring and review of the Health Ombudsman and, in relation to health, conduct and performance of registered health practitioners in Queensland, the fourteen national registration boards and the Australian Health Practitioner Regulation Agency. In addition, the committee has the function of advising the Minister for Health about appointment of the Health Ombudsman. The committee will commence its expanded review and monitoring role on 1 July 2014.

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7 Parliamentary Crime and Misconduct Committee, *A report of the Crime and Misconduct Commission's assessment of a public interest disclosure*, Report no. 87, July 2012, pp.1-3 (*The Chesterman Report*), available from <http://www.parliament.qld.gov.au/documents/committees/PCMC/2012/rpt-87-230712.pdf>

8 Hunter J R, Review of the files held by the Medical Board of Queensland, Queensland Board of the Medical Board of Australia and the Australian Health Practitioner Regulation Agency, 28 February 2013, p.1, available from <http://www.parliament.qld.gov.au/Documents/TableOffice/TabledPapers/2013/5413T2374.pdf> (*The Hunter Report*)

9 Forrester K, Davies E and Houston J, *Chesterman Report Recommendation 2 Review Panel (The Forrester Report)*, 5 April 2013, p.74, available from <http://www.parliament.qld.gov.au/documents/tableOffice/TabledPapers/2013/5413T2375.pdf>

10 Queensland Government, *Blueprint for better healthcare in Queensland*, February 2013, accessed 6 March 2014 from <http://www.health.qld.gov.au/blueprint/>

11 Legislative Assembly of Queensland, *Hansard*, 4 June 2013, p.1899 (Hon. Lawrence Springborg MP, Minister for Health), available from [http://www.parliament.qld.gov.au/documents/hansard/2013/2013\\_06\\_04\\_WEEKLY.pdf](http://www.parliament.qld.gov.au/documents/hansard/2013/2013_06_04_WEEKLY.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 5.

- 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.<sup>12</sup> If the complaint remains unresolved after 30 days, it must be assessed (section 53).<sup>13</sup>
- 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.<sup>14</sup> The HQCC (non-statutory) performance target in 2012-13 was 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 in 2012-13 was 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 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.

12 HQCC, *Resolving your complaint*, Fact sheet, Feb 2013, p.1, accessed 7 February 2014 from <http://www.hqcc.qld.gov.au/Complaints/Documents/Fact-sheet-online-consumers-resolving-your-complaint.pdf>

13 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>

14 HQCC, *Conciliating your complaint*, Fact sheet, Jan 2013, p.2, accessed 7 February 2014 from <http://www.hqcc.qld.gov.au/Resources/Documents/Fact-sheet-online-consumers-2-page-conciliating-your-complaint.pdf>

### 3 Number of complaints received 2012-13

During 2012-13, the HQCC reported that it received 3,419 complaints about health services. This total includes oral complaints that were not confirmed in writing. The total complaints received increased by 5.4 per cent (175) compared to 2011-12. Oral complaints that were not confirmed in writing decreased from 1044 in 2011-12 to 1010 or 29.5 per cent of complaints, in 2012-13. 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.<sup>15</sup> The HQCC therefore received 2409 written complaints in 2012-13, compared to 2200 in 2011-12, an increase of 9.5 per cent.<sup>16</sup>

In 2012 the HQCC indicated in oral evidence to the committee that it was concerned about the number of complaints that were not confirmed in writing.<sup>17</sup> At that time, the HQCC provided callers with a complaint form and reply paid envelope, and helped with the writing of a complaint if required.

In order to address the issue of complaints not being confirmed in writing, in 2012-13 the HQCC introduced an online facility for making a complaint. The HQCC was not able to advise the committee if the online facility had improved the rate at which oral complaints are confirmed in writing.<sup>18</sup>

The HQCC also received 1409 enquiries in 2012-13.<sup>19</sup> An enquiry is a matter that is not eligible to be considered a complaint.<sup>20</sup>

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15 HQCC, *Annual Report 2012-13*, available from <http://www.hqcc.qld.gov.au/Resources/Pages/Annual-reports.aspx> 2013, p.20

16 HQCC, *Annual Report 2012-13*, p.21

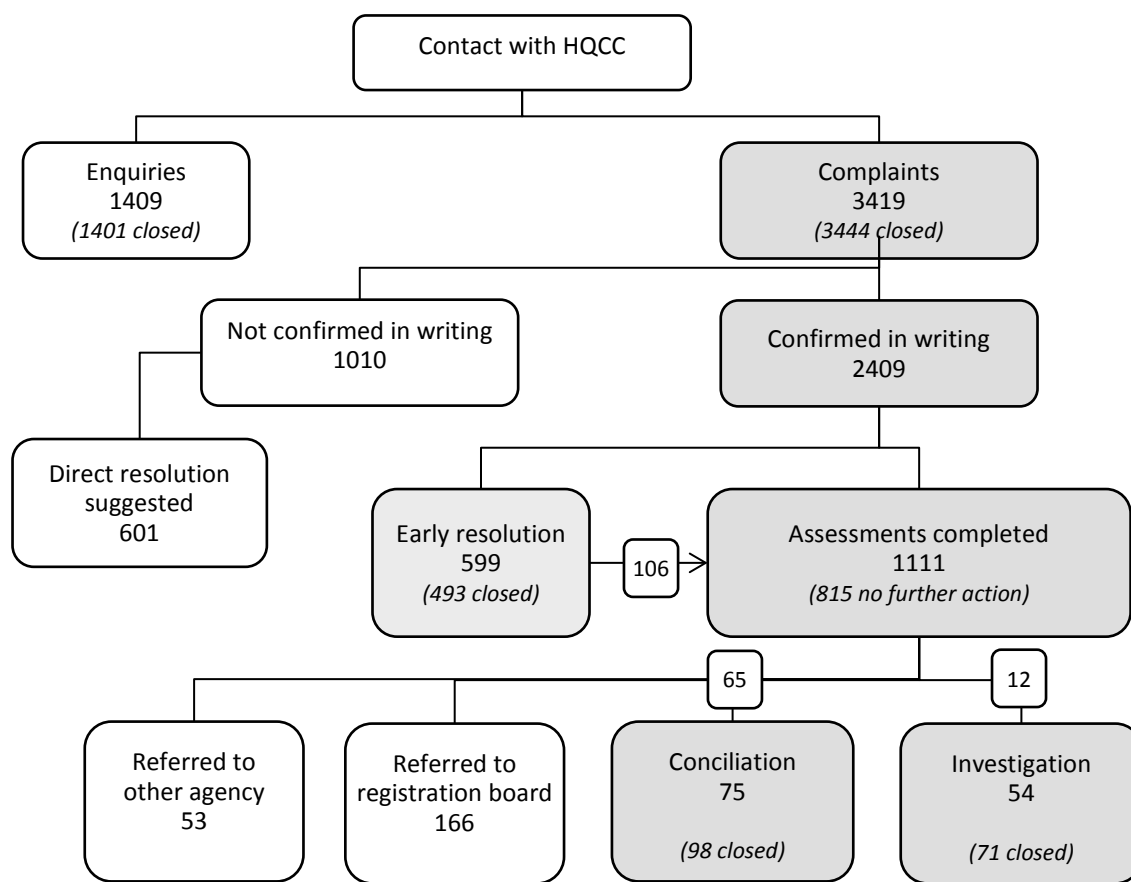
17 Mrs Cheryl Herbert, HQCC, *Public Hearing Transcript*, 1 August 2012, p.3

18 HQCC, *Response to questions arising from the committee’s oversight of HQCC*, 9 October 2013, p.7

19 HQCC, *Annual Report 2012-13*, p.20

20 HQCC, *Annual Report 2012-13*, p.20

**Figure 1: HQCC complaints received and closed in 2012-13**



**Notes:** 409 complaints were open in assessment at the commencement of 2012-13. 18 cases were open in early resolution, 92 in conciliation and 44 in investigation.

