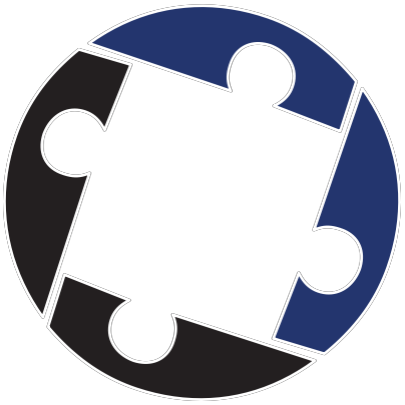

Health Complaints Commissioner Tasmania

Annual Report 2015 - 2016

Health Complaints Commissioner

Annual Report 2015-16

Enquiries about this annual report should be directed to:

The Health Complaints Commissioner

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Letter to Parliament

To:

The Honourable President of the Legislative Council

and

The Speaker of the House of Assembly

Pursuant to section 12 of the *Health Complaints Act 1995*, I present to the Parliament the annual report of the Health Complaints Commissioner for 2015-16.

Yours sincerely

(Signed)

Richard Connock
HEALTH COMPLAINTS COMMISSIONER

25 October 2016

About this Report

This report describes the functions and operations of the Health Complaints Commissioner Tasmania for the year ending 30 June 2016.

It is available in print or electronic viewing format to optimise accessibility and ease of navigation. It can also be made available in alternative formats to meet the needs of people with a disability. Requests should be directed to the Executive Officer at 1800 001 170 or Health.Complaints@ombudsman.tas.gov.au.

Table of Contents

Tables

Figures

Highlights

- Continued improvements in the quality of healthcare in Tasmania as a result of the assessment, investigation and conciliation of complaints.
- Continued efforts to improve processes to streamline and accelerate handling of complaints within the Office.
- A 23% decrease in enquiries received.
- A 12% increase in complaints received.
- A 5% increase in the number of referrals made to Registration Boards.
- A 5% increase in complaints closed.
- A 12% increase in the number of matters closed in assessment.
- A 57% decrease in cases referred to conciliation.

From the Health Complaints Commissioner

This annual report is prepared under section 12 of the *Health Complaints Act 1995*, and details the work of my Office under the Act during 2015-16.

Statistics

These are the key statistics for the year:

- a 23% decrease in enquiries received (487 in 2014-15 to 377 in 2015-16);
- a 12% increase in complaints received (320 in 2014-15 to 357 in 2015-16);
- an 8% reduction in the number of complaints notified to AHPRA;
- a 5% increase in complaints closed (328 in 2014-15 to 344 in 2015-16);
- 69 % of cases finalised within three months;
- 19% of cases assessed outside the required 90-day period;
- 14% of complaints took 12 months or more to finalise;
- a 12% increase in the number of matters closed in assessment;
- an 18 % decrease in the number of matters closed in conciliation (27 to 22); and
- a 57% decrease in the number of cases referred to conciliation (23 to 10).

Staffing

As noted in last year's report, staffing levels in the Health Complaints team had been reduced over time and steps were taken to address this two years ago with the abolition of a Band 6 senior conciliation position and the creation of a new Band 5 "early resolution" position and the creation of a Clinical Advice Committee.

The outcomes achieved throughout 2012-13 and 2013-14 appeared to vindicate this strategy with an increase in the number of cases resolved in assessment, an increase in the number of systemic improvements and fewer cases being carried forward at the start of this reporting year.

As noted in last year's report, with the retirement of a senior conciliator early in the year and the expiration of a Band 5 contract towards the end, staffing levels in the health complaints jurisdiction were the lowest they had been since 2010-11 despite increased complaint and notification numbers and increased complexity. This situation continued throughout this reporting year with the retirement of the Band 4 intake and assessment officer in August, and subsequent elevation of her replacement to the Band 5 position. The conciliator position remains vacant at the time of writing this report, and the Band 4 has not been permanently filled.

This, together with staff absences due to injury and illness, has resulted in an increase in the number of cases being carried forward at the end of this reporting year. It has also meant other activities, such as audits and monitoring, could not be undertaken, and there have been ongoing delays in progressing conciliations.

Efficiencies

We continue to search for efficiencies and have identified that considerable time and effort is expended following up providers for responses, particularly with complaints about public hospitals. We have commenced meeting with key stakeholders to explore ways in which more timely responses can be provided in both assessment and conciliation.

Legislation – Amendment

The *Justice and Related Legislation (Miscellaneous Amendments) Act 2015* received Royal Assent on 13 October 2015, and relevantly, s25 of the *Health Complaints Act 1995* has been amended by the insertion of s25(1CA) which provides that the Commissioner may extend the time for assessment if there is a delay in obtaining information sought by the Commissioner.

The amendment mirrors the provisions of s34(3) of the *Health and Disability Services (Complaints) Act 1995* (WA) by providing that *if there is a delay in obtaining information requested by* [the Commissioner], *he or she may extend the period within which a decision must be made under* [s25(1)].

Complaint Management

The number of complaints increased by 37 (10%) and they continue to be more complex, and the number of parties that need to be consulted and managed is increasing.

As reported in the last three years, after several years of growing complaint numbers the gap between opened and closed cases was widening and the number of complaints carried forward from reporting year to reporting year was increasing. The figures for 2012-13 showed an encouraging reversal of this trend. This was repeated in 2013-14 although to a lesser extent.

