health quality and complaints commission

annual report 2008–09

reaching out

08 09

Our goal

The Health Quality and Complaints Commission is an independent statutory organisation dedicated to improving the safety and quality of healthcare in Queensland. Our goal links to the Government outcome of ‘healthy, active individuals and communities’ and the *Toward Q2: Tomorrow’s Queensland* ambition of ‘making Queenslanders Australia’s healthiest people’.

Our vision and values

Our vision is POSITIVE HEALTH ACTION. In achieving our vision, we work by our values:

- Respect
- Integrity
- Independence
- Learning
- Responsiveness.

Our history

We were established on 1 July 2006 under the *Health Quality and Complaints Commission Act 2006* following a key recommendation of the 2005 Queensland Health Systems Review (Forster Review).

We formed at a time of heightened community concern about events at Bundaberg Base Hospital.

We replaced the Health Rights Commission as the external health watchdog, with extended powers in independent complaint management and investigation, and a new role to improve the safety and quality of health services in Queensland.

We are funded by the Queensland Government and report to Parliament through the Minister for Health.

In everything we do, we work with healthcare consumers, providers and other agencies to manage complaints, prevent patient harm, promote health rights and recommend improvements to our health system.

This report

This report is designed to be an easy to read record of our progress towards meeting the goals of our strategic plan (see page 4). It describes our achievements, performance, outlook and financial position for the 2008–09 year. It is our key accountability document and the principal way in which we report on our activities to Parliament and the Queensland community.

Our ‘Reaching out’ theme reflects our commitment to working with consumers and providers to achieve better healthcare for Queenslanders. The theme is brought to life in the five activity chapters of the report—*Responding, Investigating, Monitoring, Preventing and Improving*—and in the *Highlights, Challenges* and *Looking Ahead* sections that provide ‘at a glance’ information about the 2008–09 year and the year ahead.

We are committed to providing accessible services to Queenslanders from culturally and linguistically diverse backgrounds. If you need an interpreter to help you understand this report, please contact us.

Only 200 copies of our report were printed on Envi Recycled 50/50. The report can also be read on our website—www.hqcc.qld.gov.au

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Lisa Faci has more than 10 years’ experience in helping healthcare consumers and providers resolve complaints.

health quality and complaints commission

POSITIVE HEALTH ACTION

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30 September 2009

The Honourable Paul Lucas MP
Deputy Premier and Minister for Health
GPO Box 48
Brisbane QLD 4001

Dear Deputy Premier

I am pleased to present the Health Quality and Complaints Commission's Annual Report 2008–09.

I certify that this Annual Report complies with:

- the prescribed requirements of the *Financial Accountability and Audit Act 1977* and the *Financial Management Standard 1997*, and
- the detailed requirements set out in the *Annual Reporting Guidelines for Queensland Government Agencies*.

A checklist outlining the annual reporting requirements can be accessed at www.hqcc.qld.gov.au

Yours sincerely
Professor Michael Ward
Commissioner

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This year we reached out to our community more than ever before. We worked with healthcare providers, consumers and our fellow agencies towards better healthcare for Queenslanders. We acknowledge their advice and support in helping us achieve our positive health action vision. Please take a few moments to share our year.

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highlights of our year

- **226 (100%) acute hospitals and day surgeries reported against our seven healthcare standards,** with 54% aligning with all nine key patient safety areas (up from 22% in 2007–08).
- Acute hospitals and day surgeries reported more than **3000 quality improvement initiatives.**
- We received **2177 enquiries and 2534 complaints** and closed 54% of all complaints within 30 days (up from 42% in 2007–08).
- **104 investigations were closed, up 400% on 2007–08.** Of these we completed three major investigations—Mackay Base Hospital, BreastScreen Queensland and the mental health services provided to a patient at a metropolitan hospital. Our investigation into the quality of health services provided to Ryan Saunders in 2007 is in the consultation phase.
- We created the beginnings of an **early warning system** to identify healthcare risks and help prevent patient harm.
- We analysed complaint data back to 1992 to **identify concerning patterns of practice** by individual healthcare providers and hospitals.
- We collocated with our fellow complaint agencies, heralding **a new era in cooperation and cost-savings**, and creating a one-stop complaint shop.
- 70% of our employees said 'yes', the **HQCC is a truly great place to work** (up from 44% in 2007–08).

financial snapshot

Our budget

The operational budget for 2008–09 was $10.6 million plus $2.34 million in retained rollover funds totalling $12.94 million.

This budget comprised:

- $8.9 million in recurrent funds
- $1.271 million in non-recurrent funds obtained from Queensland Treasury to complete the relocation of our organisation to 53 Albert Street, Brisbane
- earned revenue of $404,160, of which $395,636 was earned from interest bearing accounts.

We ended the year with retained rollover funds of $1.1 million.

Where our money came from

We received our funding as administered output revenue through an administered grant. The bulk of the funding was transferred to our investment accounts through Queensland Treasury Corporation and then drawn down throughout the year as required.

Where we spent our money

- We spent $11.032 million in 2008–09 against a forecast of $11.168 million.
- Employee expenses accounted for most of our spending at $7.33 million (66%).
- We invested $246,000 in more robust operating and reporting systems to increase efficiency and develop our knowledge management capabilities.
- Leasehold improvements to 53 Albert Street amounted to $2.059 million, of which $660,000 was funded by HQCC from monies received from Queensland Treasury.
- Infrastructure enhancements cost $446,000.

What we own

As at 30 June 2009, our assets totalled $4.42 million and comprised:

- $2.3 million (property, plant and equipment, including leasehold improvements, furniture and equipment)
- $1.1 million (cash in bank)
- $728,000 (intangibles, software)
- $238,000 (receivables).

What we owed

Our liabilities for 2008–09 totalled $3.03 million. These included $800,000 in accounts payable to suppliers and $810,000 in accrued employee benefits, with $1.2 million in lease incentives.

our performance

Our strategic framework 2008–2011 sets out our direction, including what we want to achieve, how we will achieve it and how we will measure our success.

Our performance this year is shown in the table below, together with next year's targets. We set ourselves deliberately challenging targets, recognising that we are on a continuous improvement journey.

More detail about our performance appears in the five activity chapters of the report—*Responding, Investigating, Monitoring, Preventing and Improving*.

Community objective

Improved performance in the safety and quality of public and private health services in Queensland.

Strategy	Target	Performance	Page	Next year's target
Monitor and report on the quality of health services	Increase acute hospital and day surgery compliance with HQCC standards by December 2008. (baseline 61.5%, December 2007)	Acute hospital and day surgery compliance across 226 facilities increased to 85.9%, December 2008.	47	Implement strategy to increase acute hospital and day surgery compliance with the HQCC standards by December 2009.
Manage healthcare complaints to foster continuous improvement of health service quality	Analyse complaint data to identify recurrent patterns that may indicate high risk individuals or organisations by June 2009.	Complaint data dating back to 1992 analysed and potential risks identified.	8, 58	Identify trends in complaint data to highlight emerging risks and facilitate implementation of measures to prevent patient harm.
Engage the community across the continuum of care	Develop strategy to extend the implementation of HQCC standards beyond the acute care setting to community medical practitioners by June 2009.	'*Acute Myocardial Infarction (AMI) on and following discharge standard* across the continuum of care' strategy developed in August 2008. Implementation commenced and ongoing, guided by stakeholder reference group of healthcare providers and a consumer representative. Strategy to continue in 2009–10.	51	Develop standard implementation model for community-based medical practitioners by June 2010.

'This year we recognised knowledge management as the key to identifying healthcare risks and preventing patient harm.' Cheryl Herbert, CEO

Left: Child Safety Day, Cherbourg **Middle:** Nurses Union Conference **Right:** Multicultural Festival

Stakeholder objective

Increased stakeholder understanding of health service safety and quality.

Strategy	Target	Performance	Page	Next year's target
Proactively inform and educate stakeholders	Implement stakeholder engagement strategy to inform and educate healthcare providers, consumers, community leaders, related jurisdictions and the media by June 2009.	Achieved 87% of the strategy complete by 30 June 2009, with the balance either in progress or timetabled for 2009–10. Three stakeholder groups rated the HQCC's stakeholder engagement efforts over 2008–09 in a July 2009 survey. Respondents were given five options: Very good, good, average, below average or poor. • 95% of hospital and day surgery survey respondents rated our stakeholder engagement efforts as average or above (target 75%). • 75% of general practitioner survey respondents rated our stakeholder engagement efforts as average or above (target 75%). • 100% of Aboriginal and Torres Strait Islander focus group survey participants rated our stakeholder engagement efforts as average or above (target 75%).	31–34, 44, 52–54, 60, 62, 70	Implement 2009–10 stakeholder engagement strategy in line with specified timeframes.

our performance

Internal processes objective

Improved governance, systems, processes and measures to improve health service safety and quality.

Strategy	Target	Performance	Page	Next year's target
Align internal processes to achieve strategic and legislative requirements	Improve timeliness of complaint and investigation management processes to achieve legislated timeframes by June 2009.	Achieved 82% of complaints in early resolution closed within 30 days.	25, 28	Implement strategies to improve timeliness of complaint and investigation management processes to achieve legislated timeframes by June 2010.
		Achieved 61% of complaints in assessment closed within 90 days. A case backlog has almost been cleared and this percentage is expected to increase 2009–10.	25, 28	
		Achieved 71% of complaints in conciliation closed within 12 months. Strategies to address barriers to increasing this percentage will be implemented in 2009–10.	25, 31	
		Achieved 64% of healthcare quality investigations closed within 12 months. Implementation of hybrid and devolution investigation models will assist in increasing this percentage in 2009–10.	36, 40	
	Achieve 100% of Queensland acute hospitals and day surgeries reporting against the HQCC standards in the August 2008 and February 2009 reporting periods.	Achieved 100% – 226 acute hospitals and day surgeries in Queensland reported against the standards in August 2008 and February 2009.	46	Achieve 100% of Queensland acute hospitals and day surgeries reporting against the HQCC standards.
	Review the self-assessed standard 'not applicable' status of 100% of Queensland acute hospitals and day surgeries by June 2009.	Achieved 100% – self-assessed 'not applicable' status reviewed for 226 acute hospitals and day surgeries in Queensland.	51, 54	Review standard verification pilot program and develop 2009–10 program for acute hospitals and day surgeries.

Learning and growth objectives

Healthy, productive and customer focused workplace culture. Attract, develop and retain the right people.

Strategy	Target	Performance	Page	Next year's target
Grow our workplace culture based on our values	Implement cultural improvement plan by June 2009.	Achieved 91% of the plan complete by June 2009, with the balance in progress and scheduled for completion in 2009. Increased employee participation in cultural survey 2009 to 98%. (baseline 83%, cultural survey 2007) Increased percentage of employees identified in cultural survey as 'engaged' to 48%. (baseline 28%, cultural survey 2007) Increased percentage of employees answering 'yes' to the question: 'Is the HQCC a truly great place to work?' to 70%. (baseline 26%, cultural survey 2007)	66	Implement revised cultural improvement plan based on cultural survey 2009 as a strategy to increase the percentage of employees 'engaged'.
Implement leading practice human resource processes	Attract a minimum of three applicants suitable for appointment per permanent position advertised.	Achieved 2.7 suitable applicants per permanent position in 2008–09.	65	Implement strategy to attract a minimum of three applicants suitable for appointment per permanent position advertised.
	Increase percentage of employees who self-rate work practice improvement following learning event to 70% in 2008–09.	Achieved 70% of employees rating work practice improvement following learning event in 2008–09.	67	Implement strategy to increase percentage of employees who self-rate work practice improvement following learning event to 75% in 2009–10.
	Achieve permanent staff turnover percentage less than or equal to the Queensland public service average.	Achieved – 1.69%.	64, 65	Achieve permanent staff turnover percentage less than or equal to the Queensland public service average.

Financial objective

Funding levels are sufficient to achieve our strategic objectives.

Strategy	Target	Performance	Page	Next year's target
Align our funding to our organisational priorities	Manage financial performance within operational budget.	Our annual expenditure in 2008–09 was $11.032 million against a forecast of $11.168 million.	73	Manage financial performance within operational budget.

the year in review

This year we helped 4711 Queenslanders with healthcare concerns, investigated 104 serious or systemic issues, monitored the quality improvement processes of 226 acute hospitals and day surgeries, and explored new ways to improve the safety and quality of healthcare in Queensland.

Commissioner Professor Michael Ward and CEO Cheryl Herbert look back at the year and outline our future plans.

Mining complaints data to identify risk

Healthcare complaints offer a valuable opportunity to improve healthcare safety and quality. This year, we began analysing our complaint data in ways that have not previously been possible.

A new database allows us for the first time to combine and analyse complaints collected by our predecessor the Health Rights Commission from as far back as 1992, with the more recent data we have collected since 2006. This allows us to look for recurrent patterns of complaints that may identify high risk individuals or organisations. We will combine this information with data from other sources to determine whether intervention is needed to prevent further problems.

We would encourage healthcare providers to analyse their own complaints data for safety and quality improvement as this important resource is often under-utilised.

Learning the lessons from investigations

Since our establishment in 2006, we have investigated serious and systemic healthcare issues, and have made many recommendations for safety and quality improvement at both local and organisation-wide levels.

Through a temporary increase in investigators, improved internal processes and new models of investigation, we closed 104 investigations in 2008–09, including three major health service quality investigations—Mackay Base Hospital, BreastScreen Queensland and the mental health services provided to a patient at a metropolitan hospital. These major investigations were highly complex and involved thousands of hours of information gathering, analysis and consultation to inform our recommendations for improvement.

In 2009–10, we will begin monitoring the implementation of our recommendations, to make sure that major problems identified through investigations have been fixed.

Setting standards as catalyst for improvement

Since introducing our seven healthcare standards in July 2007 we have tracked the quality improvement processes of 226 Queensland hospitals and day surgeries. There has been significant improvement against the nine key patient safety areas in many facilities, and providers have reported more than 3000 quality improvement initiatives.

This year we piloted a verification review framework with five volunteer hospitals to check their implementation of the standards. The pilot provided us with invaluable information about the practical implementation of the standards

Over the coming year, we will open up our standards to scrutiny in a comprehensive review. This is an opportunity for healthcare providers to propose changes. Expert reference groups will be convened to review all submissions and make recommendations to the Commission.

We also propose to extend the reach of the standards beyond the treating hospital to community medical practitioners. Healthcare providers and consumers will play a critical role in shaping this work.

Measuring and managing risk

We broke new ground this year by bringing together our standards reporting data, information gathered through complaints and investigations, and external data, such as media coverage and the Root Cause Analysis reports completed by hospitals following reportable adverse events.

We built the beginnings of a provider risk profile—a means to measure and manage risk. This work is in its infancy but has the potential to become an early warning system to prevent patient harm.

Looking ahead, we will partner with healthcare providers and other organisations to enrich our data sources, increasing the integrity and reliability of the profiles we create. We will work with our stakeholders to develop early intervention strategies to mitigate risk and improve safety and quality.

Our relationship with our interstate counterparts and the Australian Commission on Safety and Quality in Health Care will be critical in developing these new approaches. We are also working with universities and other partners to develop the new skills needed.

Collocating with our fellow agencies

A highlight of the year has been our collocation with the Anti-Discrimination Commission, Commission for Children, Young People and Child Guardian, Queensland Ombudsman and Commonwealth Ombudsman. The move to new premises has helped us build new working relationships, allowed us to pool resources (such as our shared reception, interview, meeting and training rooms) and reduced our rental costs.

We are only just beginning to reap the benefits of collocation and anticipate more joint initiatives such as the successful inter-agency mentoring program and the 'It's OK to complain' brochure, web portal and promotional campaign.

Reaching out to stakeholders

The Parliamentary Select Committee review of our first year prompted us to focus attention on engaging our stakeholders. We prepared a detailed action plan that has helped us build on existing relationships with hospital and day surgery staff and start to develop new ones with general practitioners, and Aboriginal and Torres Strait Islander communities. We attended more professional and community events, hosted meetings and workshops, and improved our customer service. We also boosted our online and media presence, and refreshed our information materials.

We will continue to reach out to our stakeholders as we champion safety and quality improvement and respond to the changing healthcare environment. The National Registration and Accreditation Scheme, the Australian Charter for Healthcare Rights and the National Safety and Quality Framework will all impact on our work in the coming year.

Looking ahead

We thank the many healthcare consumers, providers and other organisations who contributed to our positive health action vision in 2008–09. We look forward to continuing to work with you towards better healthcare for Queenslanders.

Our achievements this year would not have been possible without the leadership and guidance of our Commission, the advice and feedback of our advisory committees and reference groups, the expertise of our clinical advisers, and the talent and dedication of all our staff. Thank you for rising to every challenge with enthusiasm. It is a privilege to be part of your achievements.

Professor Michael Ward
Commissioner

Cheryl Herbert
Chief Executive Officer

our commission

Our Commission sets our strategic direction and oversees our performance. The Commission is led by Commissioner Professor Michael Ward and seven Assistant Commissioners, each with specialist knowledge and experience.

Commission members are appointed by the Governor in Council for a term of not more than four years.

The Commission's role is to:

- establish annual health priorities, milestones, and timeframes for completion
- identify emerging health issues and ensure these are acted upon
- determine whether investigations and inquiries into health issues are conducted
- review the status of all complaints monthly
- provide guidance, support and mentoring to the CEO and senior staff
- ensure the Commission's role and performance are communicated to healthcare consumers, providers and the media
- review the HQCC's progress and performance against stated goals.

The Commission meets 12 times a year, including an annual two-day strategy review and planning meeting every March.

> We built the beginnings of a provider risk profile—as a means to measure and manage risk.

Left to right, top row: Professor Michael Ward, Mr John Amery, Professor Michele Clark, Professor Ken Donald
Bottom row: Ms Susan Johnston, Mr Rodney Metcalfe, Dr Margaret Steinberg, Dr Kim Forrester

Meet our Commission

Professor Michael Ward

MBBS, FRACP, FRCP (Edin)

Commissioner (two-year term to 31 December 2009)

Michael is an Emeritus Professor at the University of Queensland. His previous positions include Director of Medicine at the Royal Brisbane and Women's Hospital, Head of the Central Clinical Division of the University of Queensland School of Medicine and Senior Director of the Queensland Health Clinical Practice Improvement Centre. In his former role as co-sponsor of the Queensland Collaboratives for Healthcare Improvement, Michael was instrumental in the development of a network of more than 400 healthcare professionals in 25 Queensland hospitals working together to improve quality of care. More recently, Michael contributed to the design and development of the state-wide clinical networks in Queensland. In 2008, Michael was awarded a Queensland Public Service Medal for services to medicine.

Mr John Amery

BHA, RN, Dip Admin

Assistant Commissioner, Nursing (three-year term to 31 December 2010)

John has more than 40 years' experience as a healthcare practitioner and administrator. He is currently Chief Executive Officer of Mater Health Services North Queensland in Townsville and a Director of the Australian Private Hospitals Association and Private Hospitals Association of Queensland. With exposure to the private and public sectors, John, a registered nurse, worked in general, psychiatric and obstetric positions before moving into administration.

Professor Michele Clark

PhD, B OccThy (Hons), BA, Grad Cert Health Econ

Assistant Commissioner, Allied Health (two-year term to 31 December 2009)

After a successful career in occupational therapy and community health, Michele is now a Professor in Health Policy in the School of Public Health at Queensland University of Technology. Michele was previously Foundation Professor of Rehabilitation Sciences and Head of the Occupational Therapy Unit at James Cook University. In 1998 and 1999 she worked on the International Year of Older Persons for the United Nations in New York and in 2000, she was appointed the Inaugural Director of the Australian Centre for Prehospital Research.

Professor Ken Donald AO

MBBS, PhD, FRCPA, FRCPath, FRACS (Hon), FRACMA

Assistant Commissioner, Medical (three-year term to 31 December 2010)

Originally trained as a pathologist, Ken has held appointments as an Academic Pathologist, Director of Pathology at Royal Brisbane Hospital and in recent years, Professor of Anatomical Pathology at the University of Newcastle and Director of Pathology at the Hunter Area Pathology Services. Ken was Deputy Director-General of Health in Queensland for a decade in the 1980s. In the 1990s he was Professor and Head of the Department of Social and Preventive Medicine at the University of Queensland and more recently Head of the School of Medicine. He is now Chair of the Repatriation Medical Authority and Acting Director of Medical Services at the Royal Darwin Hospital.

Ms Susan Johnston

JD, BA, Barrister at Law

Assistant Commissioner, Safety (three-year term to 31 December 2010)

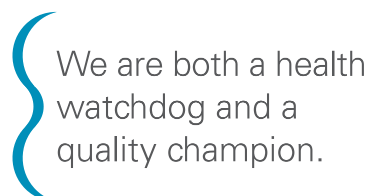
Susan has extensive experience in dealing with safety issues from outside the health sector, having led and participated in significant reviews of health and safety in the mining and energy industries. She has provided advice to both private industry and government on how to improve implementation and monitoring of safety systems and programs. Susan has postgraduate qualifications in law and extensive experience in governance. She is a former Chief Executive of the Queensland Resources Council and was previously Global Head of Safety for Anglo Coal.

Mr Rodney Metcalfe

LLB, Solicitor

Assistant Commissioner, Public Service (two-year term to 31 December 2009)

Rodney comes from a successful career in local government, after 20 years with Brisbane City Council. Prior to his appointment as the Deputy Queensland Ombudsman in 1995, Rodney was Executive Director of the Queensland Olympic 2000 Task Force. His role as the Deputy Ombudsman to 2006 included developing and implementing strategic organisational change and conducting high level investigations.



our commission

Dr Margaret Steinberg AM

PhD (Child Health and Education), MPhty (Research), BPhty (Hons), Dip Phty

Assistant Commissioner, Consumer (three-year term to 31 December 2010)

Margaret was formerly Community Commissioner on the Crime and Misconduct Commission and the Criminal Justice Commission. Her training is in population/public health and her work history has combined academic roles (at professorial level, e.g. as establishment director of a research unit on ageing at the University of Queensland Medical School); and public (health) policy and services. She is Governor of the Queensland Community Foundation and a director of other boards. She was made a Member of the Order of Australia in recognition of her work in social justice, particularly in public health and community organisations.

Dr Kim Forrester

RN, BA, LLB, LLM (Advanced), PhD, Barrister at Law

Former Assistant Commissioner, Legal (July 2006 to March 2009)

Kim is a registered nurse and barrister-at-law. She has extensive clinical experience in intensive and coronary care. Kim has been a lecturer at Griffith University in the Faculty for Nursing and Health since 1994, teaching health law and ethics to students in nursing, physiotherapy, oral health and dentistry, pharmacy and health sciences. She has a number of publications in the area of health law, is an editor of the Journal of Law and Medicine and has written a number of chapters in legal and health texts. Kim served as Assistant Commissioner, Legal from 2006, resigning in March 2009.

The role of Assistant Commissioner, Legal is currently vacant, pending an appointment by the Deputy Premier and Minister for Health.

Table 1: Commission meeting attendance 2008–09

	Total meetings attended	2008							2009				
		Jul	7 Aug	21 Aug	Sep	Oct	Nov	Dec	Feb	Mar	Apr	May	Jun
Professor Michael Ward	12/12	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mr John Amery	10/12	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✗	✓
Professor Michele Clark	12/12	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Professor Ken Donald	12/12	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓[1]
Ms Susan Johnston	8/12	✓	✗	✓	✓	✓	✓	✗	✓	✗	✗	✓	✓
Mr Rodney Metcalfe	11/12	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗
Dr Margaret Steinberg	11/12	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓
Dr Kim Forrester	8/9[2]	✓	✓	✗	✓	✓	✓	✓	✓	✓	n/a	n/a	n/a

[1] Professor Donald participated in this meeting via teleconference. [2] Dr Forrester resigned in March 2009.

Table 2: Commission remuneration 2008–09

Position	Number	Remuneration
Commissioner	1	$106,587
Assistant Commissioner	7	$25,452

The remuneration payable to the Commissioner and Assistant Commissioners was approved by the Governor in Council on 22 June 2006 (Executive Council Minute No. 593).

governance

Our governance framework sets out the way we work to deliver our strategic plan and meet our organisational objectives.

We are independent, impartial and act in the public interest.

It supports accountability and transparency in our decision-making, operations and reporting.

The framework ensures we:

- effectively manage our operations and performance
- act independently, impartially and in the public interest
- meet our legislative obligations
- identify and mitigate risks
- foster a culture of continuous quality improvement
- report on our performance.

Reporting to our community

While our organisation is independent of government, we are accountable to the Queensland community and report to Parliament through the Minister for Health. In April 2009, the Premier announced the establishment of the Social Development Committee (a select committee). One of its roles is to monitor and report on the Commission.

The Committee will:

- monitor and review the Commissioner's performance and functions, and report any issues to the Legislative Assembly
- examine and comment on our Annual Report
- report to the Legislative Assembly any changes needed to the functions, structure and procedures of the Commission or the Act that it considers desirable for the Commission's effective operation.

Governing our operations

Four governance committees report to our Commission. These committees are chaired by a Commission member and comprise Commissioners, staff and in some cases, external stakeholders. Each committee works within defined Terms of Reference.

Audit and Risk

The Audit and Risk Committee reviews the Commission's budget and financial performance, and its strategic risk management. It comprises three members of the Commission and an external member, former Auditor General of Queensland Mr Len Scanlan. Our CEO is an ex officio member. The committee meets quarterly, working within the Queensland Treasury's *Audit Committee Guidelines*. See page 15 'Auditing our performance'.

We are the cornerstone of an external health governance framework.

Left: St Vincent's and Holy Spirit Health **Right:** HQCC Code of Conduct training

governance

Our advisory committees ensure we stay in touch with the latest clinical issues and grass roots community concerns.

Stakeholder Engagement
The Stakeholder Engagement Governance Committee oversees implementation of our stakeholder engagement strategy. Membership includes two members of the Commission (one as chair), together with the CEO, Manager of Community Engagement, the Directors of Complaint Services and Standards and Quality, and a representative from our advisory committees. The committee meets quarterly.

Complaint Services
The Complaint Services Governance Committee meets monthly to review the status of complaints and investigations. The committee comprises two members of the Commission (one as chair), together with the Director and Assistant Director of Complaint Services, and the Manager Investigations.

Knowledge and Research
The Knowledge and Research Committee facilitates knowledge sharing and the development of research opportunities. Committee membership is drawn from the Commission (two members, one as chair) and staff with an interest/expertise in research and knowledge management. The committee meets monthly.

Advising on clinical and consumer issues

As required by our Act, two committees advise our Commission to ensure we stay in touch with the latest clinical issues and grass roots community concerns.

Our clinical and consumer advisory committees are each led by two Assistant Commissioners and comprise up to 12 members, drawn from a variety of backgrounds. The committees meet every quarter and members serve two-year terms.

A state-wide membership expression of interest advertising campaign was undertaken in July 2008, with committee appointments made in October 2008. A second call for expressions of interest in the Consumer Advisory Committee was made in May 2009 following a member resignation.

The role of the committees is to:

- advise on clinical/consumer concerns, and on other matters referred by the Commission
- provide strategic advice
- facilitate communication with clinicians/consumers, carers and the community
- monitor and evaluate the Commission's engagement of clinicians/consumers, carers and the community
- advise on education needs for clinicians/consumers, carers and the community.

The committees are an important and highly valued part of our organisation, providing essential clinical and consumer insights, advice and feedback on healthcare issues, as well as supporting our work in improving the safety and quality of healthcare in Queensland. See page 103 for committee membership and biographies.

Providing specialist expertise

In addition to our advisory committees, we seek the expertise and feedback of our stakeholders through our Clinical Governance Reference Group, which serves as a preliminary consultation group before we engage in broader, more formal consultation. The group has a particular focus on our seven healthcare standards. Membership includes senior officers from both public and private healthcare. The group meets monthly. See page 104 for group membership.

We also appoint Key Stakeholder Reference Groups and Expert Reference Groups for key projects, such as implementing our heart attack standard across the continuum of care. These groups are formed for a specific purpose and include representation from a broad cross-section of our stakeholders, including healthcare consumers. Meetings are scheduled as required.

Leading our team

Our executive team manages the day-to-day operations of the Health Quality and Complaints Commission. The team is headed by our Chief Executive Officer, who is appointed by the Governor in Council, and comprises the

Table 3: Advisory committee remuneration 2008–09

Position	Number	Meeting schedule	Remuneration
Advisory committee member	20	4 meetings a year	meeting > 4 hours @ $281 meeting < 4 hours @ $141

Advisory committee member remuneration is according to the *Remuneration of Part-time Chairs and Members of Government Boards, Committees and Statutory Authorities* policy administered by the Department of Employment and Industrial Relations.

Directors of Complaint Services and Standards and Quality, the Assistant Director, Complaint Services, our General Counsel and the managers of our Community Engagement, Business Services and Information Management teams. Executives meet weekly to discuss strategy, plan operations and share information. The group provides leadership and direction to our employees and ensures we meet our strategic priorities and legislative responsibilities.

Achieving legislative compliance

The Health Quality and Complaints Commission operates under the *Health Quality and Complaints Commission Act 2006*. Our compliance with the 73 applicable mandatory obligations imposed by the Act is measured and reported to the Audit and Risk Governance Committee. This year we identified that we did not fully comply with these provisions. As at 30 June 2009, we had achieved compliance with all but two of these provisions, with one provision outstanding and under consideration.