10 cases were referred to conciliation from sources other than assessment. The source is not identified in the HQCC's annual report.

15 additional matters were referred to the HQCC for investigation in 2012-13 from external agencies. One investigation was initiated by the HQCC and 26 were referred from triage and conciliation services rather than through the assessment process.

**Source:** Drawn from data in the *Annual Report 2012-13*. Data for cases open in conciliation and investigation at 1 July 2012 is from *Annual Report 2011-12*.

## 4 How complaints were managed 2012-13

### 4.1 Timeliness of complaint management

The committee has had concerns about the time taken to complete investigation and conciliation of complaints. The committee explained its concerns in its *Oversight of the HQCC*, Report no.21 of April 2013 and continued to follow up these concerns with the HQCC during 2013.<sup>21</sup>

The committee notes that, in response to the need to better understand the timeliness of complaint processes for complainants and health providers, the HQCC's Annual Report 2012-13 includes new information about the:

- average time that a complaint spends in early resolution and the number of complaints carried forward in the 'early resolution' phase
- time a complaint spent waiting for allocation to early resolution
- the average time between the receipt of a complaint and its allocation to an assessment officer and the number of complaints carried forward in the 'assessment' phase
- timeliness of conciliation and conciliation waiting periods.

The publication of this data has improved transparency of the overall timeliness of complaint management by the HQCC. It is now easier to track the time taken from receipt of a complaint to its completion, from the perspective of a complainant or health provider.

### 4.2 Direct resolution

The HQCC encourages direct resolution of less serious oral complaints. In 2012-13, direct resolution was suggested for 601 oral complaints compared to 807 in 2011-12, a decrease from 25 per cent of complaints to 18 per cent. The HQCC advises complainants to formalise their complaint in writing if direct resolution is not successful.<sup>22</sup>

In its *Annual Report 2012-13*, the HQCC reported that it intends to follow up direct resolution clients using an automated text/email messaging system.<sup>23</sup> The committee notes that, in its response to the committee of December 2012, the HQCC had indicated that it would commence follow up of direct resolution referrals in 2012-13.<sup>24</sup> The HQCC advised the committee in May 2013 that it had been unable to do so.<sup>25</sup>

### 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.<sup>26</sup> The HQCC reported that, following the trial, four triage staff were appointed in July 2012 and a permanent triage team supervisor in September 2012. An automated phone answering service directing new complainants to the triage team was also introduced in July 2012. To support better documentation and reporting, a new complaint and investigated case management system workflow was developed.<sup>27</sup>

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21 HCSC, Oversight of the Health Quality and Complaints Commission, April 2013, available from <http://www.parliament.qld.gov.au/documents/committees/hcsc/2012/hqcc/rpt-021-26apr2013.pdf>

22 HQCC, *Annual Report 2012-13*, p.20

23 HQCC, *Annual Report 2012-13*, p.34

24 HQCC, *Response to issues arising from the Health and Community Services Committee examination of the HQCC Annual Report 2011-12*, 20 December 2012, p.10

25 HQCC, *Response to questions arising from the committee's oversight report*, 14 May 2013, p.5

26 HQCC, *Annual Report 2011-12*, p.31, available from <http://www.hqcc.qld.gov.au/Resources/Pages/Annual-reports.aspx>

27 HQCC, *Annual Report 2012-13*, p.32

#### 4.4 Early resolution

The HQCC attempted early resolution of 599 complaints in 2012-13 compared to 375 in 2011-12. This significant increase of 60 per cent followed an increase the previous year, which had 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 493 complaints, and the remaining 106 complaints were assessed.<sup>28</sup>

Under the Act, the HQCC is required to meet a legislated time frame of 30 days for the early resolution of complaints.

In its *Annual Report 2011-12*, the HQCC reported a decrease in resolution of cases within 30 days from 95 per cent in 2010-11 to 91 per cent. It noted that this reduction in timeliness 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.<sup>29</sup> The *Annual Report 2012-13* reports a further significant decrease in the resolution of cases within 30 days, to 77 per cent. The committee notes that 30 days is the legislated timeframe for early resolution and that, therefore, the service standard target is set at 100 per cent.

The HQCC explained in its annual report that failure to meet the 30 day timeframe in a much larger proportion of cases in 2012-13 was due to "a number of reasons, including the resources required to establish a dedicated early resolution team, recruit and train experienced resolution officers and develop and implement policies and procedures".<sup>30</sup>

The average number of days a complaint was in early resolution in 2012-13 was 26 days in comparison with only 11 days in 2011-12.<sup>31</sup> The HQCC reported for the first time on the time complaints spent waiting for allocation, with 70 per cent of complaints waiting more than 20 days for allocation to early resolution in 2012-13.<sup>32</sup>

#### 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 time. The HQCC reports that 93 per cent of complaints were assessed in the legislated timeframe in 2012-13, the same percentage as in 2011-12.<sup>33</sup>

During 2012-13, 1111 complaints were assessed and 815 (73 per cent of those assessed) were closed and categorised as no further action required after assessment. This was very similar to the 703 (or 74 per cent of all complaints received) closed with no further action in 2011-12.<sup>34</sup> The outcome of assessment of complaints is shown in Table 1

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28 HQCC, *Annual Report 2011-12*, p.23

29 HQCC, *Annual Report 2011-12*, p.23

30 HQCC, *Annual Report 2012-13*, p.21

31 HQCC, *Annual Report 2012-13*, p.21

32 HQCC, *Annual Report 2012-13*, p.21

33 HQCC, *Annual Report 2012-13*, p.21; and HQCC, *Annual Report 2011-12*, p.24

34 HQCC, *Annual Report 2012-13*, p.22; and HQCC, *Annual Report 2011-12*, p.24

**Table 1: Complaints assessed by HQCC 2012-13**

Outcome of assessment / action	No.	Percentage of assessments
Closed, no further action	815	73.4
Referred to conciliation	65	5.9
Referred to investigation	12	1.1
Referred to healthcare practitioner registration board	166	14.9
Referred to external agency	53	4.8
<b>Total complaints assessed</b>	<b>1111</b>	

Source: HQCC, *Annual Report 2012-13*, p.22

## 4.6 Conciliation of complaints

### 4.6.1 Complaints conciliated

In 2012-13, 75 complaints were accepted for conciliation, a decrease of 18.5 per cent in comparison to 2011-12 when 92 complaints were accepted for conciliation.<sup>35</sup> The HQCC reports that the introduction of a new conciliation policy reduced the complaints accepted for conciliation in 2012-13.<sup>36</sup>

The HQCC introduced the new policy in January 2013.<sup>37</sup> Conciliation of complaints focuses on cases “where there is an opportunity to achieve resolution and healthcare improvement in a timely manner”.<sup>38</sup> Under the new policy, compensation in conciliation is now limited to payment of out-of-pocket expenses and/or corrective treatment costs. The HQCC seeks to involve the parties in conciliation directly, rather than through legal representatives, and limit conciliation to a proposed maximum timeframe of 12 months, with extension only in extenuating circumstances.<sup>39</sup> The policy was further updated on 24 June 2013. Cases accepted for conciliation prior to 29 January 2013 were not affected by the new policy.<sup>40</sup>