The reversal has not however been sustained throughout the last two years with more complaints being opened than closed.

Conciliation

Only ten matters were referred to conciliation this year. There remains a significant backlog of conciliation cases – though this too reduced in the reporting year from 34 to 22. The remaining backlog is attributable to a reduction in conciliation staff and as a result of the time taken by public hospitals to respond to requests for compensation. This appears, at least in part, to be a consequence of the stringent controls placed on access to the Tasmanian Risk Management Fund by public hospitals.

Australian Health Practitioner Regulation Agency (AHPRA)

This was the sixth year of operation of the National Registration and Accreditation Scheme (NRAS) for members of the principal health professions. The scheme is administered by the Australian Health Practitioner Regulation Agency, which works in conjunction with fourteen National Boards for the various professions covered by the scheme.

The relationship between this Office and the national boards and AHPRA is governed both by the *Health Practitioner Regulation National Law Act* 2009 (National Law)[1] and the *Health Complaints Act 1995*. A Memorandum of Understanding is in place between AHPRA and the various Health Complaints Entities to guide the interaction between those entities and AHPRA, particularly with respect to the operation of s150 of the National Law. The consultation process has been described in detail in earlier annual reports.

In accordance with the intergovernmental agreement that underpins the National Scheme, the Australian Health Workforce Ministerial Council (AHWMC) commissioned an Independent Review of AHPRA following the first three years of operation. That review highlighted a number of concerns with the current mechanisms for dealing with complaints about registered health practitioners and presents an opportunity to address the impact the current arrangements have on the ability of this Office to meet its statutory time limits and progress matters in a timely and efficient manner.

In response to recommendations made following the review, the Office has worked with AHPRA and other Health Complaints Entities to develop a communication strategy, a decision making matrix and an information brochure explaining the relationship between the different organisations. It is hoped that these strategies will increase the flow of information and improve efficiencies in the way in which consultations are managed in the future.

[1] This was applied in Tasmania by the Health Practitioner Regulation National Law (Tasmania) Act 2010.

Code of Conduct for Health Care Workers

At a meeting of the Commonwealth Parliamentary Standing Committee on Health in June 2013, Australia's Health Ministers agreed in principle to the establishment of a National Code of Conduct for Unregistered Health Care Workers, such as naturopaths, social workers and counsellors.

Such codes already then existed in New South Wales and South Australia and a draft code proposal was developed that reflects those codes. A consultation paper was released in March 2014 and consultation forums were held in each State and Territory in March and April 2014. The results of the national consultation were incorporated into a final report published in April 2015 for submission to the Australian Health Ministers Advisory Council and Health Ministers, and it's terms were agreed to at the April 2015 Council of Australian Governments (COAG) Health Council meeting. Following that the final stage of the project, Stage 3 Implementation, commenced.

Each State and Territory will be responsible for enacting new or amending existing legislation to give effect to the code, and it has been generally agreed that the code will be administered by the Health Complaints Entities in each jurisdiction. Queensland passed laws to reflect the Ministers' decision in October 2015, and amendments to Tasmania's Health Complaints Act will be required in due course.

Implementation of the code was the subject of discussion at Health Complaints Commissioners' meetings and teleconferences during the reporting year. Issues that have been considered include the consistent implementation of the Code across jurisdictions, a common framework for the collection and reporting of data and for annual performance reporting to the COAG Health Council, and the development of nationally consistent explanatory materials to support the implementation.

Those discussions are continuing and I hope to be able to report further in this regard next year.

Aged Care Complaints Commissioner

The Commissioner and I agreed to undertake an exchange of letters to formalise our information sharing arrangements in the hope that that exchange will encourage information sharing and ensure that complaints are dealt with by the most appropriate organisation.

The Commissioner and I agreed that an informal approach should be taken to communications between our offices and that our respective officers should be able to contact each other, by email or telephone, to determine jurisdictional matters and which complaints should be referred.

Systemic Improvements

A number of significant improvements in the delivery of health services have been identified or implemented over the reporting year as a result of actions taken by health providers, either on their own initiative or as a result of the assessment and conciliation of complaints received by this Office. Examples will be published on our website.

In appropriate cases, where improvements have been identified through OHCC processes, we disseminate relevant information to other organisations and health care providers both intra and interstate in the hope that the broader community will continue to benefit from the work we do. I would like to thank the healthcare providers we have worked with for their continued commitment towards improving the delivery of services in 2015-16.

Conclusion

I would like to thank my Health Complaints staff for the quality of their work, for their dedication, and for sustaining their remarkable levels of activity over a very challenging year.

The Office of the Health Complaints Commissioner

The Office of the Health Complaints Commissioner was established in 1997 by the *Health Complaints Act 1995*. The major functions undertaken by the Office are to:

- receive, assess and resolve complaints from health service users;
- assist health service providers in developing procedures to resolve complaints;
- encourage health service users to resolve complaints directly with health service providers; and
- identify and review issues arising out of complaints, and suggest ways of improving health services.

The Commissioner is an independent statutory officer who does not represent the interests of, nor act as an advocate for, either party to a complaint. The functions of the Commissioner are carried out independently, impartially and in the public interest. It is not the role of the Commissioner to attribute fault or blame, but to seek improvements in the delivery of health services in Tasmania and, where possible, resolve complaints between the parties through conciliation.