Ensuring financial accountability

The Queensland Audit Office undertakes an annual audit of our financial documentation—both source documents and electronic systems—to ensure compliance with the *Financial Administration and Audit Act 1977*. See page 101 for the independent auditor's report.

Auditing our performance

The Audit and Risk Governance Committee met for the first time on 12 February 2009. To ensure appropriate scrutiny, we appointed an external committee member and engaged an advisory firm for 12 months to assist with our internal audit plan. In 2008–09, we commissioned an external review of our complaint assessment process and, as a result, a number of quality improvement initiatives were implemented or included in 2009–10 business unit operational plans. Remuneration for the external committee member was $1170 for 2008–09.

Managing our risks

Risk management is an integral part of our decision-making, planning and service delivery. A risk register modelled on the Australian/New Zealand Standard for Risk Management AS/NZS 4360 was established in 2007. This register was reviewed in 2008 and the revised register endorsed by the Audit and Risk Governance Committee. Risk management progress is reported and reviewed quarterly. In the past 12 months, we have reduced our legislative compliance risks through improved management and better use of our complaints and investigations case management system to ensure timeliness of complaint resolution.

Making a safe workplace

We work hard to ensure a safe and healthy work environment for our people. Organisational policies cover fire and emergency evacuation, personal security, duress alarm response, unannounced visitors and workplace rehabilitation.

New employees are introduced to these policies as part of our induction program.

This year, we participated in an annual influenza vaccination clinic, provided ergonomic education sessions and held fire evacuation drills. Two staff members nominated to be our Workplace Health and Safety Officers and participated in two modules of a formal Workplace Health and Safety course in October and November 2008.

Working with integrity

Our Code of Conduct details the standards of respect, integrity, diligence, economy and efficiency expected of our people. All new employees learn about the code during orientation and we conduct biannual Code of Conduct workshops. Our code aligns with the *Public Sector Ethics Act 1994*.

Consulting with our people

Our Positive Workplace Committee meets monthly to facilitate staff consultation and communication, with the goal of making our organisation an even better place to work. Members are appointed through an expression of interest process and serve for one year. This year the committee provided invaluable ideas and feedback on our move to 53 Albert Street, Brisbane, our annual staff cultural survey and Cultural Improvement Plan, team building events and workplace health and safety issues.

Engaging consultants

We engage a range of consultants to help us with both clinical and non-clinical matters. In 2008–09, we spent $324,528 on consultancy services:

- $255,758 on clinical opinions to support our complaint and investigation processes
- $10,886 on Dr Jayant Patel mediation hearings
- $57,883 on an external review of our complaint assessment process. See page 28 'Reviewing assessment'.

Travelling internationally

International travel cost $8017.11 this year.

- Michael Ward, Commissioner and Cheryl Herbert, CEO, Australasian Health Commissioners Meeting, New Zealand, $3217.44
- Cheryl Herbert, CEO, International Society for Quality in Health Care, Denmark, $4799.67.

our organisation

Every day our dedicated employees work with healthcare consumers, providers and other organisations and agencies to achieve better healthcare for Queenslanders. Led by our executive team, our people manage complaints, investigate health quality concerns, promote our seven healthcare standards and monitor quality improvement.

'Our people make all the difference. They've turned the culture of this organisation around.'
Cheryl Herbert, CEO

Meet our executive team

Cheryl Herbert
Chief Executive Officer

Cheryl has held roles across the health and community sector, with a practical grounding as a registered nurse and midwife. She has worked in community, aged care and acute settings, as well as in clinical, academic and management positions. Before joining the Health Quality and Complaints Commission, Cheryl was the CEO of Spiritus (formerly St Luke's Nursing Service) for 10 years, taking it from a cottage industry to one of Queensland's largest not-for-profit community organisations. Cheryl sits on the boards of the Alcohol and Drug Foundation of Queensland and Anglicare Northern Territory, and is a member of the state advisory committee for the Australian Council on Healthcare Standards. A graduate of the Queensland University of Technology and Monash University, Cheryl is now an Adjunct Associate Professor of the Faculty of Health Sciences at the University of Queensland, and a member of the University of Queensland School of Nursing and Midwifery External Advisory Group Committee.

Geoff Murphy
Director, Complaint Services

Geoff has been with us since 2006 and is Director, Complaint Services. He also serves as a member of the Child Death Case Review Committee, which reviews the deaths of children associated with the child protection system in Queensland. Geoff was a police officer for more than 20 years, and he has also worked as a registered nurse and midwife. He holds a Bachelor of Health Science (Nursing) and a Master of Business Administration.

'Working with health complaints provides many opportunities to improve health services, and people's lives.' Geoff Murphy, Director, Complaint Services

Peter Johnstone
Assistant Director,
Complaint Services

Peter joined us in July 2007, after 15 years in dispute resolution with the Department of Justice and Attorney-General, with four years as Executive Manager of the Dispute Resolution Branch. With more than 20 years' service to the state government, Peter is an accredited mediator and holds a Bachelor of Commerce and Master of Business Administration. He has also been an adjunct lecturer with Griffith University's School of Law. In 1997 he received an Australia Day Award for service to the Queensland Government.

Geoff and Peter lead our Complaint Services team, responsible for independently managing healthcare complaints and investigations. Together, they ensure complainants and healthcare providers receive an impartial, professional service and a timely response, whether that is from our well-trained complaint officers, our qualified conciliators or our experienced investigators.

Samantha Norton
Acting Director,
Standards and Quality

Samantha came to us in April 2008 from the United Kingdom's Healthcare Commission (now the Care Quality Commission). She has also worked as Senior Manager for Capio Healthcare (now Ramsay Healthcare), and as a Principal Pharmacist Oncology and a Chief Pharmacist. Samantha holds a Bachelor of Science with honours in Pharmacy, a Post Graduate Certificate in Clinical Pharmacy and a Diploma in Oncology Pharmacy, as well as a Master of Business Administration.

'I enjoy working with highly skilled and motivated people who are committed to achieving a worthwhile goal together.'
Samantha Norton, Acting Director, Standards and Quality

Samantha heads up our Standards and Quality team, focusing on the long-term improvement of our health sector through the development, monitoring and verification of our seven healthcare standards. Under her guidance, the diverse team undertakes research, consultation with hundreds of healthcare providers and analysis and verification of data from Queensland's 226 acute hospitals and day surgeries.

Megan Fairweather
General Counsel

Before joining the HQCC in December 2008, Megan was a Senior Associate in private legal practice specialising in health law and commercial litigation. Megan has experience in managing complex healthcare-related coronial inquests and has acted in a variety of claims arising from negligent medical care, clinical drug trials, registration board matters and discrimination. She has advised on issues involving the treatment of people with diminished capacity and in urgent medical care situations. Megan has assisted in health policy development, holds Bachelor Degrees in Arts and Law with Honours (I), and is a member of the Medico-Legal Society of Queensland.

Megan provides legal advice on matters ranging from complaints, to human resource and industrial relations issues, to contracts. Her specialist expertise is called on in preparing complex investigation reports. Megan also oversees the officer who manages applications to access our information.

Left to right, top row: Cheryl Herbert, Geoff Murphy, Peter Johnstone, Samantha Norton **Bottom row:** Megan Fairweather, Liz Kearins Steven Moskwa, Enrico (Henry) Petracci

our organisation

‘The great thing about working here is seeing the positive changes in healthcare and knowing we’ve been a part of it.’ Liz Kearins, Manager, Community Engagement

Liz Kearins
Manager, Community Engagement

Liz has more than 20 years’ experience in public and private sector strategic community relations, communications, media management and journalism (print, radio, television and new media). She has held roles in her native New Zealand, as well as the United Kingdom and Australia. Before joining us in May 2008, Liz worked in engagement and communication roles with Seqwater, Brisbane City Council, Keep Australia Beautiful and Tourism Queensland. Liz holds a Certificate in Journalism and a Diploma in Business Studies, and is a member of the Public Relations Institute of Australia.

Liz leads the Community Engagement team, which manages our engagement strategy, corporate communication, media liaison and online presence.

Steven Moskwa
Manager, Information Management

Steven has been with us since December 2007 following three years with the Department of Justice and Attorney-General as Assistant Director of Information Technology Services. He has previously held information management roles with the Department of Housing and Queensland Police Service. He received a Queensland Police Service medal in 2006.

Steven holds a Bachelor of Commerce and a Graduate Diploma of Human Resource Management and Industrial Relations.

Steve heads our Information Management team, which provides leadership and support in information management and communication technology, including infrastructure, network, database, application, web, telecommunications, information security, desktop support and facilities management.

Enrico (Henry) Petracci
Acting Manager, Business Services

Henry joined us in June 2008 from Queensland Health, where he worked as the Business Manager, Public Health Service. In that role, Henry was involved in supporting Queensland Health’s Banda Aceh Tsunami response and other General Public Health Disaster response teams. He has also held roles with the Oral Health Unit and the Darling Downs Regional Health Authority, after working for 13 years as a laboratory technician with the Government Chemical Laboratory. Henry has an Associate Diploma in Applied Science Chemistry and a Certificate in Food Science.

‘I enjoy working in an organisation that supports its staff and cares about their personal and professional development.’
Henry Petracci, Acting Manager, Business Services

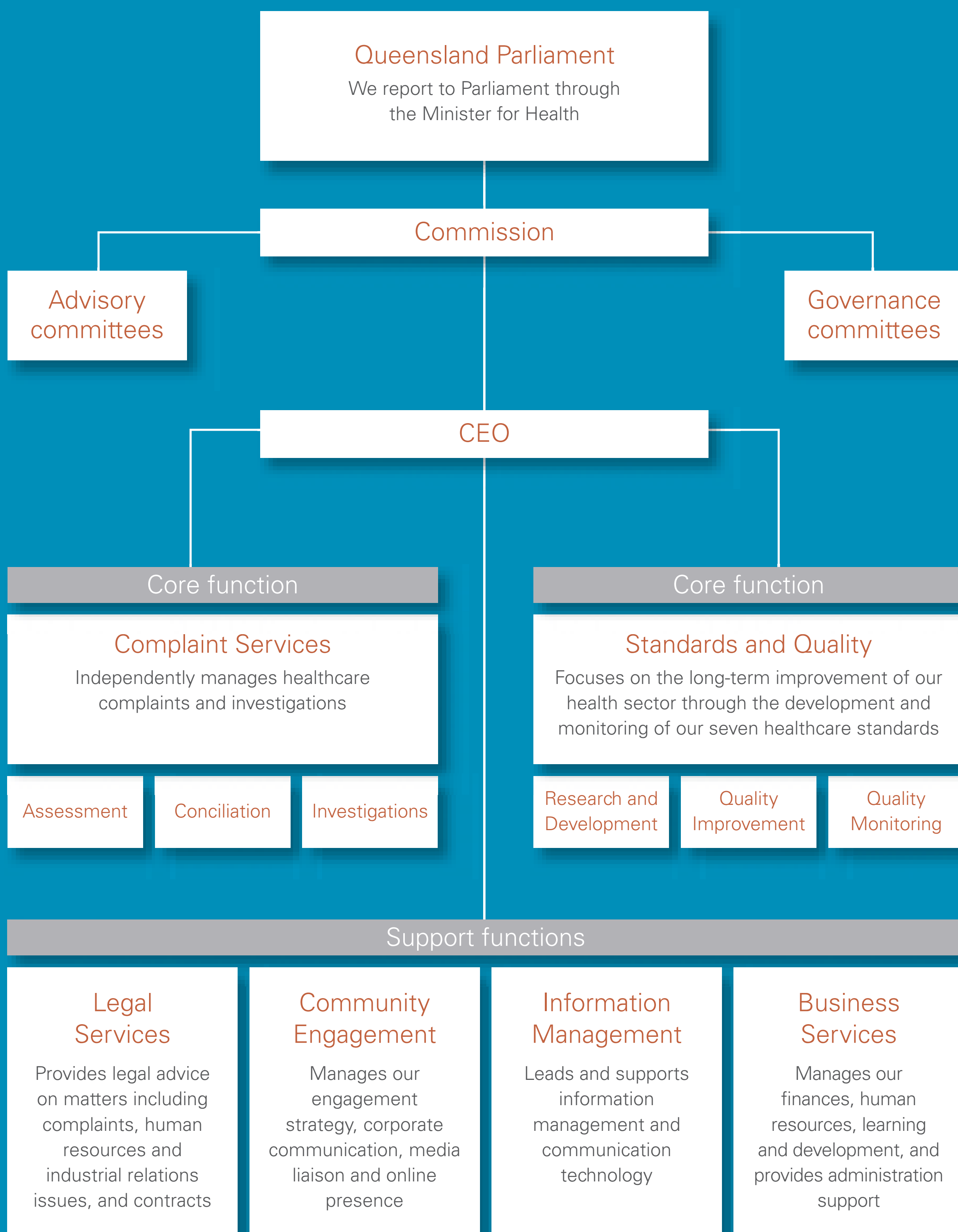
Julie Imber has been our Manager, Business Services since November 2006, but went on maternity leave in August 2008. She plans to return in September 2009. Julie has 17 years’ experience in corporate service roles with Queensland Health, including four years with the Brisbane North Division of General Practice, working in general practice policy. She holds a Bachelor of Business and a Graduate Certificate in Health Management, as well as qualifications in Management and Purchasing.

Henry and his Business Services team manage our finances, human resources and learning and development program. The team also provides vital administration support and coordination.

Former executive members

Dr Teresa Lynne was Assistant Director, Standards and Quality from July 2006 to August 2008 when she assumed the role of Acting Director, Standards and Quality, resigning in May 2009. **Dr Danielle Stowasser** was Director, Standards and Quality from June 2006 to August 2008.

organisational chart



parliamentary review

As part of its *Action Plan—Building a Better Health Service for Queensland*, the Queensland Government announced the Health Quality and Complaints Commission's performance would be reviewed after our first year of operation by an all-party parliamentary committee.

The Health Quality and Complaints Commission Select Committee was established by motion passed in the Legislative Assembly on 24 May 2007 and tabled its report *Review of the Health Quality and Complaints Commission and the Health Quality and Complaints Commission Act 2006* on 15 November 2007, making 37 recommendations to improve our operations. The committee stated that 'the implementation of these recommendations will improve the performance of the Health Quality and Complaints Commission and make it easier for both consumers and providers of health services to interact with the Commission'.

In February 2008, the Queensland Government announced that it would implement all of the Select Committee's recommendations.

With 22 of the 37 recommendations relating to communication or stakeholder engagement, the Commission set stakeholder engagement as an organisational priority.

To date, we have implemented 28 recommendations, with three in progress (Recommendations 19, 31 and 36). Of the remaining six, one is now the responsibility of Health Consumers Queensland (Recommendation 29), one is the responsibility of the Minister for Health (Recommendation 35) and four are to be implemented as part of the next parliamentary review (Recommendations 32, 33, 34 and 37).

Table 4: Status of parliamentary review recommendations at 30 June 2009

Recommendation		Status	Page
1	That the Health Quality and Complaints Commission continues to work and share information with other standard setting and quality focused organisations in other Australian and overseas jurisdictions as a means to continually improve the work being done by the commission in Queensland.	implemented	52
2	That the Health Quality and Complaints Commission continues to work with health service providers to build the lines of communication within the context of their ongoing professional relationship regarding complaints management.	implemented	53
3	That the Health Quality and Complaints Commission continues to monitor the complaints resolution and investigation units of the commission to ensure staff numbers are adequate.	implemented	65
4	That the Health Quality and Complaints Commission ensures specialist ongoing training of complaints management staff in the areas of communication and negotiation, time management, managing difficult behaviours, stress management and working with grieving complainants.	implemented	28, 43, 67
5	That the Health Quality and Complaints Commission includes in its conciliation fact sheet reference to its policy of conciliating towards an outcome and where conciliation meetings may be held.	implemented	31
6	That the Health Quality and Complaints Commission implements hardcopy and/or electronic feedback and evaluation forms to facilitate complainant and provider feedback on completion of the complaint management process	implemented	32
7	That the Health Quality and Complaints Commission continues to liaise with other standard setting organisations, such as the Australian Commission on Safety and Quality in Health Care, to ensure to the extent possible that its standards are consistent with the standards set by other Australian health bodies.	implemented	52
8	That the Health Quality and Complaints Commission continues to work with both providers and other health-related data collection agencies to streamline data collection and minimise duplication of reporting by providers.	implemented	51

	Recommendation	Status	Page
9	That the Health Quality and Complaints Commission reviews its website and other promotional material to ensure that the independence of the commission is clearly articulated.	**implemented**	31
10	That the Health Quality and Complaints Commission develops a comprehensive, overarching consumer engagement strategy for the effective engagement of all consumers of health services throughout Queensland.	**implemented**	14 and reaching out sections
11	That as part of its consumer engagement strategy, the Health Quality and Complaints Commission builds local networks and utilises these networks as a valuable source of, and conduit for, quality information and to provide assistance and information to consumers relevant to their rights regarding healthcare and quality improvement in health services.	**implemented**	33
12	That the Health Quality and Complaints Commission continues to establish strong links with the Office of the Ombudsman, consulting with it where appropriate on strategies for effective community engagement and working together to mutually promote each office's work where appropriate.	**implemented**	32
13	That as part of its consumer engagement strategy the Health Quality and Complaints Commission continues working towards raising its profile and engaging with consumers and communities through a number of initiatives such as regional visits, road trips, regular network meetings, use of the media, circulation of brochures, enhancement to its internet site and public reporting on the quality of health services.	**implemented**	31, 44, 109
14	That the Health Quality and Complaints Commission employs a dedicated community engagement manager responsible for the development and implementation of its consumer engagement strategy, provider engagement strategy and all external communications.	**implemented**	18
15	That as part of its consumer engagement strategy the Health Quality and Complaints Commission: – develops innovative outreach strategies targeting particular groups within the community, such as people with physical and mental illness, people with disabilities, older people, people with low literacy levels, Aboriginal peoples, Torres Strait Islanders, people from culturally and linguistically diverse groups and people in remote, regional and rural areas; – consults with the Consumer Advisory Committee regarding the development and implementation of innovative outreach strategies targeting those particular groups identified above; and – works with health community councils and local facilities to assist and educate the particular groups identified above on the role of the commission, its health complaints services, consumer rights and responsibilities and health quality improvement.	**implemented**	14, 29, 33, 34
16	That the Health Quality and Complaints Commission ensures that its Complaints Service Charter is widely promoted to consumers and providers and made available on the HQCC website in a number of different community languages.	**implemented**	28, 29, 32
17	That the Health Quality and Complaints Commission genuinely consults with the Consumer Advisory Committee on the content of the Code of Health Rights and Responsibilities.	**implemented**	54
18	That as part of its consumer engagement strategy the Health Quality and Complaints Commission develops a detailed consultation plan to meet its legislative responsibility for wider consultation on the content of the Code of Health Rights and Responsibilities; and that the consultation plan includes an education campaign prior to the consultation phase to clarify issues for community members and providers and inform discussion on the content of the code.	**implemented**	54
19	That the Health Quality and Complaints Commission designs and implements a promotional campaign for consumers and providers throughout Queensland on the principles and objectives of the Code of Health Rights and Responsibilities and the role the code plays in quality improvement of health services within Queensland.	**in progress**	54
20	That the Health Quality and Complaints Commission consults with health service providers regarding existing standards for quality improvement and prior to the implementation of any new standards. This would include consultation in relation to issues of implementation, data collection, compliance measurement and reporting mechanisms.	**implemented**	52, 54
21	That the Health Quality and Complaints Commission develops networks with provider stakeholder organisations to assist it to engage grass-roots providers about the quality of health services, including the making of standards and quality improvement processes.	**implemented**	46, 52

parliamentary review

	Recommendation	Status	Page
22	That the Health Quality and Complaints Commission considers extending representation on the Clinical Governance Reference Group to include representatives from other provider stakeholder groups such as General Practice Queensland, the health practitioner registration boards and the Queensland Nursing Council as it moves forward on its agenda improvement processes.	**implemented**	51
23	That the Health Quality and Complaints Commission develops a comprehensive provider focused engagement strategy to be delivered state-wide over the next three years.	**implemented**	52
24	That the Health Quality and Complaints Commission develops a communication plan and ongoing outreach program to improve access for consumers and providers of health services throughout Queensland.	**implemented**	60, 109
25	That the Health Quality and Complaints Commission continues to work with the Queensland Ombudsman and other government agencies as appropriate, to identify innovative solutions to facilitate improved access to the commission services by special needs groups.	**implemented**	32
26	That the Health Quality and Complaints Commission considers appointing Indigenous staff and/or consultants who would take the lead in liaison with Aboriginal communities and Torres Strait Islander communities to improve access to the commission and communications between these groups and the commission.	**implemented**	33, 34
27	That the Health Quality and Complaints Commission considers further extending the use of its website for complaints lodgement by including the ability to complete complaints forms online and email these directly to the commission.	**implemented**	29
28	That the Health Quality and Complaints Commission continues to explore other avenues for improved access to its services by both consumers and providers, such as the use of integrated service provision like Smart Service Queensland.	**implemented**	60
29	That the Health Quality and Complaints Commission develops, for the consideration of the Minister for Health, a proposal (including an estimate of the additional funding required) for the establishment of an independent patient support officer service provided by the non-government sector and managed through the commission.	**responsibility of Health Consumers Queensland**	–
30	That the Health Quality and Complaints Commission identifies and engages with non-government organisations providing support and assistance to healthcare consumers to ensure these organisations have a clear understanding of the commission's complaints management system.	**implemented**	31
31	That the Health Quality and Complaints Commission continues investigating options for face-to-face conciliation to be provided through third-party mediators subject to adequate education, supervision and monitoring of the provision of those services.	**in progress**	–
32	That a review of the Health Quality and Complaints Commission's process of referring matters to the relevant health practitioner registration board for disciplinary action be included in the next parliamentary review of the commission (see recommendation 37).	**responsibility of parliamentary committee**	–
33	That the Health Quality and Complaints Commission's powers regarding imposing penalties or otherwise dealing with breaches of the standards be considered by the parliamentary committee appointed to undertake the next review of the commission (see recommendation 37).	**responsibility of parliamentary committee**	–
34	That a review of the effectiveness of the Code of Health Rights and Responsibilities be included in the next parliamentary committee review of the commission (see recommendation 37).	**responsibility of parliamentary committee**	–
35	That the Minister for Health considers amendments to the *Health Quality and Complaints Commission Act 2006* of similar intent as the amendments provided for under the *Health Legislation Amendment (Unregistered Health Practitioners) Bill 2006* in New South Wales.	**responsibility of Minister for Health**	–
36	That the Minister for Health considers an amendment to section 22 of the *Health Quality and Complaints Commission Act 2006* to include the requirement for the commission to undertake an impact assessment prior to the development of any future standards.	**in progress**	–
37	That the Health Quality and Complaints Commission and the *Health Quality and Complaints Commission Act 2006* be reviewed by a parliamentary committee on an ongoing, periodic basis and that the Legislative Assembly of Queensland establishes a committee to undertake the next review in three years time. The parliamentary committee should be given a period of at least six months to undertake its review and make its recommendations to Parliament.	**responsibility of parliamentary committee**	–

responding 1

Working with healthcare consumers and providers to learn from complaints

1 responding

Most people don't like to complain. It's even harder if they're upset, busy or think it won't make a difference. But every complaint is an opportunity to improve.

This year 4711 Queenslanders contacted us to share their concerns. We worked with them and their healthcare providers to sort through the issues. Their complaints also helped us identify patterns of provider practice and emerging healthcare issues.

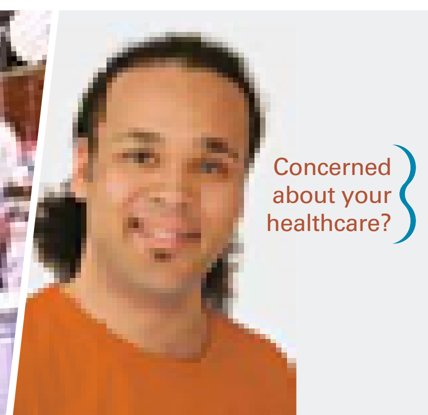
Highlights

- We increased the number of complaints closed within 30 days to 54%, up 12% on last year.
- We reduced the caseload of each complaint officer from 30–40 files to 20–30, resulting in better decisions and quicker outcomes.
- We launched our online complaint form, making it easier and faster to complain.
- We attended more community and professional events than ever before, developed new promotional material and improved our website.
- We introduced our client experience survey to seek feedback on our service.
- We appointed an Indigenous Liaison Coordinator and reached out to Aboriginal and Torres Strait Islander communities.

Challenges

- **Managing complaints within legislated timeframes**
  We work with healthcare consumers and providers to manage complaints within strict legislated timeframes of 30 days for early resolution cases and a maximum of 90 days for assessment decisions. With limited staffing and an often complex caseload, working within these timeframes is an ongoing challenge. In January 2009, we instituted more rigorous supervisory processes, resulting in significant improvement. We also closed more than twice as many assessment cases in the second half of the year as in the first half, allowing us to enter 2009–10 with only a minimal complaint backlog.
- **Ensuring data integrity**
  Accurate and complete information about complaints is essential for efficient complaint management. We regularly review our data and recognise the need for continuous quality improvement. In 2008–09, we continued to work with our staff and our software partner to improve the integrity of our data. Additional checks and balances have been put in place to ensure data accuracy.
- **Increasing access to our services**
  Ensuring the community knows where to turn with their healthcare concerns and making it easier for people to complain are challenges for a small organisation with limited resources. This year, we introduced an online complaint form, prepared new information materials, appointed an Indigenous Liaison Coordinator and developed a brochure for people from culturally and linguistically diverse communities.
- **Reaching culturally and linguistically diverse communities**
  Funding constraints meant we were unable to appoint a dedicated Multicultural Officer to coordinate our engagement of culturally and linguistically diverse peoples. Instead, we incorporated our multicultural engagement program within our broader stakeholder engagement strategy and used existing resources to deliver it.

We referred 232 complaints to external agencies and professional registration boards.



Left: Punyahra Health Expo, Logan **Right:** New promotional poster

Table 5: Performance report card

	2006–07	2007–08*	2008–09
Enquiries and complaints			
Total—Enquiries and complaints received	4451	4570	4711
Enquiries received	1529	1895	2177
Complaints received	2922	2675	2534
Total—Enquiries and complaints closed	4402	n/a	4678
Enquiries closed	n/a	n/a	2115
Complaints closed	n/a	n/a	2563
Complaints closed in direct resolution or early resolution	n/a	n/a	1786
% of complaints in early resolution process closed within 30 days	n/a	n/a	82%
% of total complaints closed within 30 days	38%	42%	54%
Complaints referred to conciliation	n/a	n/a	121
Complaints referred to investigation	n/a	n/a	78
Complaints referred to registration boards	133	143	159
Complaints referred to external agencies	7	37	73
Open complaints as at 30 June	n/a	834	610
Assessment			
Complaints closed in assessment	n/a	n/a	423
% of complaints in assessment closed within 90 days	n/a	n/a	61%
Open complaints in assessment as at 30 June	n/a	159	155
Conciliation			
Complaints closed in conciliation	n/a	104	108
% of conciliations closed within 12 months	n/a	n/a	71%
Open complaints in conciliation as at 30 June	n/a	145	150

* We introduced a new complaints and investigations case management system in December 2007, which improved the way we record, collate and analyse our data. Some data sets from previous years are not available due to this system change.

Our performance and complaint process

This year, we received 2177 enquiries from Queenslanders concerned about their healthcare. The number of enquiries has increased over the past three years.

We received 2534 formal written complaints in 2008–09. When a complaint is made, we always consider if it can be quickly resolved either through direct resolution between the complainant and the healthcare provider or with our help, through our informal 30-day early resolution process. This year 82% of early resolution complaints were closed in 30 days.

If a complaint is not resolved, we assess if further action is required. This should take up to 90 days. This year 61% of complaints assessed were closed within the 90-day time frame.

Once assessed, a complaint may be referred to a professional registration board or external agency with the power to take appropriate action. Some 232 such referrals were made in 2008–09.

A complaint may also be referred to conciliation—a confidential, free service we offer to enable open communication between a complainant and their healthcare provider. We closed 108 conciliations this year.

About 3% of complaints are referred to our investigation team for more in-depth consideration. These complaints are usually about more serious or systemic issues. Our investigators managed 78 complaint referrals this year (see page 36 'Investigating').

Sometimes after reviewing all the information provided, we decide we cannot take a complaint any further. We explain why to the complainant and keep the complaint on record to help us identify patterns of provider practice or more widespread system issues.

