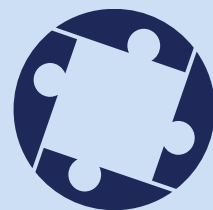


The Office of the Health Complaints Commissioner Tasmania



Annual Report

2023–24



Independence
Impartiality
Fairness
Respect



Health
Complaints
Commissioner
Tasmania

The Honourable President
of the Legislative Council

The Speaker of the
House of Assembly

Pursuant to section 12 of the *Health Complaints Act 1995*, I present to the Parliament the Annual Report of the Office of the Health Complaints Commissioner for 2023–24.

Yours sincerely

Richard Connock

HEALTH COMPLAINTS COMMISSIONER
8 November 2024

About this report

This report describes the functions and operations of the Office of the Health Complaints Commissioner Tasmania for the year ending 30 June 2024.

It is available in print or electronic viewing format (visit www.healthcomplaints.tas.gov.au/publications) to optimise accessibility and ease of navigation. It can also be made available in alternative formats to meet the needs of people with a disability. Requests should be directed to 1800 001 170 or Health.Complaints@healthcomplaints.tas.gov.au.



Acknowledgement of Country

In recognition of the deep history and culture of this Island, we would like to pay our respects to all Tasmanian Aboriginal people, the past and present Custodians of the Land.

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Message from the Health Complaints Commissioner

The year in review has been another largely positive one for my Office.

As reported last year, the recruitment of additional staff on a permanent basis as a result of increased recurrent funding enabled us to fill positions that had been vacant for several years.

Changes to staffing, particularly the retirement of the Principal Officer, Health Complaints, the continuing secondment to the Department of Health of a Senior Investigation Officer, and the resignation of a part time Conciliation Officer to take up an appointment elsewhere, had a minor effect on productivity. The recruitment process for a new Principal Officer has now been completed, with that new officer shortly to commence, and an Investigation Officer is acting as Senior Investigation Officer, with their substantive position shortly to be back filled. We have not yet recruited to the Conciliation Officer position.

This has meant an overall decrease in the number of FTEs from 6.6 FTEs at the end of June 2023 to 4.8 at the end of the reporting year, though as noted there are currently two vacancies. My Office has nonetheless been able to deliver on the services for which we exist – the resolution of health complaints and the improvement of the Tasmanian health system – in a timely way.

For example, we have been able to continue to address the backlog of complaints that has existed over a number of years. As the data bears out, we again significantly reduced the number of complaints carried forward from the previous year – these complaints were reduced by almost 40% in 2022-23 and by 41% this year. The number of open cases at the end of the reporting year had also come down from 180 to 75, a reduction of 58%.



In 2022–23 there was a minor decrease of 1% in the total number of complaints and enquiries received, from 1,178 to 1,162. There was, however, a 23% decrease in the number of complaints, from 628 to 485. This is a significant reduction, and appears to be due to our changed processes and the Intake and Assessment Officer providing complainants with more information in the enquiry stage about how to best handle their complaint.

Specifically, the Officer provides information about how complaints are assessed by this Office and the general requirement contained in s25(5)(d) of the *Health Complaints Act 1995* that complainants, in the first instance, attempt to resolve their complaint with the health service provider before lodging a complaint with this Office. The Officer ensures that the complainant understands and agrees with this course of action. An email is sent to them with information about lodging concerns with the health service provider (including a sample letter), and contains information about lodging complaints with the Office if they remain unhappy after direct resolution has been attempted. Fact sheets about how this Office manages complaints and how to lodge concerns with the health service provider are also given to complainants.

[The Intake and Assessment Officer] is helping to restore relationships between complainants and health service providers and gives complainants the tools and knowledge about complaint resolution and complaint processes.

This is helping to restore relationships between complainants and health service providers and gives complainants the tools and knowledge about complaint resolution and complaint processes. Given that the number of complaints has decreased, it seems that this process results in health service providers giving complainants the outcomes they are seeking, or resolving their concerns in some other way without the need for a formal complaint.

My Office closed nine conciliations in the last reporting year, achieving some excellent system improvements in the process. We did not commence any new investigations.

The Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings continues to have an effect on our work as agencies, particularly the Department of Health (the Department), seek to ensure that the Commission's recommendations are complied with and that incidents of child sexual abuse are noted and acted upon. In this regard, as noted later in this report, the Department established its Statewide Complaints Management and Oversight Unit to centralise complaint handling, with the worthy aim of ensuring that all complaints, whether of child sex abuse or otherwise, are appropriately addressed and that none are overlooked.

The practical outcome of this, however, has been that complaints are not always getting to those in the Department best able to respond to them in a timely manner and this in turn leads to delays in finalising and resolving complaints, both in the Department and this office. We continue to liaise with the Department to address this issue.

Once again, I would like to thank my Health Complaints staff for the quality of their work, for their dedication and professionalism and for sustaining their remarkable levels of activity over yet another challenging year.

Our people

My dedicated staff are at the heart of all the achievements we make in the improvement of the delivery of health services through complaint resolution, education and training. My staff remain committed to their work and the goals of the Office but, due to low staffing levels in previous years, we have not always reached the standard that we had hoped to achieve.

We retained the staff newly appointed in the previous financial year who have, during the reporting year, successfully tackled the backlog of complaints that had developed because of historically low staffing levels. One Officer has been seconded to the Department of Health's Statewide Complaints Management Oversight Unit. My staff have always been supported by an excellent business and administration team, without whom we could not provide our services.

Snapshot Staff profile at 30 June 2024



Position	Male	Female	Total
Commissioner	0.2	0	0.2
Principal Officer (Band 8)	0	1	1
Senior Conciliation Officer (Band 7)	0	0.6	0.6
Senior Investigation Officer (Band 6)	1	1	2
Investigation Officer (Band 5)	0	0	0
Intake and Assessment Officer (Band 4)	1	0	1
Total	2.2	2	4.8

Our work



Snapshot Restoring relationships

A critical focus of our role is restoring relationships between parties where the provision of health care has either not met expectations or has fallen short of good practice. The patient experience from previous health presentations may impact on future patient experiences. It is therefore vital that relationships are rebuilt when they have broken down, as the consumer may need to receive ongoing care and treatment from the same health practitioner in the future. Through our resolution and conciliation processes my skilled staff are able to rebuild relationships that are critical to the success of patient-centred care.