In 2012-13, 98 conciliations were closed, and 69 remained open at 30 June 2013.<sup>41</sup>

The HQCC reported that 60 per cent of conciliations closed were successful in 2012-13, similar to the 61 per cent recorded in 2011-12. There was a financial settlement in 24 cases closed during 2012-13, an increase from 19 cases with a financial settlement in 2011-12.<sup>42</sup> A financial settlement may include compensation for damages or may be a refund, fee waiver, reimbursement of fees, payment of out-of-pocket expenses, and/or reparative treatment costs.<sup>43</sup>

35 HQCC, *Annual Report 2012-13*, p.22; and HQCC, *Annual Report 2011-12*, p.24

36 HQCC, *Annual Report 2012-13*, p.22

37 HQCC, Conciliation policy, January 2013, accessed 20 February 2014 from <http://www.hgcc.qld.gov.au/Resources/Documents/Policy-Conciliation.pdf>

38 HQCC, *Response to issues arising from the Health and Community Services Committee examination of the HQCC Annual Report 2011-12*, 20 December 2012, p.6

39 HQCC, *Response to issues arising from the Health and Community Services Committee examination of the HQCC Annual Report 2011-12*, 20 December 2012, p.6

40 HQCC, ‘Updated conciliation policy’, accessed 20 February 2014 from <http://www.hgcc.qld.gov.au/News/Pages/Updated-conciliation-policy.aspx>

41 HQCC, *Annual Report 2012-13*, p.22

42 HQCC, *Annual Report 2012-13*, p.23; and *Annual Report 2011-12*, p.25

43 HQCC, *Response to issues arising from the Health and Community Services Committee examination of the HQCC Annual Report 2011-12*, 20 December 2012, p.6

#### 4.6.2 Performance measurement of timeliness of conciliation

In its April 2013 oversight report, the committee recommended that the HQCC 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.

In its *Annual Report 2011-12*, the HQCC reported on two measures of timeliness for conciliation: one measured from the point the case was assessed and referred to conciliation, the other from the point the conciliator contacted the complainant to commence the conciliation process. There is usually a waiting time for cases to be allocated a conciliator for management.<sup>44</sup> For example, the HQCC advised the committee, at its hearing in May 2013, that there was at that point a 'waiting time of about one month' for conciliation.<sup>45</sup>

The committee raised the issue of the inconsistency in measurement and lack of clarity around the use of the two measures with the HQCC as part of the committee's consideration of its *Annual Report 2011-12*. The HQCC 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.*<sup>46</sup>

The committee considered 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. The committee's view was that 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.

In response to the committee's recommendation, the HQCC decided to report on both measures of timeliness. These are reported in its *Annual Report 2012-13*, for closed conciliations only, at tables 9 and 10.<sup>47</sup> The committee notes, however, that the HQCC has reported timeliness from the date of allocation to a conciliator as its performance against service standards rather than from the date of referral to, and acceptance into, conciliation.<sup>48</sup>

#### 4.6.3 Timeliness of conciliation

The committee has been concerned about the timeliness of conciliation and has continued to monitor this issue. The committee believes that the timeliness of conciliation should be measured from the time of the decision to refer a complaint to conciliation to its completion, including any waiting time for allocation to a conciliator for management of the conciliation.

The HQCC reports that 57 per cent of conciliation cases were closed within 12 months in 2012-13 compared to 53 per cent of conciliations in 2011-12.<sup>49</sup> This is below the HQCC's conciliation timeliness performance target for 2012-13 of 60 per cent of cases closed within 12 months. The committee notes that 11 conciliation cases closed in 2012-13, which had been referred from

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44 HQCC, *Annual Report 2011-12*, p.24 Table 'Timeliness of conciliations closed' and HQCC, *Annual Report 2010-11*, p.16

45 Mrs Cheryl Herbert, HQCC, *Public Hearing Transcript*, 22 May 2013, p.8

46 HQCC, *Response to issues arising from the Health and Community Services Committee examination of the HQCC Annual Report 2011-12*, 20 December 2012, p.5

47 HQCC, *Annual Report 2012-13*, p.23

48 HQCC, *Annual Report 2012-13*, p.16

49 HQCC, *Annual Report 2012-13*, p.23 Table 10: 'Time between the date of the notice of assessment decision and the date the conciliation closed' and HQCC, *Annual Report 2010-11*, p.24 Table 'Timeliness of conciliations closed', available from <http://www.hqcc.qld.gov.au/Resources/Pages/Annual-reports.aspx>

investigation or from other boards and agencies rather than from assessment, are not included in the reporting for this measure of timeliness by the HQCC.<sup>50</sup>

The average time to complete conciliation in 2012-13 was 369 days (not including any waiting period to be allocated a conciliator).<sup>51</sup> This was a decrease from 422 days in 2011-12 and a return to around the average time taken to complete conciliation cases in 2010-11 (354 days).<sup>52</sup>

#### 4.6.4 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.<sup>53</sup> In its previous April 2013 oversight report, the committee recommended 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 should:

- 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.

The target for timeliness of conciliations remained unchanged for 2012-13 at 60 per cent as, according to the HQCC, the “vast majority of complaints conciliated during the year” were managed under the former conciliation policy.<sup>54</sup>

In its response to the committee's recommendation, the HQCC advised that the new conciliation policy should enable it to conciliate complaints “in most cases within a maximum of six months” and that therefore its 2013-14 targets have been revised as follows.<sup>55</sup>

- 70 per cent of complaints in conciliation closed in six months
- 85 per cent of complaints in conciliation closed in nine months
- 100 per cent of complaints in conciliation closed in 13 months.

#### 4.6.5 Causes of delay in conciliation

The committee continued to be interested in the reasons for delays in conciliation and any strategies the HQCC was implementing to address delays in obtaining expert clinical opinions and obtaining feedback on questions to be posed to a clinical expert.<sup>56</sup>

The HQCC provided information on the sources of delays in conciliation for cases closed in 2012-13 and the actions being taken to address each of the identified sources. The leading causes of delay were the time taken:

- to negotiate compensation (damages) and finalise deeds of release
- waiting for independent clinical opinions because the experts have other commitments
- for complainants/providers to engage or consult legal counsel
- to source suitably qualified independent clinical experts to provide opinions.<sup>57</sup>

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50 HQCC, *Annual Report 2012-13*, p.23, see note 1 to Table 10: ‘Time between the date of the notice of assessment decision and the date the conciliation closed’

51 HQCC, *Annual Report 2012-13*, p.22

52 HQCC, *Annual Report 2011-12*, p.24

53 HCSC, *Oversight of the Health Quality and Complaints Commission*, Report No.21, April 2013, p.8

54 HQCC, *Response to questions arising from the committee's April 2013 report on the oversight of the HQCC*, 14 May 2013, p.13

55 HQCC, *Response to questions arising from the committee's April 2013 report on the oversight of the HQCC*, 14 May 2013, p.13

56 As noted in HQCC, *Response to issues arising from the Health and Community Services Committee examination of the HQCC Annual Report 2011-12*, 20 December 2012, p.6



The HQCC noted that, “under the HQCC’s new conciliation policy, the parties are subject to prescribed directions from the conciliator and must adhere to strict timelines”. The conciliator can end the conciliation for “repeated or continued breach of the directions and timelines”.<sup>58</sup> The HQCC encourages the parties to conciliation to be directly involved in conciliation. As claims for damages are now excluded from conciliation, the HQCC expects that fewer complainants will elect to obtain and consult with legal counsel.<sup>59</sup>