> 'Thank you for assisting me with this process. I could not have done it on my own!'
>
> Healthcare complainant

1 responding

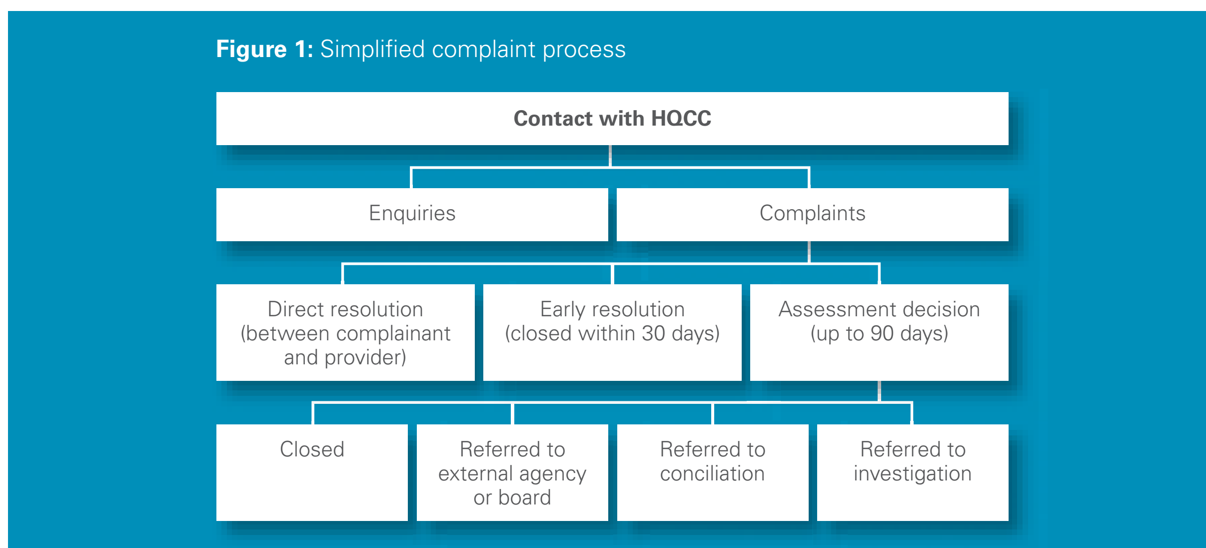


Figure 1: Simplified complaint process

Referring complaints to the right agency

Our organisation seeks to improve the quality of health services in everything we do. We do not find fault or apportion blame. We immediately refer to the appropriate agency serious allegations that may require investigation and potentially disciplinary action, such as sexual misconduct or unprofessional conduct.

A new position has been created in our Complaint Services team to ensure we stay 'in the loop' with all cases referred to external agencies. We monitor these cases and maintain an active interest through progress reports. We referred complaints to organisations such as:

- the Medical Board of Queensland
- Queensland Health's Ethical Standards Unit
- the Queensland Nursing Council
- the Crime and Misconduct Commission
- the Queensland Police Service.

Putting complaints in perspective

We received 2534 complaints in 2008–09. To put that number in perspective, throughout 2008–09:

- 57 million billable services were recorded by Medicare (of which 19.5 million were visits to general practitioners)
- 38 million Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme services were recorded by Medicare
- 881,794 people were admitted to public hospitals
- 1,524,549 people were treated in public hospital emergency departments
- 3,357,333 outpatient services were provided by Queensland Health.

Sources: Medicare 2008–09 Statistics for Queensland; June 2009; Quarterly Public Hospitals Performance Report, Queensland Health.

Reviewing our decisions

If a client is unhappy with our decision about their complaint, they can apply for their case to be reviewed. We received 48 such applications this year.

Should a client remain dissatisfied with our action and believe that we have made a decision that is unfair or incorrect, we advise that they can complain to the Queensland Ombudsman.

Managing complaints about us

We received 10 complaints about our service in 2008–09, largely about our complaint and investigation processes and access to information. We view all feedback as an opportunity to learn and improve our service.

Our Complaints Management Policy aligns with the *International and Australian Standard AS ISO 10002–2006 Customer Satisfaction—Guidelines for complaints handling in organisations*, issued by Standards Australia in April 2006; *Directive 13/06 Complaints Management Systems*, issued by the Public Service Commissioner, Queensland, in November 2006; and *Effective Complaints Management: Guide to developing effective complaints management policies and procedures*, published by the Office of the Queensland Ombudsman, in December 2006. Both our Complaints Management Policy and our Complaints Service Charter are available on our website.

In June 2009, the Queensland Ombudsman provided feedback on our internal complaints process as part of its Complaints Management Program. Our level of compliance with Directive 13/06 was assessed as *satisfactory compliance*.

Figure 2: Reason for complaint 2008–09

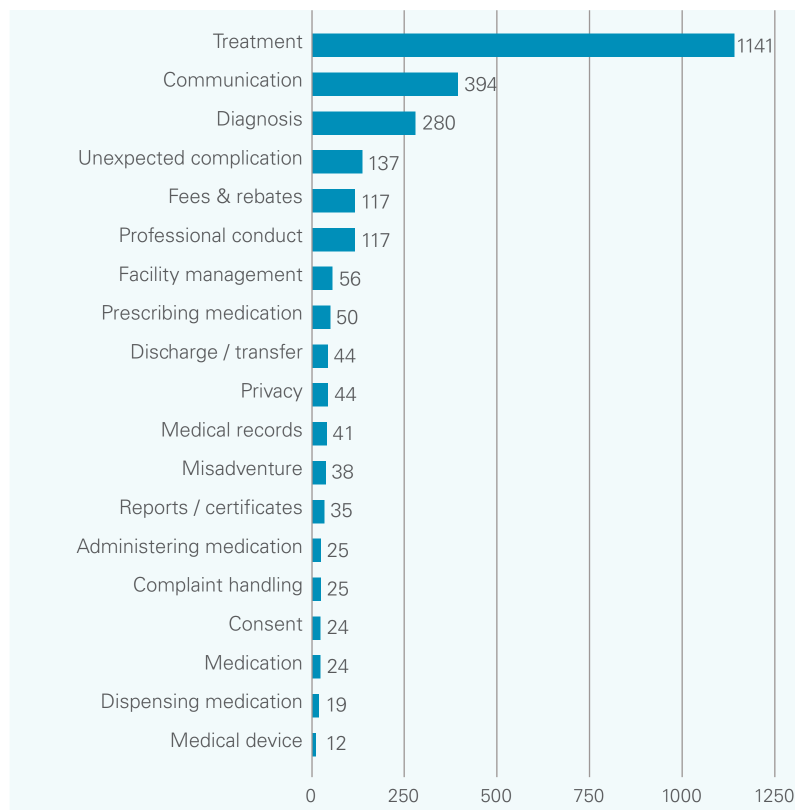
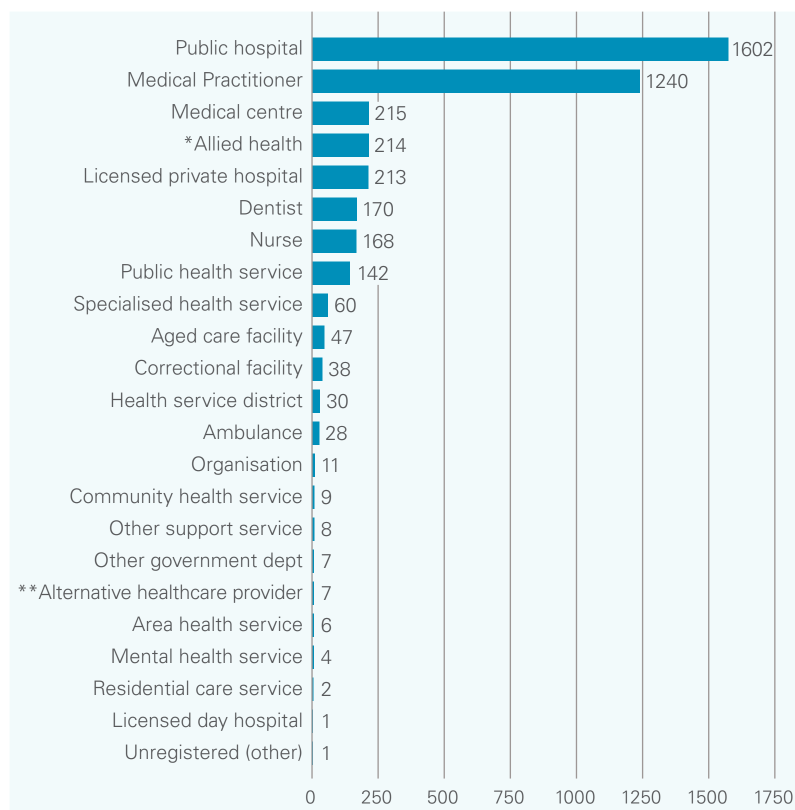


Figure 3: Complaints received by healthcare provider 2008–09



Getting the bigger picture

Our complaints are entered into a database, which allows us to analyse complaint trends and identify individual and organisational patterns of practice. These graphs show the types of issues complainants raised and the providers involved.

* Allied health comprises Chiropractor, Dental Prosthetist, Dental Technician, dental service, Medical Radiation Technologist, Occupational Therapist, Optometrist, Pharmacist, Physiotherapist, Podiatrist/Chiropodist, Psychologist, laboratory service, health promotion service and pharmaceutical service.

** Alternative healthcare providers comprise Kinesiologist, Massage Therapist, Naturopath and Homeopath.

1 responding

The Ombudsman made six recommendations for policy improvement which will be implemented in 2009–10. Our online complaint information was also reviewed. Visibility was assessed as *high* and access was assessed as *satisfactory*. An online complaint form for complaints about our service and a printable version of the form were recommended.

Improving our service

We worked hard in the past year to improve our customer service and provide a more timely outcome for our clients and healthcare providers. This is reflected in our results.

We almost halved the active caseload of our complaint officers through improved workflow. Our complaint officers previously had 30–40 open cases at any time. By improving decision making based on our legislation and our Complaints Manual, we are progressing complaints more efficiently. Our officers now work with around 20–30 open files each, resulting in better decisions and quicker outcomes.

By May 2009, we were meeting our 30-day early resolution timeframe 100% of the time—a first for us. By increasing staff supervision and support, we streamlined our reporting arrangements, reducing the number of complaints remaining open longer than the legislated timeframe. In January 2009, we had about 75 complaints that had been open for more than 90 days. By June, the figure was 12 complaints and we expect this number to drop in 2009–10.

We also began seeking feedback on our service from complainants and healthcare providers. Results will be reported in 2009–10. See page 32 ‘Helping us to help you’.

Reviewing assessment

As part of our internal audit program, we employed external consultants to review our complaint assessment process. The review report, delivered in April 2009, made 28 recommendations covering work processes, team roles, learning and development, and communication, for example:

- redeveloping our Complaints Manual into a practical procedures manual
- introducing regular short training sessions to ensure common interpretation of our Act
- establishing an additional lower level role to reduce the administrative burden on complaints officers and provide career progression.

A plan has been developed to implement the recommendations of the review.

Outside of the review process, we introduced a number of improvement strategies within our complaint assessment area n 2008–09, including:

- enhancing our complaint and investigation case system to make it easier to enter complaint information
- summarising our complaint service charter so clients know what they can expect from us
- developing a guided learning program for complaint officers to ensure understanding of legislative requirements and our processes
- organising further complaint management training for our team.

We also committed to further improving internal communications and development opportunities for complaint officers.

> ‘I truly appreciate all your help, kind words and compassion. I hope you understand how much this process and outcome means to my family and myself, as well as potentially many other women and their babies.’ Healthcare complainant

We almost halved the active caseload of our complaint officers through improved workflow.

Left: Queensland Shelter Conference **Right:** Using the quiet room in our new office

Our Complaint Services Governance Committee provided guidance on strategies to improve timeliness of complaint management.

Complaining is easier

Not only have we improved our service, we have also improved access to it.

We reviewed all of our consumer and healthcare provider information to ensure the process of making a complaint is clear and easy to follow. In June 2009, we launched an online complaint form which simplifies and speeds up the process of making a complaint. Details of the uptake of this form will be included in next year's Annual Report and we expect to see a change in how people contact us. At the moment, 59% of our complainants make first contact by telephone.

Facilitating the Bundaberg Special Process

While we had anticipated that all patient claims for compensation under the Bundaberg Special Process would be finalised in 2008–09, three cases remain open. These matters are expected to be finalised in 2009–10.

The Bundaberg Special Process was established by the Queensland Government in 2005 in response to events surrounding the work of Dr Jayant Patel. A total of 386 claims were lodged. We adopted the responsibilities of our predecessor, the Health Rights Commission, by helping unrepresented claimants and undertaking specialist independent reviews. The Bundaberg Special Process remains under the direction of an interdepartmental committee, facilitated by our organisation.

Table 6: Method of enquiries

	2006–07	2007–08	2008–09
Telephone	77%	65%	59%
Mail	19%	30%	33%
Email	3%	3%	4%
Other, fax or in person	1%	2%	4%

Table 7: Bundaberg Special Process claims settled 2006–09

	2006–07	2007–08	2008–09
Settled	334	81	5

Some cases were reopened, accounting for multiple settlements.

Case study: Helping the homeless

Our Consumer Advisory Committee plays a key role in developing strategies to reach consumers. This year we received invaluable help in engaging the homeless community from Brisbane committee member Gary Penfold. We exhibited at Queensland Shelter's annual conference and participated in Brisbane City Council's Homeless Connect event. In June we were contacted by our first homeless complainant. Gary talks about the importance of quality healthcare for the homeless.

The connection between housing and health

There is evidence that up to two thirds of Australia's homeless population struggle with mental health, drug and/or alcohol related issues. Queensland Shelter recently surveyed 26 homeless people, asking them what would help them 'maintain their tenancies if they were housed'. Regular support and access to health services featured prominently in their responses.

It is inevitable that once people are provided with housing, other needs that may have been neglected (including healthcare) will become a higher priority. This presents additional challenges to health professionals and the public health system.

Responding to homelessness

The Federal Government this year released its Homelessness White Paper—a key theme of which is ensuring mainstream health services are more responsive to the unaddressed needs of homeless people. This has enormous implications for Queensland as we have the second highest rate of homelessness per head of population (after the Northern Territory).

1 responding

Our complaint officers now work with 20–30 open files each, resulting in better decisions and quicker outcomes.

Left: Our Chief Conciliator, Joan Welsh **Right:** National Heart Foundation Conference

Case study: Driving improvement

The people who come to us with a complaint generally have one thing in common—they don't want the same thing to happen to someone else. They may also be seeking an apology, a change in process, and sometimes a financial remedy, as in the case of a man who complained to us that a plastic surgeon had failed to remove a cancerous growth during a skin cancer procedure.

The man was referred to the surgeon about a growth on the side of his nose. The surgeon confirmed the lesion was cancerous and sketched the excision site in her notes. During surgery a piece of skin was removed and a new section grafted.

When the bandages came off, the man noticed the lesion was still there and that another part of his nose had been operated on instead. He reported the error to the surgeon, who stated that an error was unlikely as she had followed her diagrams.

The patient saw the surgeon twice after surgery—on the second occasion the surgeon showed him a report that stated a microscopic amount of skin cancer had been removed. The surgeon offered to perform another surgery to remove the lesion, free of charge.

However the man chose to have another doctor do the surgery. Tests confirmed a larger skin cancer.

The man tried unsuccessfully to resolve his concerns with his original surgeon and contacted us for help. He was seeking an admission of error and an apology, as well as new procedures to prevent the same thing from happening to someone else. He also wanted to be reimbursed for his medical costs.

When we contacted the plastic surgeon, she admitted it was possible she had made a mistake.

We obtained independent clinical opinion which stated:

- the initial biopsy site was not the one excised by the surgeon
- the small skin cancer found by the first procedure was likely a new, incipient tumour and it was probably not necessary to remove it
- the surgeon should have had the patient confirm the site before surgery, in line with international leading practice and the HQCC surgical safety standard.

As a result of the complaint, the surgeon has changed the way she practises and now photographs lesion sites before biopsy as an extra safeguard.

As we do not decide or award compensation, the request for reimbursement was settled between the patient and the surgeon's insurance company.

Some details in this case study have been changed to protect the privacy of those involved.

Conciliating resolution

Conciliation offers a cooperative and non-adversarial approach to resolving complaints. The privileged and confidential process can provide an alternative to litigation in medical injury cases and offers an independent and impartial forum for exploration of health service complaints.

Legal counsel are often involved, with both plaintiff and defendant lawyers acknowledging the benefits of the process in enabling complainants to maintain a sense of involvement in their cases and avoid the feeling of powerlessness that sometimes comes with litigation.

In the past year, a significant number of obstetric complaints have been referred to conciliation for resolution. Our observation of these cases suggests that communication between the complainant and treating team or treating doctor is a key issue. While some of these complaints resulted in financial settlements, many others were resolved by having the parties come together to discuss the events that caused distress. An explanation or apology was often sufficient to defuse the anger and unhappiness that instigated the complaint.

Conciliation is not a fast route to compensation. If a complainant seeks financial recompense, the same standard of proof applies as it would if the matter was before a court. However, in 2008–09 a number of large settlements were recorded as an outcome of conciliation.

Providing freedom of information

We received 45 applications, mostly from complainants, for access or amendments to our documents, under the *Freedom of Information Act 1992*. For a detailed breakdown, see page 108.

Anticipating a change to legislation in this area, we prepared for both the *Right to Information Act 2009* and the *Information Privacy Act 2009* to ensure we share as much organisational information as possible while maintaining client privacy. Both acts have implications for our business, including the process of document release.

We created a designated position to manage applications for information.

> 'It's always our preference to resolve these matters in conciliation rather than go down legal avenues. We know that you are better equipped to deal with people in times of emotional crises.'
>
> Hospital legal representative

Reaching out

Promoting our services

We significantly increased our community presence this year with the express purpose of introducing more healthcare consumers and providers to who we are and what we do, and encouraging people to come to us with their concerns.

We participated in community and professional events, such as NAIDOC Week celebrations, the Queensland Multicultural Festival and the Heart Foundation Conference, prepared a fresh suite of information and promotion materials, and refreshed our brand to better convey our collaborative approach to quality improvement. Our new look was launched in May 2009.

To target our messages, we developed two brochures and a double-sided poster aimed at healthcare consumers and providers. Between April and June 2009, we distributed almost 40,000 brochures and 2500 posters to:

- healthcare providers, including public and private hospitals and general practitioners
- federal and state politicians and local governments
- industry leaders, such as registration boards and fellow complaint agencies
- multicultural groups, such as migrant services and ethnic community councils
- community services, including welfare groups and legal services.

Improving our online presence

We launched our redeveloped website in June 2009, with improved content and simpler navigation. The website now provides tailored information for healthcare consumers and providers, so people can find what they need quickly and easily.

The site has increased capability and new features such as:

- an online complaints form giving people the opportunity to complain anytime
- a survey tool so we can seek feedback from our stakeholders
- improved accessibility with a text only version of the site and a feature for people with impaired vision
- an e-newsletter function so we can keep people in touch with the latest news
- forums to give our advisory committee and reference group members a place to network.

The website upgrade forms part of our three-year Online Strategy (see page 62).

1 responding

'I appreciate the well established relationship between you and our hospital which facilitates appropriate and timely attention to concerns raised by patients and their families.' Healthcare provider

Knowing where to turn

We joined forces with our fellow complaint agencies to develop a shared complaint portal, which is due to be launched in October 2009. This new 'one-stop shop' will help Queenslanders know who to talk to when things go wrong.

We are working on this project with:

- Queensland Ombudsman
- Commonwealth Ombudsman
- Commission for Children Young People and Child Guardian
- Anti-Discrimination Queensland
- Crime and Misconduct Commission.

The portal will also feature information about:

- Financial Ombudsman Service
- Office of Fair Trading Queensland
- Energy Ombudsman Queensland
- Telecommunications Industry Ombudsman
- Superannuation Complaints Tribunal
- Workplace Ombudsman
- Legal Services Commission Queensland
- Private Health Insurance Ombudsman.

The web portal will be launched alongside a shared brochure entitled 'It's OK to complain'. To increase access to our services, the brochure will be available in 15 community languages—Vietnamese, Mandarin simplified, Cantonese, Korean, Japanese, Arabic, Torres Strait Creole, Hindi, Farsi, Thai, Burmese, Dari, Amharic (Ethiopian), Somali and Sudanese (Dinka).

Helping us to help you

To further improve our service, we introduced a Client Experience Survey in June 2009. Both complainants and healthcare providers will be asked for their feedback when we send our final letters from early resolution, assessment and conciliation. Data from completed surveys will help us measure our service quality and make improvements. Results will be reported in next year's Annual Report.

Top, left to right: Indigenous information sharing day (first four images); Elizabeth Marnock, Metropolitan South Institute of TAFE (last image)
Bottom left: NAIDOC celebrations **Bottom right:** Multicultural Festival

Engaging Indigenous peoples

An Indigenous Liaison Coordinator was appointed in July 2008 to coordinate implementation of our Aboriginal and Torres Strait Islander peoples engagement strategy. In the past year, we:

- held three Indigenous information sharing days to increase the cultural awareness of all employees
- implemented mandatory data collection for identified Indigenous complainants
- created a database of Indigenous consumer and provider groups, and key Queensland Aboriginal and Torres Strait Islander healthcare organisations
- developed internal resources on Aboriginal and Torres Strait Islander cultures, engagement and health
- established a network of Indigenous staff among our fellow complaint agencies and explored avenues for resource sharing
- reached out to the community by attending events such as NAIDOC Week celebrations and Punyahra Indigenous Health Expo
- held our own internal events on Close the Gap Day and National Sorry Day.

The coordinator was supported by our Cultural Broker Group (see page 107), comprising staff who champion Indigenous and multicultural action within our organisation and serve as a resource to co-workers.

Our Indigenous Liaison Coordinator was called upon to help with more than 10 complaints and four investigations. Through this work, we identified a need to develop a culturally appropriate avenue to encourage Indigenous peoples to complain (see page 34).

Engaging multicultural communities

While we drafted our Multicultural Action Plan (MAP) in 2007–08, we have been unable to realise our plans to employ a dedicated Multicultural Officer due to funding constraints. Instead, we have incorporated actions from the MAP into our Stakeholder Engagement Plan. In the past year, we:

- worked with our fellow complaint agencies to develop a shared complaint portal and brochure to be translated into 15 community languages
- reached out to culturally and linguistically diverse consumers at the Queensland Multicultural Festival, providing information and advice about our services
- distributed our new brochures and posters to migrant services and ethnic community councils
- included in our brand refresh imagery that reflects Queensland's cultural diversity
- attended meetings of the Interdepartmental Committee on Multicultural Affairs
- spent $1569 on translation and interpreter services for complainants.

Case study: Building relationships

In one year, our Indigenous Liaison Coordinator made more than 50 visits to 19 cities and communities. Elizabeth Marnock from Metropolitan South Institute of TAFE talks about how important it is for us to engage with Indigenous communities.

'The Health Quality and Complaints Commission provides a vital service to the public. But it is a service that has been generally unknown to Indigenous communities, individuals and families in Queensland until the past year.

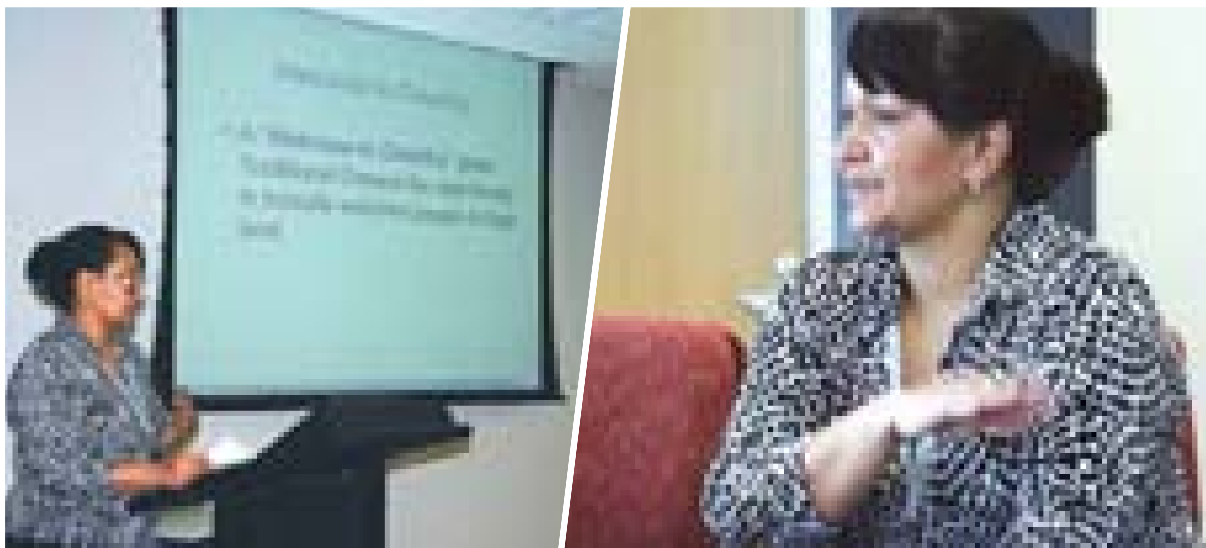
To promote the HQCC's service, and to effectively engage with Indigenous communities, it is important to gain their trust. This ensures Indigenous people are comfortable dealing and communicating with the organisation, and in accessing the services it provides.

Personally, I had no idea that the agency even existed until Indigenous Liaison Coordinator Cheryal Kyle took the time to visit me and share information about the agency's roles and functions. Because of Cheryal's credibility and effective community engagement practices with Indigenous communities, she is readily accepted by many Indigenous people. So when she contacted me, I was happy to introduce her to management within my organisation and to pass on information about the agency.

Since then, I have had regular communication with Cheryal, contact at various community events, such as NAIDOC functions, and was invited to a recent Indigenous Community Engagement Workshop.

I support the effort the HQCC has made to improve engagement with Indigenous people and it's great to know that there is an Indigenous officer within the organisation as a point of contact.'

1 responding



Indigenous Liaison Coordinator Cheryal Kyle led an Indigenous Information Sharing Day for our staff, helping us to understand the cultural sensitivities involved when working with Aboriginal or Torres Strait Islander complainants, health workers and communities.

In collaboration with the other Queensland complaint agencies, in October we will launch a campaign to promote the 'It's OK to complain' brochure and web portal, with a particular focus on culturally and linguistically diverse communities.

Looking ahead

Encouraging Indigenous complaints

We will appoint a permanent Indigenous Complaint Liaison Officer (identified) in September 2009 to provide culturally appropriate support to Aboriginal and Torres Strait Islander peoples. This officer will also have community engagement responsibilities, allowing for time out of the office to meet with Indigenous communities and healthcare providers. We will develop culturally appropriate information material by engaging Indigenous artists to interpret our key messages as artwork to be reproduced in brochure and poster form, as well as online.

> 'It's great to know that there is an Indigenous officer within the organisation as a point of contact.'
>
> Elizabeth Marnock, Metropolitan South Institute of TAFE

Recording technology

We will invest in voice recording technology to record complaints, ensuring accuracy for healthcare consumers and providers. This project was originally scheduled for completion in 2008–09 but the system is now expected to be in place by December 2009.

Sharing data

In line with our counterparts in other states, we will classify our complaints against the Australian Charter of Healthcare Rights. In 2007–08, all Australian and New Zealand health complaint agencies agreed to a standardised coding system to enable the comparison of complaint data across jurisdictions. This will improve our ability to identify trends and emerging issues. See page 54 'Championing healthcare rights'.

Enhancing data quality

We will further upgrade our complaint and investigation case management system and implement strategies to improve our data quality. We will introduce a regular audit process to ensure the accuracy and integrity of complaint data within our case management system.

Changing legislation

We will seek to address operational limitations on our management of complaints imposed by our legislation and prepare for the introduction of the National Registration and Accreditation Scheme in July 2010 (see page 53).

Educating about conciliation

We will provide education for Patient Liaison Officers and medico-legal counsel to explain our conciliation process and the benefits for complainants and healthcare providers.

investigating

2

Investigating serious healthcare issues to drive quality improvement

2 investigating

In the past three years we have learned much from our investigations into the quality of healthcare delivery. That is why we are increasingly taking a leadership, coordination and oversight role in investigations, empowering providers and other agencies to investigate and monitor healthcare quality and to learn from any mistakes.

Highlights

- We finalised 104 investigations, 400% more than in 2007–08.
- We completed three major investigations—Mackay Base Hospital, BreastScreen Queensland, and the investigation into mental health services provided to a patient at a metropolitan hospital.
- We drafted our investigation report into the quality of health services provided to Ryan Saunders in 2007 and distributed it to various parties for consultation.
- We increased our media coverage tenfold following the appointment of a dedicated Media Officer.

Challenges

- **Managing our investigation caseload**
  With a permanent team of seven investigators, managing our investigation caseload is an ongoing challenge. We started the year with 94 active investigations. Our caseload peaked at 107 and we ended the year with 35 active cases. We reduced our caseload to more sustainable levels by:
  - devolving less serious matters to healthcare providers and other agencies while maintaining our oversight role
  - increasing the number of joint investigations with other agencies
  - employing short-term contract staff
  - utilising clinical advisers more effectively.
- **Coordinating with other agencies**
  Many of our investigations involved working with other agencies, including the Coroner, Queensland Police Service and Queensland Nursing Council. Role clarity and cooperation are essential to minimise duplication and make the investigation process as efficient as possible for everyone involved. We streamlined the referral process between our fellow agencies.
- **Monitoring recommendations**
  We were unable to monitor healthcare provider implementation of our investigation recommendations this year due to resource constraints. However, with the reduction in our caseload and improved coordination with other agencies, we will have the capacity to commence monitoring in 2009–10.

Our process and performance

We investigate widespread, systemic problems that impact on numerous health services. We also investigate health services that have, or could, put patient safety at risk.