The Office of the Health Complaints Commissioner was established in 1997 under the *Health Complaints Act 1995* (the Act) as an independent, impartial body that acts in the public interest. The Commissioner is an independent statutory officer who does not represent the interests of, nor act as an advocate for, either party to a complaint.

The Commissioner seeks improvements in the delivery of health services in Tasmania and, where possible, to resolve complaints between the parties through early resolution and conciliation. It has been the practice since the commencement of the Act for the offices of Ombudsman and Health Complaints Commissioner to be held by the same person.

Our functions

The major functions of the Office are to:

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

How we do our work

The primary function of the Office is to provide an accessible, impartial and confidential service for the resolution of health complaints. In this section, we provide information about complaint management, statistics, trends and outcomes.

Our performance

Year at a glance (2023-24)

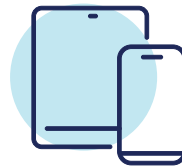
1160 Approaches (enquiries and complaints)
*excluding Notifications from AHPRA

Complaints

*excluding Notifications from AHPRA



485
complaints
opened



580
complaints
closed

Time taken

*excluding Notifications from AHPRA



303
complaints
closed in
30 days

129
complaints
closed in
6 months

148
complaints
closed in more
than 6 months

Enquiries



677
opened

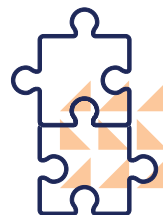


679
closed

*Notifications from the Australian Health Practitioner Regulation Agency (AHPRA)



104
received



106
closed

Complaint and enquiry activity

Data about our complaint activity is collected in our case management system, Resolve. All cases received are initially recorded as enquiries. They then proceed through different workflows in the system, according to how they are managed, and data is collected at various points through those workflows. Cases are either closed as an enquiry or they progress to a complaint or notification.

For the purpose of the statistics which follow:

- An **enquiry** is where a person or organisation is either seeking information from, or providing information to, this Office. All first contacts start as an enquiry until an assessment is made whether the enquiry is a complaint.
- A **complaint** can be made by a person about a health service sought, used or received by or administered to them as defined by the *Health Complaints Act 1995*. Complaints are initially assessed and may be subject to early resolution, referral, dismissal, assessment, conciliation or investigation. For the purposes of this report, enquiries and complaints have largely been grouped together as 'cases' or 'complaints'.
- A **notification** is where a person lodges a notification with the Australian Health Practitioner Regulation Agency (AHPRA) which, following consultation with this Office as to which is the preferred entity to deal with the matter, it is agreed that AHPRA should retain the matter.

Snapshot Raising concerns with the health service provider first



This Office continues to highlight with complainants the importance of first engaging with the health service provider about their concerns.

When they have not done this, complaints are referred back for direct resolution between the complainant and the health service provider to ensure there is an opportunity for the provider to address the problems directly with the complainant, where appropriate to do so.

This is generally the quickest and easiest way to address and fix problems in the first instance. After working through the concerns or problems with the provider, the matter can often be resolved in a way that satisfies the complainant.

However, if the complainant remains dissatisfied, they are advised that they can contact this Office for further consideration of their concerns.

We understand in some instances it is not always possible or appropriate for complainants to resolve their concerns directly with the health service provider and this is considered when they make a complaint.



Snapshot Out of jurisdiction complaints

While most complaints were about health services delivered in Tasmania, the Office also received several complaints that were out of jurisdiction. These were complaints that do not relate either to the provision of health services as defined in the *Health Complaints Act 1995*, or a health service in Tasmania. In these circumstances, staff provide information about an alternative agency that may assist the individual with their concerns. Staff also provide information about the support available to assist the individual such as advocacy or legal services.

Table 1 Summary of cases received and closed in the reporting year



Case type	Received	Closed
Enquiries	677	679
Complaints	485	580
Notifications	104	106
Total	1266	1365

Table 2 Overall case activity – excluding AHPRA notifications



Total cases	2022-23	2023-24	Variance
Cases carried forward from 1 July	290	172	-41%
Cases received	1178	1162	-1%
Cases closed	1288	1259	-2%
Cases active at 30 June	180	75	-58%

How complaints are managed



Complaints and notifications are assessed under the *Health Complaints Act 1995*

Assessment is the stage under the Act at which a determination must be made as to whether a complaint should be referred to another entity, referred to conciliation, referred to investigation, a combination of any of these, or dismissed.

This determination is meant to occur within 45 days of the complaint being received, but this period can be extended to 90 days, or longer if the Commissioner is waiting for information. This is also the stage at which attempts are made at early resolution.

This year 686 complaints were closed following assessment. Table 10 'How complaints and notifications were resolved' provides full details about the assessment outcomes.



Preliminary assessment

All complaints undergo a preliminary assessment to ascertain whether or not we have jurisdiction to deal with them.

The Act sets out a number of criteria to be satisfied before we can accept a complaint. If these criteria are not met, the complaint is dismissed. During preliminary assessment, our officers provide complainants with information including:

- outlining if the criteria has been met and if not, explaining this to the complainant;
- providing the complainant with information about direct resolution with the health service provider if they have not already complained to the provider;
- assisting the complainant to make a complaint to another organisation or person better equipped to deal with the complaint; and
- identifying further assessment is required and referral to a more senior officer to contact the complainant.



Early resolution

These cases are assessed and managed as informally as possible, and resolving complaints at the first possible opportunity is a priority.

This can involve obtaining information from the provider, or other entity, and sharing this with the complainant.

Alternatively, this can involve speaking with the parties and negotiating outcomes, such as a refund or waiver of fees, or the provision of a service. Most cases about Correctional Primary Health Services – our largest cohort – fall into this category. These cases are recorded as having been closed in assessment on the basis that a reasonable explanation has been provided or that the complaint has been resolved.



Formal assessment

All remaining complaints, including those ultimately referred to AHPRA, conciliation or investigation, undergo a more formal assessment process.

