Committee on the Health Care Complaints Commission

STUDY OF HEALTH CARE COMPLAINTS HANDLING IN QUEENSLAND
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## Membership & Staff

**Chairman**  
Jeff Hunter MP, Member for Lake Macquarie

**Members**  
Hon David Clarke, MLC  
Hon Christine Robertson, MLC (Vice-Chair)  
Hon Dr Peter Wong, MLC  
Tanya Gadiel MP, Member for Parramatta  
Allan Shearan MP, Member for Londonderry  
Russell W Turner MP, Member for Orange

**Staff**  
Catherine Watson, Committee Manager  
Cheryl Samuels, Project Officer  
Glendora Magno, Assistant Committee Officer

**Contact Details**  
Committee on the Health Care Complaints Commission  
Legislative Assembly  
Parliament House  
Macquarie Street  
Sydney NSW 2000

**Telephone**  
02 9230 -3011

**Facsimile**  
02 9230 –3309

**E-mail**  
avatson@parliament.nsw.gov.au

**URL**  
www.parliament.nsw.gov.au
Functions of the Committee

The Joint Committee on the Health Care Complaints Commission was appointed in 1994. Its functions under Section 65 of the *Health Care Complaints Act 1993* are:

a. to monitor and to review the exercise by the Commission of the Commission's functions under this or any other Act;

b. to report to both Houses of Parliament, with such comments as it thinks fit, on any matter appertaining to the Commission or connected with the exercise of the Commission's functions to which, in the opinion of the Joint Committee, the attention of Parliament should be directed;

c. to examine each annual and other report made by the Commission, and presented to Parliament, under this or any other Act and to report to both Houses of Parliament on any matter appearing in, or arising out of, any such report;

d. to report to both Houses of Parliament any change that the Joint Committee considers desirable to the functions, structures and procedures of the Commission;

e. to inquire into any question in connection with the Joint Committee's functions which is referred to it by both Houses of Parliament, and to report to both Houses on that question.

The Joint Committee is not authorised:

a. to re-investigate a particular complaint; or

b. to reconsider a decision to investigate, not to investigate or to discontinue investigation of a particular complaint; or

c. to reconsider the findings, recommendations, determinations or other decisions of the Commission, or of any other person, in relation to a particular investigation or complaint.
Chairman's Foreword

In its *Report of the inquiry into procedures followed during investigations and prosecutions undertaken by the Health Care Complaints Commission* in December 2003 this Committee outlined how the Queensland Office of Health Practitioner Registration Boards had successfully implemented an aggressive backlog reduction strategy through seeking additional funding to employ short term investigators. This was done during a time when the then Health Care Complaints Commissioner, despite receiving a $1.4m per annum budget increase to employ extra investigators, told the Committee that such radical backlog reduction was impossible to achieve.

After that Commissioner's removal such a strategy has been followed by the new Acting Commissioner and the results have been impressive.

This instance illustrates the usefulness of cross jurisdictional information sharing. Even when agencies are not exactly alike they usually share similar purposes, functions and challenges.

I believe the Queensland model for dealing with health care complaints has much to recommend it. Queensland has been innovative within Australia in introducing umbrella type legislation to cover all its health professional registration boards with the exception of the Nurses Registration Board and to also combine all investigative and disciplinary functions into the one agency in order to achieve cost savings and concentrate expertise.

While studying our own conciliation system here in New South Wales, the Committee has also had some concerns about the potential for health care complaints conciliation to turn into a form of de facto litigation where complainants expect financial compensation in most all instances. This appears to have happened in at least one other Australian state. The Committee firmly believes that outcomes such as explanations, apologies, agreements to implement reviews and for systemic policy change etc. are ultimately what conciliation should be focussing on while allowing for monetary compensation where appropriate.

It was heartening to see that the Health Rights Commission has not concentrated on the provision of financial compensation. It appears to be a good example of a robust conciliation model which conducts its activities in a non partisan and non threatening manner.