Table 8: Accepted, closed and open investigations as at 30 June 2007–09

	2007	2008	2009
Accepted for investigation	38	105	78
Investigations closed	7	24	104
Open investigations as at 30 June	31	94	35

Investigations are triggered in various ways—an external agency may refer a healthcare issue, a whistleblower may come to us with allegations, a pattern of practice or emerging issue may be identified in our complaints area, or we may be directed to investigate quality concerns by the Minister for Health.

We analyse the allegations or information supplied, together with any relevant data we already hold, then formulate an investigation action plan. We take immediate steps to ensure any patient safety risk is addressed while the matter is under investigation, including referral of registered practitioners to their professional registration board.

We aim to complete investigations as quickly as possible by working with other agencies and the healthcare provider to identify issues and take corrective action. Our investigations are about identifying opportunities for quality improvement, not finding fault or laying blame.

Investigating for improvement

Three major and complex investigations were closed in 2008–09. Given the significant public interest in these investigations, we provide a brief summary of our role and recommendations in two of these matters below. At the time of writing, our investigation into the quality of health services provided to Ryan Saunders in 2007 is awaiting finalisation following consultation with various parties.

Mackay Base Hospital

Our investigation into the quality of health services at Mackay Base Hospital was released in August 2008. The investigation revealed a complex and interrelated set of events surrounding surgeon Dr Abdalla Khalafalla—an international medical graduate who worked as an area of need deemed specialist at the hospital from May 2004 to August 2006. The investigation discovered systemic issues related to Dr Khalafalla's recruitment, employment, and supervision.

> Our investigations are about identifying opportunities for quality improvement, not finding fault or laying blame.

As a result, our recommendations for improvement included an Australia-wide reporting system for tracking the performance of registered health professionals, and the provision of protections of privilege and reprisal for healthcare providers participating in the credentialling process in both public and private healthcare. See page 39 'Investigating quality at Mackay Base Hospital'.

BreastScreen Queensland

Following concerns raised by a number of women about the quality of breast cancer screening, we decided to investigate the quality of health services provided by BreastScreen Queensland, a public health program operated by Queensland Health. BreastScreen Queensland offers follow-up assessment services to women in the target age group 50–69 years, and eligible women aged 40–49 years and over age 70 who can access its services.

We reviewed 32 cases where breast cancer was allegedly diagnosed within two years after a screening mammogram detected no cancer. These are known as interval cancers. Interval cancers tend to be faster growing and can have a worse prognosis.

To maintain a high cancer-detection rate, BreastScreen Queensland operates within a quality improvement framework which requires regular review and accreditation under 173 national standards. All of the BreastScreen Queensland quality indicators exceed or fall into acceptable ranges in accordance with national standards and in comparison with other states and territories.

There will always be an inevitable low rate of interval cancers not detected at public health screening, regardless of the quality of the program. A low interval cancer rate is one measure of the effectiveness of the screening process.

Our investigation identified four cases, where the original screening mammograms showed an abnormality that would normally warrant further assessment.

> Three major and complex investigations were closed in 2008–09.

Left: Investigator at work **Right:** Mackay Base Hospital investigation report

2 investigating

Top, left to right: Recording evidence; Legal library; Taking complaints; Keeping records secure
Bottom left: The HQCC Act **Bottom right:** Managing investigations state-wide

However, none of the interval cancer rates for Queensland was significantly different from the national rate and no evidence was found of a systemic issue related to the rate of interval cancer for BreastScreen Queensland.

An important learning from the investigation was that the limitations of breast screening are generally not well understood by consumers, in particular that:

- breast screening is not infallible
- breast screening does not prevent breast cancer, but it provides an opportunity to change the prognosis through early detection of the disease
- women who have clinical breast symptoms require diagnostic mammography, which is a distinctly different health service to breast screening.

BreastScreen Queensland has now improved its consumer information and consent processes to ensure women fully appreciate the limitations of the program.

As a result of our investigation, we recommended that Queensland Health:

- review the operations of the Queensland Cancer registry to improve the timeliness of interval cancer data
- review and update BreastScreen Queensland's Quality Improvement Plan and introduce annual reviews
- review the policy and procedures relating to symptomatic women who attend breast screening
- use an independent radiologist to review the process for management of major and/or moderate reader performance issues which continue for more than 12 months.

We will monitor the implementation of these recommendations to promote continuous quality improvement in breast screening services in Queensland.

Sharing lessons learned to improve patient safety

We investigate to identify opportunities for healthcare quality improvement. The following recommendations were made in 2008–09 to increase patient safety and prevent harm. Sharing lessons learned is one of our most important roles.

Identifying information has been removed from the information below to protect the privacy of those involved, as required by our Act.

1. A woman complained to us following the death of man at a tertiary referral hospital.

Lessons learned through our investigation:

- We recommended the hospital develop and document guidelines for the management of blocked jejunostomy tubes, including the need to change tubes when they become dysfunctional or displaced. The guidelines should include a process that requires the tube placement to be checked radiologically if a patient experiences ongoing aspiration issues.
- We also recommended amendments to the consent forms for patients who have feeding tubes inserted for oropharyngeal dysphagia. We suggested the consent process should clearly reflect the high risk of ongoing aspiration pneumonia. It is important that patients understand this problem will not be completely eradicated with tube insertion.

Case study: Investigating quality at Mackay Base Hospital

Our report into the quality of health services at Mackay Base Hospital was released in August 2008. Commissioner Professor Michael Ward travelled to Mackay to meet with staff and talk through our recommendations for improvement.

Our investigation revealed a complex and interrelated set of events surrounding surgeon Dr Abdalla Khalafalla—an international medical graduate who worked as an area of need deemed specialist at the north Queensland hospital from May 2004 to August 2006. While his conduct and clinical performance were examined, we discovered multiple systemic issues that tracked right through his recruitment, employment and supervision. As a result, we made several wide-ranging recommendations for improvement across Australia.

Tracking performance

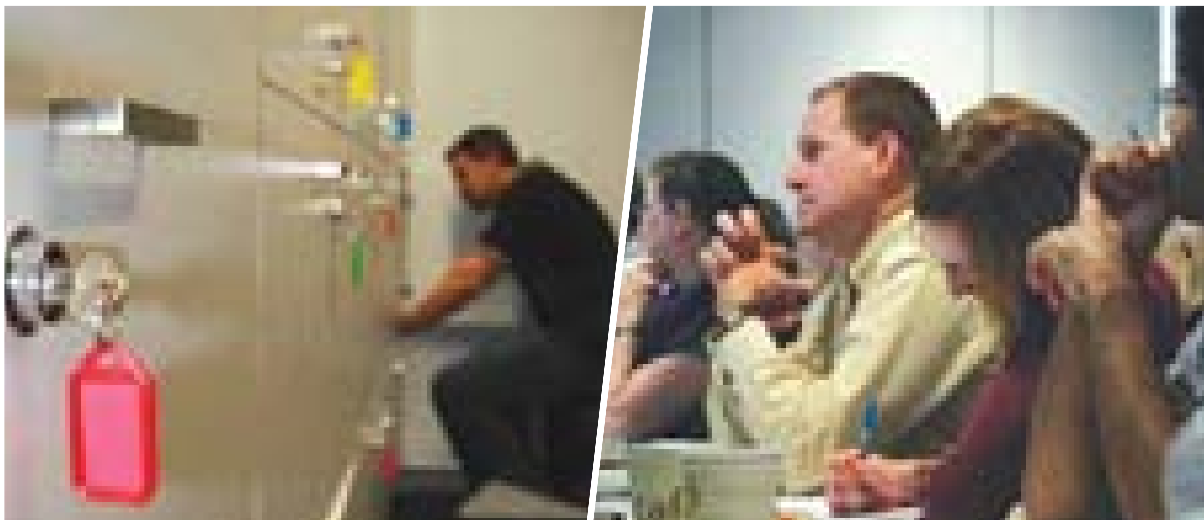
Dr Khalafalla had, prior to Mackay, worked in Townsville and country Victoria and there was substantial adverse information about his clinical performance and professional behaviour dating back to 2002. Yet concerns about his competence and conduct were not shared with Mackay Base Hospital at recruitment. This case demonstrated a systemic failure to ensure that crucial information about a registrant's clinical performance history was shared between the parties—in this case, the Royal Australasian College of Surgeons, the Medical Board of Queensland, Queensland Health and Mackay Base Hospital.

We recommended the Queensland Government pursue, as a priority, an Australia-wide tracking system for registered health professionals and consider legislation to compel sharing of information between employers, colleges, and registration boards. This has since been built in to the National Registration and Accreditation Scheme, see page 53.

Auditing clinical outcomes

A clinical review of aspects of Dr Khalafalla's surgical performance ordered by Mackay Base Hospital in September 2005 found six out of 26 cases examined involved a potentially dangerous technique. In two of these cases, the reviewing surgeon stated patients could easily have died had corrective action not been taken. Despite these findings and numerous internal concerns, Dr Khalafalla's special registration was not withdrawn until August 2006 when whistleblower concerns reached Federal Parliament.

After our investigation, and in response to our recommendations, Queensland Health conducted a full and indepth clinical audit of all surgery performed by Dr Khalafalla during his time in Mackay, Proserpine, Mt Isa and Townsville.



Left: Secure evidence storage **Right:** Adverse incidents workshop

2. A woman complained to us about the quality of obstetric ultrasonography services provided to her at a regional clinic.

Lessons learned through our investigation:

- We recommended the clinic canvass opportunities for accredited sub-specialty training for ultrasonographers conducting obstetric ultrasound examinations.
- We also recommended the clinic ensure that its staff maintained their accreditation with the Australasian Sonographer Accreditation Registry.
- Finally, we suggested a review of the current threshold for referring patients to a tertiary facility. In particular, we expressed our view that where there are indicators of potential fetal abnormalities, the threshold for referral should be very low.

3. The State Coroner asked us to investigate the quality of healthcare services provided to a woman at a regional hospital following the death of the woman's baby.

Lessons learned through our investigation:

- We recommended the hospital consider developing and implementing policies and procedures for the provision of advice to patients and/or their referring doctors. In particular, the advice provided by the hospital's treating doctor about the treatment plan.

4. A woman complained about the quality of her surgical care at a regional hospital.

Lessons learned through our investigation:

- We recommended the hospital comply with the Ensuring Intended Surgery protocol. We will monitor the hospital's compliance as part of monitoring compliance with our Surgical safety standard.

5. A public interest disclosure was made about pathology services at a regional hospital.

Lessons learned through our investigation:

- We recommended the hospital review the effectiveness of its pathology reporting system and advise us of the outcome of the audit.
- We also recommended a review of the hospital's pathology results filing backlog and requested we be advised about the status of that backlog (if any). If a backlog existed, we asked the hospital to advise us when the backlog would be cleared.

6. A woman complained to us about the quality of mental health services provided to a patient at a regional hospital. This investigation was devolved to the hospital and the Queensland Police Service for management. We maintained an oversight role.

Lessons learned through our investigation:

- We recommended a review of the patient's mental health records and that the patient be provided with appropriate mental health services or assessment. We advised that the review should include the treatment provided to the patient by the hospital's Emergency Department.
- We also recommended that the facility assess its follow-up processes in situations where a patient fails to attend for recommended psychiatric reviews after being assessed in the Emergency Department.

We empowered healthcare providers to review and act on internal issues.

Right: Upskilling investigators

- Finally, we recommended that the hospital and the Queensland Police Service determine appropriate treatment options and/or a management plan for the patient, and report outcomes to us.

7. A woman complained to us about the quality of healthcare provided to a stroke patient at a regional hospital.

Lessons learned through our investigation:

- We recommended the hospital consider the following clinical process issues identified in the investigation and provide a report to us about:
  - timeliness of performing a CT scan following suspicion of a cerebrovascular accident/ stroke
  - timeliness of the medical review
  - management of high blood pressure in stroke patients.

Specifically, we asked the hospital to report on any clinical practice improvements undertaken, and to provide copies of any supporting policies, procedures, work instructions and/or education conducted at the hospital.

Blowing the whistle

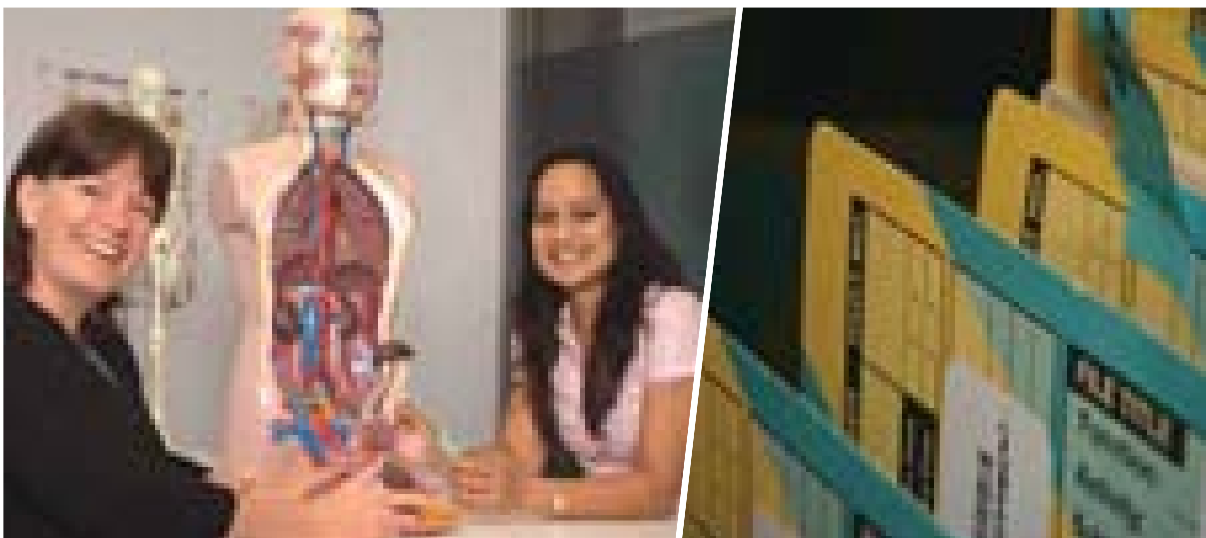
The *Whistleblowers Protection Act 1994* encourages and facilitates public interest disclosures made to us about our organisation as well as the entities within our jurisdiction. In 2008–09, we received four public interest disclosures. All four related to treatment and the coordination of treatment, with one matter also involving discharge and transfer arrangement issues. Of the four matters, one has been investigated and closed and the remaining three cases remain under investigation. Queensland Health and the Medical Board of Queensland have been advised about one of the open matters.

Streamlining investigations

Increased awareness of our organisation and greater understanding of our investigative capacity led to a significant increase in investigation numbers at the start of the financial year, peaking at 107 active cases. To meet demand for our services, we:

- devolved less serious matters to healthcare providers who undertook their own investigations, reported to us on the outcomes and took corrective action where necessary
- employed short-term contract staff to collate and analyse information
- sought expert clinical advice to identify significant systemic issues early, enabling more targeted information gathering and analysis
- partnered with other agencies to increase efficiency and minimise stress on the people who assisted with our enquiries.

> Our recommendations are based on sound judgement, good evidence and independent clinical advice.



Left: Coordinating clinical opinions **Right:** New paper record bar code system

2 investigating

Case study: Forging quality partnerships

In March 2008 we formed what we hope will be the first of many quality improvement agreements with healthcare providers. We signed a Memorandum of Understanding (MOU) with St Vincent's and Holy Spirit Health (SV&HS), which operates 12 health and aged care facilities in Queensland. SV&HS Health Safety and Quality Manager Christine Foley shares how her organisation has sought to become a leader in healthcare safety and quality.

The importance we place on quality

We established a Group Safety and Quality Unit in 2006. The unit's manager is a member of the Group executive and reports directly to the CEO, recognising the importance that the safety and quality function holds in the effective governance of health and aged care organisations.

Providing a central contact

The MOU sets the Group Safety and Quality Unit as the central contact point for liaison and communication of all matters concerning the HQCC and all SV&HS facilities. The MOU outlines a process for the Group Safety and Quality Unit to receive referrals from the HQCC to undertake investigations. This benefits both organisations in:

- meeting legislated timeframes and requirements for early complaints resolution
- building standard complaint resolution methods and processes that are transparent and reasonable
- assisting HQCC in other matters within its brief, such as standards monitoring and reporting.

Keeping up-to-date

The MOU also provides for the Group Safety and Quality Unit and HQCC senior complaints staff to meet bi-monthly to review all complaints, with the aim of early resolution and conciliation where appropriate, and in meeting with HQCC's standards monitoring and reporting staff to assist in other safety and quality matters and processes.

Becoming a leader

SV&HS has actively sought to become a leader in safety and quality through effective clinical and corporate governance programs and by working closely with regulators to ensure that patient safety, quality of care and service delivery remain a priority.

Signing our MOU. Front row left to right: General Manager St Vincent's Hospital Brisbane/Mount Olivet Hospice Daniele Doyle, Executive Director Holy Spirit Northside Private Hospital Christopher Flynn, HQCC CEO Cheryl Herbert, General Manager St Vincent's Hospital Toowoomba Carl Yuile. Back row left to right: St Vincent's and Holy Spirit Health CEO John Leahy, Group Safety and Quality Manager Christine Foley, and Corporate Counsel and Company Secretary Suzanne Greenwood.

Our MOU allows us to share resources, specialist skills and information.

Avoiding duplication

Our Memorandum of Understanding (MOU) with external agencies prevents duplication of complaint management and investigative effort, improves timeliness and enables easy referral of matters between jurisdictions. It also allows us to share resources, specialist skills and information. We hold an MOU with:

- Crime and Misconduct Commission
- Queensland Ombudsman
- Queensland Police Service
- State Coroner
- 14 professional registration boards.

Empowering healthcare providers

This year we introduced a new investigative model that saw us devolve a small number of investigations to other agencies or the healthcare organisations concerned, while retaining our oversight role. This approach:

- gave us the flexibility to cooperate with other agencies and organisations for a better health quality outcome
- ensured the appropriate agency investigated concerns
- eliminated investigation duplication
- empowered healthcare providers to review and act on internal issues while we maintained our lead role as the healthcare watchdog.

The model is similar to that used by the Crime and Misconduct Commission and is best suited to less complex matters.

We chose to devolve investigations for the following reasons:

- There was another agency better suited to investigating.
- The investigation involved allegations of unprofessional conduct or sexual misconduct by a registered provider, meaning it was better investigated by the relevant registration board with the power to potentially take disciplinary action.
- We believed the employer should try to resolve the matter through its own complaints management process before we investigated.

Recommending positive health action

When we investigate a serious or systemic health issue, we identify areas for improvement and make recommendations for action. Our recommendations are based on sound judgement, good evidence and independent clinical advice.

Our recommendations can take different forms, including recommending healthcare providers rectify an identified shortcoming in service or improve their systems and processes to prevent similar incidents/complaints arising in the future.

Upskilling investigators

As part of our ongoing development program, all of our investigators are studying or have completed Certificate IV in Government (Investigations) training. The majority are obtaining or have applied for Recognition of Prior Learning. As well as ensuring a foundation level of education among investigators, the program also facilitated a level of common understanding on leading investigation practice.

Investigators also undertook in-house education to help them:

- identify key issues
- analyse evidence
- make conclusions
- obtain appropriate expert opinion
- make meaningful recommendations.

Getting the best clinical advice

As the majority of our complaints and investigations involve a question about the standard of healthcare provided or a decision made by a registered provider, it is important that we have general medical knowledge and access to specialist clinical advice. While many of our employees have healthcare backgrounds, 37 staff across the agency undertook medical terminology training this year to assist with their work.

In managing healthcare complaints and investigations, we contracted 97 healthcare professionals to provide independent clinical opinions and advice. We sought additional opinions in cases requiring peer review or specialist knowledge. These opinions are important in determining whether the healthcare received by an individual was reasonable given the circumstances.

We employed a Manager, Clinical Support to coordinate and improve the way we work with our independent clinical advisers. This year we spent $255,758 on independent clinical opinions. Our clinical opinion model is currently under review, with the assistance of our Clinical Advisory Committee.

2 investigating

Our goal is to provide an early warning of potential healthcare issues and recommend action.

Reaching out

Working with Coroners

Coroners investigate reportable deaths in Queensland, including unexpected deaths following healthcare procedures. Sometimes, coroners will refer to us deaths for investigation.

This year we began a partnership with the Office of the State Coroner to review our investigation processes and improve the quality of our investigative reports for the Coroner. To support this work, we offered our guidance and assistance to the Queensland Police Service (QPS) when investigating a reportable death occurring in a healthcare setting. For example, we can advise on obtaining documentation or assist with expert clinical opinion contacts. We proposed changes to the QPS Operational Procedures Manual to support this approach and are awaiting the outcome.

In June, our senior investigators met with the Northern Coroner and the QPS Executive in Cairns to discuss our role and how we can assist with coronial matters. Our work with Queensland's coroners will continue in 2009–10.

Getting in the news

The media plays a significant role in improving awareness of our organisation and our work.

With a dedicated Media Officer employed in June 2008, we improved our ability to identify proactive media opportunities and introduced processes to ensure timely, accurate responses to all media enquiries. Our media activity increased dramatically. In 2008–09 we:

- distributed 74 media releases (compared to 12 in 2007–08)
- responded to 121 media enquiries (up from 23)
- multiplied our coverage more than tenfold—from 34 items to 390.

Two-thirds of our news coverage was about a current or former investigation—with the biggest stories being the investigation of whistleblower claims about Bundaberg Base Hospital in January–February 2009 and the release of our investigation into the quality of health services at Mackay Base Hospital (see page 39).

As well as keeping the media informed, our news releases are posted on our website and emailed to our stakeholders, including:

- professional groups and colleges
- healthcare providers and health districts
- non-government health organisations
- community welfare groups and support groups
- migrant services and Indigenous organisations.

Looking ahead

Identifying emerging issues

As well as investigating serious and systemic healthcare issues that happened in the past, we are developing a proactive investigation model based on emerging issues identified in our complaint and quality monitoring data. Our goal is to provide an early warning of potential healthcare issues and recommend action. We will work with healthcare providers and our fellow investigation agencies to progress this model.

Monitoring investigation recommendations

We will establish a register of recommendations from investigations in 2009–10. Healthcare provider acceptance and implementation of recommendations will then be monitored.

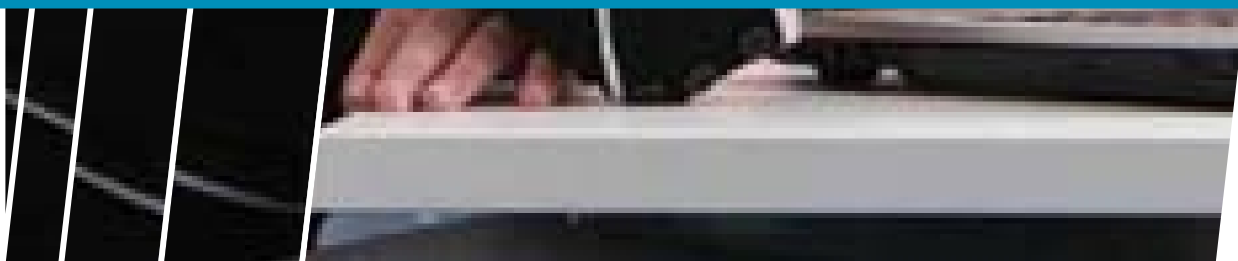
Reviewing our clinical opinion model

We will work with our Clinical Advisory Committee to review our clinical opinion model. We will improve our processes to support high quality opinions and the best value for money.

We contracted 97 independent clinical advisers to assist us with complaints and investigations.

monitoring 3

Helping our 226 acute hospitals
build a better, safer health system



3 monitoring

We have built strong relationships with the 226 acute hospitals and day surgeries reporting to us on the quality of their services. Our standards data shows their journey of improvement.

We are looking to extend the reach of our standards to community-based healthcare providers, in particular general practitioners and Visiting Medical Officers (VMOs).

Highlights

- 100% of acute hospitals and day surgeries reported against our seven healthcare standards.
- 54% of hospitals and day surgeries aligned with all nine key patient safety areas (up from 22% in 2007–08), and their ability to monitor themselves across the standards rose by between 5% and 38%.
- More than 3000 quality improvement initiatives were submitted and coded.
- We worked with five hospitals to pilot a verification framework to check quality improvement processes.

Challenges

- **Reaching frontline clinicians**
  Ensuring hospital and day surgery clinicians are aware of our standards and understand their role in implementing these leading practice guidelines continues to be a challenge. Healthcare professionals are difficult for us to reach directly so we have concentrated our efforts on building relationships with hospital management and quality officers, through whom we can share information with frontline clinicians.
- **Verifying compliance with our standards**
  As our standards reporting includes a self-assessment component, we piloted a verification framework with five hospitals to check their data and standards compliance. Verification is a new process for us and for healthcare providers and it is likely to evolve as we implement our verification program over the next year.
- **Sharing quality improvement initiatives**
  Hospitals and day surgeries have lodged more than 3000 quality improvement initiatives through our standards reporting tool StaRT. To analyse these initiatives and share those that represent leading practice will require significant resources. In addition, there are intellectual property issues to consider. We will develop improved methods to collect and disseminate quality improvement initiatives in 2009–10.

Our process and performance

Under the *Health Quality and Complaints Commission Act 2006*, all Queensland healthcare providers have a duty to:

- establish, maintain and implement reasonable processes to improve the quality of their services
- monitor their services
- protect the health and wellbeing of healthcare consumers.

We introduced our seven healthcare standards on 1 July 2007 as a reasonable basis for providers to satisfy their duty to improve the quality of healthcare. The standards follow international and national leading practice guidelines and were developed with both the healthcare environment and the consumer in mind.

Left and right: Quality Monitoring team at work

While our standards apply to every healthcare provider in Queensland, only acute hospitals and day surgeries currently report to us against the standards.

We monitor 226 hospitals and day surgeries against each of the standards, specifically:

- do they have a documented process in place to improve safety in that area
- does that process align with our standard and leading practice guidelines.

If a facility answers 'no' to either of these statements, we consider if that facility is fulfilling its legal duty to improve the safety and quality of their care.

Hospitals and day surgeries have been reporting against the standards since July 2007. In the past year, we collected data for Round 3 (January–March 2008), Round 4 (April–June 2008) and Round 5 (July–December 2008) through our web-based Standards Reporting Tool, known as StaRT. This tool enables facilities to input and approve their data for each reporting period. To assist hospital staff, we provide a helpdesk service, with around 200 enquiries received by our StaRT helpdesk in the last reporting round.

> 'We are only at the beginning of our learning and there is still much to be done, but the standards have helped us focus on making a difference to health outcomes.' Healthcare provider

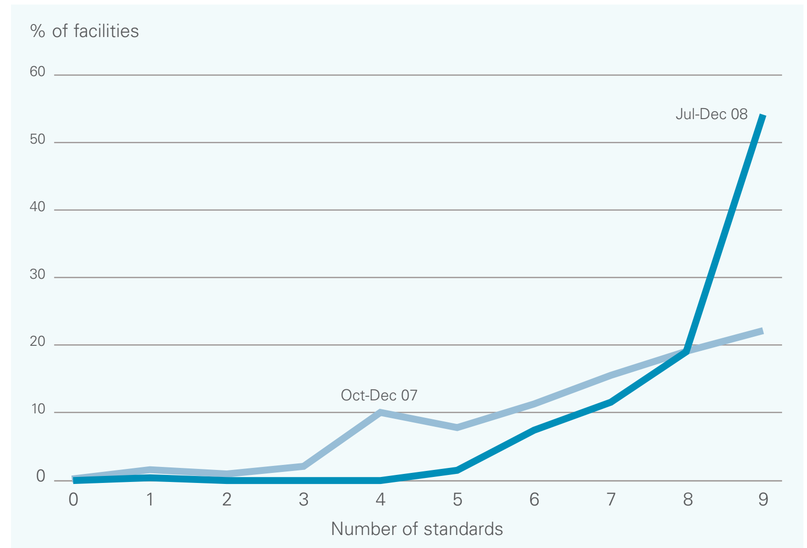
Table 9: Performance of Queensland acute hospitals and day surgeries against our standards, December 2007 and December 2008

Standard	Facilities have a process		Process aligns with HQCC	
	Dec 2007	Dec 2008	Dec 2007	Dec 2008
Review of deaths To ensure all the information on a Cause of Death Certificate is a true reflection of what happened, by reviewing every hospital-related death.	76%	97%	64%	88%
Care after a heart attack To ensure patients who have had heart attacks receive the best possible long-term care to help prevent repeat attacks.	53%	68%	36%	65%
Surgical safety—infection To reduce surgical infections.	54%	76%	44%	75%
Surgical safety—incorrect surgery To prevent incorrect surgery (i.e. wrong site, wrong side, wrong patient, wrong procedure).	87%	99%	83%	93%
Surgical safety—blood clots To minimise blood clots forming after surgery.	44%	75%	35%	71%
Clean hands To reduce the spread of infection caused by practitioners not having clean hands.	99%	100%	93%	100%
Credentialling To ensure practitioners are registered, qualified, well-supported and practising within their recognised ability.	92%	100%	86%	91%
Complaint management To make providers accountable and transparent when handling complaints from patients or their friends and families.	100%	100%	95%	99%
Provider's duty to improve To improve patient safety and the quality of health services in Queensland.	99%	100%	81%	93%

3 monitoring

> 'Staff are very helpful if I need to ask a question.'
>
> Survey respondent

Figure 4: Healthcare facilities aligning with HQCC standards



Monitoring quality

As our Surgical Safety Standard has three parts, our seven standards cover nine key patient safety areas that acute hospitals and day surgeries must report against. Some 54% of facilities align with all nine areas, up from 22% in 2007–08. Only one facility now complies with three or fewer of our standards.

