

Issues Paper for Bundaberg Hospital Commission of Inquiry

Complaints Management

July 2005

TABLE OF CONTENTS

EXECUTIVE SUMMARY	3
SECTION A	5
1. Introduction	5
2. Better Practice Complaints Management	5
3. Relationship with Quality and Safety	7
4. Accreditation	7
5. The number of complaints relating to Queensland Health services and providers	7
SECTION B	8
6. Issues related to frontline management – Level 1 Complaints Handling	8
6a Analysis of complaints management by Queensland Health, Health Service Districts	8
6b Central coordination and review of complaints management in Queensland Health Level 2 complaints handling	9
6c External Complaints Management - Level 3 Complaints Handling	10
7. Impact on Better Practice Complaints Management Criteria	12
8. Other jurisdictions	14
SECTION C	15
9. Future models for management of complaints within Queensland Health	15
9a Model 1 - Central Health Complaints Management Model	15
9b Model 2 - Regional Complaints Management Model	16
10. Future Models - Level 3 Complaints Handling -‘One Stop Shop’	18
11. Integration of Complaints Management with Governance Arrangements	20
11a Clinical Governance Framework	20
11b Quality and Safety	20
11c Clinical Culture	20
11d Complaints related to clinical performance	21
11e Relationship between elements of the system – comparative analysis	22
11f Protection for employees and for other people making public interest disclosures (Whistle Blowers)	23
12. Conclusion	24
Appendix 1	25
Appendix 1 Summary of Systems Operating in other Jurisdictions	25
Appendix 2 Implementing Model 1	28
Appendix 3 Glossary of terms	31

EXECUTIVE SUMMARY

A comprehensive overview of complaints management within Queensland Health was provided in Queensland Health's initial submission to the Bundaberg Hospital Commission of Inquiry (the Inquiry). The submission¹ detailed current processes for managing complaints about public health services and health providers. (Table 1 and Flowchart 1 detail this process). Current complaints management processes have been based on the achievement of best practice. These have been assessed by the Queensland Ombudsman, who reported that "Queensland Health's complaints management system compares very favourably to those in most other departments and meets nearly all of the criteria for good complaints management"². However, there remains considerable scope for improvement to complaints management processes to meet the needs and desired outcomes of patients, consumer groups and staff. These outcomes include increased access, transparency and responsiveness and protection for the complainant and respondent.

Several jurisdictions such as New South Wales, Victoria, Western Australia and the United Kingdom's National Health Service have recognised similar issues with regard to complaints management as those identified by Queensland Health. Most are undertaking major reviews or restructures of complaints management systems as part of achieving comprehensive quality and safety systems. While better practice principles are accepted and known; how these can be realised in practice remains unproven.

Discussion Paper No 3, Complaints Handling Systems in the Queensland Public Health Sector, released by the Commission of Inquiry, raises the following issues for Queensland Health and the broader health system:

- there is inefficient and ineffectual handling of complaints of serious misconduct or malpractice
- current culture prevents open discussion and disclosure of complaints and the open communication of events and complaints between management and clinicians
- opinions of senior medical staff do not appear to carry the weight of influence that would be expected
- complaints and issues are not dealt with in a timely and appropriate manner
- there is a lack of provision for compulsory imposition of interim protection mechanisms
- options to raise issues and complaints outside hospital management do not exist or present a degree of complexity and confusion as to discourage all but the most persistent
- options to escalate such complaints either within Queensland Health, Health Rights Commission or Health Practitioners Registration Boards are not well known or understood.

This paper presents three complaints management models that consider these issues and are dependent on the future organisational configuration of Queensland Health. The paper specifically considers the proposal for a "one stop shop" raised by the Inquiry. All models propose a three level approach for escalation, management and review of complaints and are based on the principle that local resolution is the preferred approach. The "one stop shop" option as proposed by the Inquiry does not embrace local resolution as the preferred approach, to the extent of the other models.

Model 1 Central Health Complaints Management Model

Model 2 Regional Complaints Management Model

Model 3 External Complaints Management Model – "One Stop Shop"

This paper does not address the proposals outlined in *Discussion Paper No 4 – Service Provision and Regulatory Functions in the Queensland Health System*, released by the Inquiry on 1 July 2005.

¹ <http://www.health.qld.gov.au/inquiry.pdf>

² Queensland Ombudsman, Complaints Management Project Queensland Health, Feedback on Audit and Assessment Checklist, March 2004

These proposals need to be considered in the context of the Forster Review. The Queensland Government is preparing a separate response to issues contained in the Inquiry's *Discussion Paper No. 2 – Whistleblowers in the Queensland Public Health Sector*.

Section A

1. Introduction

- 1.1 Complaints management systems are important to support the right of patients to raise issues about their treatment and expectations of care. They are one mechanism to identify individual practices issues or systemic issues. Any system of complaints management must be based on the principle that local or frontline resolution of complaints is the essential first level of complaints management because generally patients' or staff concerns can be responded to directly and most effectively. To improve the quality of services delivered to patients, a complaints management policy must also be an integral component of a comprehensive quality and safety system.
- 1.2 To be effective, these systems must be complemented by an organisational culture which upholds patients' interests as the first consideration; values its staff and promotes trust and respect between professions; practises open disclosure and continuous improvement and learning; invests in clinical leadership and governance and adopts risk management strategies.
- 1.3 This paper considers a number of issues in relation to complaints management by both Queensland Health and other agencies who operate within the broader health systems. The models presented are based on an analysis of national and international practice and research.
- 1.4 In this paper, a complaint refers to any expression of dissatisfaction by a patient; advocate acting on behalf of a patient; staff member or health service provider. Complaints from staff largely fall into three categories: conditions of employment; public interest disclosure; and peer competency.
- 1.5 The Patient Complaints and Surveys Program undertaken between 1999 and 2003 established the Queensland Health Complaints Management Policy and provided comprehensive training for nominated complaints coordinators in Health Service Districts³. Queensland Health's current system of complaints management includes frontline resolution as the preferred approach. It includes three levels of management enabling the escalation of complaints should local resolution fail. Beyond the local level there are multiple entry points including access through the Minister for Health, Director-General, Chief Health Officer or externally through the Health Rights Commission, Crime and Misconduct Commission, Ombudsman, State Coroner, Queensland Medical Board, Queensland Nursing Council and the Health Practitioner Registration Boards. The current system presents a number of issues for complainants around access, transparency, internal review, integration of investigations and information and for staff, safe mechanisms to progress issues of clinical competency. A further issue is the need to have interim protection arrangements that ensure patient safety during investigations.

2. Better Practice Complaints Management

- 2.1 Queensland Health's complaints management system was reviewed in an Audit and Assessment Checklist by the Queensland Ombudsman as part of the Complaints Management Project in 2003. A report to the Director-General dated 8 March 2004 stated that "Queensland Health's complaints management system compares very favourably to those in most other departments and meets nearly all of the criteria for good complaints management". While this assessment considered the process was good in theory, the key issue is what happens in

³ <http://www.health.qld.gov.au/complaints/documents/15184CMP&I.pdf>

practice. Systematic implementation relies heavily on a culture that embraces open disclosure, continuous improvement and systematic performance review.

2.2 The Queensland Ombudsman's *Guidelines for Complaints Management* recommend three level of complaints management⁴

- Level 1 - Frontline assistance - local management
- Level 2 - Internal review
- Level 3 - External review

Better practice complaints management encompasses the criteria identified in the Australian Standard *Complaints Handling 4269:1995*. This standard is the foundation of most, best practice systems used in Australia. These criteria apply to complaints management at the three levels recommended by the Queensland Ombudsman and form the basis of the current policy in Queensland Health.

- Demonstrated commitment and culture to complaints management
- Fairness – the procedure is fair to all parties and provides a just outcome
- Resources – there are adequate resources to manage complaints
- Visibility – the process is publicised and information is provided about the rights to complain
- Access – the complaints handling process is accessible to all
- Assistance – assistance is available to complainants
- Responsiveness – complaints are dealt with quickly
- Charges – there are no fees imposed for participation in the complaints processes
- Remedies – the complaints handling process has the capacity to determine and implement remedies
- Data Collection – there is appropriate, systematic recording of complaints and outcomes
- Systemic and recurring problems – complaints are classified and analysed for identification of systemic and recurring problems
- Accountability – there is appropriate reporting on complaints handling against documented performance standards
- Reviews – the process is reviewed regularly to ensure that it is delivering effective outcomes in an efficient manner.

⁴ <http://www.ombudsman.qld.gov.au>

Relationship with Quality and Safety

- 3.1 Complaints management can not be considered in isolation from other quality and safety related activities. At the local level, complaints management needs to occur in conjunction with other risk management strategies such as incident management and open disclosure⁶. For complaints to be taken seriously, the complaints management system needs to be an integral part of incident reporting and systems review⁷
- 3.2 An effective complaints handling system requires comprehensive policies based on the criteria outlined above as well as a culture that embraces learning and continuous improvement. A key barrier to effective complaints handling is health providers' reluctance to report adverse incidents and adopt a learning culture⁸. Central to a learning culture is the need to strike a balance between identifying the systemic cause of medical error and professional accountability.

3. Accreditation

- 4.1 Under accreditation requirements from the Australian Council of Health Standards (ACHS), complaints management is considered under standard 2.4.

Standard 2.4

The Governing Body is committed to consumer participation as a strategy to assist the improvement of quality, safe care and service.

Criterion 2.4.2 - Information is readily available for consumers/patients so that they are informed of their rights and responsibilities.

