Parliamentary Committees

# Oversight of the Health Quality and Complaints Commission

## Report No. 7

## Health and Disabilities Committee

**February 2012**

## Health and Disabilities Committee

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|---|---|
| **Chair** | Ms Lindy Nelson-Carr MP, Member for Mundingburra |
| **Deputy Chair** | Mr Mark McArdle MP, Member for Caloundra |
| **Members** | Mrs Christine Smith MP, Member for Burleigh |
| | Mrs Liz Cunningham MP, Member for Gladstone |
| | Ms Mandy Johnstone MP, Member for Townsville |
| | Ms Tracy Davis MP, Member for Aspley |
| **Staff** | Ms Sue Cawcutt, Research Director |
| | Ms Emily Booth, Principal Research Officer |
| | Ms Tamara Vitale, Executive Assistant |


| | |
|---|---|
| **Contact details** | Health and Disabilities Committee<br>Parliament House<br>George Street<br>Brisbane Qld 4000 |
| **Telephone** | +61 7 3406 7688 |
| **Fax** | +61 7 3406 7070 |
| **Email** | hdc@parliament.qld.gov.au |
| **Web** | www.parliament.qld.gov.au/hdc |

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## Abbreviations

| | |
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| ACSQHC | Australian Commission on Safety and Quality in Health Care |
| AHMAC | Australian Health Ministers Advisory Council |
| AHPRA | Australian Health Practitioner Regulation Agency |
| HDC | Health and Disabilities Committee |
| HQCC | Health Quality and Complaints Commission |
| the Act | *Health Quality and Complaints Commission Act 2006* |

## Foreword

The Health and Disabilities Committee was established in June 2011 as one of seven new portfolio committees. It has responsibility for oversight of the Health Quality and Complaints Commission (HQCC) under the Standing Rules and Orders of the Legislative Assembly. Between April 2009 and June 2011, this responsibility was undertaken by the former Social Development Committee.

This is the first report by the Health and Disabilities Committee on oversight of the HQCC under Standing Order 194A. The report has been prepared as the 53rd Parliament draws to a close. Time constraints and the progressive implementation of reforms in the national and Queensland health systems mean that the current committee has not been able to fully explore some of the issues raised in discussion with the HQCC or in documents provided to the committee. The report therefore highlights a number of matters which the committee recommends that a committee of the next Parliament consider further.

I thank the former Commissioner, Professor Michael Ward, and the Chief Executive Officer of the HQCC, Mrs Cheryl Herbert, for their participation.

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

**Lindy Nelson-Carr MP**
**Chair**

# 1 Introduction

## 1.1 Role of the committee

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

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

Representatives of the HQCC appeared as witnesses at a public hearing on 7 September 2011 and at the Budget Estimates hearing on 13 July 2011. Other evidence used in monitoring and reviewing the performance of the HQCC includes the HQCC's response to pre-hearing questions on notice, responses to committee requests for information, the HQCC's Annual Reports, *Annual Health Check 2010*, *Organisational Review Report* 2011 and its *Strategic Plan 2011-15*. The transcript of the public hearing is published on the committee's webpage at www.parliament.qld.gov.au/hdc.

This report includes examination and comment on the HQCC's Annual Report 2010-11, as required under Standing Order 194A(c).

## 1.2 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. The *Health Quality and Complaints Commission Act 2006* (the Act) divides the functions of the HQCC into four categories: health service complaints, quality of health services, provision of information and 'other' functions which include investigating or inquiring into matters and suggesting ways to improve health services. The HQCC's statutory functions are in the Appendix.

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

# 2 Complaints

## 2.1 How complaints are managed by HQCC

The Act provides for the way the HQCC must deal with complaints. Complaints must generally be confirmed in writing by the complainant. The ways a complaint may be dealt with under the Act include:

*Early resolution:* The HQCC recommends an early resolution process if the complainant and the provider agree and the HQCC believes the complaint can be resolved quickly. With the complainant's agreement the HQCC gives the health provider a copy of the complaint and asks them to comment and provide relevant information. The HQCC may also take steps to resolve the complaint. Serious complaints, for example those involving claims of sexual misconduct, are not suitable for early resolution.[2]

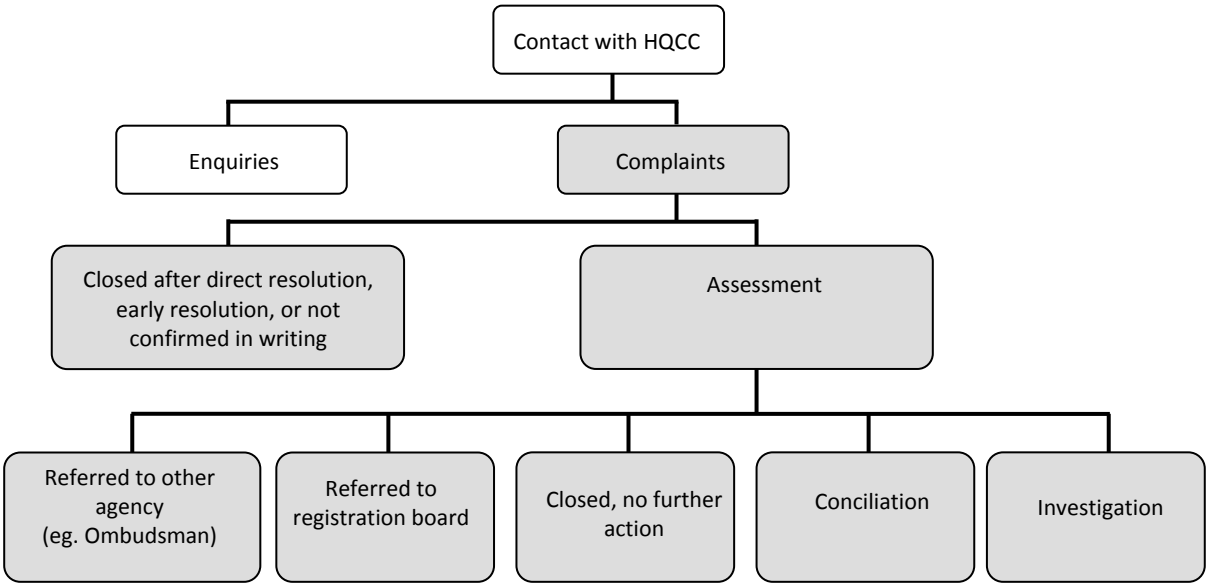
*Assessment:* A health service complaint must be assessed within 60 days, or 90 days depending on the nature of the complaint. Once a complaint has been assessed, the HQCC decides whether to take no further action (e.g. the complaint may have been resolved or further action may not be warranted) or to take action by conciliating, investigating or referring the complaint.