Under the nine key patient safety areas, we ask 44 questions about service and processes—to which responses can be 'yes', 'no', or 'not applicable'. An indicator of state-wide performance is the average number of 'yes' or 'not applicable' answers.

In the year to December 2008, the Queensland facilities average increased from 33 to 38. Breaking that down, public facilities rose from 29 to 36 while private facilities went from 38 to 39.

Queensland hospitals and day surgeries have increased their level of reporting across the standards from between 5% and 38% since the first reporting period in 2007. This shows that more facilities now have better processes in place to gather quality and clinical safety data.

Sharing success

In one year, Queensland's hospital and day surgeries undertook more than 3000 activities to improve the safety and quality of care. Three quarters of these were to establish or review policies or procedures.

Some 60% looked at improving data collection and audits. More than 30% involved educating staff. In general, the more standards a facility complied with, the more quality improvement initiatives were reported.

We have coded all of these initiatives and we will now look at how we can best capture leading practice activities so they can be promoted for wider implementation.

We moved from quarterly to six-monthly standards reporting based on provider feedback.

Right: Research and Development team at work

Case study: Making a difference

Our standards have helped healthcare facilities set goals to provide the best and safest care they can—whether at a large, metropolitan hospital or a small regional day surgery. This is the story of a small, remote hospital that was one of our biggest improvers in the past year.

'Prior to the HQCC standards, we simply had no formal structure for assessing the quality of service or driving a quality culture. We only had a low level of quality monitoring. For example, there was a number of human error and patient safety analyses conducted, but nobody to implement the recommendations, no date for completion, and little evidence of any outcomes. Staff were generally unaware of the standards, or our responsibility to comply with them. A Patient Safety and Quality Coordinator was employed last August and has been working with district staff to coordinate our response to the standards.

Planning for safety

Since then, we have made many positive changes to drive quality improvement. We introduced a new district Quality Action Plan and a new governance structure to support quality initiatives. We also developed a strategic plan for quality and risk management, and action plans to meet all the standards were put into practice. For example, we introduced a documented process for Review of Deaths and we now know that 100% of hospital-related deaths since September 2008 have been reviewed. We also have a policy for managing venous thromboembolism that exceeds the HQCC's requirements and includes monitoring of patients in the Emergency Department.

Educating staff

We introduced staff education on quality improvement and risk management, including how to manage clinical incidents and complaints. Staff are recognising clinical incidents and risks and doing something about them. The recording of clinical incidents has increased by 50–75% in the past year.

Improving healthcare

I believe our service has become safer overall and staff members are identifying ways to improve our service as they see that results can be achieved. For example, staff raised the issue that we could not manage the number of patients attending our medical clinic. This made waiting times unacceptable and our clients were dissatisfied. By bringing together medical, nursing, health workers and administrative staff, we discussed and agreed on an improved triage system and the problem has been resolved.'

Left and right: Research and Development team at work

Left and middle: Adverse incidents workshop **Right:** John Kastrissios, General Practice Queensland Chair

Case study: Partnering for better healthcare

In extending our 'care after a heart attack' standard to the community setting, we are keen to work with all those involved in providing patient care, including healthcare consumers themselves. We promoted this project at the National Heart Foundation Conference in May 2009 and continue to draw on the knowledge of our key stakeholder reference group, which provides guidance and feedback. General Practice Queensland is part of the group. Chair Dr John Kastrissios explains the importance of providing the best possible long-term care for heart attack patients.

Coordinated care

People who have had a heart attack benefit from high quality coordinated care in many ways. There is good evidence of a reduction in further cardiac events and complications when management guidelines have been appropriately applied for each individual. The best way to achieve this is to offer a management plan designed to reduce patient risks. In this way, we know which patients are taking their prescribed medications and changing their lifestyle. Working within a system that has inbuilt checks for adherence to medications and leading practice in rehabilitation after a heart attack is efficient for the healthcare team and safer for the patient.

A well designed system

Just as importantly, a well-designed system enables the patient, their care providers and support team to be well informed about the management plan and more able to ask questions about their progress. Patients often feel quite vulnerable after a heart attack and their families are unsure about their role. Anxiety is reduced when everyone is more confident about their role and what to expect. Working with management plans, where the patient has real input, improves adherence to leading practice and appropriate early reporting of issues. Equally, there is less time spent in dealing with issues based on poor understanding of symptoms or medications.

Benefits of a standard

A standard can improve patient care by ensuring that there is a consistent application of leading practice guidelines. In the longer term, having patients aware that a standard of care exists is likely to improve adherence to management plans and allow them to assess their own compliance.

Table 10: Extract from StaRT users survey

	1	2	3	4	5	6
1. I find the system easy to use and understand.	5	6	13	28	14	
2. I can easily log in to the system.	2	4	1	27	32	
3. I am aware that the StaRT system support is readily available.	2	4	9	35	16	
4. If I encounter any error in the system, I can easily recover and find my way back to the system.	3	5	10	37	9	2
5. The screens and visual presentation of the system are appealing to me.	4	8	17	24	13	
6. The countdown timer makes me aware of the current deadline of the reporting period.	4	3	5	20	32	2
7. The system is easy to navigate.	3	10	12	26	15	
8. The organisation of the menus and information lists seem logical.	3	2	17	32	12	
9. I get what I expect when I click on things in StaRT.	2	6	15	28	15	
10. It is obvious that user needs have been taken into consideration.	6	8	20	22	10	

*Answers based on a scale from 1 to 6: **1** Strongly disagree, **2** Disagree, **3** Neutral, **4** Agree, **5** Strongly agree, **6** Don't know/n/a.*

Improving our service

We are committed to improving our service and timeliness in quality monitoring. In early 2009, we surveyed acute hospitals and day surgeries about their experience in using our online standards reporting tool, StaRT. The feedback was on the whole encouraging and complimentary about the level of support provided by our staff.

When asked what aspect of the online tool respondents found the most useful, the top two responses were '*electronic rather than paper-based reporting to the HQCC*' and '*StaRT reporting assists with implementation of quality improvement at my facility*'.

The survey also invited suggestions for improvement and since then, we have concentrated on improving our data analysis and reducing the time it takes to report back to providers. Our facility-specific reports now have improved features, allowing providers to track their improvement over time and, for the first time, we will be making reports available online through a secure login.

After 18 months of data gathering, we scaled back our facility reporting requirements from every three months to every six months (commenced in Round 5). In making this decision, we sought the advice of our Clinical Governance Reference Group (see page 104). The group also provided feedback on the continued systems development of StaRT. The reduced frequency of reporting places less of a burden on healthcare providers and is a direct response to their feedback. We will continue to review reporting frequency, in line with our responsive regulation approach. Simply, if facilities are consistently complying with standards, then the burden of reporting should be reduced.

Verifying hospital compliance

For the first time this year, we began a process to check hospitals were meeting their legal obligations to improve the safety and quality of their service. We developed and tested a verification review framework at five volunteer healthcare provider sites, including public and private hospitals in both metropolitan and regional Queensland. We are finalising this framework, with a view to implementing a targeted verification program in 2009–10. The pilot highlighted the importance of analysing the data we hold about facilities across standards quality monitoring, complaint management and Root Cause Analysis reports to inform our review.

Improving the long-term care of patients

Work is underway to extend implementation of our 'care after a heart attack' standard (Management of Acute Myocardial Infarction (AMI) on and following discharge standard) beyond the treating hospital to community medical practitioners who provide follow-up care after discharge.

The 'AMI across the continuum of care project' includes general practitioners and cardiac specialists. A Key Stakeholder Reference Group has been established to guide the project and includes these providers as well as cardiac rehabilitation and other lifestyle healthcare practitioners, and healthcare consumers. Consultation has begun with providers and consumers to explore options for quality improvement in primary care.

3 monitoring

Reviewing our standards

We review our seven healthcare standards at regular intervals to ensure they remain current with evidence-based leading practice. We undertook an interim review in 2007–08 and minor amendments were made to clarify small aspects of the standards and compliance mechanisms. These were publicised and we launched a revised Standards Manual on our website (replacing the original hard copy launched in July 2007), to ensure healthcare providers can always access the most up-to-date information.

Planning for a comprehensive review of the standards began in January 2009, including the review process, consultation and evaluation. We will also be reviewing our Standards Manual. Broad consultation will be conducted between August 2009 and April 2010, seeking stakeholder feedback on all aspects of the standards through a submission process. Expert reference groups will be convened to review the submissions and make recommendations to the Commission for consideration. We will not introduce any new standards as part of the review.

Reaching out

Raising our profile

Just as we made a concerted push to increase community awareness through participation in festivals and events, we also increased our presence in industry circles through:

- exhibiting at major industry events, such as the National Heart Foundation Conference 2009 in Brisbane, where we promoted our AMI across the continuum of care project, and the Australian Council on Healthcare Standards National Forum on Safety and Quality in Health Care 2008 in Adelaide, where we exhibited posters showcasing our seven standards, the draft Code of Health Rights and Responsibilities and quality monitoring for improvement
- presenting at industry conferences (see page 109)
- attending networking opportunities such as industry events, business breakfasts, etc.

Commissioner Michael Ward and CEO Cheryl Herbert also participated in the judging panel for the inaugural Queensland Health Awards for Excellence.

Through our Knowledge and Research Governance Committee, we submitted letters and articles to industry publications, including the Medical Journal of Australia.

Sharing ideas and information

We worked closely with fellow complaint and quality improvement agencies both within Queensland and interstate to share ideas and contribute to the national quality improvement agenda.

Case study: Piloting new ideas

Our verification review framework was piloted with five volunteer hospitals from throughout Queensland. Project manager John Marquess talks about how healthcare providers responded to the pilot program.

'During our consultation phase we saw some exciting quality improvement initiatives that were a direct result of implementation of our healthcare standards. Many providers had developed sophisticated and robust quality improvement systems, some driven by a strong patient safety culture. Many of the quality improvement initiatives were very creative in their development and implementation. For example, one facility showed us an innovative cardiac intensive care patient identification system, while another shared its multidisciplinary approach to implementing the Surgical Safety—prevention of venous thromboembolism standard. This resulted in the modification of an operating theatre management system to incorporate HQCC mandatory data.

Some of the provider sites we visited were not as advanced and we will continue to work with them. We met with many healthcare executives, quality improvement leaders and clinical staff across Queensland who were extremely motivated and empowered to improve the quality of clinical services but were becoming increasingly challenged in incorporating additional activity into existing clinical commitments. We saw firsthand the burden of reporting on healthcare providers and gained better understanding of the impact of our standards. We will use this knowledge as part of our standards review in 2009–10.'

'The HQCC verification review process… was a valuable learning experience, with open forums enabling stakeholders to discuss any concerns and to explain district processes.' Healthcare provider

Left: Sir Liam Donaldson with our CEO and Commissioner **Right:** Tania Thomas, NZ Health and Disability Commission

We met regularly with Queensland's complaint agencies, attended biannual meetings with interstate and New Zealand counterparts, and hosted a visit by the Deputy Commissioner—Disability Ms Tania Thomas from New Zealand's Health and Disability Commission in May 2009. We were also visited by the United Kingdom's Chief Medical Officer Sir Liam Donaldson, who shared his insights on quality improvement with our staff at an open forum.

The Commissioner and CEO attended an Australian Commission on Safety and Quality in Health Care meeting to share our vision for a responsive approach to regulation. See figure 5, page 57.

Our CEO attended the International Society for Quality in Health Care Conference in Copenhagen in October 2008, and we have been invited to present our work in healthcare standards at their next conference in Dublin this October.

Our complaint officers attended monthly Queensland Patient Liaison Officer Network (QPLON) meetings to share information and gain feedback. Patient Liaison Officers act as a bridge between patients and health services, receiving consumer feedback and looking into concerns and complaints.

> We work closely with fellow complaint and quality agencies to share ideas and contribute to the national quality improvement agenda.

Network meetings give us the opportunity to ensure officers are familiar with how we operate and how we can help. We also provide coaching for members. Each year we host a QPLON workshop to assist these important links between patients and providers to understand our processes and improve their complaint management.

Having our say

We made five submissions on the proposed National Registration and Accreditation Scheme. The new arrangements, to be introduced in July 2010, will enable health practitioners to move and work around Australia more easily. The proposal includes a national register to ensure that a health practitioner who is restricted from practising in one state or territory is unable to practise anywhere else in Australia. We are generally supportive of the National Registration and Accreditation Scheme as it has great potential to improve the safety and quality of healthcare in Australia.

It also has potentially wide-reaching implications for healthcare delivery, especially the way complaints about registrants are handled. We will continue our cooperative approach to information sharing to avoid duplication of effort in complaint management.

A draft *Health Practitioner Regulation National Law 2009* (known as Bill B) was released in May 2009. We consulted widely with our stakeholders and prepared a final submission in July 2009. The proposed national law is being finalised for agreement by Australian Health Ministers.

3 monitoring

Looking ahead

Reviewing our standards

We will conduct a full review of our healthcare standards, with a view to releasing revised standards in July 2010.

Extending the AMI standard

We will extend implementation of our 'care after a heart attack' standard (Management of Acute Myocardial Infarction (AMI) on and following discharge standard) beyond the treating hospital to community medical practitioners and consider standard reporting for general practitioners.

Verifying and driving improvement

Following our pilot verification framework review program in 2008–09, we will formalise our framework with a focus on driving quality improvement. We will develop a hospital and day surgery review program for 2009–10 based on the complaint management, standards reporting, and Root Cause Analysis report data we hold about facilities.

Public reporting of quality improvement

We will work with our clinical and consumer advisory committees to develop new ways to report publicly on the quality improvement journeys of our 226 acute hospitals and day surgeries.

Championing healthcare rights

In 2007–08, as required by our Act, we developed a draft Code of Health Rights and Responsibilities for Queensland. The draft code, together with a report on its development, content and application, was provided to the then Minister for Health Stephen Robertson. At the same time, a national consumer rights initiative, the Australian Charter of Healthcare Rights, was in development.

We were consulted and informed the development of the Charter, and supported its implementation in Queensland.

In July 2008, the Australian Health Ministers endorsed the Australian Charter of Healthcare Rights and the Charter is being implemented nationwide. We will promote the Charter through our complaints and investigations process and community engagement program. We will also classify our complaints against it (see page 34 'Sharing data'). As an early indicator, table 11 shows our 2008–09 complaints categorised against the Charter.

Table 11: 2008–09 complaints categorised against the Australian Charter of Healthcare Rights

Healthcare right	No. of complaints
Safety the right to receive safe and high quality care	1525
Communication the right to be informed about services, treatment, options and costs in a clear and open way	670
Access the right to healthcare	166
Privacy the right to privacy and confidentiality of personal information	163
Respect the right to be shown respect, dignity and consideration	127
Participation the right to be included in decisions and choices about care	23
Comment the right to comment on care and have concerns addressed	16

See also page 34, 'Sharing data'.

'The verification review was a valuable learning experience, with open forums enabling stakeholders to discuss concerns and to explain district processes. We'd welcome the opportunity to work further with the HQCC team in the future.' Julie Watson, Manager Quality Improvement, Townsville Health Service District

preventing

4

Using our data and insight to create an early warning system

4 preventing

As separate information sources, our complaint management and quality monitoring data can show us where positive healthcare changes have been made, or where there is room for improvement.

However, we are only just starting to fully explore the potential of pooling information from across our agency. This overarching analysis has great potential to become an early warning system—that is, to predict emerging health issues and shape healthcare improvement in the future.

Highlights

- Exploring the implementation of our 'responsive regulation' model (see figure 5, page 57), which sees us empower healthcare providers to drive their own quality improvement, with our organisation stepping in to oversee, investigate or refer to another agency only when risk assessment shows a need to act.
- Development of our prototype Knowledge Management System, which for the first time brought together data about complaints and investigations, hospital and day surgery quality monitoring, media reports, and healthcare provider Root Cause Analysis reports about reportable events.
- Analysis of our complaint data to identify concerning patterns of practice by individual healthcare providers and hospitals.

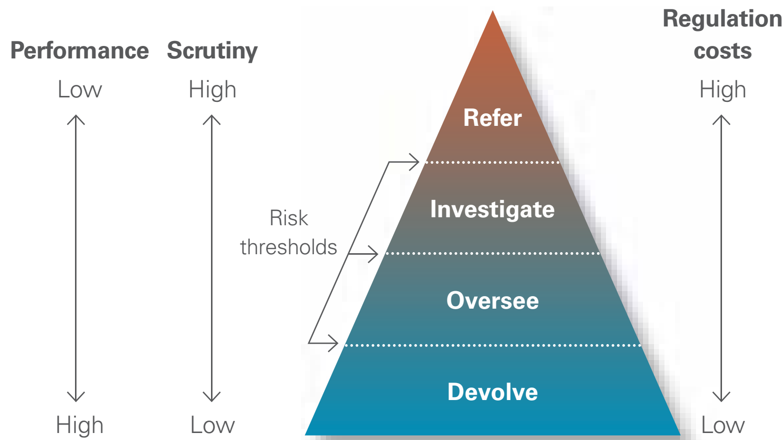
Challenges

- **Getting the right technology**
  Being a small organisation with limited resources, it has been difficult to develop the information management systems we need to achieve our vision. Knowing we needed to start small, we worked in partnership with a software developer to build our prototype Knowledge Management System, see page 58. The learnings from this project will form the basis of the ongoing development of this system to better support organisational requirements.
- **Compiling provider profiles**
  As a first step in using our data more effectively, we decided to compile healthcare provider profiles—pictures of our 226 hospitals built using information about their complaints and investigations as well as quality improvement data. This core data was supplemented by media coverage about each facility and any Root Cause Analysis reports received. Creating these profiles proved technically challenging as data was drawn from different sources. We will continue to develop the profiles with a view to then sharing and checking them with providers as a starting point for quality improvement.
- **Analysing data**
  This year we identified a need for more specialist data analysis personnel. While proposing to engage additional resources in this area in 2009–10, we also incorporated increasing our knowledge management capability in all team operational plans. We aim to foster an organisational culture that seeks to turn data into information into knowledge, and to use our intelligence and insight to recommend improvements to the healthcare system.
- **Reviewing Root Cause Analysis reports**
  Public and private healthcare facilities conduct a Root Cause Analysis (RCA) review following reportable events to find out what happened. As we are provided with only summary details and recommendations, and the quality of these reports varies, it has been difficult to use this information to drive quality improvement, see 'Learning from adverse incidents', page 58).

> The aim of this data sharing is to identify issues and enable responsive intervention.

Left: Child Safety Day, Cherbourg **Right:** Verification pilot visit to Longreach

Figure 5: Managing risk through responsive regulation



Modified from Walshe 2003 after Ayres & Braithwaite

Regulating responsibly

This year we explored the implementation of a 'responsive regulation' model, based on the work of academics Kieran Walshe, and Ian Ayres and John Braithwaite. This model of regulation moves beyond the traditional ideas of deterrence and compliance to an approach that is highly flexible and adaptable, in keeping with our positive health action vision. See figure 5 for our responsive regulation model. The model has helped us bring together our two core roles—complaint and investigation management, and standard-setting and quality improvement. We understand it is the first time this model has been used in healthcare regulation and our work is being watched by other agencies in Australia.

Knowing what we know

We recognise the limitations of our data and we are already working to overcome the barriers within our control.

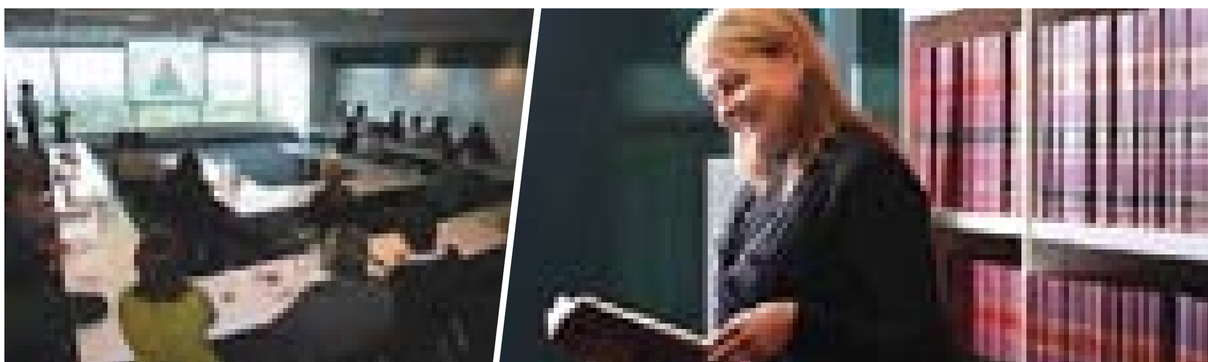
For instance, the complaints we receive are only a partial indicator of the overall standard of healthcare, as we are not the only organisation that deals with healthcare complaints in Queensland. We have considered how we can better work with the professional registration boards and healthcare providers themselves to share complaint information (see page 58).

Furthermore, we currently only monitor Queensland's 226 hospitals and day surgeries. The data they report is based on self-assessment questions and a limited number of mandatory data items. Additionally, reporting has only been in place for a relatively short time, so providers are still improving their capacity to monitor themselves.

Using our data

Our Quality Monitoring team led a project to look at the importance and limitations of our data. The project examined the potential of our information in shaping healthcare improvement.

We now have new directions for improving the limitations of our information and options for systematically gathering better quality information in future. This research helps us move towards potential future automation to identify possible risk factors and build provider profiles.



Left: Learning about responsive regulation **Right:** General Counsel at work

Case study: Sharing information

We worked closely with the Medical Board of Queensland (MBQ) this year to improve the exchange of information about medical practitioners who have been the subject of complaints. Both agencies receive complaints about doctors and while complaints are received separately, they are managed cooperatively. Here, the MBQ discusses how improved sharing of information between our organisations will be used to develop proactive strategies to improve patient safety.

'In addition to consulting with the Health Quality and Complaints Commission on the initial assessment of complaints and the outcome of investigations, the HQCC has this year provided the Board with a summary analysis of data on complaints going back to the former Health Rights Commission in 1992. We are now looking at how we can align our historical data with that held by the HQCC to identify patterns of practice. Our joint aim is to identify issues earlier and to implement targeted and effective intervention activities.'

Learning from adverse incidents

From July 2007, by law, public and private healthcare facilities had to provide to us a summary of all internal reviews of reportable adverse healthcare incidents (known as Root Cause Analyses or RCAs). To manage this important information, we developed a framework to monitor the standard of the internal review and to follow up on any recommendations for improvement. In May 2009, we hosted a workshop, 'Learning from adverse incidents', with about 100 healthcare providers attending. We believe there is more to be gleaned from the information contained in RCAs, especially when combined in a meaningful way with the other information we collect. We are working with providers to cross-reference RCA reports and to trend themes for systems quality improvement. We are also working with Queensland Health's Patient Safety Centre to ensure we receive all RCA summaries directly and electronically. We can then develop better systems to identify emerging issues state-wide.

Pulling it all together

While the development of information management systems and the improvement of our data integrity may overcome some problems, there will always be limitations to our data. We developed a knowledge management framework to guide us. The framework looks at:

- pooling information that is currently held in different databases by different operational teams, and drawing meaning from the collective data
- how this information can be meaningfully displayed
- interactivity for future use by healthcare providers.

Complaint data, quality monitoring data, Root Cause Analysis reports and media articles were logged in a prototype Knowledge Management System database from December 2008 to March 2009. The system helped us identify shortcomings in predicting possible adverse health outcomes from our information, including the connectivity of our internal data systems and issues over how to weight different sets of information on their perceived importance. Some of these issues can be overcome, others cannot.

The results of the prototype project have been encouraging and provide a solid foundation for developing an emerging issues database. They also feed into our long-term online strategy (see page 62).

Putting the spotlight on mental health

Mental healthcare quality is an area of significant concern, with emerging issues reflected in the number of complaints coming in, what our Commission, our advisers and our stakeholders are telling us, and what we read in the media.

In December 2008, both our consumer and clinical advisory committees identified mental health as an area requiring our attention. After researching the issue, we met with:

- Queensland Health Mental Health Branch
- Queensland Health Mental Health Plan Implementation Unit

Top left to right: Conciliation planning; CEO address; Conciliators meeting **Bottom left:** Quality Monitoring team discussing reports
Bottom right: Workshop in our new shared training rooms

- Cairns and Hinterland Health Service District Mental Health Service
- Townsville Integrated Mental Health Service
- Queensland Alliance
- Queensland Ombudsman
- Queensland Centre for Health Data Services
- Australia and New Zealand College of Psychiatrists.

While we await endorsement of revised National Standards for Mental Health Services, expected in 2010, we are looking at how to encourage use of existing protocols. Through quality monitoring, we are also considering how we can impact positively on the quality of mental health services by:

- improving the way mental health deaths are reported through our Review of Deaths standard, as part of the full review of standards (see page 54)
- analysing mental health deaths via Root Cause Analyses and making recommendations to mental health services.

> 'HQCC workshops I have found very valuable, for example the workshop on management of adverse events. Great to have a forum involving both private and public sectors.'

Recruiting Health Community Councils

Twice a year, we undertake a major recruitment campaign for current and future vacancies on Queensland's 36 Health Community Councils. These councils are made up of community members who advise Queensland Health about local concerns. As an independent organisation, we manage this important recruitment process and our Commission makes recommendations for appointment. Appointments are then made by the Minister for Health.

We ran a recruitment campaign for vacancies on the Rockhampton council in July 2008 and the Charleville council in September 2008, with a state-wide campaign in all metropolitan and major regional newspapers in late January 2009. In addition to advertising vacancies, we organised media story placement and promoted the recruitment drive in our stakeholder news updates.

Since then, the government has initiated a review of the number, size and composition of the councils. The outcome of the review will determine future recruitment activity.

Increasing our knowledge

Our work in standards development and quality improvement relies on evidence-based information. This year we established our library, complete with a searchable online catalogue, and temporarily employed a librarian to set up our processes. We have a collection of books, publications, magazines and other resources to help with our daily work, including specialist healthcare quality titles and resources on Aboriginal and Torres Strait Islander cultures.

4 preventing

Our responsive regulation model helped bring together our two core roles—complaint management and quality improvement.

Reaching out

Going where we're needed

Since July 2006, we have conducted a regional education program for healthcare providers to foster understanding of our organisation and, in particular, our seven healthcare standards. In 30 months of operation, we made more than 60 regional visits to public and private facilities and staged more than 30 workshops for healthcare professionals.

Having completed a full round of visits to all regions of the state, we took the opportunity to review and reinvigorate the program with an engagement and education focus. This year, our visit program will be guided by our complaint, investigation and standards compliance data. We will go where we are most needed to help healthcare providers improve service quality. Our goal is to meet with as many stakeholders as possible during each visit, from hospital staff to local consumer health groups.

We have also looked at smarter ways to deliver engagement activities. We significantly increased our community and professional presence in 2008–09 thanks to a 12-month injection of additional staff. To continue this work, we have explored ways to maintain or increase engagement with fewer resources.

For example, we increased our presence in rural and remote Queensland through a partnership with Smart Service Queensland. The Queensland Government Agency Program (QGAP) offers information via 70 regional centres across the state. A script enables QGAP staff to provide simple information about our services to potential clients. Our brochures and posters are available via the network.

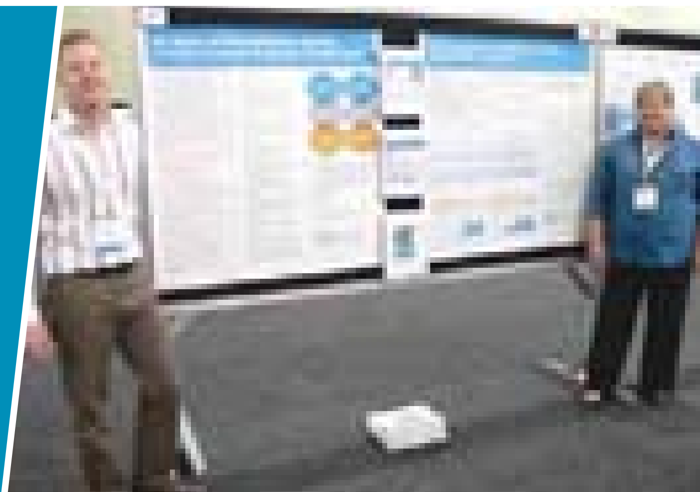
We also developed a presentation for external organisations to present on our behalf, with Avant, Australia's largest medical defence organisation, the first company to spread the word for us.

We partnered with our collocated agencies under the 'It's OK to complain' banner to reach Indigenous and culturally and linguistically diverse peoples at community events.

Forming research partnerships

The value and potential of our data is not only evident to us. Other organisations and individuals are beginning to recognise the importance of our role and the information we collect. We began forming relationships with universities, including the University of Queensland (UQ) School of Psychology, the (UQ) Queensland Centre for Health Data Services and Queensland University of Technology. We joined with Australian National University research partner Dr Judith Healy in a submission to explore the use of our responsive regulation model in health complaints management. We were also approached by numerous PhD students eager to work with us.