- 4.2 Accreditation reviewers assess the processes that the facility or District has put in place regarding complaints management. They also assess how information from complaints is collated, and how Districts use the information and act upon it as an indication of continuous improvement.

4. The number of complaints relating to Queensland Health services and providers

- 5.1 In 2004-05, Queensland Health managed over 1 million acute episodes of care to hospital and around 8.7 million non-admitted occasions of service.⁹
- Queensland Health, Health Service Districts receive approximately 10,000 complaints per annum.
 - The Minister for Health and Director-General receive approximately 2,000 complaints per annum.

⁶ National Open Disclosure Standard http://www.safetyandquality.org/articles/Publications/OpenDisclosure_web.pdf

⁷ as per 2

⁸ Legislative Council, General Purpose Standing Committee No 2, Complaints Handling within NSW Health, Report 17, June 2004

⁹ Queensland Government, Ministerial Portfolio Statement, Minister for Health, 2005-06, p1-16, p1022.

- The Health Rights Commission receives approximately 1,100 complaints per annum relating to Queensland Health.
- Audit and Operational Review Branch, Queensland Health receives approximately 167 referrals per annum for official misconduct investigations relating to staff.
- Approximately 150 formal grievance processes relating to staff per annum are lodged within Queensland Health.
- Queensland Health receives approximately 10,000 compliments per annum.
- The Queensland Ombudsman's Office receives approximately 275 complaints per annum about Queensland Health.

(Note: these numbers are not mutually exclusive)

Section B

5. Issues related to frontline management – Level 1 Complaints Handling

6.1 The vast majority of complaints are resolved either by the individual service provider, line manager or District Executive. An effective and efficient frontline complaints management system provides immediate feedback and timely responses. It increases confidence as complainants feel that their needs are addressed and valued. In the context of health it is also necessary to manage the volume of complaints received efficiently. A study of complaints by patients attending 67 hospitals from 1997-2001 in Victoria, showed that from over 13 million patients presenting, 19,156 patients or their representatives lodged 26,785 issues of which 84.5% were easily resolved locally.

6a Analysis of complaints management by Queensland Health, Health Service Districts

6.2 A survey of Queensland Health, Health Service Districts was undertaken in May 2005 to identify the status of complaints management and handling within Districts. This survey indicated that the complaints management practices of Health Service Districts vary across the following domains:

- Receipt, handling and resolution of complaints from both staff and patients including:
 - Recording of complaints and subsequent monitoring and trending
 - Collection of performance indicators for complaints and the monitoring of these performance indicators
 - Positions for complaints coordinators, who they report to and the training and support provided to them
- Referral and escalation of complaints within the District and to areas outside the District
- Processes for making public interest disclosures
- Management of clinical competency issues arising from complaints.

- 6.3** The survey indicated that the District complaints management systems seem to act in isolation to other safety and feedback strategies, such as clinical incident management, workplace health and safety and community engagement.
- 6.4** An analysis of the information received through the survey and an assessment of current practice shows that:
- The building of capacity for complaints management includes development, implementation and sustainability of both business and information systems. It requires dedicated staff resources, as well as templates, forms, posters and other support material, for example, consistent use of posters across Districts to inform patients and staff of their right to complain, where to go and what to expect.
 - Training, development and continuing education in complaints handling, complaints management and investigative processes, need to be developed for complaints coordinators, managers, all staff dealing with patients, consumers and staff. Complaints handling must be a part of induction and orientation for new staff.
 - There is a lack of coordination between complaints management and issues related to official misconduct, performance accountability (especially related to clinical performance), grievances and employment arrangements, and system and service capability. While coordination may occur at the District executive level, there is no coordination at a central level.
 - There is a lack of policy and procedures relating to staff related complaints. There is little guidance for managers on how to manage complaints related to clinical performance, including impaired performance and appropriate courses of action such as disciplinary action, suspension and referral to registration boards. There is no guidance on the management of complaints about administration or management.
- 6.5** While the emphasis is on achieving local resolution, if this is not achieved complainants are faced with an array of options for escalating their concerns. This can be difficult to navigate as the appropriate option is dependent on the underlying issue of the complaint and can result in considerable frustration. Table 1 provides examples of two types of complaints and the possible agencies that can assist in resolution, depending on the issue.
- 6b Central coordination and review of complaints management in Queensland Health Level 2 complaints handling**
- 6.6** The Patient Complaints and Surveys Program was established as part of the Quality Improvement and Enhancement Program in Queensland Health in 1999. This program led to the development of the Queensland Health Complaints Management Policy which was endorsed in July 2002. This policy, which focuses on the management of complaints from patients, has led to the standardisation of processes related to patient complaints. Districts were provided with comprehensive packages for training and education in complaints management and training. District representatives were also trained to take on the role of complaints coordinator. The role of complaints coordinators in Districts is a requirement of the Complaints Management Policy, however, it was the responsibility of the District to identify who would undertake this function.
- 6.7** While the development program was completed in June 2003, there was an expectation that Districts would sustain their commitment to complaints management. Some functions of the

program were continued by the Integrated Risk Management Program. In November 2003, additional training was provided to thirty District staff who would act as complaints coordinators and provide holiday relief. Extensive work occurred in the development of an information system to support data collection that would support complaints management and the role of complaints coordinators. Consultation on the business specifications for the information system was extensive to ensure that the system would meet operational requirements. Implementation of this system is expected to commence in mid-July 2005 and will be managed by the Patient Safety Centre.

6.8 More recent review of the central complaints management processes has identified the need to address the following aspects of complaint management:

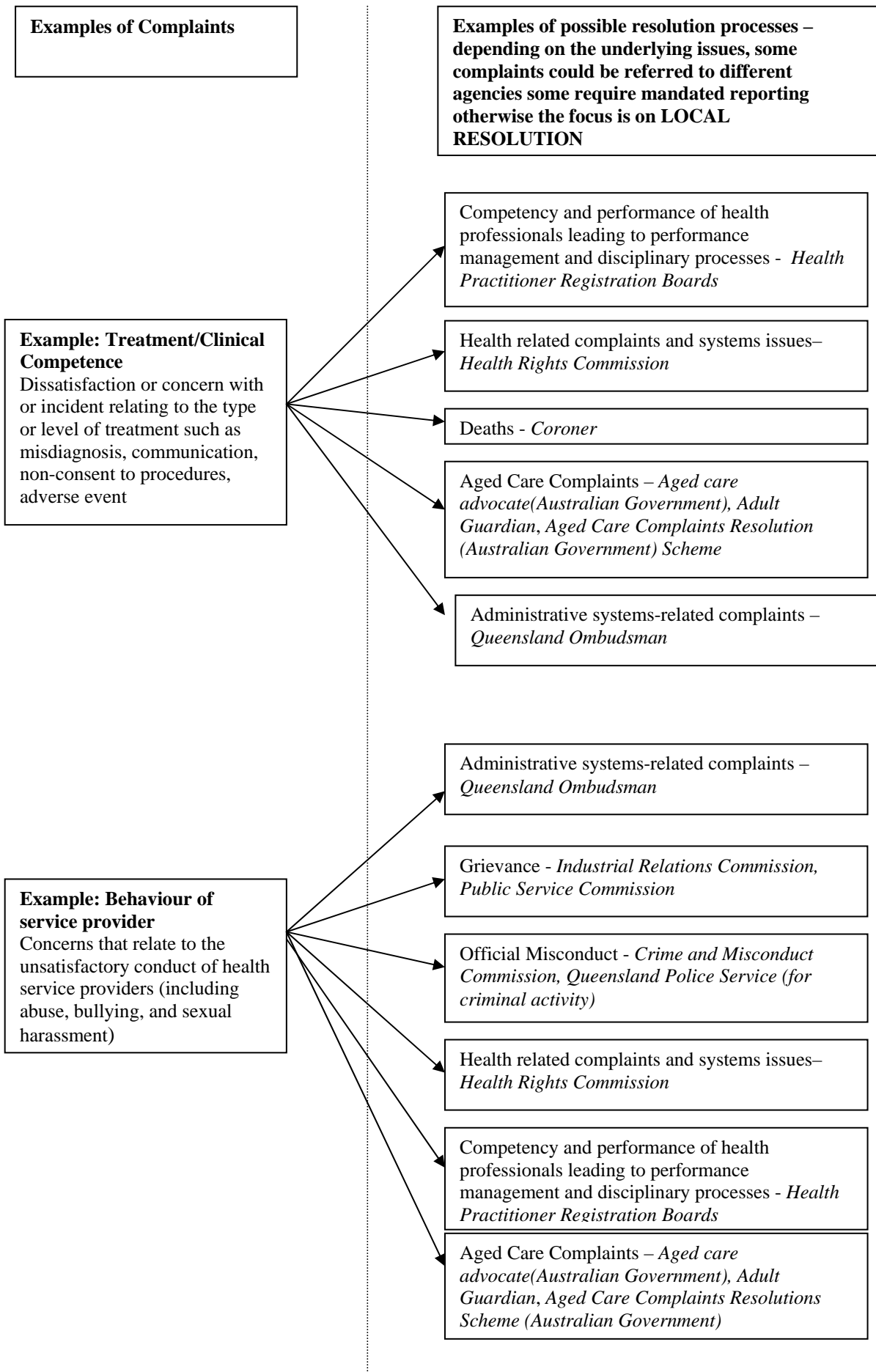
- a mechanism, independent of line management, for staff to raise complaints about administration, management and safety related issues, including clinical competence of peers and service capability.
- integration and coordination of information about sources of complaints and complaints management within Queensland Health. No one information system brings together patient complaints, staff complaints or grievances to enable analysis of the performance of local areas. A central area is required to perform benchmarking, trending and auditing of complaints processes in Districts. Integration of complaints information with incident information and audit is desirable.
- a system to capture when complaints are referred or notified by a District to the next level of management or when complaints are referred from Queensland Health to an external agency other than the Crime and Misconduct Commission.
- governance arrangements to oversee the strategic management of complaints and accountability for complaints management in Queensland Health.
- establishing an appropriate balance between “systems” approaches and individual professional accountability. The newly formed Patient Safety Centre is taking a systems approach to adverse incidents and prevention of harm caused to patients. However, there is no identified area where a complaint regarding individual professional competency is assessed or managed. This is reliant on both administrators and clinicians meeting their positional responsibilities effectively.