*Conciliation:* Complaints may be resolved by voluntary conciliation, as a forum for open and direct discussion and a less formal alternative to legal action. Independent clinical opinions may be obtained if relevant.[3]

*Investigation:* HQCC has broad powers to investigate health services. 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.

*Referral to a health professional registration board or another entity:* Complaints about registered practitioners may be referred to the relevant state or national registration board.

**Figure 1:** HQCC complaint management process[4]




[2] HQCC Fact Sheet *Resolving your complaint* p 1, site last accessed 18 February 2012 www.hqcc.qld.gov.au/_uploads/41148Fact_sheet_-_online_-_consumers_-_resolving_your_complaint_-_Feb_2010.pdf

[3] HQCC Fact Sheet *Conciliating your complaint* p 1, site last accessed 18 February 2012

[4] Based on HQCC *Annual Report 2010-11*, p 40 and HQCC complaint process diagram 2009-10 www.hqcc.qld.gov.au/_uploads/28111Complaint_process_diagram_for_web.pdf - last accessed 18 January 2012

## 2.2 Complaints received 2010-11

During 2010-11 the HQCC received 2,525 complaints about health services. While this is an increase of 13% (284) on complaints received during 2009-10, it is comparable with the number of complaints received in 2008-09. The HQCC also received 2,403 enquiries.

The majority of complaints were resolved through direct resolution, early resolution or were closed as they were not confirmed in writing (1,568 complaints, 68%).[5] The Annual Report 2010-11 does not specify how many of those 1,568 complaints closed were not confirmed in writing. It is not known how many complaints in 2010-11 were not confirmed in writing, nor is it known whether some complainants wished to pursue a complaint but were unable to prepare a written complaint, for example because of literacy or language barriers.

In a separate report on complaints about access to health services over a three year period, the HQCC reported that almost half of the complaints were not confirmed in writing or did not provide further information.[6]

The HQCC report that 95% of the complaints resolved through early resolution were closed within 30 days, meeting the legislative timeframe.

## 2.3 What were complaints about?

During 2010-11, 1,409 complaints (63%) were about treatment,[7] similar to the number received in 2009-10 (67%),[8] and higher than in 2008-09 (45%).[9] The majority of complaints about treatment were about inadequate treatment, unexpected treatment outcomes or complications and diagnosis. During the public hearing the HQCC Chief Executive Officer (CEO) stated that "…if we opened up treatment a bit more, which we do, you would find … that it is probably more about the communication that resulted in the unmet expectations of treatment."[10]

The next most common complaint category was communication and information. In 2010-11, 317 complaints (14%) were about communication and information, which is consistent with 2009-10 (15%) and 2008-09 (16%). In over half (57%) of the complaints about communication and information, the main issue was the attitude or manner of health professionals.[11]

The HQCC reported that 99 complaints (8%) in 2010-11 were about access. In December 2011 it released a report, *Why are we waiting? A spotlight report on access to healthcare in Queensland* to analyse complaints about access to health services. The report is based on 337 complaints received between 1 July 2009 and 30 June 2011.[12] The main barriers to accessing health services reported by complainants were: inadequate coordination and management; waiting time or waiting lists; and withdrawal or refusal to treat. Those issues accounted for 93% of the access complaints in the two years to June 2011. The HQCC reported that delays in the provision of health services due to inadequate coordination and management "…are associated with the highest level of harm to healthcare consumers…".[13]

5 HQCC, *Annual Report 2010-11*, p 40
6 HQCC, *Why are we waiting? A spotlight report on access to healthcare in Queensland*, 16 December 2011, p 6
7 HQCC, *Annual Report 2010-11*, p 52
8 HQCC, *Annual Report 2009-10*, p 24
9 HQCC, *Annual Report 2008-09*, pp 26-27
10 Hearing Transcript, 7 September 2011, Cheryl Herbert, CEO, HQCC, p 10
11 HQCC, *Annual Report 2010-11*, p 53
12 HQCC, *Why are we waiting? A spotlight report on access to healthcare in Queensland*, 16 December 2011, p 2
13 ibid, p 5

## 2.4 Who were complaints about?

### *2.4.1 Hospitals and other health organisations*

The HQCC reported that public hospitals were the most commonly complained about health organisation, with 841 (59%) complaints in 2010-11.[14] This is consistent with the percentage of complaints received in 2009-10,[15] and slightly less than in 2008-09 (63%).[16] The Annual Report stated, "This distribution reflects the large number of patients dealt with by public hospitals and the more complex case mix and range of health services they provide."[17]

### *2.4.2 Individual health providers*

Doctors (medical practitioners) accounted for 72% of complaints (693) about individual registered health practitioners, and dentists (including dental therapists, dental hygienists, oral health therapists and dental prosthetists) accounted for 21% (198). Nine other professions made up the remaining 7% of complaints (68) received about registered health practitioners in 2010-11.[18]

There was a decrease in the percentage of complaints received about doctors in 2010-11, down from 78% in 2009-10. The percentage of complaints received about dentists increased, up from 17% of registered practitioners in 2009-10.[19] The percentage of complaints received about doctors and dentists combined remained the same from 2009-10 to 2010-11 at 93% of registered practitioners.