We worked with Griffith University to develop a Health Complaints Management course.



Right: Poster display at national quality and safety conference, Adelaide

Case study: Learning through research

University of Queensland School of Psychology PhD student Jasmine Rijnbout conducted research into information ownership among our Complaint Services staff. Based on the data collected, she developed suggestions for future actions which will be considered in conjunction with the results of an external review of Assessment processes. Jasmine talks about her experience with us.

'I was initially drawn to the practicum opportunity at the HQCC as I have a background in group facilitation and team research and was eager to extend my experience to an organisational setting.

Upon learning more about the HQCC, I became motivated to help further facilitate the positive action the HQCC is achieving in both complaint resolution and quality monitoring.

I was warmly welcomed and found that everyone I spoke to was friendly and passionate about their work. The staff that I interviewed as part of the project were especially enthusiastic about their role and the future of the organisation.

Working under supervision enabled me to extend my existing knowledge and skill set, and to gain valuable experience as a consultant organisational psychologist. I was also lucky enough to sit in on a Knowledge and Research Governance Committee meeting and hear about the exciting research and development opportunities being undertaken by the organisation.

When communicating my findings via a future directions report and presentation to key stakeholders, I was pleased by the level of positive feedback and enthusiasm. I have no doubt the HQCC will take on board whatever it can to facilitate its growth and development as an organisation. I will definitely be recommending the HQCC as a place for fellow students to undertake practicum work.'

Jasmine Rijnbout presenting research findings

Left to right: Building relationships – HQCC and Avant softball game

4 preventing

This valuable work is coordinated by our Knowledge and Research Governance Committee (see page 107), which encourages staff to suggest research that will be of interest to the wider community and help us to identify areas for improvement. Research topics include:

- hospital quality and risk evaluation, as a topic for PhD research
- developing relationships for infection control across public and private facilities, in partnership with the Centre for Healthcare Related Infection Surveillance and Prevention
- collaborative data analysis work with the University of Queensland School of Information Technology and Electrical Engineering.

Our research focus earned us the honour of being invited to present our work on healthcare standards to the International Society for Quality in Health Care (ISQua) conference in Dublin in October 2009.

We also worked with Griffith University to develop a Health Complaints Management module as part of its Graduate Certificate in Dispute Resolution to increase practitioner knowledge and understanding. We envisage that once up and running, our complaint assessment staff will undergo the formal training. We will also help the university promote this training among our network of Patient Liaison Officers and other stakeholders.

Developing our future online

Recognising the rapid development and adoption of online technologies and the impact they will have on our work, this year we worked with an external specialist to develop an online strategy for the next three years. We will need new internet capabilities and higher levels of automation to extend our stakeholder reach in a cost-effective way.

The strategy challenges us to:

- realign our systems with our future business model
- develop a systemic information capability
- apply user-based design methods to prototype and create solutions
- enable stakeholders to interact with us and each other online
- integrate online solutions with information systems to efficiently process information
- use commercially available solutions where available to minimise cost.

Through the strategy, we will:

- support online complaints and provide education
- make it easy for healthcare providers to report online
- share our knowledge online
- collaborate online to engage stakeholders and extend our reach
- create new insights that compel healthcare providers to improve safety and quality
- grow our reputation for developing innovative online capabilities that make a real difference to healthcare safety and quality.

> 'I will definitely be recommending the HQCC as a place for fellow students to undertake practicum work.' PhD student Jasmine Rijnbout

Looking ahead

Growing online

We will implement phase one of our online strategy, reviewing our online standards reporting tool and determining our future system requirements.

Emerging issues

We will continue to examine and develop new ways to identify trends and emerging issues in our data at both an individual practitioner and organisational level.

Working collaboratively

We will work with other organisations to supplement our data sources and offer insights based on our analysis of the information we hold.

Profiling providers

We will develop healthcare provider profiles and share these with providers to help guide quality improvement.

Identifying risk

We will identify trends within our data to highlight emerging risk and then facilitate implementation of measures to prevent harm.

Sharing leading practice

We will identify and share leading practice in Indigenous healthcare to help improve health outcomes for Aboriginal and Torres Strait Islander peoples.

5 improving

Nurturing continuous quality improvement in our organisation

5 improving

Relocating to our new home at 53 Albert Street, Brisbane in March has brought our organisation together as never before. For the first time our people are all on one floor, working in an open plan environment that encourages communication. We are now neighbours with our fellow complaint agencies and we have already explored ways to share knowledge and resources.

Highlights

- Our collocation with our fellow complaint agencies in a 4-star green star (office design) building will deliver significant annual savings and reduce our carbon footprint.
- An unprecedented 98% of our employees participated in our third annual cultural survey, with 70% saying the HQCC is a truly great place to work.
- We invested more than $140,000 in staff learning and development to support continuous quality improvement.

Challenges

- **Managing the move to new premises**
  While our relocation has resulted in enormous benefits, managing such a major project and ensuring our service and information communication technology systems were maintained presented us with numerous resource and logistical challenges. Our Business Services and Information Management teams worked tirelessly to ensure a seamless transition from one building to another, with no interruption to normal service levels.
- **Growing within a limited budget**
  We have identified stakeholder engagement and knowledge management as the keys to achieving improvement in the safety and quality of health services in Queensland.

  Increasing engagement and building our knowledge management capacity within our existing budget has proved challenging. In December 2008, we lodged a Cabinet Budget Review Committee submission for additional recurring funding. With no increase in our 2009–10 budget allocation, we have reviewed our plans and made efficiencies so we can continue with this important work, albeit on a reduced scale.

Profiling our organisation

As at 30 June 2009, we had 80 permanent, temporary and casual employees, including those on parental leave and leave without pay. Some 72.5% of our people are female, with the average age of our employees sitting at 44 years. The implications of this profile have been addressed with a family-friendly policy, which includes the options of job-sharing, flexible work hours and telecommuting.

Table 12: Staff levels across teams as at 30 June 2009

Unit	AO2	AO3	AO4	AO5	AO6	AO7	AO8	PO5	SO2	SO1	SES2 High	Contract
Office of the CEO				1								1
Business Services	4	5	0	1	2	1	1					
Community Engagement				2	1	2				1		
Complaint Services				9	11	8	4			1	1	
Standards and Quality			2	1	3	5	3	1		1		
Legal Services				1					1			
Information Management			1	1	1	2				1		
TOTALS	4	5	3	16	18	18	8	1	1	4	1	1
TOTAL STAFFING	80											

Table 13: Staff employment type as at 30 June 2009

Unit	Permanent	Temporary	Casual	Total
Office of CEO	2	-	-	2
Business Services	11	3	0	14
Community Engagement	1	4	1	6
Complaint Services (Mngt)	2	-	-	2
Assessment	11	4	-	15
Conciliation	6	-	-	6
Investigations	7	1	-	8
Clinical support	2	-	-	2
Project	0	1	-	1
Standards and Quality	15	1	-	16
Legal Services	1	1	-	2
Information Management	2	3	1	6
				80

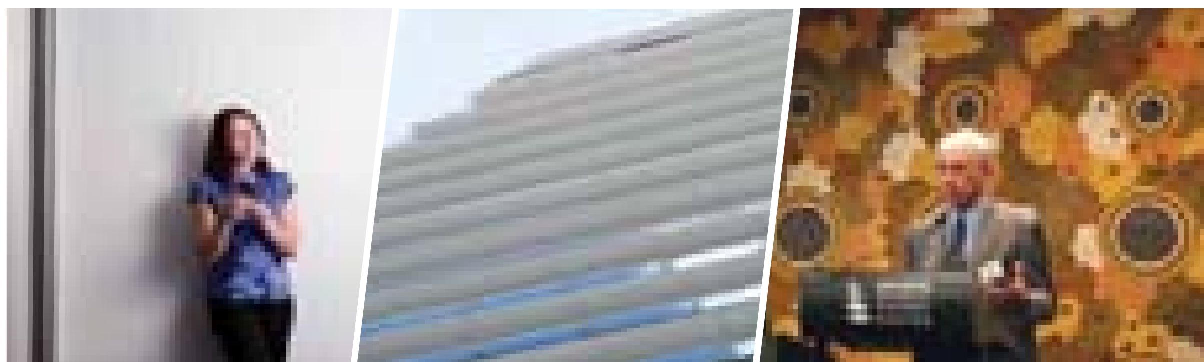
Table 14: Staff classification and remuneration as at 30 June 2009

Classification	Salary range ($)	Staff total
AO2	37,321 - 44,294	4
AO3	47,269 - 52,721	5
AO4	55,891 - 61,459	3
AO5	64,772 - 70,397	16
AO6	74,313 - 79,510	18
AO7	83,160 - 89,163	18
AO8	92,140 - 97,441	8
PO5	83,160 - 89,163	1
SO2	102,671 - 106,999	1
SO1	112,192 - 117,388	4
SES2 High	136,748	1
CEO	Contract	1

Staff numbers rose temporarily in the past year to manage a backlog of enquiries, complaints and investigations, increase community engagement and deliver new quality monitoring projects.

Increasing our permanent staffing

Recognising the additional resources required to achieve our vision, in June 2009 we decided to increase our permanent staffing by 11 full-time equivalents (FTE), from 58.2 FTE to 69.2 FTE. This increase was made possible by operational efficiencies and significantly reduced project expenditure. Recruitment of staff to permanent positions will occur in the first quarter of 2009–10.



Left: Using mobile technology to keep in touch **Middle:** New office building **Right:** Commissioner address

5 improving

‘The public speaking workshops I attended have helped me both professionally and personally—I now speak with clarity and confidence and no longer use ‘ums’ or ‘ahs’!’ Margaret Winniak, Administration Officer

Fostering a positive workplace

Getting feedback from our people about how we’re going helps us to continually grow and improve. Our third annual cultural survey was for the first time submitted electronically and completed by an unprecedented 98% of our people.

Table 15: Results of the annual cultural survey

	2007	2008	2009
% survey participation	79%	83%	98%
Staff are engaged	28%	40%	48%
Staff think the HQCC is ‘truly a great place’ to work	26%	44%	70%

After each survey, we develop a cultural improvement plan based on the opportunities identified.

In 2009–10 we will be focusing on:

- improving communication
- increasing trust in our executive management team
- improving client service.

We have committed to conducting another three annual cultural surveys to help us monitor and improve our workplace.

Keeping our staff in the loop

In the past 12 months, we made a concerted effort to keep our staff informed. Our intranet, the LOOP (the name references our logo), continued to be one of our key internal communication tools. We improved navigation and introduced features, such as a Commissioner’s blog and staff forums. We opened up the LOOP as a shared workspace, giving all interested staff training to post information and updates.

We provided helpdesk support for around 3600 internal requests.

Right: Staff celebrate Easter

We continued monthly all-of-staff meetings and introduced a weekly e-newsletter (linked to LOOP pages) to keep people up-to-date in between times. Through regular team meetings, our Positive Workplace Committee (see page 107) and staff social events, our people have an opportunity to share information and learn from one another.

Working with us

We want our employees to enjoy being part of our organisation, so we offer a range of work/life balance options, including:

- flexible work hours
- job-share arrangements
- study leave (and in some cases, study assistance)
- special leave
- home-based telecommuting.

We also offer staff and their families an Employee Assistance Program, a confidential counselling service paid for by the HQCC to help staff with personal or work-related issues.

Table 16: Employee participation in HQCC programs 2008–09

Program	No. of employees
Job-share arrangements	4
Home-based telecommuting	17
Employee Assistance Program	9

Nurturing our people

We established a learning and development strategy to assess employee training needs and source and develop appropriate education. Our plan supports staff in building personal capability as well as developing work skills across the organisation. We provided leadership and management training for senior managers to increase their skills and support our cultural improvement plan. All staff participated in an Indigenous Information Sharing program to improve their understanding of Aboriginal and Torres Strait Islander cultures.

This year, we sourced formal training programs and provided in-house training in Microsoft Excel and public speaking for all interested staff. Overall, 70% of participants said workplace practices had improved as a result of attending a training activity. To share learnings more widely, participants report back to their colleagues about their training or conference at quarterly lunchtime sessions.

We spent more than $140,000 on training and professional development in 2008–09. We supported 50 staff to attend industry seminars, professional development forums and conferences. One employee applied for and received Study and Research Assistance.

We continued our staff lunchbox sessions, which provide our people with practical introductions to a variety of self-management skills and work-related topics, including medical negligence, workplace innovation, making clinical handover safe and safe internet practices.

Left: Cutting of the cake, second birthday **Right:** Community fundraising raffle

5 improving

> In six months, our legal service provided advice on 150 matters to internal teams.

Managing performance

Our Performance Management System enables our people to support the implementation of the organisation's objectives and the ongoing achievement of sustainable improvements in performance. It provides for the ongoing development of employees and assists managers and executives to effectively motivate, support and coach individuals and their teams.

This year we developed a new performance development process, formalising the link between our strategic framework, business operational plans and individual performance development plans. The new performance development plans will be completed by all employees following the business operational planning cycle each year and formally reviewed at six and 12-month intervals, starting in 2009.

Advising on legal matters

We appointed our General Counsel in December 2008 to provide legal advice and support on matters ranging from industrial relations, to complaints and investigations, to contracts. In six months, our legal service provided advice on 150 matters to internal teams, such as Assessment, Conciliation and Investigations. This work included the review of two major investigations through analysing key evidence and editing content.

Supporting our staff through information management

Our information management strategic plan this year delivered an enhanced range of technologies and business applications to support our core activities and keep our staff in touch. These included:

- enhancements to our complaints and investigations case management database
- feature rich secure remote access to all of our business applications

Top, left to right: Whole of organisation planning day (first two images); Staff lunch room (last two images)
Bottom left: Reviewing safety and quality statistics **Bottom right:** Staff health checks

- upgraded mobile communication devices
- an upgraded anti-spam appliance
- helpdesk support for around 3600 requests.

We also implemented a number of major information management projects:

- introducing high speed data cards for laptops to support mobility and productivity.
- implementation of a new electronic document and records management system, and paper-based records system.
- piloting and implementing a virtual solution to deliver enhanced desktop support and provide an improved user experience for telecommuters and for staff working on investigations in regional and remote areas.
- increasing our data storage capacity.
- managing the information communication technology systems relocation to our new premises.

Keeping track of our records

We implemented an electronic document and records management system (eDRMS) this year to ensure we comply with records management legislation. We created a retention and disposal schedule for all of our documents, and the eDRMS tracks and records all information related to our records. The system also allows improved tracking of our paper-based records through the use of bar codes. We now have documented processes for the handling of all records, including mail.

Going green

Our relocation to a new building saw us significantly reduce our environmental impact, as our new home has a 4-star green star rating for office design. In moving, we:

- introduced paper recycling bins at every work station and in our resource room for non-confidential documents
- upgraded our printers and photocopiers and conducted staff training to allow for more energy-efficient use and reduced paper consumption
- continued to recycle ink cartridges and superseded computer equipment
- placed recycling bins for glass and plastic in our employee kitchen
- purchased appliances with superior energy ratings
- examined the power saving when choosing our new IT technology, and deciding on one which performs more efficiently (and powers off at night), substantially reducing energy consumption and greenhouse gas emissions
- ensured the new facilities came with:
  - energy efficient lighting
  - dual-flush toilet units.

> Our relocation saw us significantly reduce our environmental impact.

Top, left to right: Staff cricket day; 'How can we help you?'; Catching up over coffee (third and fourth images); New open plan workspace
Bottom left: Managing paper records **Bottom Right:** Monthly staff meeting

5 improving

Reaching out

Creating a one-stop complaint shop

After many months of cooperative planning, we moved from 288 Edward Street to 53 Albert Street, Brisbane, at the end of March 2009.

We made the move in partnership with the Queensland Ombudsman, the Commission for Children and Young People and Child Guardian, the Anti-Discrimination Commission Queensland and the Queensland branch of the Commonwealth Ombudsman, making it easier for people with complaints and concerns to access the right organisation.

Joining forces allowed the agencies to achieve economies of scale not possible on our own and we share a reception area, as well as training, interview and meeting rooms. The Queensland Ombudsman manages the reception and meeting rooms on our behalf. The HQCC shares its server room with three other agencies and our information management staff have a common workspace.

A major benefit of the move has been the opportunity to work more closely with our fellow agencies. Leaders meet monthly, with corporate services, communication and Indigenous liaison staff also meeting regularly to share ideas and plan joint projects (see page 32, 'Knowing where to turn').

Cost savings were another key driver of the collocation. Our office space lease costs have reduced by $105 a square metre annually.

Table 17: Savings in our new home (per annum)

	Saving
Office lease	$100,000
New payroll system due to IT upgrade	$15,000
New printing and photocopying technology	$30,000
Total	$145,000

Mentoring across agencies

Our inter-agency mentoring program to share experience and support individual growth and development was extended in 2008–09. Fifteen HQCC staff participated (as either mentors or mentees), compared to nine in the first year of the program. Participating agencies now include:

- the Commission for Children, Young People and Child Guardian
- the Queensland Ombudsman
- the Commonwealth Ombudsman
- the Crime and Misconduct Commission
- the Anti-Discrimination Commission Queensland.

Giving something back

Our people supported a number of charities this year. We helped our World Vision child Saleh Mousa Ma'roof and his community in Gaza through gold coin donations each 'Casual Friday'. Through the work of our Positive Workplace Committee (see page 107), we also held fundraising events for Beyond Blue, Breast Cancer research, the Victorian Bushfire Appeal and the 139 Club. Staff participated in the 10,000 steps program for a fitter and healthier workforce. The challenge was to walk a distance equivalent to walking along the Great Wall of China, a total of 3,840,000 steps in six weeks. The daily target was 10,000 steps, but competing team members averaged 13,754 daily steps with an average total of 6,402,830, far exceeding the target and ahead of time.

Looking ahead

Implementing the Capability and Leadership Framework

We will look to implement the Public Service Commission's Capability and Leadership framework to develop employees at all levels in our organisation.

Virtualising our network

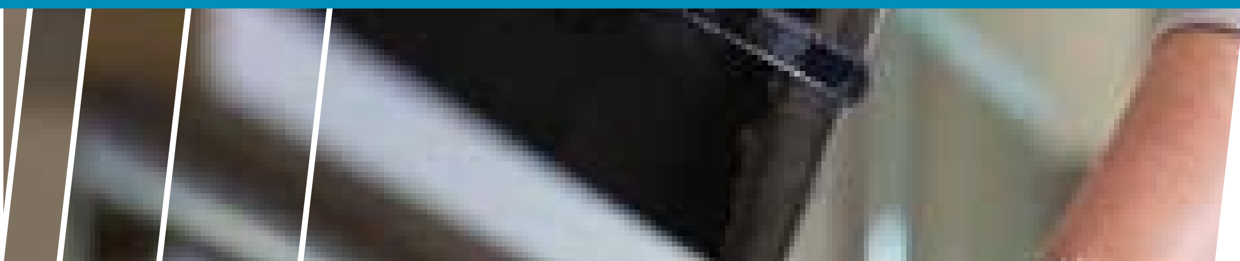
We will move to virtual computer desktops, with all software stored and managed on our servers. As well as making it easier to maintain and update systems, virtualisation will allowing employees full access to our network and applications from outside the office.

Supporting a healthier workforce

We will introduce a health and wellbeing program to inform our employees about health issues and encourage a healthy lifestyle while reinforcing understanding of medical terminology.

Stimulating ideas

We will create a new process to generate and capture staff ideas, so we can continuously improve across all areas of our organisation.



financial report

Reporting on our finances 2008–09

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General information

These financial statements cover the Health Quality and Complaints Commission. It has no controlled entities.

The Health Quality and Complaints Commission is a Queensland Government Commission established under the *Health Quality and Complaints Commission Act 2006* (Queensland).

The Commission is controlled by the State of Queensland which is the ultimate parent.

The head office and principal place of business of the Commission is:

Level 18, 53 Albert Street
BRISBANE QLD 4000

A description of the nature of the Commission's operations and its principal activities is included in the notes to the financial statements.

For information about the Commission's financial statements please call (07) 3120 5999, email henry.petracci@hqcc.qld.gov.au, or visit the Commission's website www.hqcc.qld.gov.au.

income statement

for the year ended 30 June 2009

	Notes	2009 $	2008 $
Income			
Revenue			
Grants and contributions	2	**10,194,815**	8,051,000
Other revenue	3	**404,160**	494,844
Total Income		**10,598,975**	8,545,844
Expenses			
Employee expenses	4	**7,329,143**	7,199,761
Supplies and services expenses	5	**3,221,351**	2,377,975
Depreciation and amortisation expenses	6	**211,095**	91,440
Other expenses	7	**270,868**	19,516
Total Expenses		**11,032,457**	9,688,692
Operating (Deficit)		**(433,482)**	(1,142,848)

The accompanying notes form part of these statements.

balance sheet

as at 30 June 2009

	Notes	**2009 $**	2008 $
Current Assets			
Cash and cash equivalents	8	**1,108,655**	2,340,370
Receivables	9	**238,618**	87,941
Other current assets	10	**38,970**	11,978
Total Current Assets		**1,386,243**	2,440,289
Non Current Assets			
Intangible assets	11	**728,669**	545,232
Property, plant and equipment	12	**2,306,065**	395,210
Total Non Current Assets		**3,034,734**	940,442
Total Assets		**4,420,977**	3,380,731
Current Liabilities			
Payables	13	**777,919**	600,159
Accrued employee benefits	14	**794,253**	761,740
Other current liabilities	15	**139,388**	-
Total Current Liabilities		**1,711,560**	1,361,899
Non Current Liabilities			
Accrued employee benefits	14	**124,152**	198,224
Other non current liabilities	15	**1,198,139**	-
Total Non Current Liabilities		**1,322,291**	198,224
Total Liabilities		**3,033,851**	1,560,123
Net Assets		**1,387,126**	1,820,608
Equity			
Retained surpluses		**1,387,126**	1,820,608
Total Equity		**1,387,126**	1,820,608

The accompanying notes form part of these statements.

statement of changes in equity

for the year ended 30 June 2009

	Retained Surpluses 2009 $	2008 $
Balance 1 July	**1,820,608**	2,963,456
Operating (Deficit)	**(433,482)**	(1,142,848)
Balance 30 June	**1,387,126**	1,820,608

The accompanying notes form part of these statements.

cash flow statement

for the year ended 30 June 2009

	Notes	2009 $	2008 $
Cash flows from operating activities			
Inflows:			
Grants and other contributions		**10,194,815**	8,051,000
GST input tax credits from ATO		**312,461**	311,520
GST collected from customers		**71**	1,510
Interest receipts		**398,582**	487,799
Other		**29,997**	6,497
Outflows:			
Employee expenses		**(7,371,605)**	(6,441,025)
Supplies and services and other expenses		**(3,197,287)**	(2,432,166)
GST paid to suppliers		**(432,855)**	(297,253)
GST remitted to ATO		**(79)**	(10,651)
Net cash (used in) operating activities	16	**(65,900)**	(322,769)
Cash flows from investing activities			
Outflows:			
Payments for property, plant and equipment		**(919,289)**	-
Payments for intangibles		**(246,526)**	(547,222)
Net cash (used in) investing activities		**(1,165,815)**	(547,222)
Net (decrease) in cash held		**(1,231,715)**	(869,991)
Cash at beginning of financial year		**2,340,370**	3,210,361
Cash at end of financial year	8	**1,108,655**	2,340,370

The accompanying notes form part of these statements.

notes to and forming part of the financial statements 2008–09

Objectives and Principal Activities of the Commission
Note 1: Summary of Significant Accounting Policies
Note 2: Grants and Contributions
Note 3: Other Revenues
Note 4: Employee Expenses
Note 5: Supplies and Services Expenses
Note 6: Depreciation and Amortisation Expenses
Note 7: Other Expenses
Note 8: Cash and Cash Equivalents
Note 9: Receivables
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Note 11: Intangible Assets
Note 12: Property, Plant and Equipment
Note 13: Payables
Note 14: Accrued Employee Benefits
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Note 16: Reconciliation of Operating (Deficit) to net cash (used in) operating activities
Note 17: Non-Cash Financing and Investing Activities
Note 18: Commitments for Expenditure
Note 19: Contingencies
Note 20: Controlled entities of the Health Quality and Complaints Commission
Note 21: Restricted Assets
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Note 23: Financial Instruments
Note 24: Comparative Period Reclassifications
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notes to and forming part of the financial statements 2008–09

Objectives and Principal Activities of the Commission

The objectives of the independent Health Quality and Complaints Commission are to monitor, review and report on the quality of health services, recommend action to improve the quality of health services, receive and manage complaints about health services, help healthcare consumers and providers to resolve health complaints and preserve and promote health rights in Queensland. The organisation was established under the *Health Quality and Complaints Commission Act 2006*, commencing on 1 July 2006. The Commission was established by the Queensland Government in response to a major recommendation of the Queensland Health Systems Review (known as the Forster Report) in late 2005.

All assets, liabilities and financial commitments were effectively transferred from the Health Rights Commission to the Health Quality and Complaints Commission on 1 July 2006. The Health Rights Commission ceased to exist from 1 July 2006.

1. Summary of Significant Accounting Policies

(a) Basis of Accounting

The financial statements have been prepared in accordance with Australian Accounting Standards. In addition, the financial statements comply with the Treasurer's Minimum Reporting Requirements for the year ending 30 June 2009, and other authoritative pronouncements.

These financial statements constitute a general purpose financial report.

Except where stated, the historical cost convention is used.

(b) The Reporting Entity

The financial statements include the value of all revenues, expenses, assets, liabilities and equity of the Commission. The Commission does not have any controlled entities.

The major activities undertaken by the Commission are disclosed in Note 1(w).

(c) Administered Transactions and Balances

The Commission does not administer resources on behalf of the Queensland Government.

(d) Grants and Other Contributions

Grants, contributions, donations and gifts that are non-reciprocal in nature are recognised as revenue in the year in which the Commission obtains control over them. The Commission is primarily funded by administered grant revenue from Queensland Treasury through Queensland Health.

Where grants are received that are reciprocal in nature, revenue is accrued over the term of the funding arrangements.

Contributed assets are recognised at their fair value. Contributions of services are recognised only when a fair value can be determined reliably and the services would be purchased if they had not been donated.

(e) Other Revenue and User Charges

Other revenue is principally interest derived from short term investments of surplus cash. The Commission has no administered revenue.

User charges controlled by the Commission are recognised as revenues when invoices for the related services are issued. User charges are controlled by the Commission where they can be deployed for the achievement of the Commission's objectives. At present, no user charges are raised by the Commission.

(f) Cash and Cash Equivalents

For the purposes of the Balance Sheet and the Cash Flow Statement, cash assets include all cash and cheques receipted but not banked at 30 June as well as deposits at call with financial institutions. The Commission is party to the government's banking arrangement conducted by Queensland Treasury.

notes to and forming part of the financial statements 2008–09

1. Summary of Significant Accounting Policies (contd)

(g) Receivables

Trade debtors are recognised at the nominal amounts due at the time of sale or service delivery. Settlement of these amounts is required within 30 days from invoice date.

The collectability of receivables is assessed periodically. There is no provision for doubtful debts at the balance sheet date. All known bad debts were written off at 30 June.

(h) Inventories

The Commission has no inventories as at 30 June 2009.

(i) Non-current Assets Classified as Held for Sale

Non-current assets held for sale consist of those assets which management has determined are available for immediate sale in their present condition, and their sale is highly probable within the next 12 months. Management has determined that no such assets are currently held by the Commission.

(j) Acquisitions of Assets

Actual cost is used for the initial recording of all non-current physical and intangible assets incurred. Cost is determined as the value given as consideration plus costs incidental to the acquisition, including all other costs incurred in getting the assets ready for use, including architect's fees and engineering design fees. However, any training costs are expensed as incurred.

Where assets are received free of charge from a Queensland Government entity (whether as a result of a machinery-of-Government or other involuntary transfer), the acquisition cost is recognised as the gross carrying amount in the books of the transferor immediately prior to the transfer together with any accumulated depreciation.

Assets acquired at no cost or for nominal consideration, other than from an involuntary transfer from a Queensland Government entity, are recognised at their fair value at date of acquisition in accordance with AASB116 *Property, Plant and Equipment*.

(k) Property, Plant and Equipment

Items of property, plant and equipment (where held) with a cost or other value equal to or in excess of the following thresholds are recognised for financial reporting purposes in the year of acquisition.

Plant and Equipment	$5,000
Leasehold improvements	$5,000

Items with a lesser value are expensed in the year of acquisition.

(l) Revaluations of Non-Current Physical and Intangible Assets

Where intangible assets have an active market, they are measured at fair value, otherwise they are measured at cost.

Plant and equipment, other than major plant and equipment are measured at cost. The carrying amounts for plant and equipment at cost should not materially differ from their fair value.

(m) Intangibles

Intangible assets with a cost or other value greater than $100,000 are recognised in the financial statements, items with a lesser value being expensed. Each intangible asset is amortised over its estimated useful life to the commission, less any anticipated residual value. The residual value is zero for all the Commission's intangible assets.

It has been determined that there is not an active market for any of the Commission's intangible assets. As such, the assets are recognised and carried at cost less accumulated amortisation and accumulated impairment losses.