6c External Complaints Management - Level 3 Complaints Handling

6.9 Table 1 outlines the current external mechanisms for dealing with complaints about health services and health providers in Queensland. These agencies have different areas of responsibility and expertise. Some manage complaints when local resolution has failed while others manage direct referrals as a result of a mandated or statutory requirement.

6.10 Complainants have to decide on the most appropriate agency to direct their complaint. This multi-agency approach poses several problems in relation to complaints management. For example, for some complaints, separate aspects of the complaint are investigated by different agencies which can result in recommendations being made in isolation from those of another agency. This presents difficulties for the various agencies in coordinating their activities, but also for staff, patients and their advocates in determining the best place to lodge a complaint.

Table 1 **Examples of agencies that may deal with different aspects of a complaint about a health service or health provider**



7. Impact on Better Practice Complaints Management Criteria

- 7.1 This multiple agency approach poses a number of challenges in meeting the better practice complaints management criteria.
- 7.2 There are multiple resources for complaints handling in the various organisations. Indeed, there may be concurrent investigations conducted by different agencies into different aspects of the same event^{10, 11}.
- 7.3 Visibility and access are an issue for complainants, since there are multiple web sites, information sheets and complaints forms. Some agencies only accept complaints in writing. This may disadvantage minority groups and non-English speaking complainants¹².
- 7.4 While some agencies provide support and assistance for the complainant and encourage complainants to have a 'support' person with them, there is no general health advocate in Queensland. There can be particular problems for practitioners who are the subject of investigations, who may experience anger, negativity towards patients and inability to practice in a positive frame of mind^{13, 14}.
- 7.5 There is limited consideration of whether complainants are satisfied with the different approaches taken by agencies to investigation and resolution of their complaints. A survey of 500 complainants, concerning complaints that had been finalised by the New South Wales Health Care Complaints Commission during February 1996 and August 1997, showed that most complainants were dissatisfied with the outcome¹⁵. The focus of complaints handling is on resolution. In a study of complaints lodged by patients attending Victorian Hospitals (1997 – 2001)¹⁶, 84.5% of complaints were easily resolved with over half of these resolved with an apology or explanation. However some complaints do progress to mediation (conciliation) and some to investigation. In a study by Daniel, Burn and Horarik (1999)¹⁷ more complainants thought that service providers had been disciplined than actually were.
- 7.6 Data collection requires appropriate systematic recording of complaints, resolutions and outcomes. Each of the different bodies records complaints and their outcomes on separate systems. The same categories may be used or indeed may not be relevant for use by the different agencies. Different data fields may be recorded. For example, from information published in the Health Rights Commission annual report 2003 – 2004¹⁸, it is difficult to determine the actual number of complaints that resulted from services provided by Queensland Health.
- 7.7 Due to lack of consistency in data collection and data integration, systemic and recurring problems may not be able to be identified. There may not be sharing of information between the agencies or cross referencing to even identify when a complaint is being investigated by

¹⁰ Page 9 of the Health Rights Commission Annual Report 2003 – 2004

¹¹ Paterson, R, Van Wy, M, Patients' rights in New Zealand: complaints resolution and quality improvement, *Medicine and Law* 2004 23: 29 - 37

¹² http://www.ombudsman.qld.gov.au/publications/documents/5_Visibility_and_Access.pdf

¹³ Cunningham W, The Immediate and long-term impact on New Zealand doctors who receive patient complaints, *The New Zealand Medical Journal*, 23 July, 2004 117 (1198),

¹⁴ Spencer A, Personal Views: Punishment by process, *BMJ* 2004; 328:774 (27 March)

¹⁵ as per 3

¹⁶ Taylor D, Wolfe RS, Cameron PA, Analysis of complaint lodged by patients attending Victorian Hospital, *MJA* 5 July 2004; 181 (1): 31 - 35

¹⁷ As 8 above

¹⁸ <http://www.hrc.qld.gov.au/pdf/AnnualReport0304.pdf>

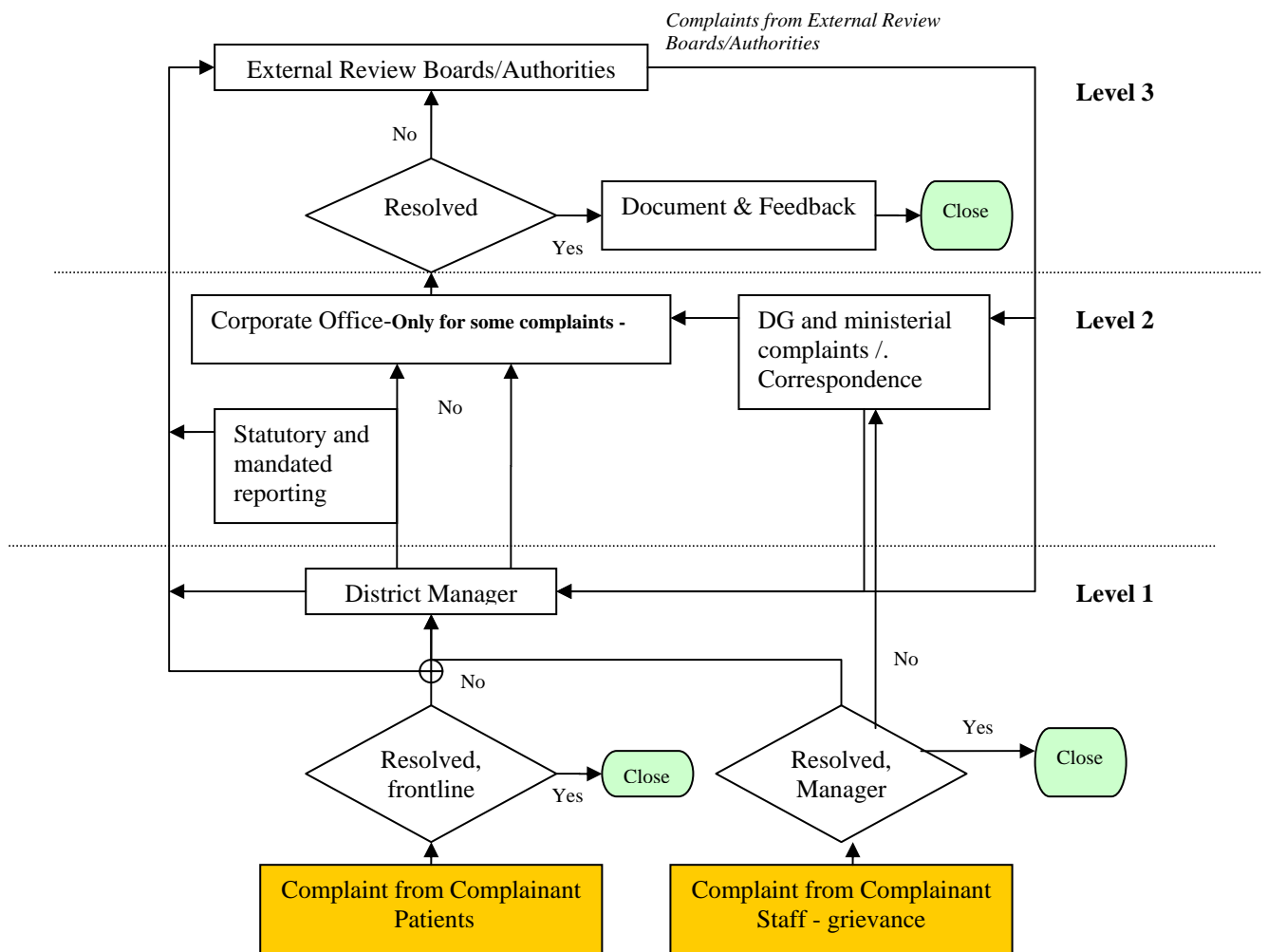
different agencies. This may only become apparent in high profile cases. The Final Report for the Special Commission of Inquiry into Campbelltown and Camden Hospitals¹⁹, outlines arrangements with the New South Wales Coroner and the New South Wales Independent Commission Against Corruption so that the work of the Commission of Inquiry and those agencies did not overlap.

7.8 Each of the agencies develops annual reports. For a Department like Queensland Health, annual reports do not provide sufficient information to identify issues related to complaints received about Queensland Health.

7.9 The following flowchart presents a summary of the current processes operating at each level of complaints management in Queensland Health.

7.10 The focus is on local frontline resolution with referral to a central area by the District Manager for Official Misconduct and Level 3 Grievances. Otherwise complaints are referred to external agencies such as the Health Rights Commission. As detailed above, this model poses several issues including minimal central coordination of complaints management, no integration or analysis of data or information which may identify individual or systemic issues and isolated investigation and resolution processes.