The HQCC reviewed and restructured its clinical advice model in 2012-13 and rolled out the new model from January 2013.<sup>60</sup> This included “targeted training of complaint staff in 2012-13 about how and when to seek clinical advice”.<sup>61</sup>

## **4.7 Investigation of complaints**

### *4.7.1 Complaints investigated*

In 2012-13, 54 complaints were accepted for investigation, an increase of 38 per cent in comparison to 2011-12 when 39 complaints were accepted for investigation.<sup>62</sup> Of the 54 investigations accepted, 15 were referrals from external agencies and one was initiated by the HQCC.<sup>63</sup> The HQCC notes in its Annual Report that 2012-13 was the first full year operating under new investigation acceptance criteria.<sup>64</sup>

In 2012-13, 71 investigations were closed, and 27 remained open at 30 June 2013.<sup>65</sup>

The HQCC reported that it made or endorsed recommendations in 41 investigations closed in 2012-13. By far the majority of recommendations made were directed to public healthcare providers (mainly hospitals).

The HQCC performance target in 2011-12 was to make recommendations in 75 per cent of its investigations. The HQCC increased this target to 80 per cent for 2012-13 as it expected that the new investigation acceptance criteria would increase the percentage of investigations resulting in recommendations.<sup>66</sup> Fifty-eight per cent of investigations closed in 2012-13 made recommendations for improvement compared to 46 per cent in 2011-12.

The HQCC monitors the implementation of investigation recommendations against agreed timelines. In 2012-13, 89 per cent of investigation recommendations due to be completed were fully implemented in comparison to 72 per cent in 2011-12.<sup>67</sup>

### *4.7.2 Increased completion of investigations*

In its oversight report in April 2013, the committee noted that new investigation acceptance criteria had significantly reduced the number of investigations accepted in 2011-12 to 39, compared to 83 in

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57 HQCC, *Response to questions arising from the committee’s April 2013 report on the oversight of the HQCC*, 14 May 2013, p.10

58 HQCC, *Response to questions arising from the committee’s April 2013 report on the oversight of the HQCC*, 14 May 2013, p.11

59 HQCC, *Response to questions arising from the committee’s April 2013 report on the oversight of the HQCC*, 14 May 2013, p.11 and HQCC, *Response to issues arising from the Health and Community Services Committee examination of the HQCC Annual Report 2011-12*, 20 December 2012, p.6

60 HQCC, *Annual Report 2012-13*, p.33

61 HQCC, *Annual Report 2012-13*, p.34

62 HQCC, *Annual Report 2012-13*, p.24; and HQCC, *Annual Report 2011-12*, p.25

63 HQCC, *Annual Report 2012-13*, p.24

64 HQCC, *Annual Report 2012-13*, p.25

65 HQCC, *Annual Report 2012-13*, p.24

66 HQCC, *Annual Report 2011-12*, p.11

67 HQCC, *Annual Report 2012-13*, p.26; and HQCC, *Annual Report 2011-12*, p.27

2010-11, and that investigation staff increased from eight to 12.<sup>68</sup> The HQCC's Annual Report 2011-12 stated that the decrease in investigations completed within 12 months was because the HQCC focussed on finalising more complex, lengthy investigations in 2011-12.<sup>69</sup>

In 2011-12 the time taken to complete investigations increased, contrary to the HQCC's expectations given that the number of cases being referred to investigation had been reduced and improved management practices put in place. The HQCC advised the committee that a major ongoing investigation had required a dedicated senior investigator for 18 months. Then, in its response to pre-hearing questions in May 2013, the HQCC advised the committee that the projected staffing level for investigations in 2011-12 had "never been able to be fully realised".<sup>70</sup>

The committee noted at its hearing in May 2013 however, that despite not achieving the projected investigation staffing levels until very recently, the HQCC had now been able to significantly reduce the number of investigations older than 12 months.<sup>71</sup>

The HQCC advised that changes to the organisation's management of investigations, such as improved priority setting from the outset, shorter investigation reports and higher level management review of the complexity of, and timeliness of investigations, had contributed to the improvement in investigation timeliness without an increase in staffing levels.<sup>72</sup>

During 2012-13 the HQCC developed investigation prioritisation criteria after reviewing the models used by other complaints agencies such as the Western Australian and Queensland Ombudsman. The HQCC noted that the new prioritisation criteria have also been of assistance in improving the timeliness of investigations.<sup>73</sup>

#### 4.7.3 *Delays in investigation and strategies implemented*

The committee continued to be interested in the causes of delays in investigations and the strategies the HQCC was implementing to address delays.

The HQCC advised that the leading sources of delays in investigations for cases closed in 2012-13 were:

- extensions to the four week deadline for information/responses
- health care providers seeking legal and/or union advice
- waiting for information from external sources
- waiting for healthcare providers to respond to adverse comment.<sup>74</sup>

The HQCC maintained that most delays are due to issues outside the HQCC's control. It advised the committee that "all identified delays that cannot be resolved by investigators are discussed on a regular basis with the Commissioner and Chief Executive Officer. A response for action is escalated if deemed necessary".<sup>75</sup>

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68 HQCC, *Annual Report 2011-12*, p.25

69 HQCC, *Annual Report 2011-12*, p.26

70 HQCC, *Response to issues arising from the Health and Community Services Committee examination of the HQCC Annual Report 2011-12*, 20 December 2012, p.7 and HQCC, *Response to the Health and Community Services Committee Questions arising from the committee's April 2013 report on its oversight of the HQCC*, 14 May 2013, p.14

71 Trevor Ruthenberg, *Public Hearing Transcript*, 22 May 2013, p.9

72 Cheryl Herbert, HQCC, *Public Hearing Transcript*, 22 May 2013, p.9-10

73 HQCC, *Response to the Health and Community Service Committee Questions arising from the committee's April 2013 report on its oversight of the HQCC*, 14 May 2013, p.15 and HQCC, *Annual Report 2012-13*, p.33

74 HQCC, *Response to questions arising from the committee's April 2013 report on the oversight of the HQCC*, 14 May 2013, p.17

75 HQCC, *Response to questions arising from the committee's April 2013 report on the oversight of the HQCC*, 14 May 2013, p.18

#### 4.7.4 *Timeliness of investigations*

The average time taken to complete the investigations closed in 2012-13 was 361 days. This was a decrease from an average time of 16 months in 2011-12.<sup>76</sup>

The HQCC's *Annual Report 2012-13* includes data on the timeliness of investigations closed over the last four financial years.

**Table 2: Timeliness of investigations closed**

	2009-10	2010-11	2011-12	2012-13
Less than 6 months	35	41	9	35
6-12 months	14	7	16	6
12-18 months	6	10	13	9
18-24 months	2	5	11	4
24-30 months	4	7	7	11
30-36 months			0	3
36-42 months			1	3
42-48 months			0	0
48-54 months			2	0
<b>Total</b>	<b>61</b>	<b>70</b>	<b>59</b>	<b>71</b>

Source: HQCC, *Annual Report 2012-13*, p.25

In 2012-13, 58 per cent of the 71 investigations closed were completed within 12 months. This is an increase in comparison to 2011-12, when 42 per cent of closed investigations were completed within 12 months.