It has been the practice since the commencement of the Act for the appointments of Ombudsman and Health Complaints Commissioner to be held by the same person. The functions which go with these two separate appointments are delivered by the same Office, the Office of the Ombudsman and Health Complaints Commissioner.

Complaint and Enquiry Activity

Enquiries

Enquiries, many of which do not develop into a complaint, represent a substantial workload for the Office. Table 1 below indicates there was a significant drop in the number of enquiries received this year compared with last year, however last year in turn showed a significant increase compared with the previous year (397 to 487). I am not able to state with any certainty the reason for this variation. It is possible however that it is attributable to some enquires being converted to complaints, and the period of time an enquiry is left open to allow this to happen.

Table 1 – Enquiry Activity

Enquiries	**2014-15**	**2015-16**	**Variance**
Health enquiries	448	303	-32%
Out of jurisdiction enquiries	39	74	90%
Total	**487**	**377**	**-23%**

Complaints

Table 2 – Complaint Activity

Complaints	**2014-15**	**2015-16**	**Variance**
Complaints carried forward	115	107	-7%
Complaints received (see Note 1)	320	357	12%
Complaints closed	328	344	5%
Complaints Active	107	120	12%

Note 1: In addition to managing complaints made directly to this Office, staff also deal with complaints about registered health practitioners which are made to registration boards through AHPRA. These are called notifications rather than complaints and are discussed later in this report.

Table 2 demonstrates an increase in the number of complaints received and closed this reporting year as well as an increase in the number of active complaints. As reported last year, after several years of growing complaint numbers the gap between opened and closed cases was widening and the number of complaints carried forward from reporting year to reporting year was increasing. Although the figures over 2012/13 and 2013/14 showed an encouraging reversal of this trend, this has not been sustained throughout the last two years.

This was attributed last year to a reduction in staffing levels through expiration of contracts and the inability to recruit new staff throughout the reporting year. The situation has continued this year, despite recruitment, due to retirement of staff, the elevation of a new recruit to a higher position and absences due to illness and injury.

We continue to seek appropriate efficiency gains across all our processes to ensure that, to the best of our ability and within the limited resources at our disposal, we can still provide Tasmanians with an effective health complaints scheme that meets their needs. This is becoming increasingly challenging as this situation continues and the backlog of cases grows. We look forward to this situation being corrected through ongoing recruitment of new staff which is still progressing at the time of writing this report.

Who complained?

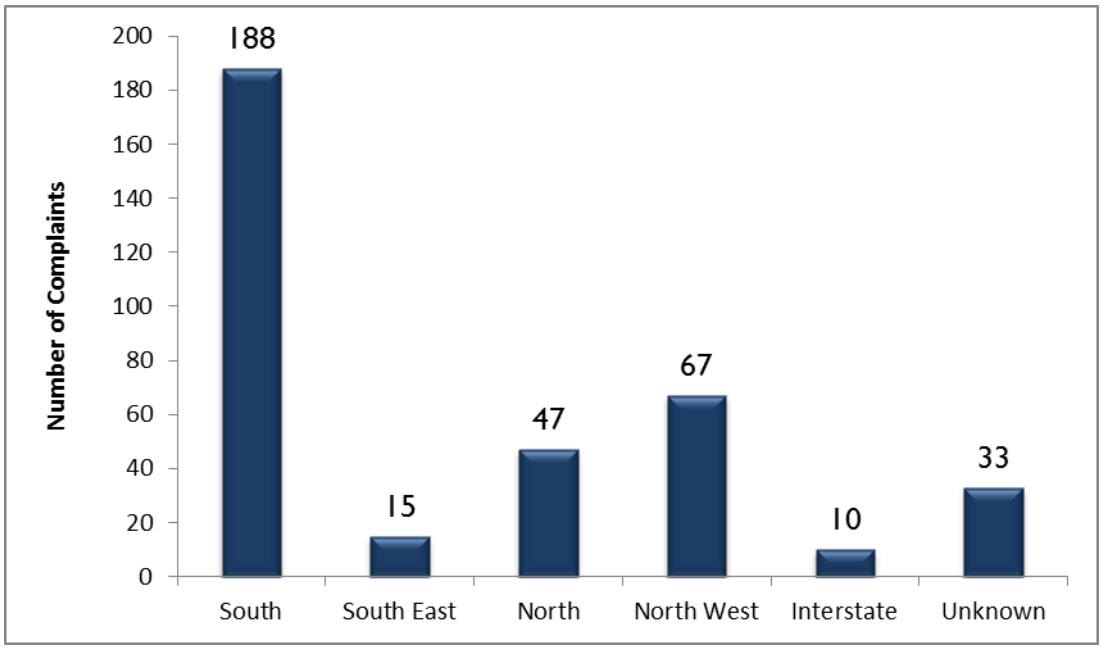
While complainants are usually the consumers of health services, the Act provides for other people, such as the parent or guardian of a child, or a person appointed by the consumer, to lodge a complaint on their behalf. I also have discretion to accept complaints from third parties where a user is unable to complain on his or her own behalf.

Table 3 provides details on these matters for the reporting year.