### *2.4.3 Unregistered health providers*

The HQCC advised the committee that while few complaints are received about unregistered providers, they are a difficult issue that is being considered nationally.[20] Unregistered providers include professions such as counsellors, dieticians and naturopaths. The 2010-11 Annual Report notes that a small number of complaints were made about unregistered providers, but does not specify the number.[21]

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 Australian Health Practitioner Regulation Agency (if an unregistered person claims to be registered).[22]

The Australian Health Ministers Advisory Council (AHMAC) is considering the regulatory or other means to protect the public from unregistered health providers who fail to observe minimum standards of professional conduct.[23] Consultation on regulatory options was undertaken by AHMAC in 2011; no outcomes had been publicly reported at this time this report was prepared.

## 2.5 Assessment of complaints

If a complaint is not resolved through 'early resolution' or the complaint is not suitable for this process, 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 90% of complaints were assessed in the legislated timeframe in 2010-11, up from 86% in 2009-10.[24]

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14 HQCC, *Annual Report 2010-11*, p 56
15 HQCC, *Annual Report 2009-10*, p 15
16 HQCC, *Annual Report 2008-09*, p 27
17 HQCC, *Annual Report 2010-11*, p 56
18 HQCC, *Annual Report 2010-11*, p 57
19 HQCC, *Annual Report 2009-10*, p 14
20 Hearing Transcript, 7 September 2011, Cheryl Herbert, CEO, HQCC, p 12
21 HQCC, *Annual Report 2010-11*, p 57
22 Hearing Transcript, 7 September 2011, Cheryl Herbert, CEO, HQCC, p 12
23 AHMAC, Consultation paper, *Options for regulation of unregistered health practitioners,* 2011, p 5
24 HQCC, *Annual Report 2010-11*, "Complaints received/closed", p 40

The Annual Report notes that managing complaints in the required timeframes is an ongoing challenge, and reports that through improved processes and temporary staff, significant progress has been made since 2008-09 in achieving these timeframes.[25] A backlog of cases awaiting allocation to an officer had been reduced at the end of June 2011 following appointment of two triage officers.[26]

Seven hundred and forty-four complaints were assessed during 2010-11 and 493 (21% of all complaints received) were closed with no further action required after assessment. The outcome of assessment of complaints is shown in Table 1.[27]

***Committee comment***

The committee notes that some of the complaints reported as 'closed' in the Annual Report, were assessed and referred to conciliation, investigation or registration boards. [28] The committee assumes that complaints that are subject to further action such as conciliation or investigation remain open until those processes are completed.

**Table 1 Complaints assessed by HQCC 2010-11[29]**

| Outcome of assessment / action | No. | % of assessments |
|---|---|---|
| Closed, no further action | 493 | 66% |
| Referred to conciliation | 89 | 12% |
| Referred to investigation | 77 | 10% |
| Referred to registration boards | 41 | 5% |
| Referred to other agencies | 44 | 6% |
| Total complaints assessed | 744 | |

## 2.6 Conciliation of complaints

### *2.6.1 Cases conciliated 2010-11*

In 2010-11, 89 cases were accepted for conciliation, 102 were closed and 116 remained open at 30 June 2011.[30]

Fifty-nine percent of conciliation cases were closed within 12 months in 2010-11.[31] This is consistent with 2009-10 and below the HQCC performance target of 75%. The HQCC expects to increase the proportion of cases closed within 12 months during 2011-12 following a review of the conciliation process, and will reduce the target rate to 60% to "…acknowledge that the review recommendations will take time to implement and conciliation timeframes will always be impacted by various factors outside of our control…".[32]

[25] HQCC, *Annual Report 2010-11*, p 13
[26] ibid, p 43
[27] "Outcome of complaint intake and assessment", HQCC *Annual Report 2010-11*, p 40
[28] HQCC *Annual Report 2010-11*, p 40
[29] ibid, p 40
[30] HQCC *Annual Report 2010-11*, p 41
[31] ibid, p 41
[32] ibid, p 13

The HQCC reported that 71% of the 102 conciliations closed were successful. The outcomes of successful conciliations are shown in Table 2.

**Table 2 Outcomes of successful conciliations**

| Outcomes in successful conciliations | % of successful cases |
|---|---|
| Explanation to complainant | 45% |
| Negotiated financial settlement | 43% |
| Reimburse complainant's fees or costs | 7% |
| Apology to complainant | 5% |
| Total | 100% |

### *2.6.2 Review of conciliation process*

The HQCC's conciliation process was reviewed in 2010-11 by an external consultant. The Annual Report 2010-11 includes the 11 recommendations made to improve the conciliation process, client understanding, timeliness and effectiveness and to outline future options. It noted that the recommendations of the review of conciliation would be considered as part of an operational review which commenced in June 2011.[33]

***Committee comment***

The committee anticipated that information about changes to be implemented to conciliation would be in the *Organisational Review Report* (the HQCC Review Report) which was provided to the committee in late December 2011. That report notes in its 'action plan' that the HQCC will "Implement agreed external conciliation review recommendations"[34] but does not report any information about which recommendations are to be implemented.

There has not been sufficient time since receipt of the HQCC Review Report on 21 December 2011 for the committee to further examine this issue. The committee recommends that a committee of the next Parliament examine the recommendations of the external review of conciliation, those which the HQCC has adopted and progress on implementation of changes to conciliation.

## 2.7 Investigation of complaints

### *2.7.1 Cases investigated 2010-11*

The Annual Report states that 83 complaints were accepted for investigation during 2010-11. The majority (55) were health service complaints which are made by or on behalf of a consumer about a health service provider within one year of the incident. The remaining 28 were health quality complaints, which can be made by anyone and can be about one or more health providers at any time since an incident.[35] Seventy investigations were closed during the year.[36] The Annual Report

[33] ibid, p 48
[34] HQCC, *Organisational Review Report*, 21 December 2011, p 5
[35] HQCC, *Annual Report 2010-11*, p 22

states elsewhere that 77 complaints were referred to investigation after assessment.[37] The reason for the apparent difference in cases referred to or accepted into investigation is not clear.

Case studies of 41 investigations were included in the Annual Report 2010-11, including the recommendations and their implementation status.[38] Matters investigated included severe post-partum bleeding and subsequent hysterectomy, ambulance care, adverse reaction to the interaction of prescribed drugs, septic shock death, antenatal shared care, inadequate nursing home care, sharps incidents and inadequate infection control.