The HQCC indicated to the committee at the public hearing that it hoped to have no investigations remaining open at the end of 2012-13 that had been open for more than 12 months.<sup>77</sup> The HQCC's Annual Report indicates that the number of investigations remaining open at the end of June that had already been open for more than 12 months fell significantly, from 34 in 2012 to five in 2013.<sup>78</sup>

#### 4.7.5 *Performance target for timeliness of investigations*

The performance target for investigations closed in 12 months was 70 per cent for 2012-13.<sup>79</sup>

The HQCC advised the committee in December 2012 that improving the timeliness of its investigations was a priority. It also advised that it would revisit its performance target of completing 70 per cent of investigations within 12 months in 2013, "in recognition of the delays to investigation which are outside the HQCC's control".<sup>80</sup> The committee acknowledged the difficulties experienced by the HQCC which may be outside its control, but noted that this did not necessarily justify lowering the HQCC performance target for completion of investigations.

In its response to the committee's April 2013 oversight report recommendation regarding the performance target, the HQCC advised that it had resolved to retain its target of 70 per cent of

<sup>76</sup> HQCC, *Annual Report 2012-13*, p.25

<sup>77</sup> Cheryl Herbert, HQCC, *Public Hearing Transcript*, 22 May 2013, p.2

<sup>78</sup> HQCC, *Annual Report 2012-13*, p.25

<sup>79</sup> HQCC, *Annual Report 2011-12*, p.16

<sup>80</sup> HQCC, *Response to issues arising from the Health and Community Services Committee examination of the HQCC Annual Report 2011-12*, 20 December 2012, p.7

investigations closed within 12 months for the 2012-13 year.<sup>81</sup> As discussed in section 4.7.3 above, the committee continued to monitor the progress being made by the HQCC in reducing delays in investigations.

The HQCC's *Annual Report 2012-13* omitted to report on its performance target for 'Percentage of investigations closed in 12 months' in its service standards report card.

The committee was disappointed to note that this measure has been discontinued for reporting in the State Budget Service Delivery Statement.<sup>82</sup> The 2013-14 Discontinued Measures statement indicates that the measure has been discontinued as "it is not an indication of the efficiency or effectiveness of the service area" but will continue to be collected and reported in the HQCC Annual Report. The measure 'Percentage of complaints in conciliation closed in 12 months' has been retained as a service standard.<sup>83</sup>

## 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 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.

During 2012-13, 166 complaints (15 per cent of all complaints assessed) were referred to health practitioner registration boards.<sup>84</sup> This was an increase compared to 2011-12 when 10 per cent of complaints were referred to registration boards.<sup>85</sup> The HQCC referred 53 (or nearly 5 per cent) were to other agencies.<sup>86</sup> The HQCC did not report on how many of the cases it had referred to registration boards, AHPRA or other agencies it was continuing to monitor.

Under the current arrangements for the management of health complaints, there are legislatively prescribed cross jurisdictional referral and consultation obligations imposed on the HQCC and the national registration boards in relation to receipt of notifications, consultation and information sharing.

The Forrester inquiry reviewed all cases of misconduct or alleged misconduct by medical practitioners, dealt with by the (former) Medical Board of Queensland (MBQ), the Queensland Board of the Medical Board of Australia (QBMA) or in which AHPRA recommended disciplinary action against a medical practitioner. The purpose of the review was to determine whether the objective of protecting the public by ensuring that medical practitioners are competent to practice was being achieved.<sup>87</sup>

The Forrester report of April 2013 found that the legislative cross jurisdictional referral and consultation obligations of the current health complaints system had resulted in substantial delays

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81 Minister for Health, *Government response to the HCSC Report No. 21 Oversight of the Health Quality and Complaints Commission*, 26 July 2013, p.4

82 State Budget 2013-14, *Service Delivery Statements Queensland Health*, p.237, available from <http://www.budget.qld.gov.au/budget-papers/2013-14/bp5-gh-2013-14.pdf>

83 State Budget 2013-14, *2013-14 Discontinued Measures*, p.41, available from <http://www.budget.qld.gov.au/budget-papers/2013-14/bp5-discontinued-measures-2013-14.pdf>

84 HQCC, *Annual Report 2012-13*, p.22

85 HQCC, *Annual Report 2011-12*, p.24

86 HQCC, *Annual Report 2012-13*, p.22

87 Forrester K, Davies E and Houston J, *Chesterman Report Recommendation 2 Review Panel* (the Forrester Report), 5 April 2013, p.i, available from <http://www.parliament.qld.gov.au/documents/tableOffice/TabledPapers/2013/5413T2375.pdf>

and inconsistencies in the progression and outcomes of complaints/notifications. The report also drew attention to a 'blurring of roles' of AHPRA and the HQCC caused by these obligations.<sup>88</sup>

The committee notes that, in commenting on cross jurisdictional referral and consultation obligations, the Forrester report stated that "significant delays ... were attributable to reciprocal referral, consultation requirements and the duplication of processes such as assessments, clinical opinions, expert opinions and investigations".<sup>89</sup> The report expressed concern about the number of complaints/notifications referred by the HQCC to the QBMBA that were either rejected by the Board or, if accepted by the Board, resulted in a 'no further action' decision.<sup>90</sup>

The Forrester report also commented that notifications were held in abeyance waiting for information from the HQCC or pending the outcome of a HQCC investigation or until clinical advice was forwarded by the HQCC. The report identified a number of cases where notifications from the HQCC to AHPRA resulted in the files being closed, "after no consultation was received from the HQCC".<sup>91</sup>

The committee anticipates that the new arrangements for the health complaints management system in Queensland, under which all health complaints will be made to the Health Ombudsman rather than being split between the HQCC and the national health practitioner registration boards, will eliminate this cause of delays and inconsistencies.

In its *Annual Report 2012-13*, the HQCC reports on its liaison with AHPRA. It notes that the two agencies worked over the year to reduce consultation times and that the time taken for AHPRA to respond fell significantly in comparison to 2011-12. The consultation period was three months or less for 61 per cent of complaints in 2012-13.<sup>92</sup>

#### 4.8.2 Devolution to health providers

During 2011-12, the HQCC formalised its use of devolution of complaints to health providers as an alternative approach, noting that it would make greater use of section 20 of the Act and take an oversight role.<sup>93</sup> 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.<sup>94</sup>

The committee indicated in its April 2013 oversight report that it would continue to monitor the number and type of complaints that are devolved to health providers, and the outcomes of those complaints.<sup>95</sup>

Between March and June 2012, the HQCC devolved seven complaints to health care providers. None had been finalised at the time of the HQCC's *Annual Report 2011-12*.<sup>96</sup>

The committee notes that the number, type and outcomes of devolved complaints are not reported in the HQCC's *Annual Report 2012-13*. The committee requested information on devolved complaints and their outcomes from the HQCC. The HQCC advised that the seven devolved matters were completed and closed but did not provide details about the outcomes of the complaints.