The formal assessment process involves making preliminary enquiries, which can include obtaining formal written responses from the health service provider; receiving and reviewing medical records and identifying and reviewing relevant clinical standards. It also involves, where necessary, consulting with AHPRA in relation to registered health practitioners involved in the episode of care.

These cases are more complex than a preliminary assessment and represent a large percentage of the Office's cases. The reasons for closure do not always reflect the complexity or extent of the work undertaken. In some cases, officers provide suggestions to health service providers for improvement to delivery of health services.



Referral to registration boards

The relationship between this Office and the Australian Health Practitioner Regulation Agency (AHPRA) is governed by the *Health Practitioner Regulation National Law Act 2009* (the National Law).

When a complaint concerning a registered practitioner is made to the Office, we are required to advise and consult with AHPRA as to whether any aspects of the complaint should be referred to AHPRA.



Working with AHPRA

AHPRA works with 15 National Boards to help protect the public by regulating Australia's registered health practitioners. AHPRA deals with the registration and accreditation, as well as the health, performance and professional conduct of individual health practitioners across Australia.

A memorandum of understanding is in place between AHPRA and the various health complaints entities in Australia. My officers continue to work closely with AHPRA to ensure complaints and notifications concerning registered health practitioners are jointly considered with AHPRA through consultation and a determination made on whether any aspect of the complaint and notification should be referred to AHPRA or this Office.



Snapshot Working with AHPRA

A complainant notified this Office of concerns surrounding a registered practitioner conducting an internal examination of their child without the consent of the parent. The practitioner did not during the consultation seek or receive consent, before proceeding to complete the examination. This Office consulted with AHPRA on the issues identified and it was agreed that it was appropriate for this Office to refer the matter to AHPRA for further management of the concerns raised.

Snapshot “Complaints overview”

Enquiry

The intake team provides information on:

- The complaint process
- Raising a complaint with the service provider
- Referral to a more appropriate agency
- Other complaint resolution options.

Assessment

Complaints are assessed to ensure they meet a range of threshold criteria, including whether they relate to:

- The provision of health services
- Services provided in Tasmania
- An incident occurring in the past two years
- An incident that has already been raised with the service provider.

In some circumstances where the person making the complaint has not tried to resolve the matter directly with the provider, a facilitated referral for early resolution of the matter may be initiated.

Complaint resolution

Complaints can be resolved in the following way:

Early resolution

We assist with the exchange of information to reach an outcome which is often acceptable to both parties.

Conciliation

Encourages resolution by facilitating discussions between the parties to assist in reaching an agreement.

Investigation

This is normally only undertaken if a complaint raises a serious systemic or public interest issue.

Outcomes

The Office is able to achieve a range of outcomes for both the person who made the complaint and for improved service delivery.

These include provision of explanations by service providers, apologies, refunds, reduction or waiver of fees and facilitating access to services.

We also attempt to address gaps in service provision by suggesting further staff training, changes to processes and procedures, and introduction of new policies and/or procedures.

We may also be able to assist in the obtaining of compensation.

Closed

Once the complaint resolution process is complete, the parties are informed of the outcome by letter or a report containing details of any outcome of the complaint.

Issues raised by complainants

Consistent with previous reports, recurring issues raised in complaints related to concerns about treatment, access to services, poor communication and medication. Tables showing comparative data, including all issues and breakdowns, can be found at 'Complaint and enquiry summaries' later in this report.



Snapshot Top common issues overall

Issue	2022-23	2023-24
Treatment	492	555
Access	174	228
Communication and information	153	160
Medication	127	144
Professional conduct	36	40
Grievance processes	19	38

*Most complaints raise more than one issue.



Most common treatment concerns

2023-24

135

Inadequate treatment

115

Inadequate care

53

Unexpected treatment outcome or complications

61

Diagnosis

49

Delay in treatment

2022-23

93

Delay in treatment

92

Inadequate care

90

Inadequate treatment

61

Unexpected treatment outcome or complications

21

Diagnosis

Table 3 Complaints about health service organisations



Organisation	2022-23	2023-24	Variance
Correctional Primary Health	228	212	-7%
Public Hospitals	114	80	-30%
Medical Practices/ Clinics	60	38	-37%
Private Hospitals	14	13	-7%

Issues raised about health service organisations

My Office continues to build and maintain excellent working relations with the main health service providers in Tasmania. This enhances the effectiveness, responsiveness, and overall impact of complaints, ultimately leading to better patient-centred care, outcomes and improved systems.

Correctional Primary Health Services (CPHS) continues to be the main source of complaints about health organisations. Complaints are received from prisoners in the Tasmanian Prison Service about the delivery of the health service provided by the CPHS. As in previous years, primary public hospitals in Tasmania are the second main source.

Correctional Primary Health Services

Prisoners and remandees have access to my Office by way of a direct telephone line at no cost to them. Although my Office saw a 7% decrease in the number of complaints

about CPHS, the number of complaints still remains high at 212.

Examples of the health issues raised by prisoners include issues with communication about appointment time and booking appointments, access to the opioid replacement therapy program, access to restricted medications, access to specialist care and oral health service wait times.

The issues have remained relatively the same from previous financial years. However, there was a significant increase in complaints about access to health services. Complaints about lockdowns, which result in limited access to clinics, continue to be an issue.

My Office continues to facilitate direct resolution between prisoners and CPHS by ensuring complaints and information received by telephone are provided to the Statewide Mental Health Service (SMHS). A response to the prisoner's concerns is obtained from the CPHS which the SMHS then provide to the prisoner. If the prisoner is unhappy with the direct resolution response, a formal complaint can be lodged with my Office whereupon we assess the concerns by engaging with SMHS and CPHS.

Tasmanian Health Service

My Office closed 80 complaints about public hospitals in the reporting year. Consistent with previous years, public hospitals were the subject of the next highest number of complaints closed. This total represents a

48% decrease in the number of complaints closed about public hospitals in the last financial year, down from 114. Treatment continues to be the major issue raised about public hospitals with an increase to 207 complaints from 131 in the last financial year.