Flowchart 1 Summary of current process for complaints management in Queensland Health



¹⁹Final Report for the Special Commission of Enquiry into Campbelltown and Camden Hospital, Brett Walker, July 2004

8. Other jurisdictions

- 8.1 There is significant variation in the way complaints are managed within other Australian state health jurisdictions. Most states are currently reviewing policies and procedures related to complaints management. In some states, the processes have been developed as a result of recommendations made from major inquiries. The extent to which current complaints management policies and procedures have been implemented and reflect current practice is not evident.
- 8.2 Under the Medicare Agreements (1993-1998) the States and Territories agreed to establish independent complaints bodies to resolve complaints made in respect of public hospital services. The Australian Health Care Agreement (AHCA) (2003-2008) stipulates the ongoing maintenance of the independent complaints bodies with minimum standards consistent with the 1993-1998 agreement. Each state body is to be:
- independent of the State's Hospitals and the State's Department of Health
 - given powers to investigate, conciliate and adjudicate upon complaints received
 - given a role in recommending improvements in the delivery of hospital services in respect of which the Commonwealth provides financial assistance.
- 8.3 All states have in place independent statutory complaints bodies. However, the degree of their independence varies. In South Australia, Tasmania, and the Australian Capital Territory, the statutory bodies report to the Minister responsible for the health portfolio, while in New South Wales, Victoria, Western Australia and the Northern Territory, these bodies report to Parliament or a Parliamentary Committee.
- 8.4 All jurisdictions, have local (facility based) complaints handling processes in place. This is the first level of complaints management. In establishing the second level of complaints management, central coordinating bodies in state health departments have various roles that may consist of the establishment of policies and procedures, complaints handling training, implementation of complaints information systems and collection and collation of data and performance measures.
- 8.5 A comparison of these various systems is provided in Appendix 2.
- 8.6 An analysis of these systems indicates that the following elements support good mechanisms and behaviours.
- Investment in local resolution as the predominant method of management.
 - Managing intake of complaints for either level 2 or level 3 complaints handling to provide a single point for complaints lodgement. This reduces confusion for complainants on where to go.
 - Timely assessment and investigation requiring coordination of complaints handling processes and the establishment of performance standards that are monitored and reviewed for each agency involved. This is particularly important when there are dependencies between the different components of the investigations.
 - Responsiveness that demonstrates complainants are listened to and treated seriously. This is supported by training and development, post resolution surveys of complainants and the establishment of advocate or support services.

- A monitoring system that consolidates relevant information from different agencies, identifies trends, and provides feedback to identify patterns of individual behaviour or systemic issues.

Section C

9. Future models for management of complaints within Queensland Health

9.1 Three models have been developed to address issues identified to date by both internal review and the Commission of Inquiry into Bundaberg Hospital.

9.2 All models are dependent on the:

- development of capacity and resources at a the local level to support local resolution
- support of external agencies in the management of complaints from staff and patients.

9.3 The development of a central function in Queensland Health for the management of complaints is required for coordination and analysis of information, training and monitoring. Location of this function is dependent on future administrative and structural arrangements.

9.4 All models require the development of interim protection arrangements for complainants and the public. At the same time these arrangements also need to respect the rights of respondents.

9a Model 1 - Central Health Complaints Management Model

9.5 In this model, local resolution remains the predominant method of management. This model requires the development of significant capacity through dedicated positions within Health Service Districts.

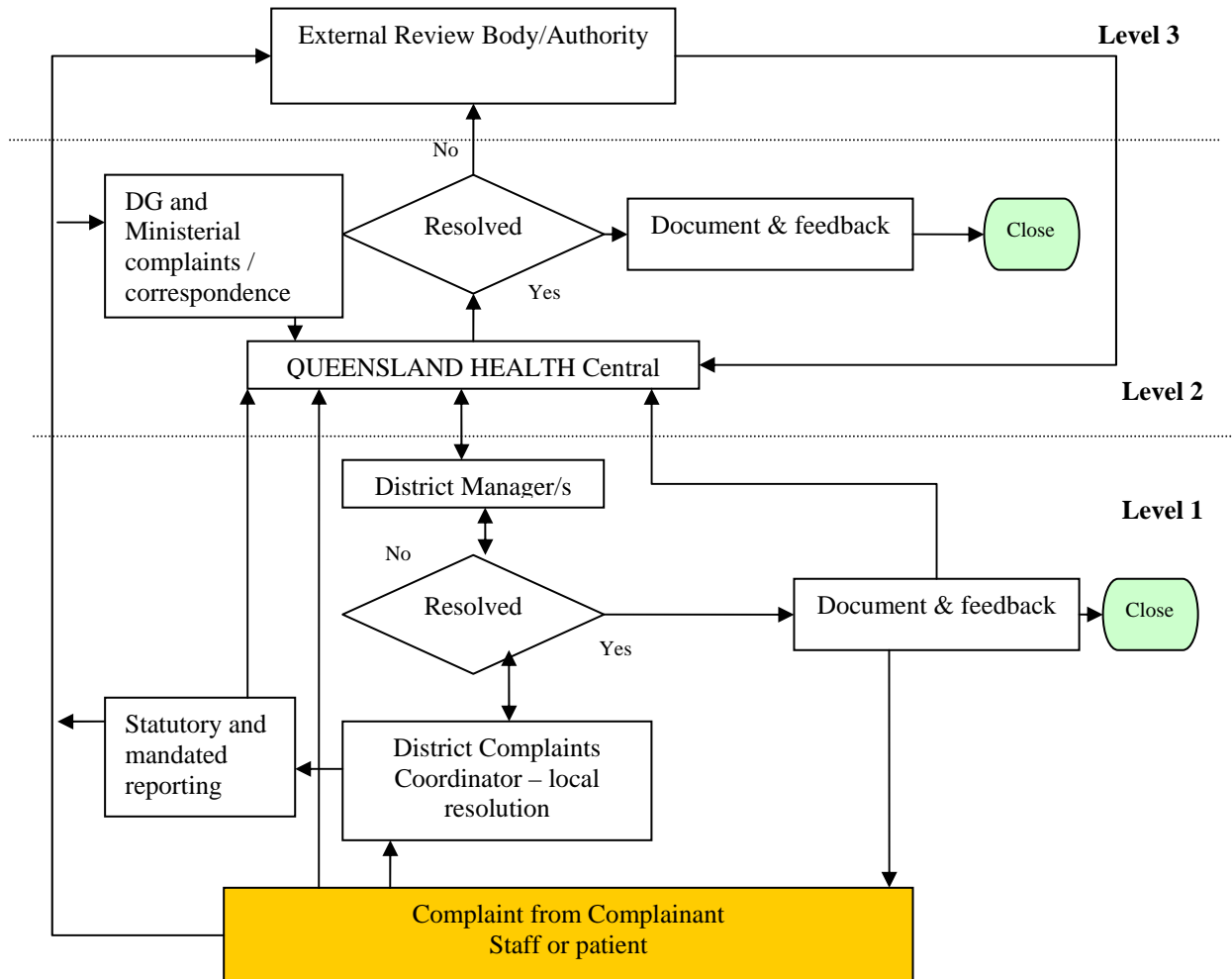
9.6 Escalation of unresolved and high level complaints and those that require mandated or statutory reporting would be to a Queensland Health central complaints coordination area. This area would also provide a mechanism for staff to raise concerns and complaints regarding District services, activities and professional competency issues. It would also monitor and review local complaints handling, oversee the implementation of the complaints management information system, provide complaints handling training (including investigation) for complaints coordinators, managers and staff.

9.7 Given the numbers of complaints managed, this would be the most effective and efficient way of improving and coordinating the local resolution and management of complaints. This model also promotes one central group to liaise with external agencies.

9.8 The Level 2 central complaints management area would need to maintain some level of independence from line management so that staff in particular can raise issues. Significant policy and procedure development would be required to ensure transparency in the management of complaints. Governance arrangements that support integration with the quality and safety agenda would also need to be clearly articulated.

9.9 A detailed explanation of how this model could be implemented is provided in Appendix 3.

Flowchart 2 Central Health Complaints Management Model (Model 1)