Table 3 – Profile of complainants

Complainant	**Percentage**
Another person permitted by the Commissioner	3.4%
Consumer	84.9%
Parent or guardian of a child	2.5%
Person appointed by the user	6.7%
Other	2.5%
Total	**100%**

Figure 1 - Geographical location of complainants



What did they complain about?

A breakdown of the issues arising from complaints closed in the reporting year is set out in Tables 4 to 16. It should be noted that a significant number of complaints contain more than one issue.

Issues by category

Table 4 – Access Issues

Issue	**2014-15**	**2015-16**
Access to facility	1	0
Access to subsidies	1	3
Refusal to admit or treat	16	30
Remoteness of service	1	0
Service availability	32	20
Waiting lists	9	8
Total	**60**	**61**

Table 5 – Communication and Information Issues

Issue	2014-15	2015-16
Attitude / Manner	43	45
Inadequate information provided	19	20
Incorrect / misleading information provided	10	9
Special needs not accommodated	4	1
Total	**76**	**75**

Table 6 – Consent Issues

Issue	2014-15	2015-16
Consent not obtained or inadequate	8	9
Involuntary admission or treatment	5	5
Uninformed consent	2	1
Total	**15**	**15**

Table 7 – Discharge and Transfer Arrangements

Issue	2014-15	2015-16
Delay	0	1
Inadequate discharge	3	2
Mode of transport	1	1
Patient not reviewed	1	0
Total	**5**	**4**

Table 8 – Environment / Management of Facilities Issues

Issue	2014-15	2015-16
Administrative processes	2	8
Cleanliness/hygiene of facility	0	1
Physical environment of facility	2	6
Staffing and rostering	0	2
Total	**4**	**17**

Table 9 – Fees and Costs

Issue	2014-15	2015-16
Billing Practices	17	11
Cost of treatment	2	9
Financial consent	8	3
Total	**27**	**23**

Table 10 – Grievance Processes

Issue	2014-15	2015-16
Inadequate / no response to complaint	10	13
Information about complaints procedures	1	1
Total	**11**	**14**

Table 11 – Inquiry Service Issues

Issue	2014-15	2015-16
Request for information – Health Service	0	1
Request for information - Other	0	1
Request for Information - Commission	0	2
Request for information – Complaint mechanisms	0	1
Total	**0**	**5**

Table 12 – Medical Records

Issue	2014-15	2015-16
Access to/transfer of records	12	12
Record keeping	6	1
Records management	1	1
Total	**19**	**14**

Table 13 – Medication Issues

Issue	2014-15	2015-16
Administering medication	5	13
Dispensing medication	6	11
Prescribing medication	67	23
Supply/security/storage of medication	1	3
Total	**79**	**50**

Table 14 – Professional Conduct

Issue	2014-15	2015-16
Assault	5	2
Boundary violation	2	2
Breach of condition	1	0
Competence	24	17
Discriminatory conduct	1	0
Emergency treatment not provided	1	0
Financial fraud	1	0
Illegal practice	0	1
Impairment	0	1
Inappropriate disclosure of information	3	6
Total	**38**	**29**

Table 15 – Reports / Certificates

Issue	2014-15	2015-16
Accuracy of report/certificate	0	2
Refusal to provide report/certificate	1	2
Report written with inadequate or no consultation	1	0
Timeliness of report/certificate	3	2
Total	**5**	**6**

Table 16 – Treatment Issues

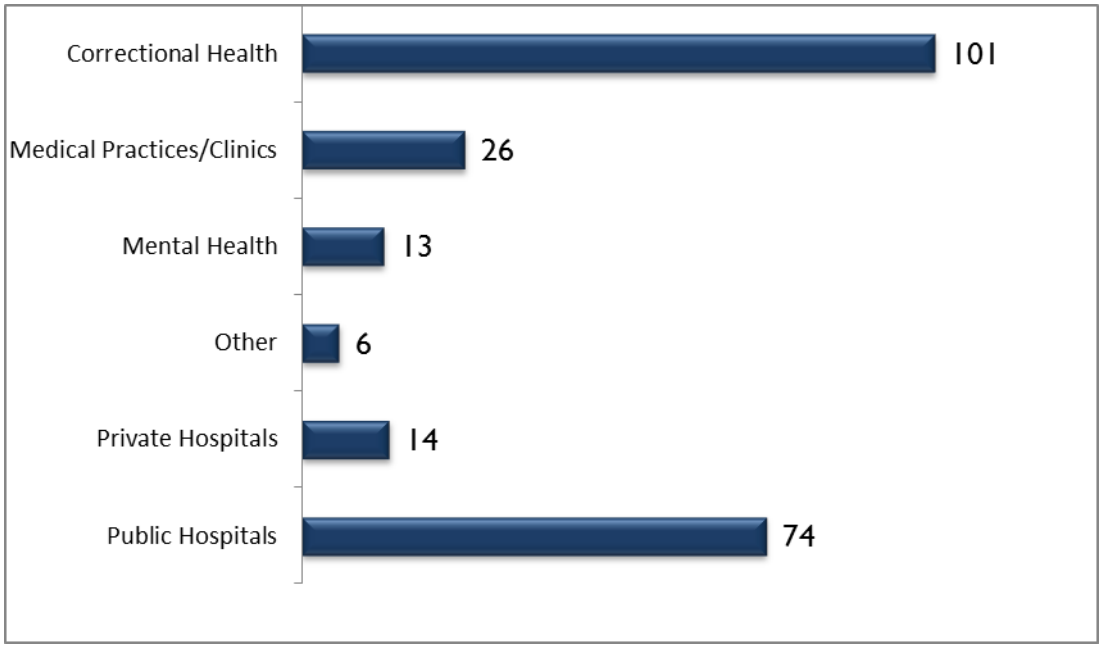
Issue	2014-15	2015-16
Attendance	2	1
Coordination of treatment	9	4
Delay in treatment	19	39
Diagnosis	32	25
Excessive treatment	2	5
Inadequate care	32	34
Inadequate consultation	2	6
Inadequate prosthetic equipment	5	1
Inadequate treatment	33	48
Infection control	0	1
No/inappropriate referral	4	2
Rough and painful treatment	8	10
Unexpected treatment outcome/complications	32	29
Withdrawal of treatment	3	17
Wrong/inappropriate treatment	10	19
Total	**193**	**241**