Table 4 Main issues arising from complaints about CPHS



Issue	2021-22	2022-23	2023-24
Treatment	72	108	188
Access	145	132	104
Medication	100	85	94
Communication and information	18	12	27

Table 5 Main issues arising from complaints about public hospitals



Issue	2021-22	2022-23	2023-24
Treatment	98	131	207
Communication and information	38	38	41
Medication	7	10	16
Access	20	19	15
Grievance processes	6	12	9

Private hospitals

Complaints about private hospitals remained largely the same with only an 8% decrease. The main issue continues to be in relation to treatment, which has remained consistent in the last two financial years.

Medical practices and clinics

We saw a decrease in complaints about medical practices and clinics with the main issue being treatment concerns. We saw a significant decrease in issues surrounding fees and costs.

Table 6 Main issues arising from complaints about private hospitals



Issue	2021-22	2022-23	2023-24
Treatment	10	18	17
Communication and information	7	2	4
Medication	0	1	2
Environment/ management of facilities	1	1	2

Table 7 Main issues arising from complaints about medical practices/clinics



Issue	2021-22	2022-23	2023-24
Treatment	20	33	26
Communication and information	30	24	15
Medical records	5	5	9
Fees and costs	11	24	9
Access	23	22	8

Table 8 Main issues arising from complaints about individual providers

Provider Type	Count
Unknown	39
Medical Practitioner	32
Psychologist	5
Dental	2
Osteopath	1
Optometrist	1
Chiropractor	1
Nurse	1
Total	82

Individual providers

We received 82 complaints about individual health service providers this year in comparison to 199 in the last reporting year. This is in addition to 104 notifications received from AHPRA which is an increase from 66 notifications received last year. Complaints about individual providers decreased 59% from last year.

The majority of complaints and notifications we received about individual providers related to medical practitioners. As noted in previous reports, this is attributable to there being more doctors than other individual health providers who practice in their own right. Complaints about nurses, for example, are usually incorporated into complaints about hospitals. There was a 43% decrease in the number of complaints about medical practitioners received this year from 56 down to 32.



Time taken to assess and finalise complaints

Time taken to assess complaints

The *Health Complaints Act 1995* requires that a complaint be assessed within 45 days. This can be extended to 90 days, and longer in some cases. There are a number of circumstances, described in past annual reports and referred to earlier in this report, that are beyond our control and have an impact on this Office’s ability to meet these statutory periods, including seeking information from health service providers to adequately assess the complaint issues.

Time taken to finalise complaints

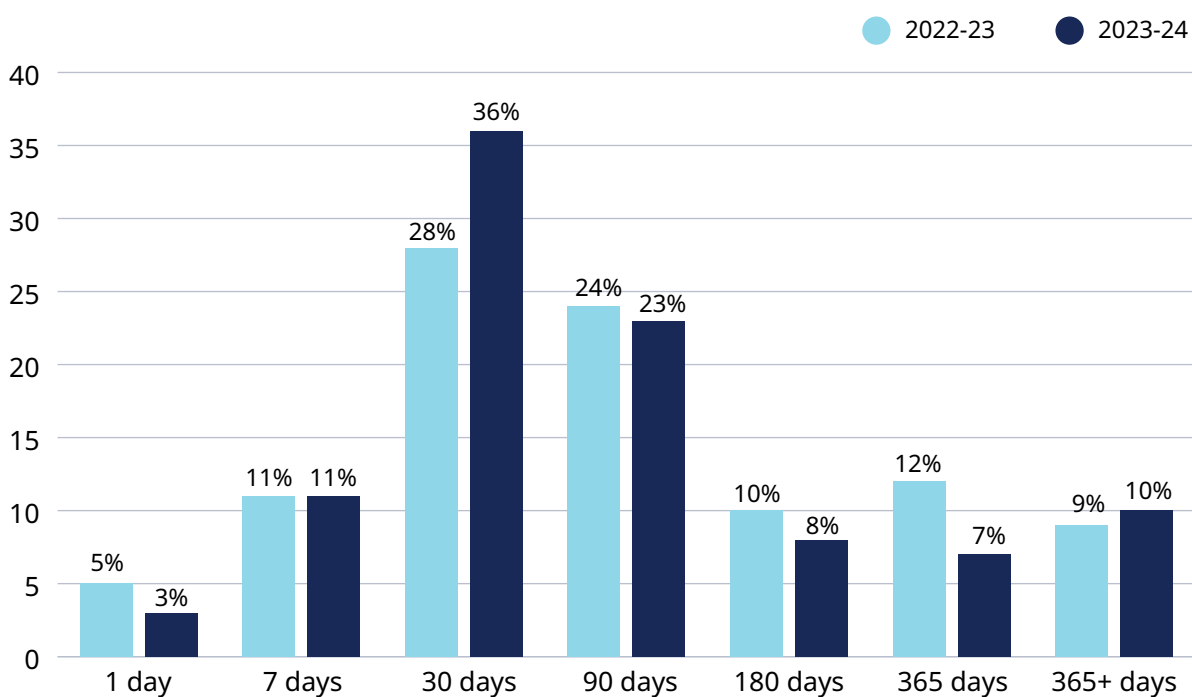
Table 9 and Figure 1 below show the time it takes to finalise complaints. As previously noted, less complex complaints were generally resolved within three months and made up around 73% of all complaints

Table 9 Time taken to finalise complaints

Timeframe	Number	%
1 week or under	98	17%
8 to 30 days	205	35%
1 to 6 months	129	22%
More than 6 months	148	26%

received. The remaining 27% tended to be more complex and required the application of more formal assessment processes (see page 9). Figure 1 provides a comparison to last year’s timeliness of finalising complaints, with more complaints finalised within 30 days this reporting year.