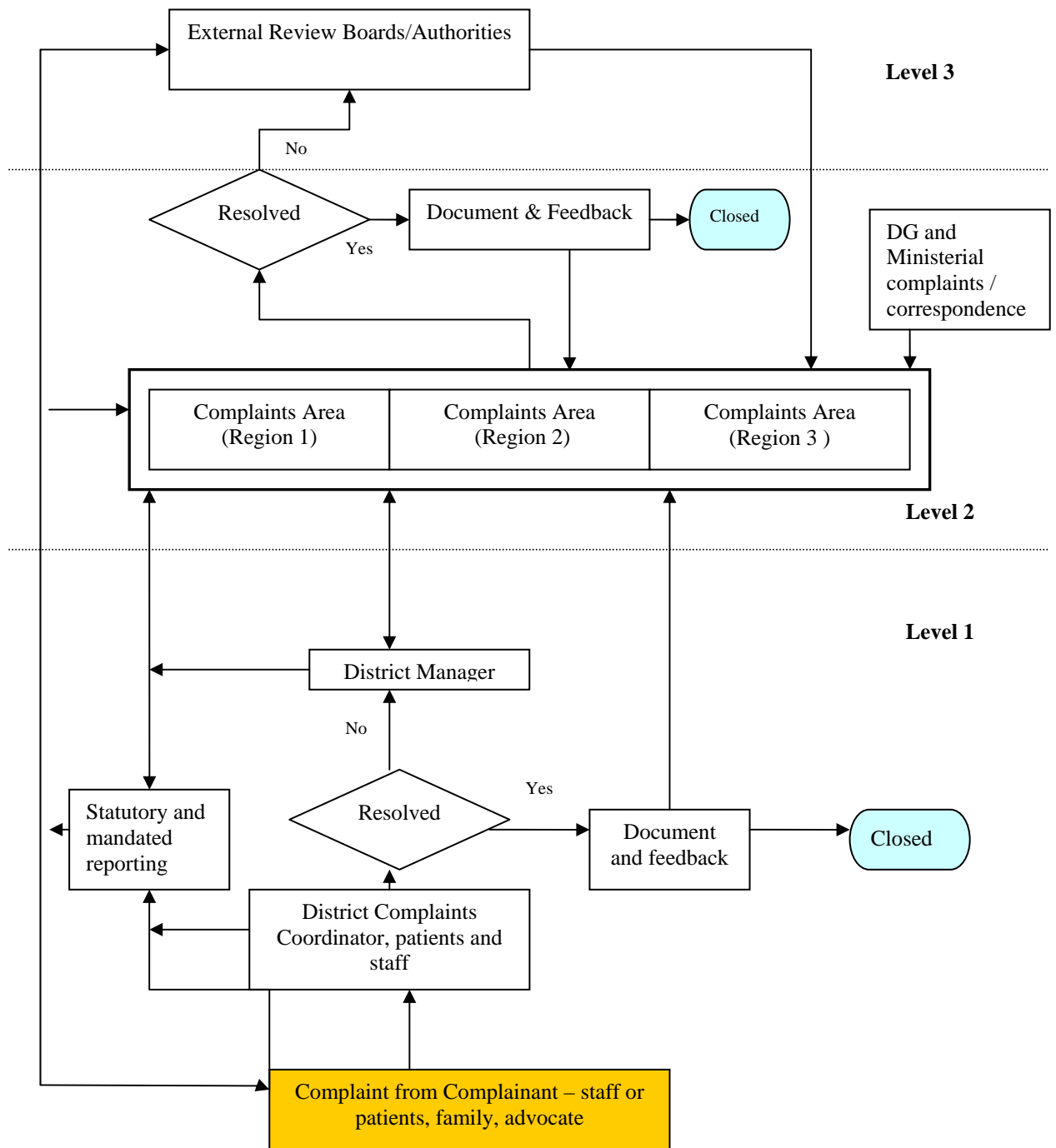


9b Model 2 - Regional Complaints Management Model

9.10 This model allows for a Queensland Health sponsored alternative structure. The overseeing and coordination role of the central group described in Model 1, would be duplicated within each regional structure. Data coordination, training, escalation of unresolved and high level complaints would occur in each different regional area.

9.11 There may potentially be lack of coordination between the structures with each area focusing on different priorities, for example different training may be provided at different times. There is also potential for administrative duplication, for example data analysis, between the areas. There would be numerous areas liaising with external agencies.

Flowchart 3 Regional Complaints Management Model (Model 2)



10. Future Models - Level 3 Complaints Handling - 'One Stop Shop'

- 10.1 Flowchart 4 presents a possible model for complaints handling for Level 3 complaints management that incorporates a 'one stop shop' external agency. This model requires all complaints to be referred to a single external 'one stop shop' agency. As stated in *Discussion Paper No 3, Complaints Handling Systems in the Queensland Public Health Sector*²⁰, this agency would receive complaints from any interested party, refer complaints to be addressed by the appropriate authority, monitor the investigation and handling of complaints, ensure that the investigation of the complaint is escalated to the appropriate level and ensure the complainant received appropriate and timely feedback. It is not clear whether in addition to these roles, the "one stop shop" as proposed by the Inquiry has an investigation function. The "one stop shop" would require a clear charter to avoid presenting another layer of complexity for complainants.
- 10.2 This model does not promote local presentation and resolution of complaints to the extent of the other models discussed. In relation to Queensland Health, it is possible that the agency would handle over 12,000 complaints per annum, of which more than 8,000 could have been managed locally on initial presentation without double handling. This does not include numbers of complaints from other service providers.
- 10.3 This agency would also need to audit, provide training and education, and coordinate state-wide approaches as well as coordinate and integrate external agencies approaches. There would be extensive resource requirements to implement this across the state and to include all health services.
- 10.4 The suggestion by the Inquiry that this could be achieved by the establishment of a "Health Ombudsman" is noted. In the *Report of the Strategic Review of the Queensland Ombudsman 1998*, Professor Ken Wiltshire strongly recommended that the term "ombudsman" should only be used for that office, and that the previous trend of applying it more widely should ceased and be reversed where possible.²¹
- 10.5 The Health Rights Commission already has a number of these functions. It would be preferable to strengthen the role and capacity of the Commission to provide an overarching coordination and investigatory role in relation to escalated complaints, with a stronger focus on system change and monitoring, as envisaged by the review of the Health Rights Commission in 2002²². Local resolution must remain the predominant method of resolution.
- 10.6 Future models for Level 3 complaints handling or external management impact largely on the relationships between the following agencies:
- the Health Rights Commission
 - Ombudsman
 - State Coroner
 - Health Practitioner Registration Boards
 - Queensland Nursing Council
 - Queensland Health

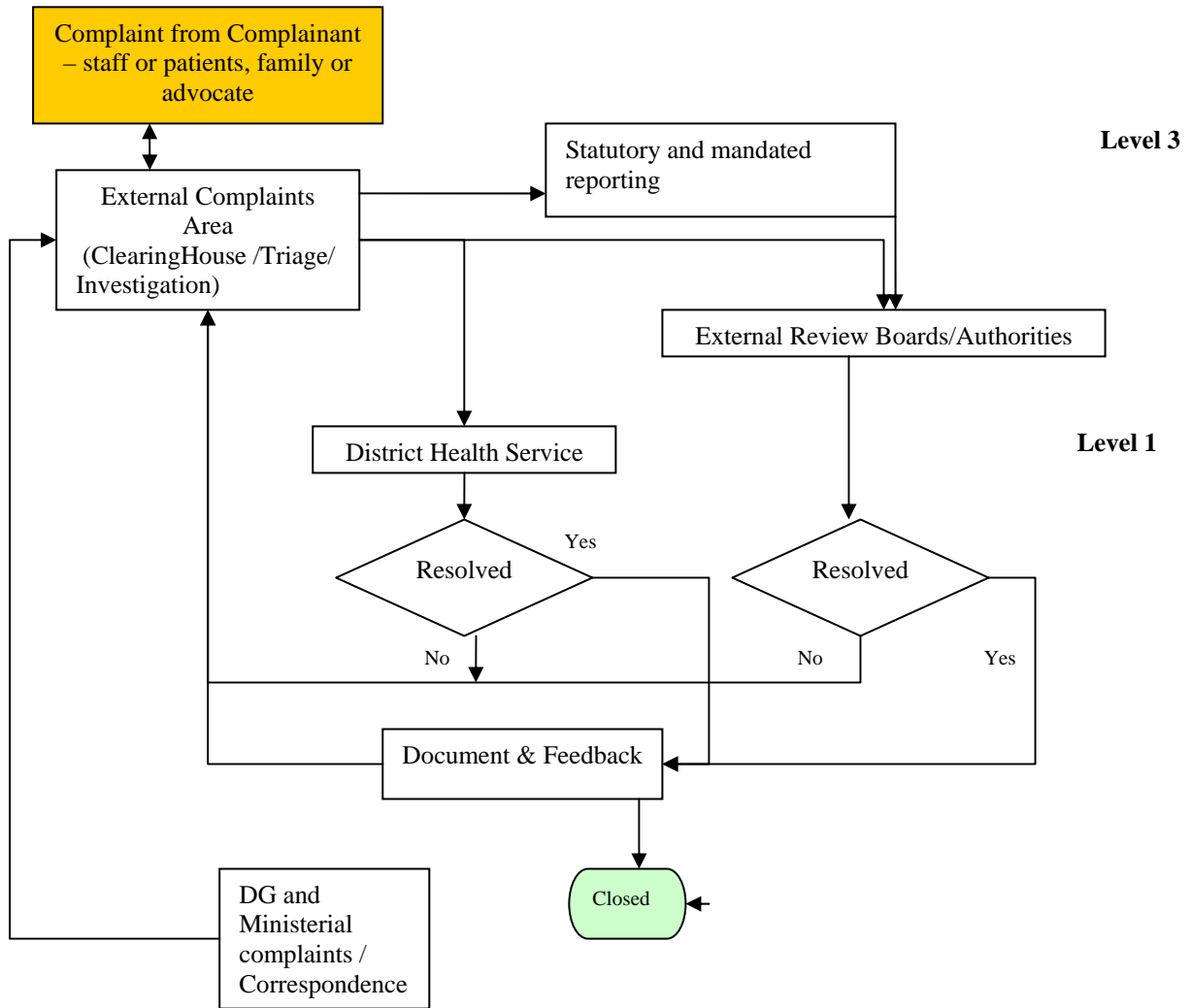
²⁰ Bundaberg Hospital Commission of Inquiry, Discussion Paper No:3 Complaints Handling Systems in the Queensland Public Health Sector, June 2004

²¹ Professor K Wiltshire, Report of the Strategic Review of the Queensland Ombudsman (Parliamentary Commissioner for Administrative Investigations, 1998, R28, p8.

²² The Consultancy Bureau, The Report on the Review of the Health Rights Commission, 2002.