Who did they complain about?

Table 17 – Complaints received about Health Organisations

Health Organisation	2014-15	2015-16
Aged Care	2	1
Ambulance	5	5
Community Health	4	5
Correctional Health	103	101
Dental	1	5
Dept of Health & Human Services	6	6
Diagnostic Services	6	5
Disability Services	1	2
Medical Practices/Clinics	24	26
Mental Health	15	13
Optometrist	2	1
Oral Health Services	3	1
Other	8	6
Pathology	2	2
Pharmacy/Pharmaceutical	7	8
Private Hospitals	9	14
Public Hospitals	54	74
Total	**252**	**275**

Figure 2 – Most complained about organisations



Hospitals

Issues in relation to private hospitals are set out in Table 18, and issues in relation to public hospitals are set out in Table 19.

Table 18 – Issues relating to Private Hospitals

Issue	**2014-15**	**2015-16**
Access	0	2
Communication & Information	1	3
Discharge and Transfer Arrangements	3	0
Environment/Management of Facilities	1	0
Fees & Costs	4	4
Grievance Processes	1	0
Medication	0	1
Professional Conduct	0	1
Treatment	11	9
Total	**21**	**20**

Table 19 – Issues relating to Public Hospitals

Issue	**2014-15**	**2015-16**
Access	9	12
Communication & Information	11	16
Consent	2	4
Discharge & Transfer Arrangements	0	3
Environment/Management of Facilities	0	7
Fees and Costs	3	0
Grievance Processes	2	4
Medical Records	2	1
Medication	4	5
Professional Conduct	13	7
Reports/Certificates	1	1
Treatment	42	57
Total	**89**	**117**

Individual Providers

Table 20 (below) gives a breakdown of complaints recorded against individual providers during 2015-16.

Table 20 – Complaints received about Individual Providers

Provider	2014-15	2015-16
Chiropractor	1	0
Dental	8	8
Medical Practitioner	49	60
Medical Radiation Technologist	1	0
Nurse	5	2
Occupational Therapist	0	1
Optometrist	0	1
Other/Unknown	0	6
Pharmacist	0	1
Podiatrist / Chiropodist	1	0
Total	**65**	**79**

How were complaints resolved?

Table 21 shows the stages at which complaints were finalised.

Table 21 – Stages when complaints were finalised

Stage	2014-15	2015-16
Assessment	258	290
Conciliation	27	24
Investigation	4	4
Referred	39	26
Total	**328**	**344**

Figure 3 – Time taken to finalise complaints

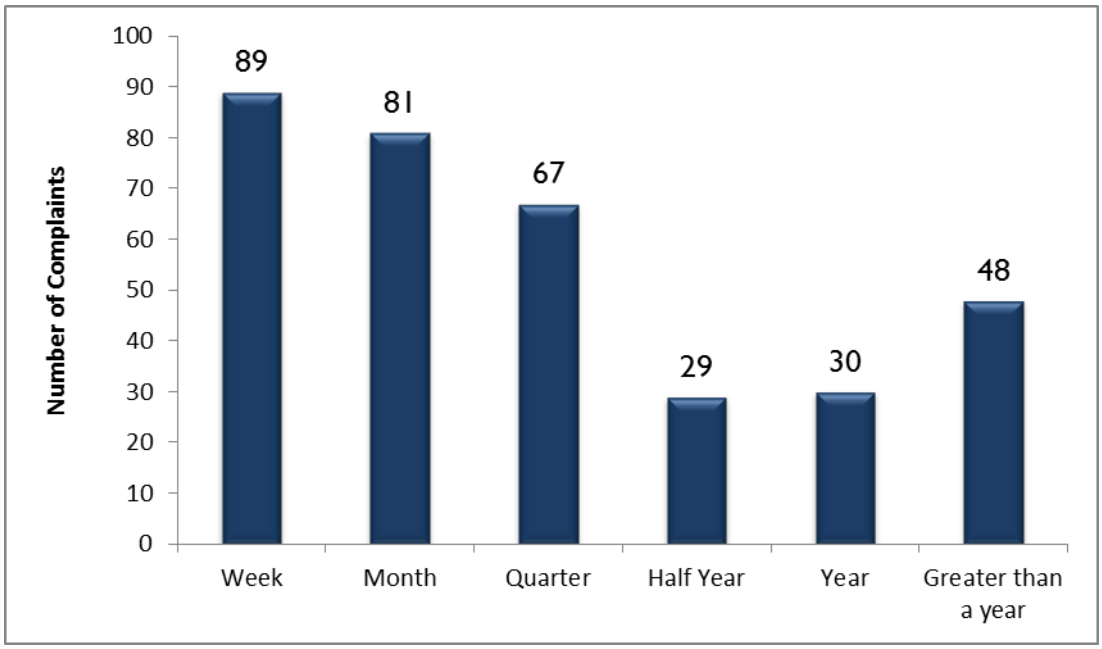


Figure 3 illustrates the time it takes to finalise the various types of complaints received by my Office. As previously noted, the less complex complaints are generally resolved within three months; these complaints generally make up around 60% of all complaints received. The remaining 40% tend to be more complex.