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88 Forrester report, p.33

89 Forrester report, p.35

90 HQCC, *Annual Report 2012-13*, p.31

91 Forrester report, pp.35-36 and 37

92 HQCC, *Annual Report 2012-13*, p.30

93 HQCC, *Organisational Review Report*, 20 December 2011, p.9, available from

<http://www.parliament.qld.gov.au/documents/committees/HDC/2011/HQCC-oversight/111220-OrgReviewRpt.pdf>

94 HQCC, *Annual Report 2011-12*, p.33

95 HCSC, *Report on oversight of the HQCC*, April 2013, p.13

96 HQCC, *Annual Report 2011-12*, p.33

In 2012-13 the HQCC devolved 49 complaints to health care providers for management, including 11 to correctional facilities and one to an 'Other government department'.<sup>97</sup>

#### 4.9 Review of HQCC decisions

On closure of a complaint by the HQCC, an opportunity to request a review of the decision is provided. A request for review must be received within 60 days of the date of the decision. The HQCC's conciliation and investigation processes are exempt. In these cases, an external review can be requested through the Queensland Ombudsman.<sup>98</sup>

Requests for reviews of HQCC decisions continued to increase in 2012-13, from 113 in 2011-12 to 166. The HQCC accepted 42 of these review requests and revoked its original decision in 18 cases. The Queensland Ombudsman received 86 complaints about the HQCC in 2012-13.<sup>99</sup>

## 5 What were complaints about?

The HQCC reports on the issues people complain about. In its *Annual Report 2012-13* the HQCC reported notable increases in the number of complaints about access to health services, fees and costs and grievance processes. Interestingly, the proportion of complaints about professional conduct fell in 2012-13, despite the nearly 10 per cent increase in complaints overall.<sup>100</sup>

In its April 2013 oversight report the committee identified that the data published by the HQCC on issues in complaints for 2010-11 and 2011-12 in its *Annual Report 2011-12* were incorrect.<sup>101</sup> In its *Annual Report 2012-13* the HQCC has published the corrected data, as requested by the committee.

During 2012-13, 2327 complaints (53 per cent) were about treatment, compared to 48 per cent in 2011-12. The majority of those complaints were about inadequate treatment, unexpected treatment outcomes or complications, diagnosis or inadequate care.<sup>102</sup>

The next most common complaint category was communication and information. In 2012-13, 737 complaints (17 per cent) were about communication and information, which is consistent with past years. In over half (56 per cent) of the complaints about communication and information, the main issue was the attitude or manner of health professionals.<sup>103</sup>

In its advice to the committee in December 2012, 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 its new complaint triage process.<sup>104</sup> The number of complaint issues recorded in 2012-13 fell, despite the increase in complaints between 2011-12 and 2012-13.<sup>105</sup> This may reflect the organisation's adjustment to better complaint triage and issue recording.

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97 HQCC, *Response to the HCSC Questions arising from the committee's consideration of the HQCC's Annual Report 2012-13*, p.6

98 HQCC, 'Request a review', p.23, accessed 13 March 2014 from <http://www.hqcc.qld.gov.au/Complaints/Pages/Request-a-review.aspx>

99 Queensland Ombudsman, *Annual Report 2012-13*, p.23, available from [http://www.ombudsman.qld.gov.au/Portals/0/docs/Publications/Annual\\_Reports/2012-13%20AnnualReport\\_FINAL\\_12.9.13\\_V2.pdf](http://www.ombudsman.qld.gov.au/Portals/0/docs/Publications/Annual_Reports/2012-13%20AnnualReport_FINAL_12.9.13_V2.pdf)

100 HQCC, *Annual Report 2012-13*, p. 37

101 HCSC, *Report on oversight of the HQCC*, April 2013, p.15

102 HQCC, *Annual Report 2012-13*, p. 37

103 HQCC, *Annual Report 2012-13*, p. 37

104 HQCC, *Response to issues arising from the Health and Community Services Committee examination of the HQCC Annual Report 2011-12*, 20 December 2012, p.10

105 HQCC, *Annual Report 2012-13*, p.37

## 6 Who were complaints about?

### 6.1 Hospitals and other health organisations

In 2012-13, 1959 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 996 (51 per cent) of complaints about health organisations in 2012-13.<sup>106</sup> There was a significant decrease in complaints in comparison to 2011-12 (63 per cent). To put this in context, in Queensland each day in 2012-13, 8554 people received admitted care in acute public hospitals and 34 742 non-admitted patient services, including emergency services, were provided in public hospitals.<sup>107</sup> There was also a significant increase in the number of complaints about health services provided by correctional facilities, up from 85 in 2011-12 to 211 in 2012-13. This followed a significant increase in 2011-12.<sup>108</sup> The HQCC notes in its *Annual Report 2012-13* that this increase can be “attributed to a greater awareness among detainees of their ability to make a complaint ...”.<sup>109</sup>

### 6.2 Individual health providers

Doctors accounted for 66 per cent of complaints (968) about individual health providers, and dental practitioners (including dental therapists, dental hygienists, oral health therapists and dental prosthetists) accounted for 15 per cent (226). At 66 per cent, there was a decrease in the percentage of individual health provider complaints that were about doctors in 2012-13, down from 68 per cent in 2011-12 and continuing the decreasing trend from 2009-10.<sup>110</sup> Unregistered or alternative practitioners were the subject of three per cent of complaints about individuals, with complaints falling from 127 in 2011-12 to 50 in 2012-13.<sup>111</sup> Nine other professions, and 110 complaints where the HQCC did not have information about the practitioner and their profession, made up the remaining 16 per cent of complaints received about individuals in 2011-12.

### 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 former HDC recommended more detailed reporting. In 2011-12, the HQCC reported on the number of complaints received about alternative or unregistered health providers for the first time.

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).<sup>112</sup>

On behalf of State, Territory and Commonwealth Health Ministers, the Australian Health Ministers Advisory Council (AHMAC) has been considering the regulatory or other means to protect the public from unregistered health providers who fail to observe minimum standards of professional

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106 HQCC, *Annual Report 2012-13*, p.39

107 The State of Queensland (Department of Health), *Annual Report 2012-13*, p.3, available from [http://www.health.qld.gov.au/about\\_qhealth/annual-report/12-13/default.asp](http://www.health.qld.gov.au/about_qhealth/annual-report/12-13/default.asp)

108 Complaints about health care in correctional facilities rose from 12 in 2010-11 to 85 in 2011-12. HQCC, *Annual Report 2012-13*, p.39

109 HQCC, *Annual Report 2012-13*, p.39

110 HQCC, *Annual Report 2012-13*, p.40. The percentages of individual health provider complaints that were about doctors were 72 per cent in 2010-11 and 78 per cent in 2009-10; HQCC, *Annual Report 2011-12*, p.40

111 HQCC, *Annual Report 2012-13*, p.40

112 Cheryl Herbert, *Public Hearing Transcript*, 2011, p.12

conduct.<sup>113</sup> Consultation on regulatory options was undertaken by AHMAC in 2011 and a regulatory impact statement assessing the options for regulation of unregistered health practitioners was released in April 2013.

On 14 June 2013, the Australian Health Ministers agreed in principle to strengthen state and territory health complaints mechanisms via:<sup>114</sup>

- a single national Code of Conduct for unregistered health practitioners to be made by regulation in each state and territory, and statutory powers to enforce the code by investigating breaches and issuing prohibition orders
- a nationally accessible web-based register of prohibition orders and
- mutual recognition of prohibition orders across all states and territories.

Under the proposed arrangements, each State and Territory will be responsible for:

- enacting new (or amending existing) legislation and regulations to give effect to the national Code of Conduct, the national register of prohibition orders, and mutual recognition of prohibition orders across state boundaries and
- determining a suitable local body to receive and investigate breaches of the Code of Conduct and issue prohibition orders.

The *Health Ombudsman Act 2013* implements some aspects of these responsibilities as part of the new Queensland health complaints management system.

Ministers have asked AHMAC to undertake a public consultation on the terms of the first national Code of Conduct and proposed policy parameters to underpin nationally consistent implementation of the code. The Victorian Department of Health is currently undertaking the public consultation on AHMAC's behalf.