I would like to very much thank all the agencies who gave their valuable time to talk to us. I speak confidently on behalf of the Committee when I say that this was an extremely valuable learning and information sharing experience.

Jeff Hunter MP
CHAIRMAN
## ITINERARY

<table>
<thead>
<tr>
<th>Date/Time</th>
<th>Comments</th>
<th>Meetings</th>
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<tbody>
<tr>
<td>Wednesday 8 September 2004</td>
<td>Depart Sydney - 11:05 am</td>
<td>Meeting with Health Rights Commission</td>
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<tr>
<td></td>
<td>Arrive Brisbane 12:30pm</td>
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<td>3:00 pm</td>
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<tr>
<td>Thursday 9 September 2004</td>
<td>10:00 am</td>
<td>Meeting – United Medical Protection</td>
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<td></td>
<td>12:30 pm</td>
<td>Meeting – Legal, Constitutional and Administrative Review Committee</td>
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<tr>
<td></td>
<td>3:00 pm</td>
<td>Office of Health Practitioner Registration Boards</td>
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<tr>
<td>Friday 10 September 2004</td>
<td>10:00 am</td>
<td>Queensland Nursing Council (QNC)</td>
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<tr>
<td></td>
<td>Depart Brisbane – 13:10pm</td>
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<tr>
<td></td>
<td>Arrive Sydney – 14:40pm</td>
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List of Delegation:

- Jeff Hunter MP, Chairman
- Allan Shearan MP
- Russell W Turner MP
- Hon David Clarke, MLC
- Hon Dr Peter Wong, MLC
- Catherine Watson, Committee Manager
Meeting with:

Mr David Kerslake, Commissioner,

The Health Rights Commission's role is to oversee, review and improve health services in Queensland by resolving complaints about health services and assisting users and providers in the resolution of these complaints.

It was established in 1992 in accordance with the Health Rights Commission Act 1991 (Qld) and endeavours wherever possible to take an informal and conciliatory approach. The Act specifically requires the Commission to conduct its proceedings with "as little formality and technicality, and with as much expedition, as practicable".

The Commission may resolve complaints either informally, by investigation, by conciliation or by referral to the relevant registration board.

Commissioner Kerslake formerly headed the Office of Health Review in Western Australia for five years before taking up his current position.

He believes strongly that models of health care complaint handling should not only be independent and must be seen to be independent and that ideally Commissioners should be placed on a ten year non-renewable contract to ensure their fearless independence.

Enabling legislation must support a range of resolution processes such as informal enquiries, conciliation, formal investigation etc. However, the emphasis should be on informal resolution as much as possible to avoid complaint handling backlogs.

Health Care Complaints bodies must have a power to compel the provision of information. In Western Australia, while the commissioner had such a power, it rarely needed to be used. The fact that information could be obtained compulsorily in itself encouraged cooperation. In Queensland the Commission has no power to compel provision of information. This sometimes means that cases have to be referred to registration boards, which do have that power, even though the issues involved would not otherwise warrant a board's intervention.

Legislation governing health care complaints bodies must support a range of purposes including: dealing with individual complaints; contributing to quality improvement; and protecting the public interest.

Any legislative framework and legislative powers must complement a disciplinary/public protection process but not actually conduct those processes. There must be a co-regulatory framework which allows for the sharing of information with the relevant disciplinary body.
It is essential that health care complaints bodies maintain the confidence of both consumers and providers. There should always be agreement between the relevant parties whether it is appropriate to seek a peer review and who should provide it.

Although the Commission mostly resolves matters through conciliation it finds that conciliation agreements which provide monetary compensation are very much in the minority.

The Commission puts this largely down to the fact that it always does a “reality check” with patients about what are realistic outcomes before they go into conciliation.

Commissioner Kerslake finds it important that the Commission is non adversarial and works cooperatively with all stakeholders. It must also deal with cases in a timely and efficient manner.

It is also essential that the Commission adds value to the health system through systemic improvement and an inexpensive alternative to the legal systems.