The statistics for this reporting year (Table 22) show a slight decrease in the percentage of complaints taking more than 12 months to finalise. As reported last year this is attributable to the increased complexity of complaints, decreased staffing levels and delays and difficulty in receiving necessary advice and information from various sources.

Table 22 – Complaints finalised over time 2011-12 to 2015-16

Time	2011-12	2012-13	2013-14	2014-15	2015-16
Week	13%	13%	15%	12%	26%
Month	35%	32%	31%	36%	50%
Quarter	55%	62%	72%	68%	69%
Six Months	71%	82%	84%	77%	77%
12 months	81%	91%	91%	83%	86%
More than 12 months	19%	9%	9%	17%	15%

Consultations with Registration Boards

As outlined in Table 23, there has been an 8% reduction (87 to 80) in the number of notifications this Office has made to AHPRA. Of the 80 matters arising from OHCC complaints 18 were formally referred to AHPRA for consideration by the respective registration boards. This is one more referral than was made last reporting year.

National Law requires the Boards (through AHPRA) to notify Health Complaints Entities of any notification that would also provide a ground of complaint. Table 27 indicates a significant decrease in the number of notifications advised to this Office by AHPRA (106 to 18). This decrease is largely attributable to this Office separating notifications that might form the basis of a complaint from notifications under s150(7) of the National Law which requires the Boards to notify health complaint entities when action is taken by the Board in relation to a registered health practitioner. The latter do not require consultation between the two entities and are now being recorded within this Office as AHPRA enquiries. There were 31 such notifications this year. Excluding those cases information was exchanged between this Office and AHPRA in relation to 122 matters. Seventy one percent of these related to complaints lodged with OHCC.

Consultations with AHPRA

Table 23 – OHCC Notifications to AHPRA

Issue	2014-15	2015-16
Chiropractors Board of Australia	1	0
Dental Board of Australia	7	8
Medical Board of Australia	59	63
Nursing and Midwifery Board of Australia	17	7
Occupational Therapy Board of Australia	0	0
Optometrist Board of Australia	0	0
Pharmacy Board of Australia	1	2
Physiotherapy Board of Australia	0	0
Podiatry Board of Australia	1	0
Psychology Board of Australia	0	0
Total	**87**	**80**

Table 24 – Referrals to AHPRA

Issue	2014-15	2015-16
Chiropractors Board of Australia	0	0
Dental Board of Australia	2	3
Medical Board of Australia	11	13
Nursing and Midwifery Board of Australia	4	2
Occupational Therapy Board of Australia	0	0
Optometrist Board of Australia	0	0
Pharmacy Board of Australia	0	0
Physiotherapy Board of Australia	0	0
Podiatry Board of Australia	0	0
Psychology Board of Australia	0	0
Total	**17**	**18**

Table 25 – Retained by OHCC

Issue	2014-15	2015-16
Chiropractors Board of Australia	1	0
Dental Board of Australia	5	3
Medical Board of Australia	39	20
Nursing and Midwifery Board of Australia	12	4
Occupational Therapy Board of Australia	0	0
Optometrist Board of Australia	0	0
Pharmacy Board of Australia	1	1
Physiotherapy Board of Australia	0	0
Podiatry Board of Australia	0	0

Issue	2014-15	2015-16
Psychology Board of Australia	0	0
Total	**61**	**28**

Table 26 – Ongoing as at 30/6/16

Issue	2014-15	2015-16
Chiropractors Board of Australia	0	0
Dental Board of Australia	0	2
Medical Board of Australia	9	30
Nursing and Midwifery Board of Australia	1	1
Occupational Therapy Board of Australia	0	0
Optometrist Board of Australia	0	0
Pharmacy Board of Australia	0	1
Physiotherapy Board of Australia	0	0
Podiatry Board of Australia	1	0
Psychology Board of Australia	0	0
Total	**11**	**34**

Table 27 – AHPRA Notifications to OHCC

Issue	2014-15	2015-16
Chiropractors Board of Australia	1	0
Dental Board of Australia	5	0
Medical Board of Australia	44	14
Nursing and Midwifery Board of Australia	30	2
Occupational Therapy Board of Australia	1	0

Issue	2014-15	2015-16
Optometrist Board of Australia	1	0
Pharmacy Board of Australia	19	1
Physiotherapy Board of Australia	1	1
Podiatry Board of Australia	0	0
Psychology Board of Australia	4	0
Total	**106**	**18**

Referral of Complaints

Some complaints received by me require attention from agencies other than registration boards. For example, complaints against aged care facilities might be referred to the Aged Care Complaints Commissioner, and complaints relating to mental health facilities might be referred to the Mental Health Official Visitor Scheme established under the *Mental Health Act 1996* and now covered by the *Mental Health Act 2013*. Appropriate consultation occurs prior to referral. These matters are generally closed in the assessment stage because, unlike referrals to registration boards, they do not generally require further consideration by me. There were four such cases this year.