## **7 Health service quality and standards**

### **7.1 Introduction of national standards**

As part of national health reforms, governments agreed to the introduction of national standards for health providers. 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.

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.

Prior to the move to a national framework for health service standards, the HQCC made the standards that applied to public and licensed private hospitals and day hospitals in Queensland. Standards compliance was self-assessed and reported to the HQCC. The HQCC maintained reporting

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113 Australian Health Ministers Advisory Council (AHMAC), *Options for regulation of unregistered health practitioners*, Consultation paper, 2011, p.5, accessed 12 March 2014 from: [http://www.ahmac.gov.au/cms\\_documents/Consultation%20Paper%20-%20Options%20for%20Regulation%20of%20Unregistered%20Health%20Practitioners.pdf](http://www.ahmac.gov.au/cms_documents/Consultation%20Paper%20-%20Options%20for%20Regulation%20of%20Unregistered%20Health%20Practitioners.pdf)

114 Council of Australian Governments Standing Council on Health, 'Options for regulation of Unregistered Health Practitioners', accessed 12 March 2014 from <http://www.ahmac.gov.au/site/home.aspx>,



against the existing Queensland healthcare standards until the national standards were fully implemented in 2013.<sup>115</sup>

Full implementation of national safety and quality standards for health services in 2013 resulted 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.

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 continued to require providers to report against three clinical standards not covered by the new national standards in 2012-13:

- *Review of hospital related deaths*
- *Management of acute myocardial infarction on and following discharge or transfer standard, and*
- *Reducing the risk of venous thromboembolism.*<sup>116</sup>

## 7.2 HQCC standards and reporting

The HQCC reported on the nine retired Queensland health care standards for the last time in *Standards of care: A report on Queensland acute and day hospital self-assessed compliance* in December 2012. This report covered the period July 2011 to June 2012.<sup>117</sup>

In 2012-13 the HQCC did not require acute and day hospitals to report on self-assessed compliance with the remaining three standards. The HQCC states that it monitored compliance through its analysis of healthcare complaints and reportable events, random audits and its Annual Quality and Activity Return (AQAR) process.<sup>118</sup> The AQAR was due to be submitted to the HQCC in September 2013.<sup>119</sup>

## 7.3 Reportable event monitoring and analysis

In its report on oversight of the HQCC in April 2013, the committee noted the HQCC's expansion, from 1 July 2012, of its approach to monitoring reportable events to include all reportable events and not just reports of root cause analysis. The committee suggested that the HQCC report on the results of its monitoring relevant to safety and quality in health services and the resources allocated to the expanded reporting.<sup>120</sup>

The HQCC's *Annual Report 2012-13* reported that, over 2012-13, 248 reports had been reviewed and that 13 healthcare providers were monitored for safety and quality improvements as a result. A report on the results of the analysis was to be published by January 2014.<sup>121</sup>

The HQCC provided an analysis of the expanded reportable events monitoring over 2012-13 to the committee and its report on learning from reportable event reviews in March 2013. The HQCC noted

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115 HQCC, *Response to questions on notice*, 1 September 2011, p.7

116 HQCC, *Annual Report 2011-12*, p.63

117 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>

118 HQCC, *Annual Report 2012-13*, p.51

119 HQCC, *Annual Report 2012-13*, p.60

120 HCSC, *Report on oversight of the HQCC*, April 2013, p.19

121 HQCC, *Annual Report 2012-13*, pp. 52-53 & 60

in its response to the committee that the expanded monitoring had identified opportunities for improvements in the following areas:<sup>122</sup>

- surgical safety
- prevention of patient suicide in the community
- management of mental health service inpatient leave
- recognition and management of postpartum haemorrhage
- patient diagnosis
- reportable event review and reporting practices.

The HQCC provided the committee with information about the resources it allocated to the expanded reportable events monitoring over 2012-13.<sup>123</sup>

#### **7.4 Monitoring quality improvement**

The HQCC's Annual Report 2012-13 states that it employed greater use of section 20 of the HQCC Act over the year. The HQCC also brought the importance of section 20, and its key role in health system improvements, to the committee's attention at the public hearing in May 2013 in response to the absence of this power in the Health Ombudsman Bill.<sup>124</sup>

Under section 20 of the HQCC Act all Queensland healthcare providers:

*must establish, maintain and implement reasonable processes to improve the quality of health services provided by or for the provider, including processes—*

*(a) to monitor the quality of the health services; and*

*(b) to protect the health and well being of users of the health services.*

During 2012-13 the HQCC reports that it developed "a more efficient and effective process for applying s.20 within our complaints management system". Under the new arrangements, 46 health care providers' quality improvement activities were monitored in 2012-13. Of these, 33 had been identified during the HQCC's complaint management processes and 13 through the HQCC's reportable events monitoring.<sup>125</sup> In its response to committee questions about quality improvement action plans in October 2013, the HQCC indicated that another 11 healthcare facilities were being monitored against their plans to improve.<sup>126</sup>

The HQCC also applied newly developed complaint information profiles during 2012-13 in order to better identify individual practitioners at "high risk of attracting recurrent complaints". The HQCC's updated policy on profiling individual practitioners was published in July 2013.<sup>127</sup>

## **8 HQCC clients and stakeholders**

### **8.1 Awareness of the HQCC**

The committee continues to be concerned about Queenslanders' access to the health complaints system and awareness of HQCC and its procedures.

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122 HQCC, *Response to the HCSC Questions arising from the committee's consideration of the HQCC's Annual Report 2012-13*, p.4

123 HQCC, *Response to the HCSC Questions arising from the committee's consideration of the HQCC's Annual Report 2012-13*, p.5

124 HQCC, *Annual Report 2012-13*, p.58 and Dr John O'Donnell, Assistant Commissioner, HQCC, *Public Hearing Transcript*, 22 May 2013, p.2

125 HQCC, *Annual Report 2012-13*, p.58

126 HQCC, *Response to questions arising from the committee's oversight of HQCC*, 9 October 2013, pp.8-9

127 HQCC, *Annual Report 2012-13*, p.59

### 8.1.1 *Complaints from people from culturally and linguistically diverse communities*

In 2012-13, 11.5 per cent of complainants were born overseas (including those born in English-speaking countries), down from 12.7 per cent in 2011-12. In comparison, at the last census in 2011, 20.5 per cent of Queensland's population was born overseas. Enquiries from people born overseas also fell.<sup>128</sup>

### 8.1.2 *Complaints from Aboriginal and Torres Strait Islander people*

Complaints made by Aboriginal and Torres Strait Islander people decreased from 104 in 2011-12 to 87 in 2012-13. In 2012-13, 2.5 per cent of complaints and one percent of enquiries were made by Aboriginal and Torres Strait Islander people, falling in comparison with 2011-12 when 4.4 per cent of complaints and 3.6 per cent of enquiries were made by Aboriginal and Torres Strait Islander people. The proportion of complaints is lower than the proportion of Aboriginal and Torres Strait Islander people in Queensland (3.6 per cent). The HQCC noted that Aboriginal and Torres Strait Islander peoples are less likely to complain about their healthcare.<sup>129</sup>

## **8.2 Improvements in provision of information about complaint progress**

In its *Annual Report 2011-12*, the HQCC stated that it had 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. The HQCC recognised that the time taken to manage complaints affects client satisfaction.