10.7 An enhanced role for the Health Rights Commission would require an examination of the specific roles of these agencies to avoid duplication and overlap. Further consideration of the relative investigative powers of these bodies to investigate the conduct and clinical competence of individual practitioners and to instigate either disciplinary or prosecutorial action is required.

Flowchart 4 External Complaints Management Model (Model 3)



11. Integration of Complaints Management with Governance Arrangements

11.1 Any complaints management system must be considered and integrated with the broader corporate and clinical governance arrangements within Queensland Health. In particular, the complaints management system must be considered as part of an integrated approach to clinical governance, quality and safety and clinical performance within a culture of learning and continuous improvement.

11a Clinical Governance Framework

11.2 Complaints management is one of the elements of a Clinical Governance Framework. Further consideration of the framework for clinical governance in Queensland Health is required, including mechanisms to support clinical leadership, measure performance and compliance and promote learning and clinical practice improvement. Approaches to these issues are currently being progressed through the Patient Safety Centre and the Centre for Clinical Practice Improvement in Queensland Health.

11b Quality and Safety

11.3 Synthesis of information from complaints, clinical audits and clinical incidents needs to occur as part of the implementation of the quality and safety agenda. At the local level, the Open Disclosure Project, which all Health Ministers have endorsed, will provide improved communication with patients and their families and carers, as processes are put in place for incidents (adverse events) to be disclosed to patients with follow-up, including the sharing of outcomes of investigations and analysis.

11.4 The management of complaints is only one component of a quality and safety agenda. It is imperative that findings and recommendations from the complaints management process are able to be implemented and monitored. This is especially important in relation to systems improvements when the recommendations have application beyond the individual complaint.

11c Clinical Culture

11.5 A culture open to disclosure and discussion of error and mistakes, that values complaints not as a criticism but as a learning opportunity, is fundamental to effective complaints management^{25,26}. Central to this culture is the balancing of system-based approaches with

²⁵, Responding to formal complaints about the emergency department: Lessons from the service marketing literature, Doig G, Emergency Medicine Australasia; 2004, 16: 353 – 360

²⁶ The immediate and long-term impact on New Zealand doctors who receive patients complaints, Cunningham W, The New Zealand Medical Journal, 23 July 2004 117 (1198)

individual professional accountability and recognition that not all errors are caused by carelessness²⁷.

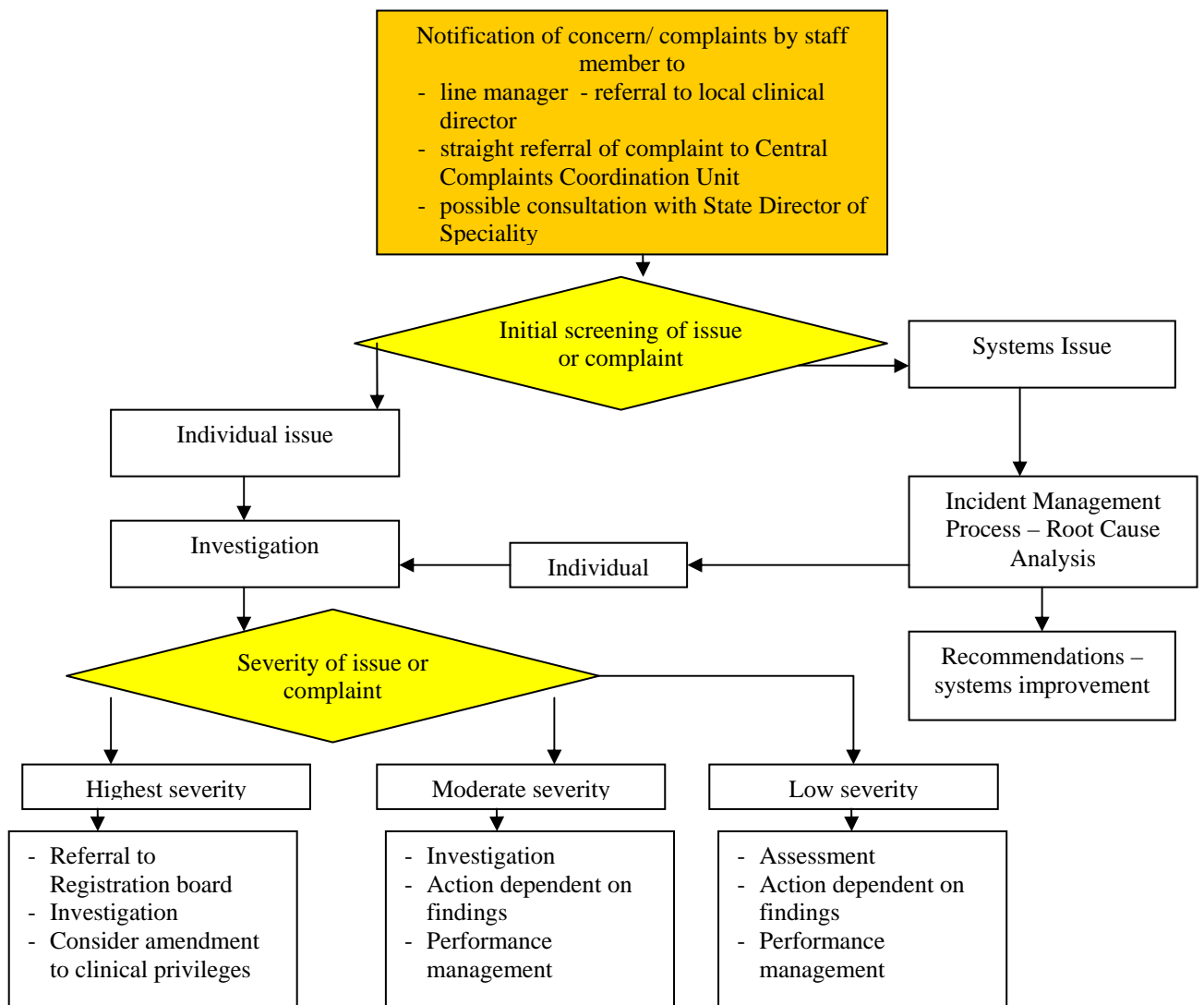
11d Complaints related to clinical performance

- 11.6 Specific issues relate to complaints regarding the clinical performance of individual practitioners. These issues may arise as a result of a complaint from a patient or their advocate²⁸, from an incident or series of incidents being reported or as a complaint from a staff member. Queensland Health needs to develop explicit processes and policies to deal with this issue within the quality and safety systems and clinical governance framework. Levels of severity of concern or complaint need to be developed and expert advice needs to be provided at the point of decision making in relation to this issue, such as the ‘initial screening of the issue or complaint’ and decision regarding the ‘severity of the issue or complaint’ as shown in Flowchart 5.
- 11.7 It is worth noting that New South Wales has introduced legislation mandating the reporting of clinical competency issues by Chief Executive Officers of Area Health Services. This complements the legislation which protects staff undertaking ‘root cause analysis’ of very high and extreme risk incidents and the disclosure of the root cause analysis reports, so that they can not be used to defend or implicate service providers. This is necessary in order to support the balance between systems approaches to harm minimisation and professional accountability. It is recommended that Queensland reviews its legislation to ensure adequate provisions for this balance.
- 11.8 The underlying principle for managing a complaint or concern about a clinician is that patient safety is paramount and needs to be maintained. The process for managing a complaint or a concern about a clinician needs to provide clear guidance on how to protect patients during the process from initial screening of a complaint or concern, through the assessment of severity of the complaint or concern and ultimately, any action taken by a registration board. The complaints management system should outline the process for performance review, clinical competency assessment and determination of disciplinary actions ranging from remediation, supervision, restriction of duties, to revision of clinical privileges and suspension. Timely assessment of the complaint is vital, not only to protect patients but to ensure natural justice and protection of the individual practitioner’s reputation.

²⁷ Final Report of the Special Commission of Inquiry into Campbelltown and Camden Hospitals, Brett Walker, 30 July 2004

²⁸ http://www.jcaho.org/accredited+organizations/ambulatory+care/sentinel+events/se_sources.htm

Flowchart 5 – Escalation of complaints or concerns relating to clinical performance