### *2.7.2 Length of time to complete investigations*

The time taken to complete investigations and the number of investigation staff was discussed at the public hearing in September 2011 and was the focus of media attention in October 2011. The HQCC reported the following data about the time taken to complete investigations.[39]

**Table 3 Time to complete investigations**

| | 2009-10 | 2010-11 |
|---|---|---|
| Less than 6 months | 35 | 41 |
| 6 – 12 months | 14 | 7 |
| 12 – 18 months | 6 | 10 |
| 18 – 24 months | 2 | 5 |
| More than 24 months | 4 | 7 |
| **Total** | **61** | **70** |

Of the 70 investigations closed in 2010-11, this data indicates that 22 investigations (31.4%) took over 12 months to complete and 48 (68.6%) were completed within 12 months. Elsewhere the Annual Report states that 81% of investigations were closed within 12 months[40] (see section 8 for further comment). During the public hearing, the CEO explained that complex investigations can take two or three years to complete depending on the nature of the case.[41]

The HQCC Annual Report 2010-11 notes a 15% increase in the number of investigations (9 cases) closed compared with 2009-10, and stated that the increase results from process efficiencies. Half of all cases were closed within six months. The HQCC reported that 15 of the 70 active cases at 30 June 2011 had been open for more than a year, because the investigations are more complex and "…involve multiple witnesses, clinical opinions and legal/medical indemnity providers – all of which can extend the investigation process."[42]

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36 ibid, p 23
37 ibid, p 40
38 ibid, pp 26-36
39 HQCC, Response to pre-hearing questions on notice, 7 September 2011, p 31; and *Annual Report 2010-11*, p 23
40 HQCC, *Annual Report 2010-11*, p 17
41 Hearing Transcript, 7 September 2011, Cheryl Herbert, CEO, HQCC, p 8
42 ibid

***Committee comment***

The committee draws attention to the apparent inconsistency in performance reporting on the time taken to complete investigations on pages 17 and 23 of the HQCC Annual Report 2010-11.

The committee recommends that a committee of the next Parliament monitor the time taken for HQCC investigations and consider any changes that may be desirable.

### *2.7.3 Criteria for commencing an investigation*

In response to questions about the time taken to complete investigations at the committee's September 2011 hearing, the CEO stated that in the HQCC's early years it accepted cases into investigation when assessment completion times could not be met, and it was "…almost a work around", but "going forward we are going to look at it quite differently."[43] The committee had been informed during the July estimates hearing that the HQCC was undertaking a review of its internal procedures.

In November 2011 the HQCC advised the committee that its organisational review (discussed in section 7) considered investigation processes, including the criteria for commencing an investigation. Draft criteria for commencing an investigation were developed during the review and included in the HQCC response to the committee's request for information, and the HQCC Review Report provided to the committee in December 2011. The draft criteria are "largely based on current business practice…"[44] and a focus on using limited resources to investigate "…the most serious complaints that are likely to result in safety and quality improvement recommendations which impact on multiple healthcare providers."[45] The draft criteria consist of nine questions considered at an Assessment Recommendation Meeting, which makes decisions on complaints that require further action. The HQCC advised the committee that the new draft criteria for commencing an investigation will be implemented from January 2012.[46]

***Committee comment***

The committee notes that the draft criteria are largely based on current practice, and questions what degree of change can be expected in decisions to commence an investigation as a result of the HQCC Organisational Review.

The committee recommends that a committee of the next Parliament further examine the implementation of draft criteria for decisions to commence an investigation by the HQCC, and the impact of any changes on the number and type of complaints that are investigated.

[43] Hearing Transcript, 7 September 2011, Cheryl Herbert, CEO, HQCC, p 8
[44] HQCC, *Organisational Review Report*, p 9
[45] HQCC, Response to request for information, 23 November 2011, pp 11-12
[46] ibid, p 12

### *2.7.4 Investigation outcomes and cost*

The HQCC made or endorsed recommendations in 22 investigations, and made 84 recommendations for improvement in 2010-11. In more than half of the investigations the allegation was proven or provided evidence of a systems issue. The HQCC reported that 88% of the recommendations made to health providers since 1 July 2006 were implemented at 30 June 2011.[47]

The committee considered evidence about the timeliness of implementation by health providers of recommendations made as a result of an investigation.[48] Timeframes to implement recommendations are given by the HQCC to the health provider. In making recommendations the HQCC advised that it considers the degree of harm being addressed and what is reasonable and achievable. The Commissioner stated that HQCC considers an essential part of its role is to make recommendations and to report to the public on whether those recommendations have been followed up.[49] The CEO said:

> We do not allow it [implementation of recommendations] to be years, but we do not say, 'It has to be done next week,' unless it would cause harm and it would be in the public interest. We have been known, in fact, to say that we might be considering closing a facility for a while until something happens. We look at the degree of harm, what is achievable and in a reasonable time frame for the public and for the facility itself.[50]

The cost of investigations was raised by the committee at the public hearing and the CEO advised that costs would be considered after the end-to-end review.[51] The average cost of an investigation conducted during 2010-11 was later reported to the committee as $28,041.[52]

***Committee comment***

The committee recommends that a committee of the next Parliament examine the cost of an investigation and the methodology by which the HQCC's average cost of $28,041 was calculated.