The Western Australian model does not allow parties to conciliation to be legally represented. In Queensland, parties can have legal representation during the conference.

Commissioner Kerslake considers that the ideal health care complaints handling model provides for a single body to handle all alternative dispute resolutions while another separate body handles prosecutorial and disciplinary functions.

The ADR body must not have an advocacy role nor should it have any prosecutorial role. However, the ADR body must be able to split complaints and share information with disciplinary boards.

Any agreements reached in ADR should be binding.
UNITED MEDICAL PROTECTION

BRISBANE

Meeting with:

Ms Jane Schmit, Queensland Manager
Mr Harry McCay, Senior Solicitor
Dr David Pakchung, State Claims Manager

UNITED Medical Protection is Queensland’s largest medical defence organisation. It is also the largest Australia-wide.

An all Australian doctors’ insurer since 1893, UNITED now operates as the UNITED Medical Protection Group of Companies. This group is the result of a merger by UNITED Medical Defence and the Medical Defence Society of Queensland and the Medical Protection Society of New South Wales.

UNITED’s wholly owned insurance subsidy, Australasian Medical Insurance Limited offers insurance to protect members against legal actions and complaints arising from incidents that occur in the course of their professional practice.

UNITED considers that the separation between the Health Rights Commission and the Queensland Medical Board is an important one. It believes that the Health Rights Commission has operated effectively under the current Commissioner, David Kerslake.

Initially UNITED had concerns that the Queensland Health Rights Commission legislation would just engender a culture of complaint but it appears to have instead introduced a forum for information sharing rather than achieving outcomes which involve monetary compensation.

The system is also non threatening for the doctor as conciliations have no disciplinary content.

If a matter is in conciliation a plaintiff must issue a notice to the stakeholders within 30 days that they intend to file a statement of claim in relation to civil litigation.

United finds that there is a strong overlap between the type of matters which are handled by the Health Rights Commission and cases settled via civil litigation. It therefore believes that the Health Rights Commission successfully avoids matters entering the court system in many instances.

Unlike New South Wales, where the the Registrar of the Medical Board selects Medical Tribunal members, in Queensland the Court Registrar selects Tribunal members. This provides for a more “arms length” approach.
The Office of Health Practitioner Registration Boards was established under s 7 of the Health Practitioner Registration Boards (Administration) Act 1999 (Qld) on 7 February 2000.

As an independent statutory body, the Office is responsible under s 8 of that Act to provide the administrative and operational support necessary or convenient to assist 13 of the 14 Queensland Health Practitioner Registration Boards to perform their functions.

The Office provides administrative and operational support to assist the Health Practitioner Boards to meet their statutory obligations in relation to: (a) registration; (b) Board meeting support; (c) complaints management; (d) health assessment and monitoring; (e) professional advice and support; (f) statutory compliance, planning and reporting; (g) corporate support; (h) records management; and (i) Freedom of Information.

Boards fully fund all their investigations and prosecutions before the Health Practitioner Tribunal, the Professional Conduct Review Panel, and the Board. In this regard, the Queensland Medical Board incurs approximately $600,000 per annum to prosecute its disciplinary matters.

The Queensland Nursing Council was not brought in under the Health Practitioners (Professional Standards) Act 1999 as it was considered to already be operating extremely effectively at the time of the legislative review. There had been no public or professional disquiet about how the Nursing Council was handling its disciplinary matters.

After receipt, health consumer complaints go before a joint meeting of the Health Rights Commission and the Office of Health Practitioner Registration Boards where it is decided whether the complaint will be closed or go into conciliation or be investigated by the Board.

After completion of an investigation by the Office of Health Practitioner Registration Boards the Health Rights Commission is provided with a copy of each investigation report and has fourteen days in which to provide comment and/or recommendations to the relevant Registration Board.