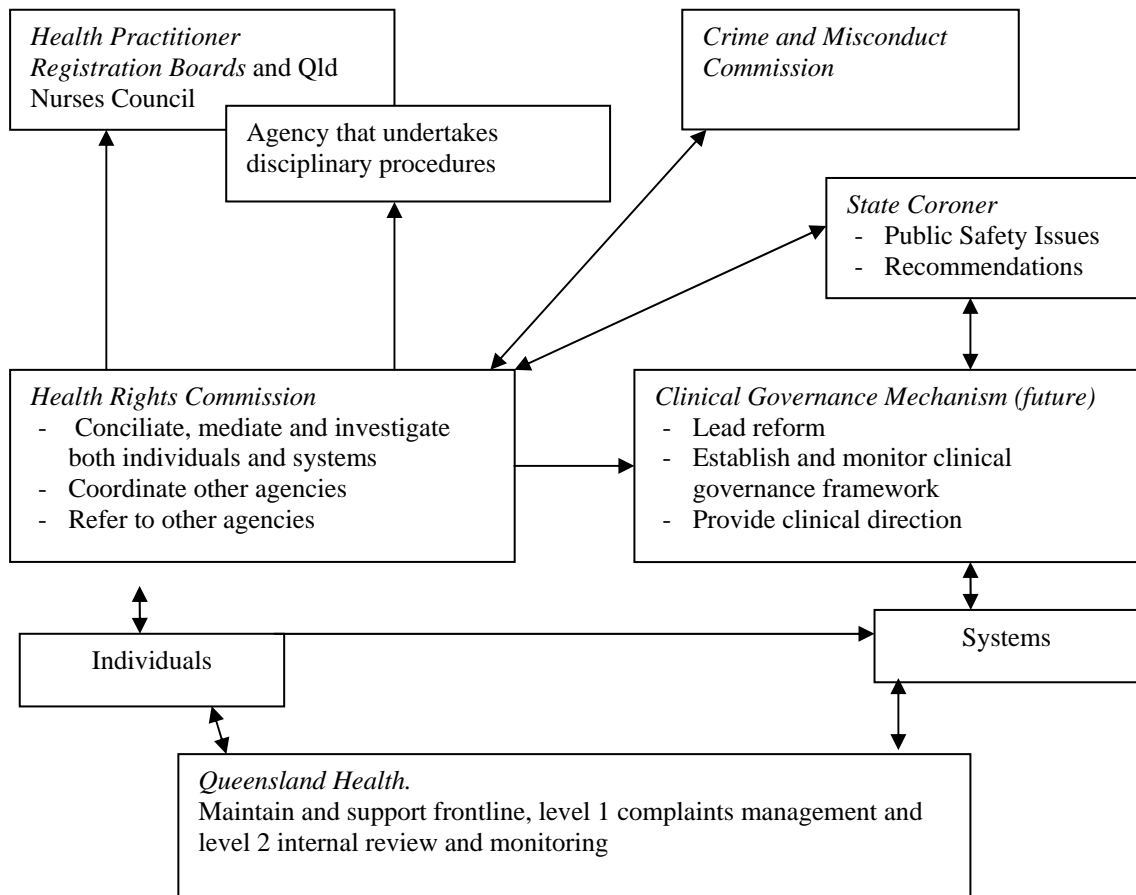


11e Relationship between elements of the system – comparative analysis

- 11.9 Flowchart 6 demonstrates that the relationship between the elements of the system presents a balance of accountabilities for registration of practitioners, management of service systems, mediation and resolutions of complaints, investigating criminal activity and official misconduct and public safety.
- 11.10 Trending and monitoring of issues needs to occur so that problem areas can be identified. Eventually, some proactive integrated auditing and assessment of systems will need to be established to prevent problem areas from developing or to minimise the harm caused.
- 11.11 Effective triage and referral to the appropriate area may require an initial level of investigation and assessment skills and time²⁹. Based on the information contained in a complaint, it may not be known what the underlying issues are and certain skills and powers may be required to ascertain appropriate referral.

²⁹ Health Rights Commission Annual Report 2003 – 2004

Flowchart 6 - Summary of Level 3 Complaints Management Process – relationships of agencies



11f Protection for employees and for other people making public interest disclosures (Whistle Blowers)

11.12 It remains clear that Whistle Blowers are an important last resort for safety systems³⁰ and it is necessary to provide protection for employees and for others making public interest disclosures. Much has been written regarding the establishment of additional legislation and policy regarding reporting of public interest disclosures, especially in relation to protection of individuals against future retribution. Faunce and Bolsin (2004) recommend that ‘increasing legislative protections indicating the role of whistleblowers must be formally acknowledged and incorporated as a ‘last resort’ component of clinical governance structures’³¹

11.13 The Queensland Government is preparing a separate response to issues contained in the Inquiry’s Discussion Paper No. 2 which is entitled “whistleblowers in the Queensland Public Health Sector.

³⁰ Three Australian whistle-blowing sagas: lessons for internal and external regulation
Faunce TA, Bolsin SNC.MJA 2004; 181 (1) 44 -47

³¹ As 29

12. Conclusion

- 12.1 This paper has presented three models to illustrate how the future management of complaints by Queensland Health could occur within the current structural arrangements. Ultimately the model adopted will depend on the future structural arrangements for both Queensland Health and the broader health system. However, any model of complaints management must be imbedded within a strong clinical governance framework and a culture that embraces open disclosure and quality and safety. The fundamental principle for any future model is that local resolution is the preferred approach in the first instance.
- 12.2 The preferred and best practice approach to complaints management is local resolution, as this is likely to satisfactorily resolve the majority of issues relating to patients and staff. An enhanced Health Rights Commission could perform the coordination and integration role for complaints that are escalated, as envisaged in the “one stop shop” concept. Further consideration of this approach should occur in the context of the outcomes of both the Commission of Inquiry and the Forster Review.

Summary of Systems Operating in other Jurisdictions

1. New South Wales and New Zealand

- 1.1 There have been several inquiries into complaints management in New South Wales Health since issues regarding Campbelltown and Camden Hospitals came to public attention³². The Final Report of the Special Commission of Inquiry into Campbelltown and Camden Hospitals was published in July 2004. In this report the Commissioner expressed concern about the need for balance between adopting a systems approach and performance accountability. In New South Wales this has resulted in changes in legislation regarding complaints management by the Health Care Complaints Commission and protection of root cause analysis and systems approaches.
- 1.2 The Parliamentary Committee on the Health Care Complaints Commission (HCCC)³³, considered the creation of two separate bodies; one to conduct investigations and one to resolve complaints by all other means. This Committee also considered models such as the New Zealand Health and Disability Commissioner, which includes the ability to appoint a Director of Proceedings who acts independently of the Health and Disability Commissioner and decides, on referral from the Commissioner, whether to institute proceedings under the Health and Disability Commissioner Act 1994. The HDC can also appoint a Director of Advocacy who also acts independently. The parliamentary committee in New South Wales recommended the transfer of the Health Conciliation Registry to the HCCC, who would be similar to the position of Director of Advocacy in New Zealand. The New South Wales Patient Support Service and Patient Support Officers have been transferred to Health Conciliation Registry. Patient Support Officers work with both parties to identify the issues and facilitate a negotiated agreement and consensual resolution. This effectively created a 'one stop shop' for dealing with all complaints about health care services in New South Wales³⁴.
- 1.3 In New Zealand the Health and Disability Commission is the single point of entry for all complaints about patient care except for confidentiality, with increased flexibility to refer complaints back to the provider to resolve or to refer immediately for mediation.³³
- 1.4 The Queensland Health Rights Commissioner, in the Commission's 2003 – 2004 Annual Report indicated that the Commission no longer has the capacity to investigate individual registrants and can only investigate systems issues across an organisation³⁴. The Commissioner further states that 'without the power to compel provision of relevant information (from individuals), the Commission often finds that it has no other option but to immediately refer a complaint against an individual registrant to the relevant registration board which does have the power to obtain such information'.

³² Van der Weyden, MJ, The 'Cam affair': isolated incident or destined to be repeated? MJA 2004; 180 (3) 100-101

³³ Report into alternative dispute resolution of health care complaints in New South Wales, Committee on the Health Care Complaints Commission, Parliament of New South Wales, Report No. 5/53 October 2004

³⁴ as for 12

³³ Paterson, R. Complaints and quality: handle with care! The New Zealand Medical Journal, 23 July 2004 117 (1198)

³⁴ page 9, Annual Report 2003 -2004, Health Rights Commission

2. National Health Service – United Kingdom

- 2.1 The National Health Service has had a single complaints system since 1996 that covered hospital, community and primary care services and could handle concerns about both administration and clinical treatment. In this system the complaints were first considered and responded to by the service provider (known as local resolution) and if dissatisfied, complainants could ask a ‘convener’ (usually a non-executive member of the organisation) to arrange a review by a panel of lay people with access to any necessary clinical advice. If complainants remained dissatisfied, they could complain to the Health Service Ombudsman.
- 2.2 In 1999 – 2001, it became clear that there were major difficulties with this single system with the most important structural failure the perceived lack of independence of the convening decision and the review process generally. The Health Service Ombudsman for England³⁵ has identified several issues that need to be addressed as a result of partial implementation of changes in 2004 and the recommendations from inquiries into situations where serious failings in systems or standards (Bristol Inquiry³⁶, Ayling³⁷ and Neale³⁸ Inquiries and the 5th report of the Shipman Inquiry³⁹).
- 2.3 These include:
- special training in the handling sensitive matters for Patient Advice and Liaison Services and the Independent Complaints Advocacy Services staff
 - the establishment of systems to ensure that complaints about the same practitioner working in different organisations could be linked
 - training for all middle managers in particular, but all staff in complaints handling
 - an independent element to the system⁴⁰
- 2.4 As well as Patient Advice and Liaison Services and Independent Complaints Advocacy Services, the National Health Service has a new independent review mechanism called the Commission for Health Care Audit and Inspection (now known as the Healthcare Commission).
- 2.5 The Healthcare Ombudsman outlines a 3 stage process – Stage one remains local resolution, Stage 2 is progression to the Health Care Commission and Stage 3 is the Health Service Ombudsman. The ombudsman has recommended that the National Health Service set core standards that need to be met by all providers and that these are monitored as part of the regulatory and inspector roles of the Health Care Commission⁴¹.