## 2.8 Referral and devolution of complaints

### *2.8.1 Referral to registration boards and other agencies*

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

During 2010-11 41 complaints (1.7% of all complaints received) were referred to health practitioner registration boards, and 44 (1.9%) were referred to other agencies.[53]

At June 2011 the HQCC reported that it was monitoring 278 cases that had been referred to registration boards, AHPRA or other agencies.[54]

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47 HQCC, *Annual Report 2010-11*, p 23
48 Hearing Transcript, 7 September 2011, Cheryl Herbert, CEO, HQCC, p 11
49 Hearing Transcript, 7 September 2011, Michael Ward, Commissioner, HQCC, p 11
50 ibid
51 Hearing Transcript, 7 September 2011, Cheryl Herbert, CEO, HQCC, p 9
52 Correspondence to HDC from Cheryl Herbert, CEO, HQCC, 20 December 2011
53 HQCC, *Annual Report 2010-11*, p 40
54 ibid, p 50

### *2.8.2 Devolution to health providers*

The HQCC Review Report describes an approach to devolving complaints to health providers, with oversight by the HQCC. The Report describes the approach as follows:

> This devolution approach will be employed when issues remain outstanding following assessment which the HQCC believes are best managed by the healthcare provider. The HQCC will make greater use of section 20 of the HQCC Act – the duty of a provider to establish, maintain and implement reasonable processes to improve the quality of health services – to oversight local investigation of outstanding complaint issues and monitor action plan implementation.[55]

***Committee comment***

The committee notes the HQCC's intention to devolve some complaint issues to health providers after a complaint is assessed. The committee has not had sufficient time to consider this aspect of the HQCC's work since it received the HQCC Review Report. The committee recommends that a committee of the next Parliament consider the HQCC's devolution of complaints to health providers.

[55] HQCC, Organisational Review Report, 21 December 2011, p 9

# 3 Health service quality and standards

## 3.1 HQCC standards and reporting

The HQCC functions include making standards about the quality of health services, and monitoring and reporting on health service providers' compliance with standards. The HQCC made nine standards in 2007, and implemented updated standards in July 2010. The standards apply to public and licensed private hospitals and day hospitals.

A total of 225 acute hospitals and day hospitals self-assess and report against the standards.[56] The average rate of compliance with the standards reported by hospitals in September 2010 was 93%. Hospitals reported increases in alignment with quality standards between 2007, when reporting commenced, and 2010. The Annual Report noted there is often a disparity between the level of compliance claimed by hospitals and the actual compliance, and that further studies are required to determine whether compliance with standards is linked with improvements in patient outcomes.[57] The Commissioner and CEO discussed these issues with the committee at its hearing in September 2011.

The HQCC published *Healthcare standards: A report on Queensland acute and day hospital self-assessed compliance* on 22 December 2011 for the period 1 July 2010 to 30 June 2011. The report shows the level of hospital performance against each of the HQCC's standards, and changes in performance since HQCC standards were introduced in 2007.

The report identifies improvements in the self-assessed performance of hospitals since 2007, and some areas where further improvement is required. For example, with regard to the standard for management of acute myocardial infarction only 57% of patients were reported as "…discharged or transferred with a care plan given to the provider of their ongoing care."[58] This figure is the same as reported in 2007. The report notes that this may be as a result of the new criteria reported against in 2010, where the elements of discharge care plans are specified. The HQCC expects reporting against this standard to improve in the next reporting period.

## 3.2 Introduction of national standards

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

Ten national standards were endorsed by Australian Health Ministers in September 2011 and health services are required to be accredited against them by 1 January 2013. The primary aim of the national standards is to:

> … protect the public from harm and to improve the quality of health service provision. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure minimum standards of safety and quality are met, and a quality improvement mechanism that allows health services to realise aspirational or developmental goals.[59]

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[56] HQCC *Annual Report 2010-11*, p 62

[57] HQCC *Annual Report 2010-11,* p 66

[58] HQCC, *Healthcare standards: A report on Queensland acute and day hospital self-assessed compliance*, 22 December 2011, p 17

[59] Australian Commission on Safety and Quality in HealthCare, *National Safety and Quality Health Service Standards*, http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/NationalSafetyAndQualityHealthServiceStandards

Until January 2013 health providers that are due for accreditation may 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.

### *3.2.1 Potential for duplication of standards*

The committee was concerned about any potential duplication of health quality standards and reporting for health providers, and sought information from the HQCC about the extent of overlap between the HQCC and the national standards. The HQCC advised that five of the HQCC standards overlap with four of the national standards.

At the public hearing in September 2011, the Commissioner confirmed that there will be no duplication between the HQCC standards and the national standards. He stated:

> …there will not be duplicate standards. There will not be two sets of standards. There will be some that become the national standards and they will be the ones the whole country will work to. Our view is that for any areas that those national standards do not cover, we would continue our standards for a couple of years for two reasons: one, to make sure that we get the maximum benefit out of them and report to the public on whether they have made a difference or not, but secondly, and this we have discussed with the national authorities, we believe that Queensland, being ahead in the use of regulated standards, can be a very useful test bed and the nation can learn from what has happened in Queensland.[60]

Until the national standards are fully implemented in 2013, the HQCC advised the committee it will "…maintain reporting against our existing suite of healthcare standards in Queensland….".[61] After the national standards are fully implemented, the HQCC propose to continue requiring providers to report against two clinical standards; *Management of acute myocardial infarction on and following discharge or transfer standard* and *Reducing the risk of venous thromboembolism*.[62] Those standards do not overlap with the current national standards.

### *3.2.2 Implications of national standards for HQCC*

It is apparent that full implementation of national safety and quality standards for health services will result in a reduced role for the HQCC in making standards and monitoring and reporting on health services' compliance. However, the extent of the implications for the HQCC's functions is not yet clear.

***Committee comment***

The committee recommends that a future committee of the next Parliament continue to monitor developments in national safety and quality standards for health services and the quality standards made by the HQCC, and report to the Legislative Assembly on the implications.

[60] Hearing Transcript, 7 September 2011, Michael Ward, Commissioner, HQCC, p 2
[61] HQCC, Response to questions on notice, 1 September 2011, p 7
[62] HQCC, Response to questions on notice, 1 September 2011, p 7

# 4 Information to clients and stakeholders

## 4.1 Awareness of the HQCC

The committee sought information about community awareness of the HQCC as reflected in the population groups which make complaints about health services. The CEO commented that public awareness about the organisation is one of the greatest areas for improvement for the HQCC.[63] The organisation is considering doing public research and using social media to increase awareness. The CEO stated:

> We are looking at things like social media, ways of using the website and going out and actually doing some public research; getting some really good companies who know how to do this asking of the questions that might elicit really sensible responses. Our sense is we are not well known and we need to be more well known and we need to be ready for that, too, because how do we deal with the onslaught of, perhaps, complaints.[64]

### *4.1.1 Complaints from Indigenous people and those born overseas*

In 2010-11, 8.8% of complainants and 7.5% of enquirers were born overseas, while 17.9% of Queensland's population was born overseas (this includes those born in English speaking countries).[65, 66] In 2009-10 only 5.7% of complainants and 4.8% of enquirers were born overseas. The HQCC noted that some complainants' country of origin was not stated.