Figure 1 Time taken to finalise complaints, comparison between 2022-23 and 2023-24



How complaints and notifications were resolved

Table 10 Reasons for closure (*including notifications from AHPRA)

Reason	2021-22	2022-23	2023-24
Dismiss – Section 25(5)(g) Complainant has been given reasonable explanation and information	231	283	322
Dismiss – Section 25(5)(d) Complainant has not attempted direct resolution	168	255	133
Retained by AHPRA pursuant to MoU (Section 57 (1) (c) (ii) Retention by the Registration Board)	57	69	106
Other	3	12	26
Section 25(1)(a) Complaint referred to the Ombudsman or another person	18	14	14
Referred to AHPRA pursuant to MoU - Section 25 (1) (a)	23	5	12
Dismiss – Section 25(5)(b) Complaint does not disclose a subject matter referred to in section 23	29	11	13
Dismiss – Section 25(5)(j) Complaint has been resolved	112	74	10
Section 30(1) The complaint has been withdrawn in writing	12	29	7
Resolved	0	0	7
Dismiss – Section 25(5)(a) Complainant not a person entitled under section 22	10	7	6
Dismiss – Section 25(5)(h) The complaint lacks substance	8	18	6
Closed in conciliation	0	11	9
Dismiss – Section 25(5)(c) Complainant became aware of the circumstance leading to complaint more than 2 years ago	10	4	5
Dismiss – Section 25(7) Complainant has failed to provide information under section 24	1	0	4
Out of jurisdiction	4	13	4
Dismiss – Section 25(5)(e) Issues adjudicated by court or tribunal	2	3	1
Dismiss – Section 25(5)(f) Court has commenced hearing of subject matter	0	0	1
Dismiss – Section 25(5)(i) The complaint is frivolous, vexatious or not made in good faith	0	0	0
Total	688	808	686

Location of complainants

Figure 2 Where were the complainants from?



Conciliation

When there is an adverse outcome from an episode of care, most complainants want to understand what happened, why it happened, and are often seeking an apology, ongoing care and/or compensation. They also want to know what can be done to prevent what happened to them happening to someone else.

Conciliation under Part 5 of the *Health Complaints Act 1995* is confidential and privileged and provides a safe forum where the parties can have open and honest discussions about these issues.

Table 11 Outcomes of complaints

Outcome	2023-24
Explanation given	9
Apology given	8
Concern registered	5
Information obtained	4
Service obtained	3
Quality improvement	2
Compensation received or agreed	2
Change in policy	1

In previous years, conciliation has been utilised extensively and with great success in resolving complaints, and as a vehicle for exploring and bringing about systemic change.

As reported last year, the recruitment of a permanent part-time (0.6 FTE) conciliator in March 2022 enabled us to resume our conciliation service. However, changes in both governance arrangements in the Department of Health (the Department) and in senior management roles in the Tasmanian Health Service (THS), following hearings of the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings, resulted in significant delays in progressing and finalising a number of complex complaints about services provided by the THS. These delays were particularly pronounced in cases where compensation was sought.

As these new arrangements bed down, and as new staff in both THS and the Department become more familiar with the Office's conciliation process and aware of the benefits of resolving matters through a collaborative and restorative approach (rather than a medico legal/defensive/adversarial approach), it is hoped that conciliation will once again gain acceptance and be regarded not only as a useful adjunct to open disclosure and model litigant policies but as the preferred way in which to resolve complaints.

Unfortunately, although progress was made with some of these matters, there remain a significant number of cases still awaiting advice as to the availability of appropriate staff to meet with the complainant in an attempt to address their concerns. This is largely attributable to further issues emerging at the Launceston General Hospital but, as I reported last year, my

Office hopes to be able to consult with the relevant departments about the best way of addressing these delays in the near future.

Nine cases were closed within conciliation this year. Of those matters:

- two resulted in the payment of compensation to the complainant;
- three resulted in a commitment to providing ongoing care or rectification services;
- three resulted in significant policy change or quality improvements being implemented within the provider organisation; and
- in almost all cases, including those that did not result in any tangible outcome, the complainant, upon sharing their perspective of what happened to them, received an acknowledgment and a genuine apology for the events giving rise to the complaint.

Investigations

A decision was made some years ago that formal investigations would only be conducted into complaints which give rise to a matter of public interest, and that conciliation would be used more extensively. One of the reasons for this was that, in many cases, by the time the matter is brought to our attention, the provider has already engaged in a root cause analysis, and this has led to the identification and implementation of systemic changes necessary to prevent a recurrence of the subject incident. These changes are then shared with the complainant at conciliation. The matters referred to investigation have tended to be those that affect vulnerable groups. My Office is currently undertaking one own-motion investigation.



Topical issues during 2023-24

Review of the *Health Complaints Act 1995*

The *Health Complaints Act 1995* is long overdue for a review of its effectiveness, functionality and response to the current work that is conducted by this Office. A consultant has been engaged to complete the review.

Stakeholder engagement

This Office continues to maintain highly productive working relationships with the health service providers about whom we receive most complaints.

These understandably are the bigger organisations such as the Department of Health (the Department), particularly through its services at the Royal Hobart Hospital, the Launceston General Hospital, the North West Regional Hospital and the Latrobe Mersey Hospital and Correctional Primary Health Service.

During the year, this Office also maintained strong links with staff of Equal Opportunity Tasmania (now the Office of the Anti-Discrimination Commissioner), the Australian Health Practitioner Regulation Agency, Health Consumers Tasmania and the Radiation Protection Unit.

The Department of Health and the Statewide Complaints Management Oversight Unit

The Department created the Statewide Complaints Management Oversight Unit (SCMOU) to provide oversight and governance for monitoring and managing complaints across the entire Department.

This Office now refers all complaint enquiries related to the Department to SCMOU. In last year's report, I noted that the system is yet untried. This Office is striving to build a strong working relationship with the unit to ensure timely and effective complaint handling. However, we have seen an increase in delays to requests for information and responses from the Department. In some cases, we are waiting over 300 days for responses despite following up regularly.

It is recognised that SCMOU has had limitations, including high workloads and limited resourcing which the Department is working towards improving. The results of the first year of the implementation of SCMOU, however, have not provided a timely and efficient complaint handling process. SCMOU's limitations have resulted in delays to this Office's complaint closures.

This Office will continue to liaise with SCMOU to ensure timely resolution and decisions for complainants.

“

The Office continues to maintain highly productive working relationships with the health service providers about whom we receive most complaints.

National Code of Conduct for Unregistered Health Practitioners

The Code of Conduct for Unregistered Health Care Workers (the Code) is to be administered by the health complaints entities in each jurisdiction. As previously reported in annual reports by this Office, the Tasmanian legislation to implement the Code had passed through Parliament but has still not yet been proclaimed.