The HQCC planned to 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. In its previous oversight report, the committee undertook to continue to monitor client satisfaction with the HQCC's complaint service and the outcomes of the HQCC's improvement action plan.

The HQCC redesigned its complaint case management system in 2013 to enable reporting on complaint allocation waiting times. In the *Annual Report 2012-13*, the HQCC noted that it had "increased complaint through-put and improved customer service by reducing staff caseloads from 30 to 25". The HQCC also implemented a way for complainants to monitor complaint progress on its website. The HQCC planned to improve communication with clients about waiting times in 2013-14 through SMS and email updates and by providing advice in writing when waiting times exceed 90 days.<sup>130</sup>

## **8.3 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. In 2012-13, 383 clients responded to the client satisfaction survey, a significant increase on the response in 2011-10. The HQCC's target is 75 per cent satisfaction with the complaint service, and 60 per cent satisfaction with complaint outcomes.

The percentage of parties satisfied with the timeliness of the complaint service in 2012-13 was 74 per cent, a significant increase on the satisfaction level of 61 per cent in 2011-12. The percentage of parties satisfied with the complaint outcome was 62 per cent, also an improvement on 2011-12 and above target.<sup>131</sup> The HQCC noted that its analysis of the client satisfaction survey results

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128 HQCC, *Annual Report 2012-13*, p.44

129 HQCC, *Annual Report 2012-13*, p.43

130 HQCC, *Annual Report 2012-13*, pp.30 and 34

131 HQCC, *Annual Report 2012-13*, pp.12 and 29

indicated that “the time taken to manage complaints impacted on this measure, as well as the fact we do not discipline healthcare providers”.<sup>132</sup>

The committee is pleased to see the improvement in client satisfaction with the complaint management provided by the HQCC.

## 9 HQCC staffing and resourcing

### 9.1 Staffing

The former HDC recommended that the committee continue to examine HQCC staffing. The HDC had concerns about the proportion of temporary staff and turnover rates.

At 30 June 2013, the HQCC had a permanent staff establishment of 71. Of the 65 actual staff at 30 June 2013 (compared to 75 at 30 June 2012), 86 per cent (56) were permanent employees and 14 per cent (9) were temporary.

At 30 June 2013, 66 per cent of staff were deployed in complaint management which includes triage, early resolution, assessment, conciliation, investigation and complaint support.<sup>133</sup> This is an increase from the 60.5 per cent of staff involved in complaint management in 2011-12.<sup>134</sup>

The HQCC’s permanent retention rate was 81.7 per cent in 2012-13. The permanent separation rate was 11.88 per cent. The committee noted in its previous oversight report that, in the HQCC’s *Annual Report 2011-12*, data on retention and separation in 2010-11 differed from the data in the *Annual Report 2010-11*. In its *Annual Report 2012-13* the HQCC provides corrected data for the permanent retention rate in 2010-11 as the figure reported was erroneous.<sup>135</sup>

### 9.2 Resourcing

The HQCC’s operating budget was \$10.631 million in 2012-13 with \$10.170 million of this received in grants and \$461 249 from retained rollover funds. The HQCC ran an operating surplus of \$366 992 in 2012-13, spending \$9.934 million against a forecast expenditure of \$10.301 million.<sup>136</sup>

The HQCC’s Budget allocation for 2013-14 is \$9.941 million. The decrease in grant in comparison with the HQCC’s grant allocation in 2012-13 is due to HQCC Payroll Project funding ending in 2012-13.<sup>137</sup> Funding of \$272 000 was provided in 2012-13 for payroll and finance system transition.<sup>138</sup>

## 10 HQCC Reporting

### 10.1 Annual Report 2012-13

The HQCC *Annual Report 2012-13* was tabled in Parliament on 30 September 2013. The committee considers that the *Annual Report 2012-13* complies with the Queensland Government’s *Annual report requirements for Queensland Government agencies*.<sup>139</sup>

The presentation of data has been improved in response to recommendations made by the former HDC in 2012 and this committee in 2013. The HQCC has published corrected data for 2011-12 as requested by the committee.

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132 HQCC, *Annual Report 2012-13*, p.12

133 HQCC, *Annual Report 2012-13*, p.63

134 HQCC, *Annual Report 2011-12*, p.69

135 HQCC, *Annual Report 2012-13*, p.66

136 HQCC, *Annual Report 2012-13*, p.5

137 State Budget 2013-14, *Service Delivery Statements*, Queensland Health, p.242, available from <http://www.budget.qld.gov.au/budget-papers/2013-14/bp5-gh-2013-14.pdf>

138 HQCC, *Annual Report 2012-13*, p.5

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

In its *Annual Report 2011-12* the HQCC indicated that in 2012-13 it would refine its complaints and investigations case management system to improve data capture.<sup>140</sup> In its previous oversight report, the committee recommended that the HQCC consider how it might provide more consistent and transparent reporting on the total time for management of complaints to completion.<sup>141</sup>

During 2012-13 the HQCC redesigned its complaint case management system to allow monitoring and reporting on complaints that are “waiting allocation”. The availability of this information provides a better picture of the overall timeliness of complaint management in line with the concerns expressed by the committee in its previous oversight report.<sup>142</sup>

## 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 2012-16* on 1 July 2011. The plan included additional KPIs in comparison to the *Strategic Plan 2011-15*. Baselines for a number of KPIs were to be established by 30 June 2013.<sup>143</sup>

The HQCC reported on its performance against the plan and the 2012-16 KPIs in its *Annual Report 2012-13*. Three key performance indicators reported in the HQCC’s *Annual Report 2011-12* were deleted during 2012-13.<sup>144</sup>

The HQCC’s service standards are part of the Queensland Government’s *Performance Management Framework*. The HQCC did not meet its service standard timeframes for complaints closed (in early resolution, assessment or conciliation). As noted earlier, in section 4.7.5, the committee was concerned that the HQCC’s *Annual Report 2012-13* omitted to report on its performance target for ‘Percentage of investigations closed in 12 months’ in its service standards report card. The committee was also disappointed to note that this measure has been discontinued for State Budget Service Delivery Statement reporting purposes.

## 10.3 Other reports

During 2012-13, the HQCC released reports on complaints about dental care and cosmetic surgery, credentialing of doctors in Queensland hospitals, perceptions and experiences of healthcare in Queensland, and self-assessment by acute and day hospitals of compliance with HQCC standards.<sup>145</sup>

The HQCC also released *Annual Health Check 2012*, 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:

- the HQCC’s role in improving healthcare in Queensland (*Driving quality improvement*, 30 January 2014) and
- credentialing and defining the scope of clinical practice for doctors working in Queensland hospitals (30 January 2014).

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

In September 2013 the HQCC released a spotlight report on complaints about clinical deterioration in Queensland hospitals, a bulletin on the review and follow-up of test results in October 2013, a

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140 HQCC, *Annual Report 2011-12*, p.52

141 HCSC, *Report on oversight of the HQCC*, April 2013, p.5

142 HQCC, *Annual Report 2012-13*, p.30

143 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>

144 HQCC, *Annual Report 2012-13*, pp.10-15

145 HQCC reports are available from its website at: <http://www.hqcc.qld.gov.au/Resources/Pages/Reports.aspx>

spotlight report on complaints about mental health services in Queensland in January 2014 and a report on learning from reportable event reviews in March 2014.

In 2013 the HQCC also released position statements on:

- hand hygiene
- appropriate use of surgical antibiotic prophylaxis
- ensuring correct patient, site, side and procedure
- dental health services
- review and follow-up of test results.

## 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.