The rate of complaints and enquiries from Aboriginal and Torres Strait Islander (ATSI) people was slightly higher than the proportion of Indigenous people in Queensland (3.3%[67]). In 2010-11 4.1% of complaints and 2.8% of enquiries were received from Indigenous people.[68] It is important to note that Indigenous people "…have higher rates of hospitalisation and higher prevalence rates for many health conditions compared to other Australians."[69] The HQCC reported that the number of complaints from Indigenous people in Far North Queensland increased from 3 in 2009-10 to 15 in 2010-11.[70]

The committee asked the HQCC about the under-representation of complainants from culturally and linguistically diverse (CALD) communities and people of Aboriginal or Torres Strait Islander background.[71]

The HQCC described their efforts to engage with people from CALD and ATSI communities, while acknowledging that there is still "…a lot of work to do."[72] The CEO continued:

> It is not just the language; it is what is culturally appropriate within the health system ... When we do get complaints, sometimes they are about their sense of what their expectation of treatment was and in some cases, unfortunately, the death and how the death was dealt with. With the Indigenous community, we do have an Indigenous liaison officer. We are trying to measure just how many complaints we get from Indigenous persons. We are finding they are not usually likely to complain to us, but if we can have someone who can advocate for them, yes, they will complain. We still have more work to do.

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63 Hearing Transcript, 7 September 2011, Cheryl Herbert, CEO, HQCC, p 4
64 ibid
65 HQCC, Response to request for information, 11 November 2011, p 6
66 Australian Bureau of Statistics, www.censusdata.abs.gov.au, site last accessed 3 February 2012
67 ibid
68 HQCC, Annual Report 2010-11, p 51
69 ibid
70 ibid
71 Hearing Transcript, 7 September 2011, Cheryl Herbert, CEO, HQCC, p 5
72 ibid

The HQCC told the committee that an Indigenous Liaison Officer supports people from ATSI communities to communicate their healthcare concerns.[73] The officer liaises with the Apunipima Health Council in Far North Queensland to assist with complaint resolution and information sharing. The officer also travels throughout the state, particularly to Thursday Island and North Queensland, to identify ways to improve engagement.[74]

The HQCC advised that a staff group has been established to identify how the organisation can better engage with people from CALD backgrounds.[75]

***Committee comment***

The HQCC has agreed to provide the committee with six-monthly updates on the engagement strategies implemented and the nature of complaints received from each of the different CALD communities.[76] The committee recommends that a committee of the next Parliament continue to monitor HQCC activities to make its complaint services accessible to people from CALD communities, and the complaints received from people in those communities.

## 4.2 Satisfaction with HQCC complaint management

The HQCC surveys complainants and health providers when complaints are closed to seek feedback about satisfaction levels and whether expectations were met during early resolution, assessment and conciliation.[77] In 2010-11, 161 clients responded to the client satisfaction survey. The HQCC's target is 75% satisfaction on 17 performance measures, and 60% satisfaction with complaint outcomes.

The HQCC exceeded their target on eight measures and achieved below target ratings on ten measures.

In comparison to the results for 2009-10, there was a decrease in the level of satisfaction for 12 of the 13 measures. The Annual Report 2010-11 states that this is not statistically significant due to the small sample size. The average overall performance across the 18 measures was 73%, which is down from 79% in 2009-10.[78] Satisfaction with the timeliness of complaint management was 64%. As this performance measure was not included in the 2009-10 survey, no comparison is possible.

The decrease in results of some performance measures in the client satisfaction survey is of concern to the committee. While the committee acknowledges that the sample size was small, decreases ranged from 1% for promptness in responding to communications, up to a 9% decrease in satisfaction in the way complaints were handled. The committee also notes that while there was an overall reduction in the level of satisfaction since 2009-10, the HQCC exceeded its targets on eight measures.

[73] HQCC, Response to request for information, 11 November 2011, p 8
[74] Hearing Transcript, 7 September 2011, Cheryl Herbert, CEO, HQCC, p 6
[75] ibid, p 5
[76] HQCC, Response to request for information, 11 November 2011 p 7, and 23 November 2011, pp 12-16
[77] HQCC, Annual Report 2010-11, p 42
[78] ibid

# 5 HQCC staff

At 30 June 2011 the HQCC employed 75 staff, 80% (60) of whom were permanent employees and 20% (15) were temporary.[79] During 2010-11 the HQCC recruited 42 new staff, 13 of whom were permanent and 29 were temporary. The HQCC Annual Report 2010-11 highlights an 86% permanent retention rate, but does not report on the overall staff retention rate.

The HQCC identified recruitment as a challenge due to the nature of the skills set required for some roles.[80]

The HQCC Review Report states that two positions were reallocated from Quality Services to Complaint Services following a 2010 review, and that a further two positions were temporarily redirected as a result of the 2011 organisational review.[81] The HQCC Review Report states that the review "identified the need to develop a dedicated business intelligence and analysis function …(a) team will be established within the Information management unit of the organisation, sourced from three positions redirected from Quality Services."[82]

In addition, the HQCC Review Report lists the additional staff positions the HQCC considers are needed to implement the future 'service delivery model' and strategic plan. HQCC report that existing staff positions have been redistributed to deliver a new 'service delivery model'.[83]

***Committee comment***

The committee notes that 15% of HQCC staff were temporary in 2010-11. It recommends that a committee of the future Parliament monitor the staffing of the HQCC, including staff retention and turnover rates and the proportion of permanent and temporary staff.