³⁵ The Health Service Ombudsman for England, Making things better? A report on reform of the NHS complaints procedure in England HC 413, 2 March 2005 www.ombudsman.org.uk

³⁶ Learning from Bristol. The report of the public inquiry into children’s heart surgery at the Bristol Royal Infirmary 1984 – 1995 CM5207

³⁷ Committee of Inquiry: Independent Investigation into how the NHS handled allegations about the conduct of Clifford Ayling July 2004, CM6298

³⁸ Committee of Inquiry: Independent Investigation into how the NHS handled allegations about the conduct of Richard Neale August 2004, CM6315

³⁹ Fifth report – safeguarding patients: lessons form the past – proposals for the future. CM6394

⁴⁰ The Health Service Ombudsman for England, Making things better? A report on reform of the NHS complaints procedure in England HC 413, 2 March 2005 page 3

⁴¹ Guidance to support implementation of the National Health Service (Complaints) Regulations 2004

- 2.6 Key elements of the National Health Service complaints management system are⁴²:
- patient centeredness
 - advocacy
 - single area for taking unresolved complaints and ensuring independent review of the second stage of National Health Service Complaints Process – Healthcare Commission
 - overarching body of the Health Service Ombudsman
- 2.7 As a result of the inquiries and questions regarding fitness to practice, the National Health Service is also considering ‘revalidation or the assurance that doctors are up to date, ethical and in all aspects fit to practice’⁴³

Key elements of complaints handling arising from the National Health Service(UK), New Zealand and New South Wales models

- Maintain a focus on local resolution in the first instance that is centred on support of patient and consumers. Level 1 complaints handling is strengthened and supported to optimise local resolution and frontline management.
- Level 2 reviews in the National Health Service have been transferred to an external independent body (Health Commission). This may be due to the sheer volume of complaints, 86,536 complaints were received for hospital and community services in 1999 – 2000¹. The Health Ombudsman for England in 2003- 2004 received 4,700 complaints¹. Publication of the numbers of complaints requiring level 2 review has not been published for the National Health Service.
- New South Wales, New Zealand and the National Health Service provide an ‘advocacy’ service or some other type of patient support service.
- All ensure that an independent body where unresolved complaints can be lodged is established. The New Zealand and New South Wales models include a ‘one stop shop’ where complaints are triaged and referred for local resolution, or for investigation and mediation (conciliation).
- The relationship between investigations of complaints by various bodies is formalised and integrated.

⁴² <http://www.dh.gov.uk>

⁴³ Irvine, DH,. Time for hard decisions on patient centre professionalism, MJA 2004: 181 (5) 271 – 274.

Implementing Model 1

1. Visibility and Access - Managing intake

- 1.1 Intake would be managed by two areas within Queensland Health:
- 1.2 Locally (Health Service District) funding would be allocated for dedicated resources (staff) to manage complaints from both patients and staff.
- 1.3 An internal central unit would also be established to provide for an alternative entry point or point where complaints can be lodged if staff or patients are not satisfied with local resolution or they do not wish to lodge a complaint at the local level. For complaints that are not satisfied with local resolution, this would not be a rehandling of the complaint but an assessment and referral if appropriate. The Queensland Health central complaints unit would act as a coordination point for other external agencies and for other points of entry for complaints such as Ministerial and Director-General correspondence.
- 1.4 Complaints would be accepted via web (web based complaints form), email, phone, face to face, letter and possible hotline. Active promotion of these methods would occur via posters, inclusion on health service literature (handouts) and the Queensland Public Patients' Charter. Awareness sessions would be available for all staff.
- 1.5 A single external agency (such as an enhanced Health Rights Commission) could be the point for all health consumers to take unresolved complaints or disputes. The Queensland Health central complaints unit could act as a coordination point for this agency.

2. Assistance

- 2.1 Assistance could be provided to support patients, the patients' families and other advocates and staff to lodge complaints. Specific processes would be used for complainants who are cognitively impaired, non-English speaking or from a cultural background where making a complaint is difficult.

3. Timely assessment / investigation

- 3.1 Performance standards would be set and monitored for local, internal and external mechanisms. These would be reported to respective authorities on the regular basis. A timely decision would be communicated to the complainant from the local complaints coordinator or the central group, regarding whether the complaint warrants mediation, investigation or referral. Investigation processes would be initiated promptly and undertaken by appropriately trained staff.
- 3.2 Trained and dedicated investigators are currently located within the Special Investigations Team, Audit and Operational Review Unit. Staff trained in 'root cause analysis' approaches are employed within the Patient Safety Centre and will be soon located in each District with specialist training and provision of patient safety officers. There is also a proposal for a specifically trained investigation unit to be developed to address formal staff grievances.

3.3 One area of need remains within the proposed central complaints unit, where investigators would be needed for the timely investigation of unresolved complaints especially those related to performance issues.

4. Responsive – people are listened to and treated seriously

4.1 Processes would be established to survey complainants and to monitor satisfaction rates with complaints resolution processes.

4.2 Monitoring of organisational improvement activities which occurs as a result of complaints would also be monitored and benchmarked. It is worth noting that in a retrospective review of Victorian Health Department complaints from 1997 to 2002, very few complaints led to a procedure or policy change (1.7%)⁴⁶. The optimal rate of organisational improvement activities which occurs as a result recommendations from a complaint investigation or from trending complaint categories needs to be established.

4.3 Outcomes of complaints investigation need to be included as part of the quality improvement cycle and the quality and safety agenda to ensure both local implementation of solutions and where applicable state wide implementation.

5. Monitoring system to identify trends

5.1 As a matter of urgency:

- the implementation of an information system that supports consumer feedback needs to be fully funded and supported.
- this information system needs to be extended to include all complaints management, including staff complaints.
- implementation and use of the system needs to be mandated in all areas.
- business systems changes need to be supported with dedicated staff to manage and coordinate complaints within Districts
- complaints from patients need to be linked to incidents reported by staff. This needs to be integrated and coordinated at a District level as well as for the whole of state.
- data analysis staff will need to be dedicated within the central complaints unit to ensure data completion, monitoring of trends and production of benchmarking reports. These reports would be provided to the Director-General and to external agencies such as the Health Rights Commission.

⁴⁶ Complaints from emergency department patients largely result from treatment and communication problems Taylor, D, Wolfe R, Cameron PA, Emergency Medicine, 2002 14: 43 – 49

6. **Training and Education**

- 6.1 Training and ongoing development and education would be coordinated by the central complaints unit. This unit would also provide mentoring, support and ‘just in time’ training for complaints coordinators. This area would have extensive expertise in management and investigation of complaints.
- 6.2 Training in complaints management and investigation processes would be provided at three levels. The first priority would be comprehensive skilling of complaints coordinators; the second would be training for managers in Districts who deal with complaints such as Directors of Nursing and Medical Superintendents; and the third would be training for all staff. Training would be for both the management of staff and patient complaints.

Glossary of terms

‘Administrative action’ is an act or omission of an administrative character done or made by, in or for a public sector entity, and includes, for example-

- (a) a decision or failure to decide; and
- (b) a formulation of a proposal or intention⁴⁷.

An **‘adverse event’** is an incident in which unintended harm resulted to a person receiving health care.

‘Care type’ defines the overall nature of a clinical service provided to an admitted patient during an episode of care, or the type of service provided by the hospital for boarders or posthumous organ procurement. The care type changes when a principal clinical intent changes.

‘Complaint’ is an expression of dissatisfaction or concern with an aspect of a health care service (made by consumers, their carers or others). Complaints may be expressed orally or in writing and may be made through a complaints process or as part of other consumer feedback mechanisms such as consumer survey or focus groups (NSW HCCC)^{46, 47}.

A **complaint** is any expression of dissatisfaction with a product or service offered or provided⁴⁸.

‘Complaints handling’ encompasses the structures, guidelines and procedures that are used to report and respond to complaints.

‘Complaints management’ process as an organised way to respond, record, report and use complaints to improve the services.

‘Dispute’ is a pursued unsatisfied complaint

‘Episode of Care’ – the period of admitted patient care between a formal or statistical admission and a formal or statistical separations, characterised by only one care type.

A **‘Grievance’** is a personal complaint or difficulty about a work related issue that affects a staff member and that he/she considers to be discriminatory, unfair or unjustified.

‘Incident’ is defined as an event or circumstance which could have lead or did lead to an unintended and/or unnecessary harm to a person and/or complaint, loss or damage.

‘Maladministration’ is widely defined to cover illegal, arbitrary, oppressive or improper public sector ‘administrative action’.⁴⁹ As well **“maladministration”** is administrative action that is unlawful, arbitrary, unjust, oppressive, improperly discriminatory or taken for an improper purpose⁵⁰.

⁴⁷ Schedule 6 – Whistleblowers Protection Act 1994

⁴⁶ Queensland Health Complaints Management Policy 15184,
<http://www.health.qld.gov.au/complaints/documents/15184CMP&I.pdf>

⁴⁷ The Australian Council for Quality and Safety in Health Care, Better Practice Guidelines on Complaints Management for Health Care Services (July 2004)

⁴⁸ Australian Standard, Complaints Handling 4269: 1995

⁴⁹ Section 8(3) Whistleblowers Protection Act 1994.

⁵⁰ Schedule 6 – Whistleblowers Protection Act 1994

‘Near miss’ is an incident that did not cause harm.

‘Non-admitted patient occasion of service’ occurs when a patient attends a functional unit of the hospital for the purpose of receiving some form of service but is not admitted. A visit for administrative purposes is not an occasion of service.

The **Sentinel Event List** is a prescribed list of events. In Queensland Health, **Sentinel Event** is defined as an undesired event that signals that some serious or sentinel has occurred and warrants in-depth investigation.

‘Separation’ is the process by which an admitted patient completes an episode of care. A separation may be formal or statistical.

‘Open disclosure’ is the open discussion of an incident that resulted in harm to a patient while receiving health care⁵³.

⁵³ http://www.safetyandquality.org/articles/Publications/OpenDisclosure_web.pdf