The *Health Complaints Act 1995* has been amended to reference the Code and regulations setting out its terms have been drafted, but these are yet to be finalised. Interstate jurisdictions have implemented the Code and are regulating this sector to ensure public safety in access to unregistered health service providers.

As previously reported, it is not possible to say how many complaints this Office will receive relating to possible breaches of the Code. The trend interstate indicates that the number of complaints will be high.

I have referenced in previous annual reports that any introduction of further complaints to this Office will be an added strain on existing resourcing, which will not be sufficient to manage the increase in complaints. I also have raised concerns about the need for extensive modifications to our case management system to accommodate workflows related to the administration of the Code.

I remain concerned that, without additional resources and funding, we will not be able to perform this new function adequately.

Children and young people

The safety and wellbeing of children and young people has been at the fore in Tasmania for the last few years with the establishment of the Commission of Inquiry. My Office continues to focus on promoting our various services to children and young people.



Looking ahead

Strategic planning

The Office is ensuring steps are being taken to achieve the targets of the current Strategic Plan, including:

- progression on the amendments to the *Health Complaints Act 1995*;
- revision of the *Charter of Health Rights* which is overdue and which my Office is mandated to undertake; and
- review of current processes to achieve improvement in complaint handling and decision-making.

Outreach and education

My staff continually provide information to both complainants and health service providers on how they can make and respond to complaints most effectively. As previously reported, due to a backlog of cases and ensuring the Office focused on recruitment and resourcing, delivery of training has not been possible. To ensure improvement in health services and especially in complaint resolution, this Office will be continuing to focus on ensuring more outreach and education is provided in the upcoming year.



Complaint case summaries

Feedback and complaints can be helpful to identify areas of improvement.

Improvement to booking systems and procedures

A patient experienced delays in accessing services needed following a surgery, specifically six weeks after the requested post-surgery appointment.

The complainant reported that in a delayed appointment following surgery, it was identified there were post-surgery issues that would require a further surgery. The complainant said that they suffered anxiety, depression, stress and pain.

In response to this Office's enquiries, the health service provider confirmed that due to appointments being fully booked, the patient was not seen post-surgery for 12 weeks. They acknowledged that while this would ordinarily have been an acceptable timeframe, for the patient it had contributed to a delay in diagnosing a complication from surgery.

The results

The health service provider:

- conducted a review into its outpatient booking system and implemented a new system to leave sufficient appointments for post-operative patients so they can be accommodated in the time frame the operating surgeon suggests;
- made further changes including prioritising appointments for patients requiring follow up, especially when clinically indicated; and
- introduced a medical officer tasked with weekly triage of referrals for further oversight of the appointments.

This Office provided suggestions for improvements to the booking system to ensure there is minimal delay between the procedure and the follow up appointment. It was further suggested that the provider review information given to patients about complications post-surgery.

Further explanation and recognition of suggested improvements resulted in a satisfied complainant

A complaint was received from the parent of a child who received care from a provider. The child presented to the provider on numerous occasions and the complainant said she felt she was not listened to by the medical staff about her child's condition and recent treatment that had not improved the child's health. The complainant believed the provider had been negligent in the treatment of the child.

The complainant was not satisfied with the response of the provider and sought an apology, explanation, and quality improvement for services to other families in the future.

The result

In its response to this Office the provider acknowledged that their communication with the complainant could have been clearer, they provided an apology and advised that the staff involved had been provided with feedback to improve practices.

The provider also gave the complainant a more detailed explanation of the treatment provided to the child.

The complainant was satisfied the complaint had been taken seriously and addressed by the provider, including the suggestions for improvement discussed with this Office, and said the complaints process through the Office had been a positive experience.

Providing ongoing education and training to those responsible for investigating complaints is important to reduce the likelihood of incidents escalating and ensuring policies and procedures are adhered to.

Training and improvement in documentation

The complainant raised concerns about treatment at two hospitals following an accident. They were originally admitted to the first hospital, but due to the extent of their injury and limited available staff, they were informed that they would receive further medical treatment at a different hospital. There was no transport available between the two hospitals and the complainant was required to seek private transport.

On arrival at the second hospital the complainant raised concerns about the inadequate communication throughout the treatment and lack of clear advice and instruction post treatment.

The result

The Office obtained responses from both hospitals. Although the responses provided a reasonable explanation to the complainant about their concerns, this Office provided suggested improvements about the management of the complainant's injury, including ensuring that relevant protocols and guidelines were in place in relation to the specific injury sustained and improvement in documentation and discussion about transport.

These suggestions were accepted by the provider who further explained that education and training had been undertaken by relevant staff about the importance of clear, accurate and timely documentation, which has resulted in positive outcomes.

Improvements in conducting investigations of complaints

The complainant claimed they were being pushed in a wheelchair by a staff member too quickly and collided with a structure which resulted in further injury. The complainant was seeking multiple outcomes including disciplinary action and compensation.

The result

With the consent of the complainant, this Office obtained their medical records from the provider as well as an incident report and relevant policy and procedures.

During the assessment, a review of the provider's complaints policy and procedure and incident management policy found deficiencies in the incident reporting and the investigation by staff into the concerns raised by the complainant at the time.

Specifically, it was found that in conducting an investigation into the complainant's concerns:

- the complaint was not recorded appropriately in accordance with the policies and procedures; and
- there had been insufficient compliance with the policies and procedures in the management of the complaint.

It was suggested by this Office that the provider review its internal investigation of how the complaint had been managed which would identify opportunities for improvement. It was also suggested that training and education be provided for those conducting investigations into complaints.

Health service provider made reasonable attempts to resolve issue

The complainant attended a dental clinic to have their dentures realigned. The dentures were very old and needed to be replaced and if not replaced, realigned. The provider realigned them in accordance with the complainant's request.

On a return appointment the complainant sought to have the dentures realigned back to the first shape and fit, or a refund.

Having attempted direct resolution with the provider, the complainant raised their concerns with this Office, asserting the dentures were now uncomfortable and that they wanted new dentures and the costs waived.

The result

This Office conducted an assessment of the provider's response during direct resolution. To properly assess the issues identified, medical records were requested after seeking consent from the complainant.