Purchased Software

The purchase cost of this software has been capitalised and is being amortised on a diminishing value basis over the period of the expected benefit to the Commission, namely ten 10 years.

notes to and forming part of the financial statements 2008–09

1. Summary of Significant Accounting Policies (contd)

(n) Amortisation and Depreciation of Intangibles and Property, Plant and Equipment

Property, plant and equipment is depreciated on a diminishing value basis so as to allocate the net cost or revalued amount of each asset, less its estimated residual value, progressively over its estimated useful life to the Commission.

Assets under construction (work in progress) are not depreciated until they reach service delivery capacity.

Where assets have separately identifiable components that are subject to regular replacement, these components are assigned useful lives distinct from the asset to which they relate and are depreciated accordingly.

Any expenditure that increases the originally assessed capacity or service potential of an asset is capitalised and the new depreciable amount is depreciated over the remaining useful life of the asset to the Commission.

The depreciable amount of improvements to or on leasehold property is allocated progressively over the estimated useful lives of the improvements or the unexpired period of the lease, whichever is the shorter. The unexpired period of the leases includes any option period where exercise of the option is probable.

For each class of depreciable asset, where held, the following depreciation rates were used:

Class	*Depreciation Rate %*
Plant and equipment	
• Office equipment	12.50% to 30.00%
• Audio visual equipment	20.00%
Leasehold improvements	10.00%
Intangibles	*Amortisation Rate %*
• Business applications	10.00%

(o) Impairment of Non-Current Assets

All non-current physical and intangible assets are assessed for indicators of impairment on an annual basis. If an indicator of possible impairment exists, the Commission determines the asset's recoverable amount. Any amount by which the asset's carrying amount exceeds the recoverable amount is recorded as an impairment loss.

The asset's recoverable amount is determined as the higher of the asset's fair value less costs to sell and depreciated replacement costs.

An impairment loss is recognised immediately in the Income Statement, unless the asset is carried at a revalued amount. When the asset is measured at a revalued amount, the impairment loss is offset against the asset revaluation reserve of the relevant class to the extent available.

Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of its recoverable amount, but so that the increased carrying amount does not exceed the carrying amount that would have been determined had no impairment loss been recognised for the asset in prior years. A reversal of an impairment loss is recognised as income, unless the asset is carried at a revalued amount, in which case the reversal of the impairment loss is treated as a revaluation increase.

(p) Investment Property

The Commission did not hold any investment property during the financial year.

1. Summary of Significant Accounting Policies (contd)

(q) Leases

A distinction is made in the financial statements between finance leases that effectively transfer from the lessor to the lessee substantially all the risks and benefits incidental to ownership, and operating leases under which the lessor effectively retains substantially all risks and benefits.

Where a non-current asset is acquired by means of a finance lease, the asset is recognised at the lower of the fair value of the leased property and the present value of the minimum lease payments. The liability is recognised at the same amount.

Lease payments are allocated between the principal component of the lease liability and the interest expense.

Operating lease payments are representative of the pattern of benefits derived from the leased assets and are expensed in the periods in which they are incurred.

Incentives received on entering into operating leases are recognised as liabilities. Lease payments are allocated between rental expense and reduction of the liability.

(r) Payables

Trade creditors are recognised upon receipt of the goods or services ordered and are measured at the agreed purchase/contract price gross of applicable trade and other discounts. Amounts owing are unsecured and are generally settled on 30 day terms.

(s) Financial Instruments

Recognition

Financial assets and financial liabilities are recognised in the Balance Sheet when the Commission becomes party to the contractual provisions of the financial instrument.

Classification

Financial instruments are classified and measured as follows:

Cash and cash equivalents – held at fair value through profit and loss

Receivables – held at amortised cost

Payables – held at amortised cost

Borrowings – held at amortised cost

Borrowings are initially recognised at fair value, plus any transaction costs directly attributable to the borrowings, then subsequently held at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of a financial instrument (or, when appropriate, a shorter period) to the net carrying amount of that instrument.

Any borrowing costs are added to the carrying amount of the borrowing to the extent they are not settled in the period in which they arise. Borrowings are classified as non-current liabilities to the extent that the Commission has an unconditional right to defer settlement until at least 12 months after balance sheet date.

The Commission does not enter into transactions for speculative purposes, nor for hedging. Apart from cash and cash equivalents, the Commission holds no financial assets classified at fair value through profit and loss.

All disclosures relating to the measurement basis and financial risk management of other financial instruments held by the Commission are included in Note 23.

1. Summary of Significant Accounting Policies (contd)

(t) Employee Benefits

Wages, Salaries, Recreation Leave and Sick Leave

Wages, salaries and recreation leave due but unpaid at reporting date are recognised in the Balance Sheet at the nominal salary rates. Payroll tax and workers' compensation insurance are a consequence of employing employees, but are not counted in an employee's total remuneration package. They are not employee benefits and are recognised separately as employee related expenses. Employer superannuation contributions and long service leave levies are regarded as employee benefits.

For unpaid entitlements expected to be paid within 12 months the liabilities are recognised at their undiscounted values. Entitlements not expected to be paid within 12 months are classified as non-current liabilities and are recognised at their present value, calculated using yields on Fixed Rate Commonwealth Government bonds of similar maturity, after projecting the remuneration rates expected to apply at the time of likely settlement.

Prior history indicates that on average, sick leave taken each reporting period is less than the entitlement accrued. This is expected to continue in future periods. Accordingly, it is unlikely that existing accumulated entitlements will be used by employees and no liability for unused sick leave entitlements is recognised.

As sick leave is non-vesting, an expense is recognised for this leave as it is taken.

Long Service Leave

Under the Queensland Government's long service leave scheme, a levy is made on the Commission to cover the cost of employees' long service leave. The levies are expensed in the period in which they are payable. Amounts paid to employees for long service leave are claimed from the scheme quarterly in arrears.

No provision for long service leave is recognised in the Commission's financial statements, the liability being held on a whole-of-Government basis and reported in the financial report prepared pursuant to AASB 1049 *Whole of Government and General Government Sector Financial Reporting*.

Superannuation

Employer superannuation contributions are paid to QSuper, the superannuation plan for Queensland Government employees, at rates determined by the Treasurer on the advice of the State Actuary. Contributions are expensed in the period in which they are paid or payable. The Commission's obligation is limited to its contribution to QSuper.

Therefore, no liability is recognised for accruing superannuation benefits in the Commission's financial statements, the liability being held on a whole-of-Government basis and reported in the financial report prepared pursuant to AASB 1049 *Whole of Government and General Government Sector Financial Reporting*.

notes to and forming part of the financial statements 2008–09

1. Summary of Significant Accounting Policies (contd)

(t) Employee Benefits (contd)

Executive Remuneration

The executive remuneration disclosures in the employee expenses note (Note 4) in the financial statements include:

- the aggregate remuneration of all senior executive officers (including the Chief Executive Officer) whose remuneration for the financial year is $100,000 or more; and
- the number of senior executives whose total remuneration for the financial year falls within each successive $20,000 band, commencing at $100,000.

The remuneration disclosed is all remuneration paid or payable, directly or indirectly, by the entity or any related party in connection with the management of the affairs of the entity or any of its subsidiaries, whether as an executive or otherwise. For this purpose, remuneration includes:

- wages and salaries;
- accrued leave (that is, the increase/decrease in the amount of annual and long service leave owed to an executive, inclusive of any increase in the value of leave balances as a result of salary rate increases or the like);
- performance pay paid or due and payable in relation to the financial year, provided that a liability exists (namely a determination has been made prior to the financial statements being signed), and can be reliably measured even though the payment may not have been made during the financial year;
- accrued superannuation (being the value of all employer superannuation contributions during the financial year, both paid and payable as at 30 June);
- car parking benefits and the cost of motor vehicles, such as lease payments, fuel costs, registration/ insurance, repairs/maintenance and fringe benefit tax on motor vehicles incurred by the agency during the financial year, both paid and payable as at 30 June, net of any amounts subsequently reimbursed by the executives;
- housing (being the market value of the rent or rental subsidy – where rent is part-paid by the executive – during the financial year, both paid and payable as at 30 June);
- allowances (which are included in remuneration agreements of executives, such as airfares or other travel costs paid to/for executives whose homes are situated in a location other than the location they work in); and
- fringe benefits tax included in remuneration agreements.

The disclosures apply to all senior executives appointed under the *Public Service Act 2008* and classified as SES1 and above, with remuneration above $100,000 in the financial year. 'Remuneration' means any money, consideration or benefit, but excludes amounts:

- paid to an executive by an entity or its subsidiary where the person worked during the financial year wholly or mainly outside Australia during the time the person was so employed; or
- in payment or reimbursement of out-of-pocket expenses incurred for the benefit of the entity or any of its subsidiaries.
- In addition, separate disclosure of separation and redundancy/termination benefit payments is included.

notes to and forming part of the financial statements 2008–09

1. Summary of Significant Accounting Policies (contd)

(u) Provisions

Provisions are recorded when the Commission has a present obligation, either legal or constructive as a result of a past event. They are recognised at the amount expected at reporting date at which the obligation will be settled in a future period. Where the settlement of the obligation is expected after 12 or more months, the obligation is discounted to the present value using an appropriate discount rate.

(v) Financing/Borrowing costs

Finance costs are recognised as an expense in the period in which they are incurred.

Finance costs include:

- Interest on bank overdrafts and short-term and long-term borrowings;
- Amortisation of discounts or premiums relating to borrowings; and
- Ancillary administration charges.

(w) Major Activities of the Health Quality and Complaints Commission

The Health Quality and Complaints Commission Act 2006 (the Act) is the legislation that governs and guides the work of the HQCC. The legislation establishing HQCC was enacted on 29 May 2006, and came into force on 1 July of that year. Some of the key HQCC functions, detailed in the Act are;

- receiving and managing complaints about health services;
- endorsing quality, safety and clinical practice standards;
- making standards relating to the quality of health services and monitoring compliance with these standards;
- receiving, analysing and disseminating information about the quality of health services;
- investigating on its own initiative and where necessary reporting on systemic failures;
- suggesting ways of improving health services and of preserving and promoting health rights.

(x) Insurance

The Commission's non-current physical assets and other risks are insured through the Queensland Government Insurance Fund, premiums being paid on a risk assessment basis. Motor vehicles are leased from QFleet and insurance is provided by the leasing arrangements. In addition the Commission pays premiums to Workcover Queensland in repect of its obligations for employee compensation.

(y) Services Received Free of Charge or For Nominal Value

Contributions of services are recognised only if the services would have been purchased if they had not been donated and their value can be measured reliably. Where this is the case, an equal amount is recognised as a revenue and an expense.

(z) Contributed Equity

Non-reciprocal transfers of assets and liabilities between wholly-owned Queensland State Public Sector entities as a result of machinery-of-Government changes are adjusted to 'Contributed Equity' in accordance with Interpretation 1038 *Contributions by Owners Made to Wholly-Owned Public Sector Entities*.

(aa) Taxation

The Commission is is a State body as defined under the *Income Tax Assessment Act 1936* and is exempt from Commonwealth taxation with the exception of Fringe Benefits Tax and Goods and Services Tax (GST). FBT and GST are the only taxes accounted for by the Commission. GST credits receivable from, and GST payable to the ATO, are recognised (refer to note 9).

(ab) Issuance of Financial Statements

The financial statements are authorised for issue by the Commissioner and the Chief Executive Officer of the Health Quality and Complaints Commission .

1. Summary of Significant Accounting Policies (contd)

(ac) Judgements

The preparation of financial statements necessarily requires the determination and use of certain critical accounting estimates, assumptions, and management judgements that have potential to cause a material adjustment to the carrying amounts of assets and liabilities within the next financial year. Such estimates, judgements and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised and in future periods as relevant.

Estimates and assumptions that have a potential significant effect are outlined in the following financial statement notes:

Valuation of Property, Plant and Equipment – note 12

(ad) Rounding and Comparatives

Comparative information has been restated where necessary to be consistent with disclosures in the current reporting period.

(ae) New and Revised Accounting Standards

The Commission did not change any of its accounting policies during 2008–09. The significance of those new and amended Australian accounting standards that were applicable for the first time in the 2008–09 financial year and have had a significant impact on the Commission's financial statements is as follows.

A review has been undertaken of revised accounting standard AASB 1004 *Contributions*, and it is considered the financial statements adequately reflect the matters to be disclosed, given the Commission's present operating circumstances.

The Commission is not permitted to early adopt a new accounting standard ahead of the specified commencement date unless approval is obtained from the Queensland Treasury. Consequently, the Commission has not applied any Australian accounting standards and interpretations that have been issued but are not yet effective. The Commission will apply these standards and interpretations in accordance with their respective commencement dates.

At the date of authorisation of the financial report, a number of new or amended Australian accounting standards with future commencement dates will have a significant impact on the Commission. Details of such impacts are set out below.

The Commission will need to comply with a revised version of AASB 101 *Presentation of Financial Statements as from 2009–10*. This revised standard does not have measurement or recognition implications. However, in line with the new concept of 'comprehensive income' in the revised AASB 101, there will be significant changes to the presentation of the Commission's income and expenses that are currently presented in the Income Statement and the Statement of Changes in Equity.

In addition, where there have been retrospective accounting policy changes, retrospective re-statement of items in the financial statements or re-classifications of financial statement items during the current reporting period, the revised AASB 101 will require a statement of financial position to be presented as at the beginning the earliest comparative period included in the financial statements.

A revised version of AASB 123 *Borrowing Costs* has been released, but such revisions will not impact on the Commission until 2009–10 and will not have any material effect on the Commission's position.

AASB 1050 *Administered Items* has been released, and will not impact on the Commission.

The new accounting standard AASB 1052 *Disaggregated Disclosures* will not impact on the agency as from 2008–09 as the Commission has only one output.

The revised standard AASB 140 *Investment Property* does not apply as the Commission does not control any investment properties.

All other Australian accounting standards and interpretations with future commencement dates are either not applicable to the Commission, or have no material impact on the Commission.

notes to and forming part of the financial statements 2008–09

	2009 $	2008 $
2. Grants and Contributions		
Operational grant	**10,194,815**	8,051,000
Total	**10,194,815**	8,051,000
3. Other Revenues		
Interest earned	**395,636**	489,667
FOI application fees	**471**	738
Other	**8,053**	4,439
Total	**404,160**	494,844
4. Employee Expenses		
Employee Benefits		
Wages and salaries	**5,661,135**	5,449,008
Employer superannuation contributions *	**691,989**	747,654
Long service leave levy	**116,376**	81,292
Annual leave expenses	**461,413**	577,098
Employee Related Expenses		
Payroll tax and fringe benefits	**382,532**	333,428
Workers' compensation premium **	**15,698**	11,281
Total	**7,329,143**	7,199,761

* Employer superannuation contributions and the long service leave levy are regarded as employee benefits.

** Costs of workers' compensation insurance and payroll tax are a consequence of employing employees, but are not counted in employees' total remuneration package. They are not employee benefits, but rather employee related expenses.

The total number of employees includes both full-time employees and part-time employees measured on a full-time equivalent basis.

	2009	2008
Number of employees:	**75**	74

notes to and forming part of the financial statements 2008–09

	2009 $	2008 $
4. Employee Expenses (contd)		
Executive Remuneration		
The following is remuneration paid/payable to senior executives or were due to receive total remuneration of $100,000 or more:		
$140,000 to $159,999	**-**	2
$200,000 to $219,999	**2**	-
$340,000 to $359,000	**1**	1
Total	**3**	3
Aggregate amount of total remuneration of executives shown above[#]	**783,181**	744,787
[#] The amount calculated as executive remuneration in these financial statements includes the direct remuneration received, as well as items not directly received by senior executives, such as the movement in leave accruals and fringe benefits tax paid on motor vehicles. This amount will therefore differ from advertised executive remuneration packages which do not include the latter items.		
Aggregate amount of separation and redundancy/termination benefit payments during the year to executives shown above	**128,696**	55,097
5. Supplies and Services Expenses		
Administrative expenses	**561,720**	458,739
Catering	**10,274**	12,797
Consultancy	**324,528**	359,107
Legal expenses	**47,557**	43,301
Library expenses	**8,234**	1,417
Maintenance costs	**22,454**	29,207
Motor vehicle – operating lease	**47,015**	53,451
Motor vehicle – other	**63,956**	37,019
Plant & equipment purchases <$5,000	**32,842**	8,378
Printing expenses and postage	**28,293**	109,436
Network support	**345,067**	194,844
Rent – operating lease	**848,759**	347,974
Software licences	**181,177**	176,578
Staff development	**177,640**	105,180
Stationery and office supplies	**79,535**	49,341
Telephone expenses	**141,382**	29,250
Temporary staff expenses	**222,829**	232,212
Translation services	**1,569**	4,335
Travel expenses	**74,748**	124,183
Memberships	**1,772**	1,226
Total	**3,221,351**	2,377,975

notes to and forming part of the financial statements 2008–09

	2009 $	2008 $
6. Depreciation and Amortisation Expenses		
Depreciation and amortisation were incurred in respect of:		
Plant and equipment	**68,629**	43,302
Leasehold improvements	**79,377**	35,143
Software purchased	**63,089**	12,995
Total	**211,095**	91,440
7. Other Expenses		
Insurance premiums – QGIF	**2,065**	2,216
External audit fees*	**14,500**	17,300
Losses from disposal of plant & equipment	**254,303**	-
Total	**270,868**	19,516

* Total external audit fees relating to the 2008–09 financial year are estimated to be $14,500 (2007–08: $14,500). There are no non-audit services included in this amount.

	2009 $	2008 $
8. Cash and Cash Equivalents		
Cash at bank	**631,028**	10,476
Cash on hand	**500**	500
QTC 24 hour call deposits	**477,127**	2,329,394
Total	**1,108,655**	2,340,370

Interest earned on cash held with the Queensland Treasury Corporation earned between 3.39% to 8.32% in 2009 (2008: 6.31% to 8.08%). Average interest earned on cash held with the Commonwealth Bank was 3.96% (2008: 4.36%). The Treasurer's approval has been obtained for these investments.

	2009 $	2008 $
9. Receivables		
GST receivable	**178,764**	58,362
	178,764	58,362
Accrued interest	**926**	3,872
Sundry debtors	**-**	21,473
Long service leave reimbursements	**58,928**	4,234
Total	**238,618**	87,941

notes to and forming part of the financial statements 2008–09

	2009 $	2008 $
10. Other Current Assets		
Prepayments	**38,970**	11,978
Total	**38,970**	11,978
11. Intangible Assets		
Software Purchased:		
At cost	**804,753**	558,227
Less: Accumulated amortisation	**(76,084)**	(12,995)
Total	**728,669**	545,232

Intangibles Reconciliation

Reconciliations of the carrying amounts of each class of intangible assets at the beginning and end of the current reporting period.

	Software Purchased 2009	Software Purchased 2008	**Software Work In Progress 2009**	Software Work In Progress 2008	**Total 2009**	Total 2008
	$	$	**$**	$	**$**	$
Carrying amount at 1 July	**545,232**	-	**-**	11,005	**545,232**	11,005
Acquisitions	**246,526**	547,222	**-**	-	**246,526**	547,222
Transfers between classes	**-**	11,005	**-**	(11,005)	**-**	-
Depreciation	**(63,089)**	(12,995)	**-**	-	**(63,089)**	(12,995)
Carrying amount at 30 June	**728,669**	545,232	**-**	-	**728,669**	545,232

Amortisation of intangibles is included in the line item 'Depreciation and Amortisation' in the Income Statement.

All intangible assets of the Commission have finite useful lives and are amortised using the diminishing value method. Refer to Note 1(m) and Note 1(n).

No intangible assets have been classified as held for sale or form part of a disposal group held for sale.

	2009 **$**	2008 $
12. Property, Plant and Equipment		
Plant and equipment:		
At cost	**445,754**	270,252
Less: Accumulated depreciation	**(146,466)**	(136,201)
Total	**299,288**	134,051
Leasehold improvements		
At cost	**2,059,948**	409,490
Less: Accumulated depreciation	**(53,171)**	(148,331)
	2,006,777	261,159
Total	**2,306,065**	395,210

Plant and equipment is valued at cost in accordance with Queensland Treasury's *Non-Current Asset Accounting Guidelines for the Queensland Public Sector*.

Reconciliation

Reconciliations of the carrying amounts of each class of property, plant and equipment at the beginning and end of the current reporting period.

	Plant & Equipment 2009 $	Plant & Equipment 2008 $	**Leasehold improvements 2009 $**	Leasehold improvements 2008 $	**Total 2009 $**	Total 2008 $
Carrying amount at 1 July	**134,051**	177,353	**261,159**	296,302	**395,210**	473,655
Acquisitions	**258,650**	-	**660,639**	-	**919,289**	-
Acquisitions through operating lease incentives	**-**	-	**1,393,875**	-	**1,393,875**	-
Disposals	**(24,784)**	-	**(229,519)**	-	**(254,303)**	-
Depreciation	**(68,629)**	(43,302)	**(79,377)**	(35,143)	**(148,006)**	(78,445)
Carrying amount at 30 June	**299,288**	134,051	**2,006,777**	261,159	**2,306,065**	395,210

	2009 $	2008 $
13. Payables		
Trade creditors	**759,275**	568,409
Accrued Expenses	**18,644**	31,750
Total	**777,919**	600,159
14. Accrued Employee Benefits		
Current Liability		
Recreation leave	**438,285**	440,240
Salary and wages payable	**330,793**	297,259
Long service leave levy payable	**25,175**	24,241
	794,253	761,740
Non-current Liability		
Recreation leave	**124,152**	198,224
Total	**918,405**	959,964
15. Other Liabilities		
Current Liability		
Lease incentive	**139,388**	-
	139,388	-
Non-current Liability		
Lease incentive	**1,198,139**	-
Total	**1,337,527**	-
16. Reconciliation of Operating (Deficit) to net cash (used in) operating activities		
Operating (Deficit)	**(433,482)**	(1,142,848)
Depreciation and amortisation expense	**211,095**	91,440
Leasehold liability amortisation	**(56,348)**	-
Loss on disposal of property, plant and equipment	**254,303**	-
Changes in assets and liabilities:		
(Increase)/decrease in GST input tax credit receivables	**(120,402)**	5,125
(Increase)/decrease in accrued interest	**2,946**	(1,868)
Decrease in sundry debtors	**21,473**	1,320
(Increase) in long service leave reimbursements	**(54,694)**	(4,234)
(Increase)/decrease in prepayments	**(26,992)**	4,127
Decrease in payables	**177,760**	229,947
Increase/(decrease) in accrued employee benefits	**(41,559)**	494,222
Net cash (used in) operating activities	**(65,900)**	(322,769)

notes to and forming part of the financial statements 2008–09

	2009 $	2008 $
17. Non-Cash Financing and Investing Activities		

Non-cash investing activities in the 2008–09 reporting period consisted of the acquisition of leasehold improvements through operating lease incentives. These acquisitions are set out in the property, plant and equipment reconciliation in Note 12.

There were no non-cash financing activities during the 2008–09 reporting period.

18. Commitments for Expenditure

(a) Non-Cancellable Operating Lease

Commitments under operating leases at reporting date are inclusive of anticipated GST and are payable as follows:

	2009 $	2008 $
Not later than one year	**808,860**	518,630
Later than one year and not later than five years	**3,235,442**	76,414
Later than five years	**3,707,277**	-
Total	**7,751,579**	595,044

Operating leases are entered into as a means of acquiring access to office accommodation and storage facilities. Lease payments are generally fixed, but with inflation escalation clauses on which contingent rentals are determined.

(b) Capital expenditure commitments

There were no material capital commitments at reporting date that are not included in the accounts.

19. Contingencies

There were no material contingent assets or liabilities as at 30 June 2009.

20. Controlled entities of the Health Quality and Complaints Commission

HQCC did not have control over any other entities during the 2008–09 reporting period.

21. Restricted Assets

There were no restrictions on the use of cash held as at 30 June 2009.

22. Events Occurring after Balance Date

There were no significant events occuring after 30 June 2009.

23. Financial Instruments

(a) Categorisation of Financial Instruments

The Commission has the following categories of financial assets and financial liabilities:

Category	Note	2009 $	2008 $
Financial Assets			
Cash and cash equivalents	8	**1,108,655**	2,340,370
Receivables	9	**238,618**	87,941
Total		**1,347,273**	2,428,311
Financial Liabilities			
Financial liabilities measured at amortised costs:			
Payables	13	**777,919**	600,159
Total		**777,919**	600,159

(b) Financial Risk Management

The Commission's activities expose it to a variety of financial risks – interest rate risk, credit risk, liquidity risk and market risk.

Financial risk management is implemented pursuant to Government and Commission policy. These policies focus on the unpredictability of financial markets and seek to minimise potential adverse effects on the financial performance of the Commission.

All financial risk is managed by Executive Management under policies approved by the Commission. The Commission provides written principles for overall risk management, as well as policies covering specific areas.

The Commission measures risk exposure using a variety of methods as follows –

Risk Exposure	Measurement method
Credit Risk	Ageing analysis, earnings at risk
Liquidity Risk	Sensitivity analysis
Market Risk	Interest rate sensitivity analysis

23. Financial Instruments (contd)

(c) Credit Risk Exposure

Credit risk exposure refers to the situation where the Commission may incur financial loss as a result of another party to a financial instrument failing to discharge their obligation.

The maximum exposure to credit risk at balance date in relation to each class of recognised financial assets is the gross carrying amount of those assets inclusive of any provisions for impairment.

The following table represents the Commission's maximum exposure to credit risk based on contractual amounts net of any allowances:

Maximum Exposure to Credit Risk

Category	Note	2009 $	2008 $
Cash	8	**1,108,655**	2,340,370
Receivables	9	**238,618**	87,941
Total		**1,347,273**	**2,428,311**

No collateral is held as security and no credit enhancements relate to financial assets held by the Commission.

The Commission manages credit risk through the use of management reports. This strategy aims to reduce the exposure to credit default by ensuring that the Commission invests in secure assets and monitors all funds owed on a timely basis. Exposure to credit risk is monitored on an ongoing basis.

No financial assets and financial liabilitites have been offset and presented net in the Balance Sheet.

The method for calculating any provisional impairment for risk is based on past experience, current and expected changes in economic conditions and changes in client credit ratings. Economic and geographic changes form part of the Commission's documented risk analysis assessment in conjunction with historic experience and associated industry data.

No financial assets have had their terms renegotiated so as to prevent them from being past due or impaired, and are stated at the carrying amounts as indicated.

23. Financial Instruments (contd)

(c) Credit Risk Exposure (contd)

Aging of past due but not impaired as well as impaired financial assets are disclosed in the following tables:

2009 Financial Assets Past Due But Not Impaired

Contractural Repricing/Maturity:

	Not Overdue	Overdue: Less than 30 Days	Overdue: 30–60 Days	Overdue: 61–90 Days	Overdue: More than 90 Days	Total	Total Financial Assets
	$	$	$	$	$	$	$
Financial Assets							
Receivables	238,618	-	-	-	-	-	238,618
Total	**238,618**	**-**	**-**	**-**	**-**	**-**	**238,618**

2008 Financial Assets Past Due But Not Impaired

Contractural Repricing/Maturity:

	Not Overdue	Overdue: Less than 30 Days	Overdue: 30–60 Days	Overdue: 61–90 Days	Overdue: More than 90 Days	Total	Total Financial Assets
	$	$	$	$	$	$	$
Financial Assets							
Receivables	87,941	-	-	-	-	-	87,941
Total	**87,941**	**-**	**-**	**-**	**-**	**-**	**87,941**

(d) Liquidity Risk

Liquidity risk refers to the situation where the Commission may encounter difficulty in meeting obligations associated with financial liabilities.

The Commission is exposed to liquidity risk in respect of its payables.

The Commission manages liquidity risk through the use of management reports. This strategy aims to reduce the exposure to liquidity risk by ensuring the Commission has sufficient funds available to meet employee and supplier obligations as they fall due. This is achieved by ensuring that minimum levels of cash are held within the various bank accounts so as to match the expected duration of the various employee and supplier liabilities.

23. Financial Instruments (contd)

(d) Liquidity Risk (contd)

The following table sets out the liquidity risk of financial liabilities held by the Commission. It represents the contractural maturity of financial liabilities, calculated based on cash flows relating to the repayment of the principal amount outstanding at balance date.

		2009 Payables in			
		<1 year	1–5 years	>5 years	Total
	Note	$	$	$	$
Financial Liabilities					
Payables	13	777,919	-	-	777,919
Total		**777,919**	**-**	**-**	**777,919**

		2008 Payables in			
		<1 year	1–5 years	>5 years	Total
	Note	$	$	$	$
Financial Liabilities					
Payables	13.	600,159	-	-	600,159
Total		**600,159**	**-**	**-**	**600,159**

23. Financial Instruments (contd)

(e) Market Risk

The Commission does not trade in foreign currency and is not materially exposed to commodity price changes. The Commission is only exposed to interest rate risk through cash deposits in interest bearing accounts.

Interest Rate Sensitivity Analysis

The following interest rate sensitivity analysis is based on a report similar to that which would be provided to management, depicting the outcome to profit and loss if interest rates would change by +/-1% from the year-end rates applicable to the Commission's financial assets and liabilities. With all other variables held constant, the Commission would have a surplus and equity increase/(decrease) of $11,087 (2008: $23,404). This is attributable to the Commission's exposure to variable interest rates on interest bearing cash deposits.