The current legislation also gives the Health Minister powers of direction regarding the Boards which are quite specific. Any Ministerial directions given to a Board must be published in the relevant annual report for the year it occurred.
During the 2002/03 financial year the Office of Professional Registration Boards undertook an aggressive backlog reduction program via the employment of additional short term investigators. The backlog of cases has now been reduced by 35.6% and this significant trend is expected to continue. In addition, each board now has a budget line item for contract investigations so no backlog should again arise.

The Office receives approximately 400 complaints a year across the thirteen Boards, 50% of which are made against medical practitioners.

The Office would like further legislative amendment to require more information from the health professional registration boards and greater powers to refer complaints to other agencies.

Presently the Office has only limited options when dealing with complaints. It must either refer matters for investigation, conciliation or closure.

The Office needs more options for non-adversarial pathways. Particularly in relation to complaints about competence issues. These should be discriminated from the performance assessment approach used by the New South Wales Medical Board which is directed toward issues of consistent poor performance.

There are currently 63 full time equivalent positions at the Office.

Health Professional Registration Board Members cannot sit on disciplinary tribunals or panels.
The Queensland Nursing Council is established under the Nursing Act 1992 (Qld). Under the previous legislative framework the Board of Nursing Studies accredited nursing courses and course providers and the Nurses Registration Board managed registration and disciplinary issues. Following its establishment in 1993, the Council assumed responsibility for these functions.

The Act provides for the establishment of a Health Assessment Advisory Panel to undertake independent health assessments of health impaired practitioners. The Nursing Tribunal is established under the Act as a body independent of Council to hear any charge of professional misconduct referred to it. Tribunal members cannot be members of the Nursing Council. Tribunal members are appointed by the Governor in Council for a period of 3 years.

There are approximately 50,000 nurses registered/enrolled in Queensland.

Last year the Nursing Council received 177 complaints. Numbers of complaints are consistently increasing each year. Of the complaints received, 45 (about one quarter) involved health impairment.

Anyone may make a complaint about a nurse. However, statistics indicate that the majority of complaints come from employers. While there is no mandatory reporting obligations, employers and their representatives have a responsibility to both the public and the profession to report such concerns to Council.

The average time taken to complete an investigation is between three and six months. All inspectors are trained in investigation methods and report writing for investigations. If an investigation is initiated an inspector is appointed. The nurse who is the subject of the complaint is notified in writing by the inspector of a number of matters including the particulars of the complaints and the nurse's right to make a formal or informal submission in response to the particulars. After conducting interviews, reviewing files and records and preparing witness statements, the inspector prepares a report with the finding and particulars of any adverse findings against the nurse. Legal advice is sought regarding whether there is sufficient evidence to prefer a charge of professional misconduct.

The report, legal advice and a draft Notice of Charge (as appropriate) are considered by the Professional Standards Committee for recommendation of action to Council. The report,
particulars of any adverse findings and the Committee's recommendations are then sent to the nurse and the Health Rights Commissioner.

The nurse is invited to make a further submission to Council about the contents of the report and the Committee's recommendations and the Commissioner is invited to give Council information, comments or recommendations about these matters.

Council introduced a 'without prejudice" process a number of years ago. Without prejudice" meetings are intended to streamline the resolution and determination of conduct, health and competence matters. A "without prejudice" meeting is one in which parties can make statements for the purpose of settling matters in dispute. Such statements cannot subsequently be interpreted as an admission of liability, or used in evidence against the person making them.

Council has a procedure for nurses to provide undertakings to Council when cancellation, suspension or the imposition of limited registration or enrolment may not be appropriate or justified. An undertaking is a written agreement between the nurse and the Council and is legally binding.

In making decisions about assessment of concerns, investigations, health concerns and competence concerns, Council has a rehabilitative focus. While Council's primary purpose is to ensure safe and competent nursing for the people of Queensland, this does not imply that nurses whose conduct, health or competence has been below standard will not be given the opportunity to continue in practice with appropriate supervision and/or support. Considerable public financial investment has been made in educating nurses and it is therefore in the public interest to support processes that enable continued safe practice.