The committee notes that the HQCC Review Report does not give a clear rationale for the additional staff reported to be needed. The committee has not had sufficient time to fully consider the staffing issues raised in the HQCC Review Report since it was received in December 2011. It recommends that a committee of the next Parliament examine this issue further.

# 6 Legislation

The committee asked the HQCC for its views on any necessary amendments to the *Health Quality and Complaints Commission Act 2006,* including proposals which the HQCC had discussed with the former Social Development Committee.

At the public hearing in September 2011 the CEO advised that the HQCC no longer see a need to pursue its independence through legislative change, explaining that independence is "…laid down in the CEO's role and there is quite a firm sense in the legislation that [the HQCC] should be independent."[84]

The HQCC confirmed that some legislative amendments it previously sought were included in the Health Legislation Amendment Bill 2011, which was introduced into the Legislative Assembly on 23

79 HQCC, *Annual Report 2010-11*, p 76
80 ibid, p 81
81 HQCC, *Organisational Review Report*, 21 December 2011, p 10
82 ibid, p 10
83 HQCC, *Organisational Review Report*, 21 December 2011, p 10
84 Hearing Transcript, 7 September 2011, Cheryl Herbert, CEO, HQCC, p 6

August 2011 and subsequently passed. The amendments related to the definition of registration boards, consultation and notification between the HQCC and the Australian Health Practitioner Regulation Agency, how the HQCC may deal with a notification made under the *Health Practitioner Regulation National Law (Queensland)* and the process of a preliminary assessment of a health complaint about a nationally registered provider.[85] Those amendments to the Act came into effect on 24 November 2011.

***Committee comment***

The committee has not identified any changes to the HQCC's legislative functions that are required. It notes that amendments to the HQCC quality functions may be required in future as a result of implementation of the national quality and safety standards.

[85] HQCC, Response to pre-hearing questions on notice, 11 September 2011, p 9

# 7 Organisational review

## 7.1 Introduction

The HQCC advised the committee in a response to a question in the Budget Estimates hearing in July 2011 that it was undertaking an organisational review.[86] The HQCC also raised the review at the committee's public hearing in September 2011 in discussion of investigation staffing.[87]

In November the committee sought information from the HQCC about the organisational review. The HQCC's response to initial questions of 1 November 2011 included advice that:

> Issues identified in the review have been considered by the executive management team and an action plan to implement the new service delivery model and process improvements is in progress. Implementation of the action plan is reviewed quarterly through the organisation's operational performance review process. Many actions are due for completion by 31 December 2011, while implementation of more complex process improvements will continue into 2012.[88]

The committee requested further information about the new service delivery model and the action plan to implement it, details of the opportunities identified for process improvement, and other information about progress of the review. The HQCC provided further information on 23 November 2011, including the project schedule, a diagram titled "Future service delivery model", a "Review action plan" and draft criteria for decisions to commence an investigation.

The HQCC also advised the committee that a "… report on the review outcomes will be provided to the Health and Disabilities Committee in December 2011."[89] The HQCC's *Organisational Review Report* (the HQCC Review Report) was provided to the committee on 21 December 2011.

## 7.2 Purpose and scope of the review

The HQCC Review Report states that it examined complaint management and quality oversight and improvement functions to ensure that the staffing was appropriate to fulfil the objectives of the strategic plan. The review also intended to ensure that the HQCC was operating as efficiently and effectively as possible. Two HQCC staff members led the review and the CEO and executive management team oversaw it.[90] The Review Report states that "One of the key drivers for the internal operational review was the need to consider the investigation process, including the criteria for commencing an investigation."[91]

## 7.3 Outcomes of the review

Most of the HQCC Review Report consists of material already provided to the committee in response to its two requests for information in November 2011. The new information in the HQCC Review Report is: a description of the purpose of the review and approach, a description of staffing the HQCC considers is required to implement the 'future service delivery model', and a short section titled 'Review results'.

The review results reported[92] are, in summary:

- identification of process improvements to the core functions of Complaint Services and Quality Services (the identified process improvements are not specified)

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86 Estimates Hearing Transcript, Cheryl Herbert, CEO, HQCC, p 46
87 Hearing Transcript, 7 September 2011, Cheryl Herbert, CEO, HQCC, p 8
88 HQCC, Response to request for information, 11 November 2011, p 5
89 HQCC, Response to request for information, 23 November 2011, p 7
90 Ibid, p 2
91 HQCC, *Organisational Review Report*, 21 December 2011, p 8
92 Ibid, pp 4-5

- identification of "…the need to build the information collation, analysis and sharing capacity of our organisation to drive healthcare safety and quality improvement…" as shown in a diagram titled 'Future functions of the HQCC'."[93] This diagram was titled 'Future service delivery model' when provided to the committee in response to its request for information about the HQCC's new service delivery model in November 2011
- identification of support and enabling strategies to enact new processes and the model in the 'Future functions of the HQCC' diagram (the strategies are not specified)
- highlighted the need for enhanced data analysis
- identified opportunities to increase sharing of data and information with other agencies and publicly.

The HQCC Review Report states that "most recommendations will be completed by 31 December 2011", and others will continue into 2012.[94]

***Committee comment***

The HQCC advised that it would provide the committee a report on the outcomes of its review in December 2011. The HQCC Review Report was received on 21 December 2011. It consisted largely of material contained in the HQCC responses to committee requests, and also reported some matters as results of the review (summarised above). However the committee considers that the HQCC Review Report lacked clear and tangible results and did not report any outcomes of the organisational review.

### 7.4 Consideration by a future committee

The committee recommends that a committee of the next Parliament consider the HQCC Review Report and the proposed changes to the HQCC operations that arise from it, and their implementation. The changes include the criteria for commencing an investigation; recommendations of an independent review of the conciliation process; devolution of complaints to health providers; and the proposed 'analysis', 'collation' and 'sharing' functions of the HQCC.

[93] HQCC, *Organisational Review Report*, p 4
[94] ibid, p 4

# 8 HQCC Reporting

## 8.1 Annual Report 2010-11

The HQCC Annual Report 2010-11 was tabled in Parliament on 30 September 2011. The Annual Report has been examined by the committee, as referenced throughout this report. The committee commends the inclusion of complaint and investigation case studies to illustrate the issues that consumers complain about and the way the HQCC responds.