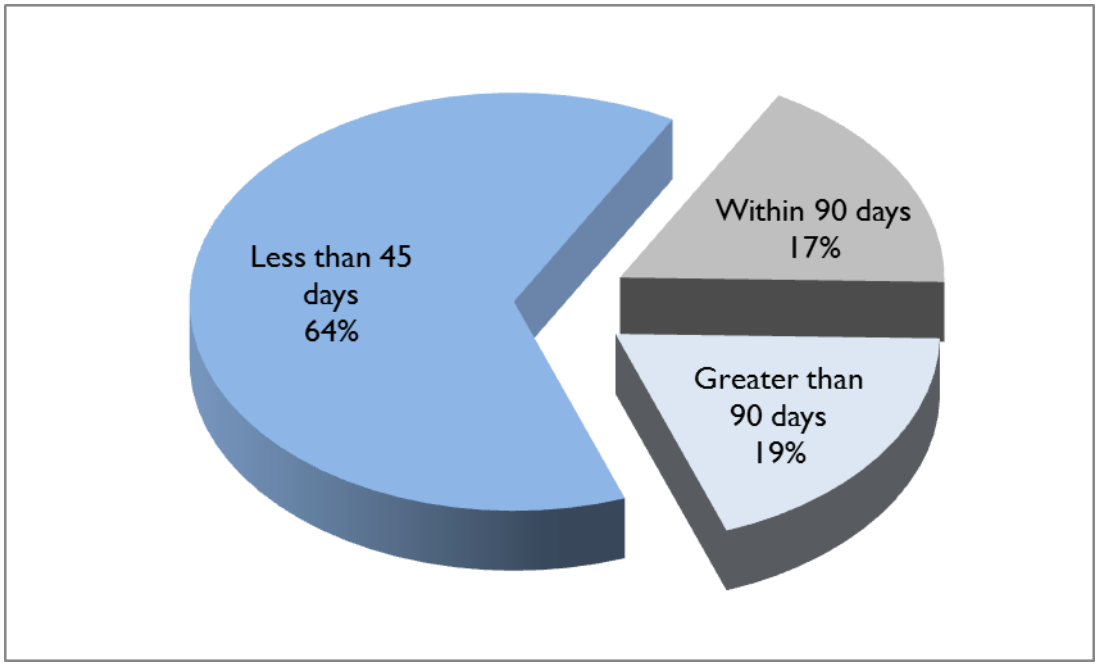
Cases assessed under Part 4 of the *Health Complaints Act 1995*

The Act requires that a complaint be assessed within 45 days. This can be extended to 90 days, and longer in some cases. There are a number of circumstances, described in the last four annual reports, which have an impact on OHCC's ability to meet these statutory time frames. These include delays in receiving responses and other information necessary to undertake an assessment from providers, and delays occasioned by the required consultation process with AHPRA.

In last year's report I foreshadowed an amendment to the *Health Complaints Act* 1995 which was intended to address the difficulty in meeting our statutory timeframes caused by these delays. That amendment, which mirrors the provisions of s34(3) of the *Health and Disability Services (Complaints) Act 1995* (WA) by providing that *if there is a delay in obtaining information requested by* [the Commissioner], *he or she may extend the period within which a decision must be made under* [s25(1)], came into effect on 13 October 2015.

This reporting year 19% were assessed outside the 90-day period (Figure 4 below).

Figure 4 – Time taken to assess complaints



The majority of complaints received are closed within the assessment stage. This was the case for 290 complaints closed this year. In the language of the Act, complaints closed in assessment are recorded as having been "dismissed" (as opposed to being referred to investigation, conciliation, a registration board, or elsewhere). This terminology is unfortunate, as it fails to convey the extent of the work undertaken during the assessment phase and the significant outcomes achieved from the assessment process.

The various reasons for a complaint being closed in assessment are set out in Table 28. These reasons accord with the language of s25(5) of the Health Complaints Act, which stipulates the circumstances in which a complaint must be dismissed. Most of these relate to threshold issues, which can result in a complaint being dismissed at an early stage in the assessment process. The remaining two reasons, which account for 78% of all complaints dismissed in assessment during the reporting year, are that the complainant has been given a reasonable explanation about the incident that led to the complaint, or that the complaint has been resolved.

Other outcomes that resulted in complaints being resolved included apologies, provision of services, refunds of costs, concerns being noted, and recommendations for (and the implementation of) quality improvements such as changes in policy or procedure.