A review of the response and the medical records indicated the provider's treatment had been in accordance with the complainant's wishes. The provider had recommended the dentures be replaced. This had been declined by the complainant and the provider was not able to reverse the work already completed. This Office found in assessing the information that the response was empathetic and detailed.

No further action was taken by this Office, as, from the information provided, the provider had made significant effort to assist the complainant, including realignments and suggestions to have the dentures replaced.



Complaint and enquiry summaries

Summary of issues by category

Table 12 Summary of issues by category

Issue	2021-22	2022-23	2023-24
Access	144	174	228
Communication and Information	149	153	160
Consent	18	6	5
Discharge and transfer arrangements	14	6	8
Environment/management of facilities	56	10	10
Fees and costs	26	47	22
Grievance processes	16	19	38
Inquiry service only	21	22	7
Medical records	16	19	24
Medication	136	127	144
Professional conduct	47	36	40
Reports/certificates	23	9	6
Treatment	382	492	555
Total	1048	1120	1247

Breakdown of issues by category

Table 13 Access

Issue	2021-22	2022-23	2023-24
Access to facility	5	3	0
Access to subsidies	1	0	0
Refusal to admit or treat	36	25	9
Remoteness of service	2	1	0
Service availability	80	121	144
Waiting lists	20	24	75
Total	144	174	228

Table 14 Communication and information

Issue	2021-22	2022-23	2023-24
Attitude/Manner	68	68	74
Inadequate information provided	42	39	66
Incorrect/misleading information provided	27	32	17
Special needs not accommodated	12	14	3
Total	149	153	160

Table 15 Consent

Issue	2021-22	2022-23	2023-24
Consent not obtained or inadequate	12	6	5
Involuntary admission or treatment	4	0	0
Uninformed consent	2	0	0
Total	18	6	5

Table 16 Discharge and transfer arrangements

Issue	2021-22	2022-23	2023-24
Delay	2	2	0
Inadequate discharge	9	4	7
Mode of transport	1	0	1
Patient not reviewed	2	0	0
Total	14	6	8

Table 17 Environment/management of facilities

Issue	2021-22	2022-23	2023-24
Administrative processes	44	3	4
Cleanliness/hygiene of facility	4	1	1
Physical environment of facility	7	4	2
Staffing and rostering	1	2	1
Statutory obligations/accreditation standards not met	0	0	2
Total	56	10	10

Table 18 Fees and costs

Issue	2021-22	2022-23	2023-24
Billing practices	17	31	13
Cost of treatment	3	14	9
Financial consent	6	2	0
Total	26	47	22

Table 19 Grievance processes

Issue	2021-22	2022-23	2023-24
Inadequate/no response to complaint	14	14	35
Information about complaints procedures not provided	1	1	2
Reprisal/retaliation as a result of complaint lodged	1	4	1
Total	16	19	38

Table 20 Inquiry service

Issue	2021-22	2022-23	2023-24
Request for information – Complaint mechanisms	10	5	1
Request for information – Health Service	3	2	2
Request for information - Other	2	4	2
Request for information - Commission	6	10	1
Request review	0	1	1
Total	21	22	7

Table 21 Medical records

Issue	2021-22	2022-23	2023-24
Access to/transfer of records	14	13	18
Record keeping	1	5	6
Records management	1	1	0
Total	16	19	24

Table 22 Medication

Issue	2021-22	2022-23	2023-24
Administering medication	9	12	14
Dispensing medication	4	6	4
Prescribing medication	122	89	124
Supply/security/storage of medication	1	20	2
Total	136	127	144

Table 23 Professional conduct

Issue	2021-22	2022-23	2023-24
Assault	0	1	0
Boundary violation	3	6	3
Breach of condition	0	1	1
Competence	13	15	21
Discriminatory conduct	10	5	1
Financial fraud	1	0	1
Illegal practice	2	1	3
Impairment	14	3	1
Inappropriate disclosure of information	2	3	7
Misrepresentation of qualifications	0	1	0
Sexual misconduct	2	0	2
Total	47	36	40

Table 24 Reports and certificates

Issue	2021-22	2022-23	2023-24
Accuracy of report/certificate	5	4	4
Cost of report/certificate	0	1	0
Refusal to provide report/certificate	9	2	2
Report written with inadequate or no consultation	2	1	0
Timeliness of report/certificate	7	1	0
Total	23	9	6



Table 25 Treatment

Issue	2021-22	2022-23	2023-24
Attendance	1	2	0
Coordination of treatment	52	44	41
Delay in treatment	75	93	49
Diagnosis	27	21	61
Excessive treatment	6	5	3
Experimental treatment	1	3	2
Inadequate care	48	92	115
Inadequate consultation	10	15	27
Inadequate prosthetic equipment	4	4	0
Inadequate treatment	64	90	135
Infection control	1	3	2
No/inappropriate referral	11	13	14
Public/private election	0	0	2
Rough and painful treatment	6	13	13
Unexpected treatment outcome/complications	43	61	53
Withdrawal of treatment	15	17	26
Wrong/inappropriate treatment	18	16	12
Total	382	492	555

Summary of outcomes of complaints

Table 26 Outcomes from cases closed in assessment stage

Outcomes	2021-22	2022-23	2023-24
Apology given	44	28	28
Change in policy	10	8	8
Change in procedure	9	9	8
Compensation received or agreed	1	4	1
Concern registered	213	420	424
Declined/referred	17	24	15
Explanation given	204	207	110
Fees/costs – refunded, waived or reduced	11	7	4
Information obtained	267	242	43
Quality improvement	22	14	13
Service obtained	148	86	5
Total	946	1049	659

Enquiries about this annual report should be directed to:

Health Complaints Commissioner
Level 6, 86 Collins Street
Hobart, Tasmania 7000

Telephone: 1800 001 170

Email: health.complaints@healthcomplaints.tas.gov.au

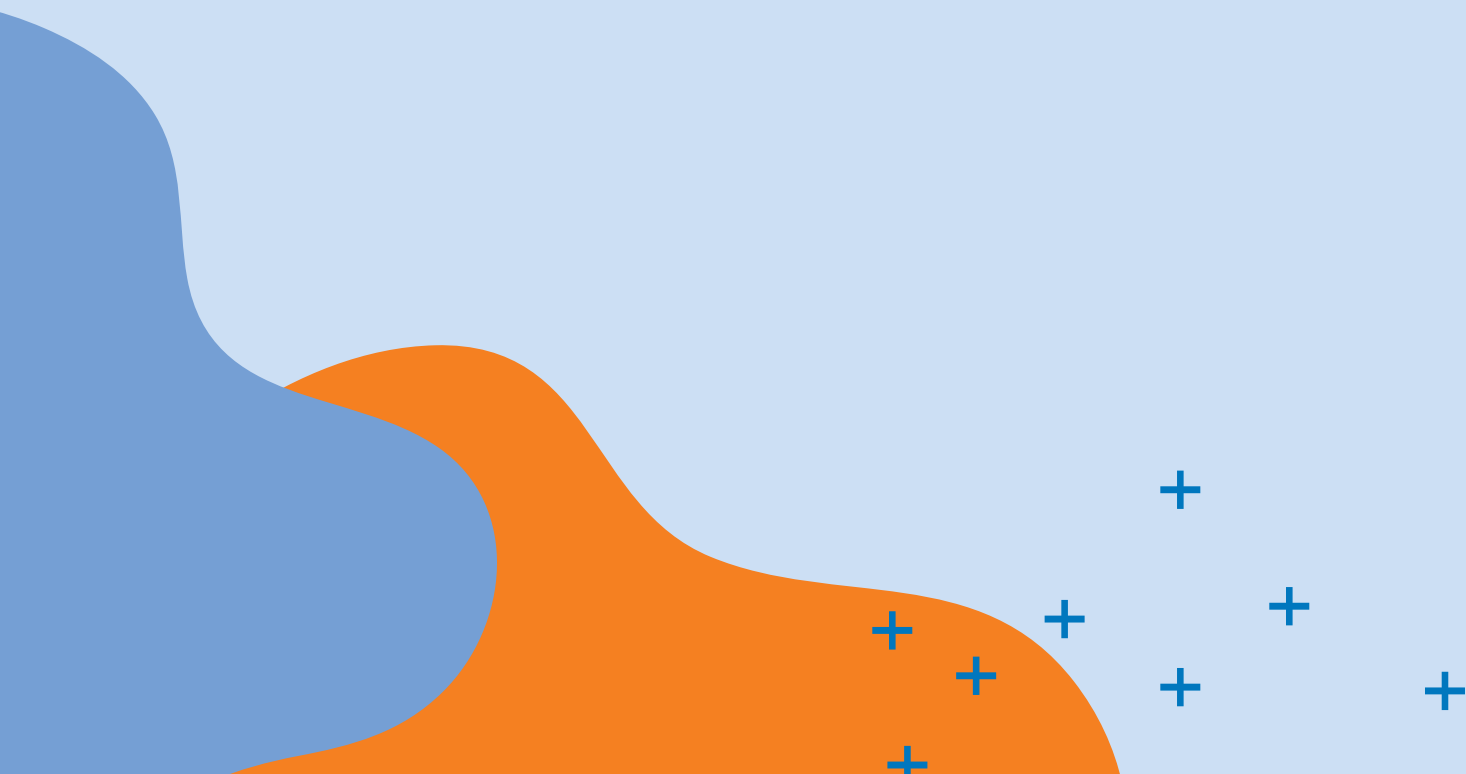
Website: www.healthcomplaints.tas.gov.au

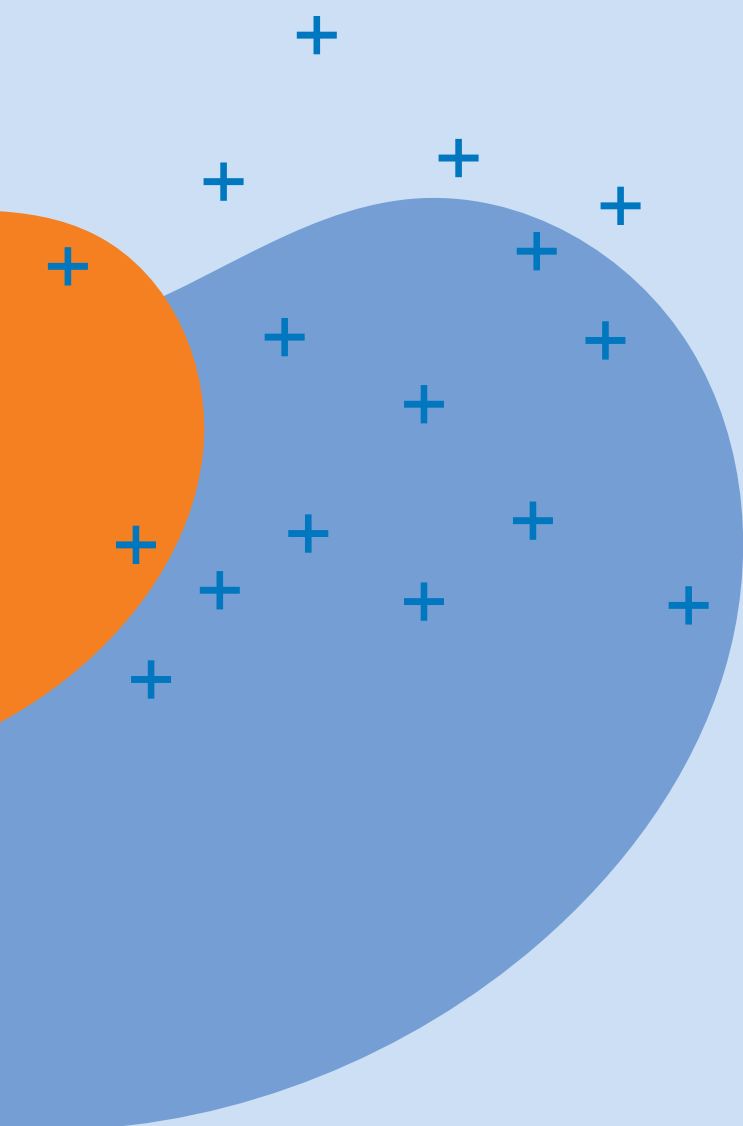
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