While the committee considers that the Annual Report 2010-11 complies with the Queensland Government Annual Reporting Requirements for Queensland Government Agencies, it recommends that future reports include more complete data about complaints. Specifically, the committee noted the following issues about complaint data in 2010-11:

- the number of complaints closed after 'direct resolution', 'early resolution' and because they were 'not confirmed in writing' are aggregated. The committee considers that each should be reported separately
- the number of complaints about each provider type is not fully reported. The total number of complaints received is reported as 2,525;[95] 1,438 about health care organisations and 959 about registered health practitioners, totalling 2,397. The provider type for the remaining 128 complaints is not reported, although the report notes that a small number of complaints about unregistered providers is not reported[96]
- data about complainants' includes their regional location, and the number of complaints from Indigenous people. No information is reported about the number of people from other cultural backgrounds, or the gender of complainants. The HQCC provided the committee with information about the cultural background of complainants, and considers that summary information should be included in Annual Reports.

The committee also noted that reporting of performance against HQCC service standards appeared to be inconsistent in relation to the time taken to complete investigations. Page 17 of the Annual Report shows that 81% of investigations closed in 2010-11 were closed within 12 months, but does not report the actual number closed within 12 months. In contrast, page 23 of the report shows that 48 (68%) of the 70 investigations closed in 2010-11 were closed within 12 months.

It is not clear whether the apparent inconsistency in performance reporting on investigations completed within 12 months in the 2010-11 Annual Report arises from reporting on different data criteria, from an oversight in reporting or for another reason.

***Committee comment***

The committee recommends that the HQCC ensure that future Annual Reports give information about complaints and performance in a clear, consistent and transparent way. In particular, the committee recommends that HQCC Annual Reports include:

- data about the number of complaints that are closed because they were not confirmed in writing, separately from complaints that are closed by 'direct resolution' and 'early resolution'
- complete data about the type of health provider about whom complaints are made, including health providers in professions which are not registered

[95] HQCC, *Annual Report 2010-11*, p 40
[96] ibid, pp 56 – 57

- data about the number of complainants from culturally and linguistically diverse backgrounds
- consistent performance reporting, including sufficient information to enable the achievements that are reported in percentages to be examined.

## 8.2 Other reports

The HQCC has advised the committee of its planned schedule of reports for 2011-12.[97] In December 2011 the HQCC released two reports, one on complaints about access to health services and another about acute and day hospitals' self-assessment of compliance with HQCC standards. During 2011-12 the HQCC plans to release further reports on: HQCC's work in 2011, dental complaints, community experience and perception of health care safety and quality, obstetric and gynaecology complaints and mental health care.

In addition, the HQCC intends to provide the Minister with special reports about: credentialing and defining the scope of clinical practice for doctors employed by Queensland Health and in private hospitals, and follow up special reports on progress in implementing HQCC recommendations; and investigations completed by the HQCC. Under section 173 of the Act, the Minister must table a special report from the HQCC in the Legislative Assembly.

[97] Correspondence to HDC, Cheryl Herbert, CEO, HQCC, 31 January 2012

# 9 Summary of committee recommendations

Most of the issues highlighted in this report arise either from the HQCC's Review Report or from the committee's examination of the HQCC Annual Report under Standing Order 194A(c). Time has not permitted the committee to fully examine issues arising from the HQCC Review Report. Issues related to the HQCC's functions in making standards and monitoring the quality of health services require ongoing examination as national health reforms are progressively implemented.

The committee has recommended that a future committee of the next Parliament continue to monitor or to further examine a number of issues, and that the HQCC's future Annual Reports include particular data. The committee's recommendations are summarised below.

| Committee recommendations to a committee of the next Parliament with responsibility for oversight of the HQCC | Section of report |
|---|---|
| ○ examine the recommendations of the external review of conciliation, those which the HQCC has adopted and progress on implementation of changes to conciliation | 2.6.2 |
| ○ monitor the time taken to complete investigations and any changes that may be desirable | 2.7.2 |
| ○ examine the implementation of draft criteria for decisions to commence an investigation by the HQCC and the impact of any changes on the number and type of complaints that are examined | 2.7.3 |
| ○ examine the cost of an investigation and the methodology by which the average cost of $28,041 was calculated | 2.7.4 |
| ○ consider the HQCC's devolution of complaint issues to health providers, referred to in the HQCC Review Report | 2.8.1 |
| ○ continue to monitor developments in national safety and quality standards for health services and the quality standards made by the HQCC, and report to the Legislative Assembly on the implications | 3.2.2 |
| ○ monitor HQCC activities to make its complaint services accessible to people from CALD communities, and the complaints received from people in those communities | 4.1.1 |
| ○ monitor the staffing of the HQCC, including staff retention and turnover rates and the proportion of permanent and temporary staff | 5 |
| ○ examine the rationale for additional staff requirement reported in the HQCC Review Report | 5 |
| ○ examine the HQCC Review Report and the proposed changes that arise from it and their implementation. In addition to specific recommendations noted above, those changes include proposed 'analysis', 'collation' and 'sharing' functions of the HQCC | 7.4 |

| Committee recommendations to the HQCC | Section of report |
|---|---|
| ○ that the HQCC ensure that future Annual Reports give information about complaints and performance in a clear, consistent and transparent way. In particular, the committee recommends that HQCC Annual Reports include:<br>○ data about the number of complaints that are closed because they were not confirmed in writing, separately from complaints that are closed by 'direct resolution' and 'early resolution'<br>○ complete data about the type of health provider about whom complaints are made, including health providers in professions which are not registered<br>○ data about the number of complainants from culturally and linguistically diverse backgrounds<br>○ consistent performance reporting, including sufficient information to enable the achievements that are reported in percentages to be examined | 8.1 |

# Appendix

### Statutory functions of the Health Quality and Complaints Commission

The HQCC functions are in sections 13 – 16 of the *Health Quality and Complaints Commission Act 2006*.

**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.