Table 28 – Reasons for closure in Assessment Stage

Reason	2014-15	2015-16
Dismiss - Section 25 (5) (a) Complainant not a person entitled under s22	1	3
Dismiss - Section 25 (5) (b) Complaint does not disclose a subject matter referred to in s23	1	1
Dismiss - Section 25 (5) (c) Complainant became aware of the circumstance more than 2 years ago	3	2
Dismiss - Section 25 (5) (d) Complainant has not attempted direct resolution	2	9
Dismiss - Section 25 (5) (e) Issues adjudicated by court or tribunal	1	1
Dismiss - Section 25 (5) (g) Complainant has been given reasonable explanation and information	173	157
Dismiss - Section 25 (5) (h) The complaint lacks substance	2	3
Dismiss - Section 25 (5) (j) Complaint has been resolved	61	70
Dismiss - Section 25 (7) Complainant has failed to provide information under s24	0	1
Other	6	15
Out of Jurisdiction	5	11
Section 25 (1) (a)Complaint referred to the Ombudsman or a relevant Board or another person	3	9
Section 30 (1) The complaint has been withdrawn in writing	0	8
Total	**258**	**290**

A number of quality improvements were achieved through the assessment process this year. Examples of these improvements appear in the case studies which have been and will continue to be published on our website.

Table 29 shows the outcomes achieved during the reporting year. It should be noted that more than one outcome may be achieved from one complaint.

Table 29 – Outcomes from Assessment

Outcomes	**2014-15**	**2015-16**
Apology Given	21	31
Change in Policy	3	2
Change in Procedure	7	3
Compensation Received	0	1
Concern Registered	90	17
Declined/Referred	8	13
Dismissed (no other outcome)	16	68
Explanation Given	173	159
Fees/Costs - Refunded, waived or reduced	7	11
Information obtained	5	31
Quality Improvement	12	8
Section 25 (1) (a) Referral to Registration Board or other person	4	7
Service Obtained	47	28
Total	**393**	**379**

Conciliations under Part 5 of the *Health Complaints Act 1995*

Most complainants generally want to understand what happened and why and, in appropriate cases, to receive an apology, ongoing care and/or compensation. They also want to know what can or is being done to prevent the same thing happening to someone else.

Conciliation under Part 5 of the Act is confidential and privileged, and as such provides a safe forum within which the parties can have open and honest discussions about these issues. It provides a number of benefits over litigation. To identify just a few - it is far cheaper; it can be therapeutic; it avoids the blame, acrimony and confrontation which arises with litigation; it can restore and preserve the relationship between clinician and patient; and it is less destructive of the morale and self-confidence of clinicians.

To achieve these benefits, the parties need to be brought together as early as possible and there needs to be an honest commitment from both sides to do whatever is necessary to progress the process. Grievances that are allowed to fester can develop out of all proportion and end up consuming unnecessary time, money and energy to resolve. In the meantime, the damage originally done is amplified. Likewise, delays in getting legal advice which is necessary for the process to continue, or to formalise an agreement reached, detract from the goodwill engendered between complainant and clinicians within the conciliation meeting.

The average age of matters closed in conciliation this reporting year was 833 days. This time includes the assessment period and often lengthy periods of time waiting for the outcome of AHPRA investigations. Another significant factor in the time it takes to bring conciliations to conclusion is the limited availability of provider representatives to attend conciliation meetings, coupled with significant delays in receiving the necessary legal advice for the matter to be finalised.

As reported in the last three years, there continued to be a number of cases involving public hospitals or public health services where there have been significant delays in obtaining this advice. These delays, coupled with poor communication about the reasons for the delay, not only damage any good will or rapport established between the parties at conciliation but have the tendency to exacerbate the original complaint. In four cases closed this year (three of which had already undergone lengthy assessment process and referral to AHPRA), the time taken for a response to a request for compensation ranged from nine to 16 months. In two of these cases compensation was declined but the delay in providing that advice kept the complainants expectations alive with one of the complainants resorting to social media. All four complainants advised of the frustration and feeling that they were being treated with disdain by these delays.

The number of complaints referred to conciliation this year decreased from 23 to ten. This reduction is as a consequence of retaining matters in assessment which might otherwise have benefitted from a face to face conciliation meeting, and undertaking informal negotiations within that stage. This has been necessary as a result of reduction in conciliation staff and the need to reduce the increasing backlog of conciliations. The number of matters closed decreased from 27 to 24. Of these cases, five resulted in the payment of compensation or waiver of fees and ten resulted in significant quality improvements, including changes in policy or procedure. In a number of cases, the complainants' concerns were resolved by receiving further information or an explanation, in language they could understand, or simply by having those concerns acknowledged and receiving an apology.

Examples of outcomes achieved through the conciliation process will be published on our website.

Table 30 – Outcomes from Conciliation

Outcomes	**2014-15**	**2015-16**
Apology Given	20	13
Compensation Received	6	4
Concern Registered	13	13
Explanation Given	21	23
Fees/Costs - Refunded, waived or reduced	1	1
Information obtained	1	2
Quality Improvement	15	16
Service Obtained	6	0
Total	**83**	**72**

Investigations under Part 6 of the *Health Complaints Act 1995*

A decision was made six years ago that formal investigations would only be conducted into complaints which give rise to a matter of public interest, and that conciliation would be used more extensively. The reasons for this were that findings of fact made by the Health Complaints Commissioner following an investigation are not legally enforceable, and that providers would in most cases be keen to implement whatever systemic changes were necessary to prevent adverse events.

While I agree that it is not necessary to undertake an investigation in order to effect change, I have formed the view that there would be benefit in referring more matters to investigation in future for the purpose of information gathering rather than prolonging the assessment stage.

No matters were referred to investigation but four other matters were closed in investigation during the reporting year. Summaries of these will be published on our website in due course.