		2009 Interest rate risk			
		-1%		+ 1%	
Financial Instruments	Carrying Amount	Profit	Equity	Profit	Equity
Cash	1,108,655	(11,087)	(11,087)	11,087	11,087
Overall effect on profit and equity		(11,087)	(11,087)	11,087	11,087

		2008 Interest rate risk			
		-1%		+ 1%	
Financial Instruments	Carrying Amount	Profit	Equity	Profit	Equity
Cash	2,340,370	(23,404)	(23,404)	23,404	23,404
Overall effect on profit and equity		(23,404)	(23,404)	23,404	23,404

Fair Value

The fair value of financial assets and liabilities must be estimated for recognition and measurement and for note disclosure purposes.

The Commission does not hold any available for sale financial assets.

The fair value of trade receivables and payables are assumed to approximate their nominal value less estimated credit adjustments.

24. Comparative Period Reclassifications

Supplies and services expenses and other expenses for the year ending 30 June 2008 were previously disclosed in the 2007–08 financial report as executive services expenses and health rights services expenses. Management considers the reclassification of these expenses as supplies and services expenses provides more reliable and relevant information regarding the nature of the incurred expenses. 2008 executive services expenses of $1,818,218 and health right services expenses of $528,008, as disclosed in the 2008 financial report, have been reclassified in the 2008 comparative period figures of this report as supplies and services expenses of $2,346,226.

2008 executive services expenses of $19,517, as disclosed in the 2008 financial report, have been reclassified in the 2008 comparative period figures of this report as other expenses of $19,517. Supplies and services expenses reported in the 2008 comparative period accounts of this report have also increased by $31,749 as a result of an error correction pertaining to the erroneous capitalisation of software expenses in the 2008 reporting period. Refer to Note 25 for more information regarding this error correction.

GST receivable of $57,269, as at the 30 June 2008, was disclosed in the 2008 financial report as trade debtors of $56,573 and GST payable of ($696). Management considers the reclassification of these items as GST receivable provides more reliable and relevant information regarding the full amount of GST input tax credits receivable from tax authorities as at 30 June 2008. This comparative period reclassification has resulted in an increase of GST receivable by $57,269, a decrease in trade debtors by $56,573 and an increase of GST payable by $696 as at 30 June 2008.

Long service leave reimbursement receivable of $4,234 as at 30 June 2008 was disclosed in 2008 financial report as part of the sundry debtors balance of $25,707. Management considers the reclassification of this item as long service leave reimbursements provides more reliable information regarding the nature of receivables pertaining to employee expenses. This comparative period reclassification has resulted in an increase of long service leave reimbursement by $4,234 and decreasing sundry debtors by $4,234 as at 30 June 2008.

The opening balance of software work-in-progress of $11,005 for the year ending 30 June 2008 was classified as part of 2008 software acquisitions contained in the intangible reconciliation of the 2008 financial report. Management identified in the current reporting period that this item required reclassification in order to provide more relevant and reliable information regarding intangible acquisitions and transfers between classes occurring in the 2008 reporting period. This comparative period reclassification of the intangibles reconciliation has resulted in an increase in the opening balance of software work-in-progress and transfers between classes by $11,005 for the year ending 30 June 2008. This transfer did not have any effect on the closing balance of intangible assets, total assets and total equity as reported in the Balance Sheet.

These reclassifications have been performed by restating each of the affected financial statement line items for the prior year and making applicable adjustments and reclassification to the cash flow statement and the reconciliations of operating deficit to net cash used in operating activities disclosed in Note 16.

25. Correction of Errors

An accrual of $297,259 for salary and wages expenses and payable outstanding at year end was omitted from the accounts for the year ending 30 June 2008. This error has had the effect of understating current accrued employee benefits and total current liabilities by $297,259 and overstating total equity by $297,259 as at 30 June 2008. The error also had the effect of understating employee expenses, the total expenses and total operating deficit by $297,259 for the year ending 30 June 2008.

An accrual of $24,241 for the long service leave levy expense and payable was omitted from the accounts for the year ending 30 June 2008. This error had the effect of understating payables and total current liabilities by $24,241 and overstating total equity by $24,241 as at 30 June 2008. The error also had the effect of understating employee expenses, the total expenses and total operating deficit by $24,241 for the year ending 30 June 2008.

Due to the incorrect capitalisation of two purchased software packages during the year ending 30 June 2008, intangible asset additions recognised for the year ending 30 June 2008 were overstated by $31,747. Management identified in this reporting period that these software purchases should have been expensed during the year ending 30 June 2008 as the value of each software purchase was less than the intangible asset recognition threshold as described in the Note 1(m). This error had the effect of overstating intangible assets, total non-current assets and total equity by $30,566 as at 30 June 2008. The error also had the effect of overstating depreciation and amortisation expense by $1,181, understating the supplies and services expenditure by $31,747 and the total expenses and operating deficit by $30,566 for the year ending 30 June 2008.

Due to the incorrect capitalisation of desktop computer additions costing $49,094 during the year ending 30 June 2007, the closing balance carrying amount of property, plant and equipment for the year ending 30 June 2008 was overstated by $29,614. Management identified in the current reporting period that these computer additions should have been expensed during the year ending 30 June 2007 as the value of each computer addition was less than the property, plant and equipment asset recognition threshold as described in the Note 1(k). This error had the effect of overstating property, plant and equipment, total non-current assets and total equity by $29,614 as at 30 June 2008. As well, this error had the effect of overstating the opening balance of retained surpluses and total equity by $40,127 for the year ending 30 June 2008. The error also had the effect of overstating depreciation and amortisation expense by $10,513 for the year ending 30 June 2008.

These errors have been corrected by restating each of the affected financial statement line items for the prior year and making associated adjustments and reclassifications to the cash flow statement and the reconciliation of operating deficit to net cash used in operating activities disclosed in Note 16.

certificate of the health quality and complaints commission

These general purpose financial statements have been prepared pursuant to section 40(1) of the *Financial Administration and Audit Act 1977* (the Act), and other prescribed requirements. In accordance with section 40(3) of the Act we certify that in our opinion:

(a) the prescribed requirements for establishing and keeping the accounts have been complied with in all material respects: and

(b) the statements have been drawn up to present a true and fair view, in accordance with prescribed accounting standards, of the transactions of Health Quality and Complaints Commission or the financial year ended 30 June 2009 and of the financial position of the entity at the end of that year.

Professor Michael Ward	**Mrs Cheryl Herbert**
Commissioner	Chief Executive Officer

31 August 2009

INDEPENDENT AUDITOR'S REPORT

To the Accountable Officer of the Health Quality and Complaints Commission

Matters Relating to the Electronic Presentation of the Audited Financial Report

The auditor's report relates to the financial report of the Health Quality and Complaints Commission for the financial year ended 30 June 2009 included on Health Quality and Complaints Commission 's website. The Accountable Officer is responsible for the integrity of the Health Quality and Complaints Commission's website. I have not been engaged to report on the integrity of the Health Quality and Complaints Commission's website. The auditor's report refers only to the statements named below. It does not provide an opinion on any other information which may have been hyperlinked to/from these statements. If users of the financial report are concerned with the inherent risks arising from electronic data communications they are advised to refer to the hard copy of the audited financial report, available from Health Quality and Complaints Commission, to confirm the information included in the audited financial report presented on this website.

These matters also relate to the presentation of the audited financial report in other electronic media including CD Rom.

Report on the Financial Report

I have audited the accompanying financial report of the Health Quality and Complaints Commission which comprises the balance sheet as at 30 June 2009, and the income statement, statement of changes in equity and cash flow statement for the year ended on that date, a summary of significant accounting policies, other explanatory notes and certificates given by the Commissioner and the Chief Executive Officer.

The Accountable Officer's Responsibility for the Financial Report

The Accountable Officer is responsible for the preparation and fair presentation of the financial report in accordance with prescribed accounting requirements identified in the *Financial Administration and Audit Act 1977* and the *Financial Management Standard 1997*, including compliance with applicable Australian Accounting Standards (including the Australian Accounting Interpretations). This responsibility includes establishing and maintaining internal controls relevant to the preparation and fair presentation of the financial report that is free from material misstatement, whether due to fraud or error; selecting and applying appropriate accounting policies; and making accounting estimates that are reasonable in the circumstances.

Auditor's Responsibility

My responsibility is to express an opinion on the financial report based on the audit as prescribed in the *Auditor-General Act 2009*. This Act, including transitional provisions, came into operation on 1 July 2009 and replaces the previous requirements contained in the *Financial Administration and Audit Act 1977*.

The audit was conducted in accordance with the *Auditor-General of Queensland Auditing Standards*, which incorporate the Australian Auditing Standards. These auditing standards require compliance with relevant ethical requirements relating to audit engagements and that the audit is planned and performed to obtain reasonable assurance whether the financial report is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The procedures selected depend on the auditor's judgement, including the assessment of risks of material misstatement in the financial report, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial report in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control, other than in expressing an opinion on compliance with prescribed requirements. An audit also includes evaluating the appropriateness of accounting policies and the reasonableness of accounting estimates made by the Accountable Officer, as well as evaluating the overall presentation of the financial report including any mandatory financial reporting requirements as approved by the Treasurer for application in Queensland.

I believe that the audit evidence obtained is sufficient and appropriate to provide a basis for my audit opinion.

Independence

The *Auditor-General Act 2009* promotes the independence of the Auditor-General and QAO authorised auditors. The Auditor-General is the auditor of all Queensland public sector entities and can only be removed by Parliament.

The Auditor-General may conduct an audit in any way considered appropriate and is not subject to direction by any person about the way in which audit powers are to be exercised. The Auditor-General has for the purposes of conducting an audit, access to all documents and property and can report to Parliament matters which in the Auditor-General's opinion are significant.

Auditor's Opinion

In accordance with s.40 of the *Auditor-General Act 2009* –

(a) I have received all the information and explanations which I have required; and

(b) in my opinion –

  (i) the prescribed requirements in respect of the establishment and keeping of accounts have been complied with in all material respects; and

  (ii) the financial report has been drawn up so as to present a true and fair view, in accordance with the prescribed accounting standards of the transactions of the Health Quality and Complaints Commission for the financial year 1 July 2008 to 30 June 2009 and of the financial position as at the end of that year.

B S CLOWES CPA
as Delegate of the Auditor-General of Queensland

Queensland Audit Office
Brisbane

appendices

Appendix 1
Committee membership

Audit and Risk Governance Committee

Chair Mr John Amery – Assistant Commissioner, Nursing

Secretariat Mrs Jacqueline Denyer – Executive Assistant

Membership:

Mrs Cheryl Herbert – CEO

Mr Rodney Metcalfe – Assistant Commissioner

Mr Enrico (Henry) Petracci – Manager, Business Services

Mr Len Scanlan – external member

Professor Michael Ward – Commissioner

The Audit and Risk Governance Committee observes Queensland Treasury's Audit Committee Guidelines.

Clinical Advisory Committee

Chair Professor Ken Donald – Assistant Commissioner, Medical

Secretariat Ms Tracey Jenkins – Administration Officer

Dr Cameron Bardsley
(October 2006 – present)
Cameron has worked as a doctor for the past 20 years, most of that time at St George Hospital where he is currently the medical superintendent. He has worked as a procedural rural doctor across Queensland, including Redcliffe, the Gold Coast, Rockhampton and Kippa Ring, as well as doing fly-in fly-out work in Aboriginal communities. Cameron has served on our Clinical Advisory Committee since its inception in 2006.

Dr Monique Beedles
(October 2008 – present)
Monique is a pharmacist with hospital, community and management experience. She has previously served on hospital committees, was the director of pharmacy services at the Noosa Hospital and is a past member of the Pharmaceutical Society of Australia Queensland Council. With qualifications in management and pharmacy, Monique has had her research work published both in Australia and overseas. She was appointed to our Clinical Advisory Committee in October 2008.

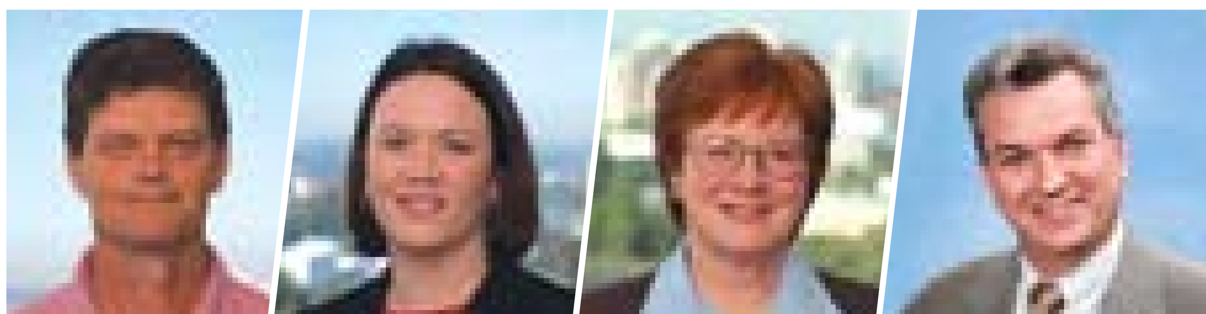
Ms Leanne Bisset
(October 2008 – present)
A physiotherapist with 19 years' experience in both public and private services, Leanne is also a university lecturer in physiotherapy and rehabilitation sciences. She has been recognised nationally for advanced standing in the fields of sports and musculoskeletal physiotherapy and is working as a research fellow with the Royal Brisbane and Women's Hospital and Griffith University. Leanne is president of the Queensland/Northern Territory branch of the Australian Physiotherapy Association (commencing 2009). She was appointed to our Clinical Advisory Committee in October 2008.

Dr Stephanie Fox-Young
(October 2008 – present)
Stephanie is the national president of the Royal College of Nursing Australia and has more than 30 years' experience in clinical practice, education and regulation roles. She is also the teaching and learning coordinator for the School of Nursing and Midwifery at the University of Queensland. Her work has been published in nursing and medical journals. Stephanie was appointed to our Clinical Advisory Committee in October 2008.

Dr Allan Hilless
(October 2008 – present)
Founding director of cardiothoracic surgery at the Wesley Hospital, Allan has a wide range of practical and clinical experience in quality control within health services. He has worked in New Zealand and the United Kingdom as a surgical and senior registrar, including 13 years as the director of cardiothoracic surgery and services with the Wellington Area Health Board. Allan has also held positions on health boards, committees and national advisory councils. He was appointed to our Clinical Advisory Committee in October 2008.

Dr Derek Lewis
(October 2006 – present)
Derek has been a dental practitioner in Queensland for almost 30 years, including 12 years in remote and regional areas. He was a member of the Health Rights Advisory Council (under the former Health Rights Commission) for six years, serving as president for three. Derek is a member of both state and national councils of the Australian Dental Association and is a member of several dental study groups. He has served on our Clinical Advisory Committee since its inception in 2006.

Dr Jacinta Powell
(October 2006 – present)
An experienced psychiatrist, Jacinta is the director of the Inner North Brisbane Mental Health Service at the Royal Brisbane and Women's Hospital. Her previous roles include chair of the Royal Australian and New Zealand College of Psychiatrists Queensland branch and principal advisor in psychiatry and director of mental health with the State Government. Jacinta has served on our Clinical Advisory Committee since its inception in 2006.



Clinical Advisory Committee: Cameron Bardsley, Monique Beedles, Stephanie Fox-Young, Derek Lewis
Not pictured: Leanne Bisset, Allan Hilless, Jacinta Powell

appendices

Ms Theresa Rutherford
(October 2006 – present)
Theresa is a registered nurse experienced in the training and supervision of medical and nursing staff. She has been a clinical nurse in the cardiology unit at the Gold Coast Hospital since 1996. Theresa holds a Diploma of Health Science (Nursing) from the University of Western Sydney. She has served on our Clinical Advisory Committee since its inception in 2006.

Dr Ian Scott
(October 2006 – present)
Ian is a senior consultant and general physician with a longstanding interest and involvement in quality improvement in healthcare. Currently the director of the Department of Internal Medicine and Clinical Epidemiology at Princess Alexandra Hospital, he is also:

- a member of the Queensland Health Patient Safety and Quality Board
- an associate professor at the University of Queensland
- a past federal councillor and president of the Internal Medicine Society of Australia and New Zealand
- an adjunct associate professor of public health and preventive medicine at Monash University.

Ian has served on our Clinical Advisory Committee since its inception in 2006.

Dr Jane Truscott
(October 2006 – present)
A nurse practitioner with a background in acute and community settings, Jane also has more than 25 years of experience in clinical, education, research and business areas. She has extensive qualifications in both clinical and management disciplines. Jane has served on our Clinical Advisory Committee since its inception in 2006.

Dr Peter Woodruff
(October 2006 – present)
Peter is a member of the Medical Board of Queensland and has held senior executive positions such as:

- president of the Australian and New Zealand Society of Vascular Surgeons
- president of the Australian Council on Health Care Standards
- chairman and director of vascular surgery at the Princess Alexandra Hospital
- vice president of the Royal Australasian College of Surgeons.

He was also an investigator in the Bundaberg Base Hospital inquiry. Peter has served on our Clinical Advisory Committee since its inception in 2006.

Former committee members

Elizabeth Benson-Stott
(October 2006 – September 2008)

Michael Bourke
(October 2006 – September 2008)

Ian Coombes
(October 2006 – September 2008)

Christine Foley
(October 2006 – September 2008)

Kim Forrester, Assistant Commissioner, Legal
(October 2006 – March 2009)

Jayne Ingham
(October 2006 – September 2008)

Stephen Rashford
(October 2006 – September 2008)

Elizabeth Robertson
(October 2006 – September 2008)

Leonie Smith
(October 2006 – September 2008)

Clinical Governance Reference Group

Chair Ms Samantha Norton – Acting Director, Standards and Quality

Secretariat Ms Tracey Jenkins – Administration Officer

Membership:

Ms Annette Anning – Principal Quality Officer

Ms Pat Avey – Principal Quality Officer

Ms Kerry Brady – Senior Quality Officer

Ms Lucy Fisher – Private Hospitals Association of Queensland (PHAQ)

Mrs Cheryl Herbert – CEO

Ms Lorraine Hooper – Public Health Unit (PHU), Queensland Health

Mr Andrew Lockhart – Principal Quality Officer

Mr Don Martin – Clinical Governance Unit, Queensland Health

Ms Susan O'Dwyer – Clinical Workforce Solutions, Queensland Health

Mr Matthew Vance – Manager, Quality Monitoring

Dr John Wakefield/Ms Amanda Kivic – Patient Safety Centre, Queensland Health

Ms Susie Wilson/Ms Giselle Latta – Clinical Safety and Quality Unit, Mater Health Services

Clinical Advisory Committee: Theresa Rutherford, Ian Scott, Jane Truscott **Not pictured:** Peter Woodruff

Complaint Governance Committee

Chair Mr Rodney Metcalfe – Assistant Commissioner, Public Service

Membership:

Mr Peter Johnstone – Assistant Director, Complaint Services

Mr Geoff Murphy – Director, Complaint Services

Professor Michael Ward – Commissioner

Mr Robert Wilson – Manager, Investigations

Consumer Advisory Committee

Chair Dr Margaret Steinberg – Assistant Commissioner, Consumer Issues

Assistant Chair Professor Michele Clark – Assistant Commissioner, Allied Health

Secretariat Ms Tracey Jenkins – Administration Officer

Ms Margaret Deane
(October 2006 – present)
Now CEO of the Queensland Aged and Disability Advocacy Inc, Margaret comes from a background in healthcare policy and program management including community health services and in particular aged care and palliative care. She is a member of the Aged Care Standards and Accreditation Liaison Group, a committee working to improve standards in aged care facilities. Margaret has been instrumental in establishing and participating in a number of community networks focused on improving healthcare outcomes for service recipients. She has served on our Consumer Advisory Committee since its inception in 2006.

Mrs Myrtle Green
(October 2006 – present)
Myrtle Green represents consumers on numerous health registration boards and councils, such as the:

- Consumer Health Forum of Australia
- West Moreton South Burnett Primary Health Partnerships Council
- West Moreton Division General Practitioners Board
- West Moreton BreastScreen Service
- Queensland Medical Radiation Technologists Registration Board
- Queensland Pharmacists Registration Board
- Queensland Health Cancer Screen Unit Consumer Reference Group.

In 2005 she was awarded an Order of Australia Medal for service to the community through health, law, education and women's affairs. Myrtle has served on our Consumer Advisory Committee since its inception in 2006.

Ms Kathy Kendell
(October 2006 – present)
Kathy has represented health consumers on committees and projects in health at both a state and national level for more than 15 years. She wrote Queensland Health's first published code of health rights in 1992. Kathy was a founding member of the former Health Consumer Advocacy Network, the predecessor of the Health Consumers Queensland, which she coordinated the lobbying for during the Forster Inquiry. She has been a member of health professional regulatory bodies and is an executive member of the Australian Health Care Reform Alliance. She currently assists on projects involving the Australian Commission on Safety and Quality in Healthcare and Consumers Health Forum. Kathy has served on our Consumer Advisory Committee since its inception in 2006.

Ms Mary Martin
(October 2006 – present)
With experience in rural and Aboriginal and Torres Strait Islander health, Mary has played a role in various community organisations at a board and member level.

She works with the Queensland Aboriginal and Islander Health Council as the General Practice Education and Training Officer and was until recently a member of the Queensland Health Minister's Rural Health Advisory Council.

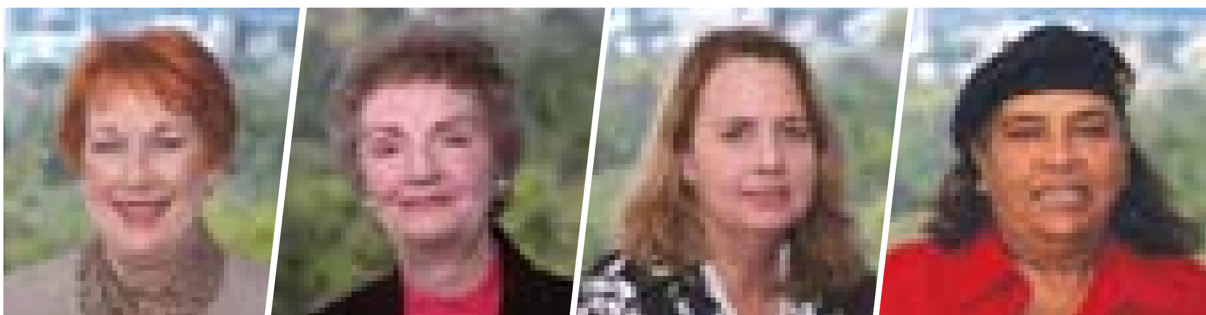
Mary previously worked as a registered nurse with the Aboriginal and Islander Community Health Service in Brisbane and was instrumental in setting up Yulu Burri Ba Aboriginal Corporation for Community Health on Minjerribah (North Stradbroke Island, her Dad's country).

She has served on our Consumer Advisory Committee since its inception in 2006.

Mr Gary Penfold
(October 2008 – present)
Gary is a long-time housing and disability worker. He has worked with Queensland Shelter and has also held positions with:

- West End Community House
- the Queensland Disability Housing Coalition
- the Homelessness Task Force (as coordinator)
- the Queensland Public Housing Tenants Association
- the Hepatitis Council of Queensland.

Gary was appointed to our Consumer Advisory Committee in October 2008.



Consumer Advisory Committee: Margaret Deane, Myrtle Green, Kathy Kendell, Mary Martin

Mrs Marie Pietsch
(October 2008 – present)
A grazier in the Inglewood district, Marie is a strong supporter of the delivery of safe and sustainable health services in rural and remote areas. In 2003, she received a Centenary Medal for distinguished service to the community as Chair of the Southern Downs District Health Council. In 2005, Marie also received an Australia Day medal for outstanding service as a consumer representative. She is currently:

- chair of the Ministerial Rural Health Advisory Council
- chair of the Southern Downs Health Community Council
- member of the Queensland Emergency Medical Services Advisory Council
- member of the Queensland Medical Transport Board and the Patient Transport Quality Council
- member of the Patient Safety and Quality Executive Committee and the Queensland Maternity Stakeholder Reference Group.

Marie was appointed to our Consumer Advisory Committee in October 2008.

Mrs Myra Pincott
(October 2006 – present)
Myra serves on the Queensland Nursing Council Professional Conduct Tribunal and the Queensland Dental Board. She is also a member of the Queensland Primary Health Care Research, Evaluation and Development Advisory Committee, Health Consumers Queensland and Patient Safety Council Advisory Committee. Myra was awarded as an Officer in the Order of Australia and the Centenary Community Service Medal. She was the state president of the Country Women's Association, and has been a member of the National Rural Health Alliance, the Rural Health Advisory Council and the Rockhampton District Health Council. She has served on our Consumer Advisory Committee since its inception in 2006.

Mrs Coral Rizzalli
(October 2006 – present)
Motivated by a lack of regional services to support her son, Coral has established various services for children with disabilities for which she was awarded an Order of Australia medal in 1993. She has served on regional disability councils in north Queensland, as well as many state and federal advocacy groups. Coral is a member of the Australian Consumer Health Forum and is chair of the Ingham Consumer Group. Coral has served on our Consumer Advisory Committee since its inception in 2006.

Ms Helen Whitehead
(October 2006 – present)
After some personal health issues, Helen founded the Queensland Acoustic Neuroma Association and subsequently the Brain Tumour Support Group. She has since served as the CEO of Epilepsy Queensland for 16 years and has more than 30 years' experience in the health sector. Helen has qualifications in speech therapy and psychology. She has served on our Consumer Advisory Committee since its inception in 2006.

Ms Michele Barry
(October 2006 – January 2009)
Michele is the CEO of LifeTec Queensland, a not-for-profit organisation that promotes assistive technology for people with disabilities or those who suffer from chronic disease. With qualifications in applied science, health promotion and public health, she has previously worked with Vision Australia, the Office of the Public Advocate and in various public health and aged care roles in local government. Michele served on our Consumer Advisory Committee from 2006 until January 2009.

Former committee members

Jeff Cheverton
(October 2006 – September 2008)

Allan Coker
(October 2006 – September 2008)

Beryl Crosby
(October 2006 – September 2008)

Melissa Fox
(October 2006 – September 2008)

Consumer Advisory Committee: Gary Penfold, Marie Pietsch, Myra Pincott, Coral Rizzalli **Not pictured:** Helen Whitehead, Michele Barry

Cultural Broker Group

Chair Ms Joan Welsh – Chief Conciliator

Membership:
Ms Kate Boffey – Acting Principal Complaints Officer

Ms Claire Bunton – Quality Officer

Ms Karen Harbus – Complaints Officer

Ms Gabriele Kuhnert – Conciliator

Ms Susan Litherland – Business Manager

Mr Paul Rogers – Complaints Officer

Mr Robert Wilson – Manager, Investigations

ICT Governance Committee

Chair Mr Steven Moskwa – Manager, Information Management

Membership:
Ms Megan Fairweather – General Counsel

Mrs Cheryl Herbert – CEO

Mr Peter Johnstone – Assistant Director, Complaint Services

Ms Liz Kearins – Manager, Community Engagement

Ms Teresa Lynne – Acting Director, Standards and Quality (to May 2009)

Mr Geoff Murphy – Director, Complaint Services

Ms Samantha Norton – Acting Assistant Director, Standards and Quality

Knowledge and Research Governance Committee

Chair Professor Michele Clarke – Assistant Commissioner, Allied Health (formerly Dr Kim Forrester – Assistant Commissioner, Legal to March 2009)

Secretariat Ms Tracey Jenkins – Administration Officer

Membership:
Ms Pat Avey – Principal Quality Officer

Ms Andrea Doyle – Learning and Development Coordinator

Ms Kate Grant-Taylor – Principal Quality Officer

Ms Emma Gumbleton – Media Officer

Ms Janette Henderson – Acting Research and Development Manager

Mrs Cheryl Herbert – CEO

Mr Peter Johnstone – Assistant Director, Complaint Services

Ms Sandy Lewis – Principal Conciliator

Ms Teresa Lynne – Director, Standards and Quality (to May 2009)

Mr Steven Moskwa – Manager, Information Management

Mr Geoff Murphy – Director, Complaint Services

Mr Matthew Vance – Manager, Quality Monitoring

Professor Michael Ward – Commissioner

Mr Robert Wilson – Manager, Investigations

Positive Workplace Committee

Chair Ms Gabriele Kuhnert – Concilator

Secretary Ms Susan Litherland – Business Manager

Membership:
Ms Annette Anning – Principal Quality Officer

Ms Pat Avey – Principal Quality Officer

Mr John Bradney – Conciliator

Mrs Cheryl Herbert – CEO

Ms Liz Kearins – Manager, Community Engagement

Ms Leah Milburn-Walker – CIPHA Administrator

Mr Matthew Vance – Manager, Quality Monitoring

Stakeholder Engagement Governance Committee

Chair Ms Susan Johnston – Assistant Commissioner, Safety

Secretariat Ms Tracey Jenkins – Administration Officer

Membership:
Mrs Cheryl Herbert – CEO

Ms Liz Kearins – Manager, Community Engagement

Ms Teresa Lynne – Acting Director, Standards and Quality (to May 2009)

Mr Geoff Murphy – Director, Complaint Services

Dr Jacinta Powell – Clinical Advisory Committee representative

Dr Margaret Steinberg – Assistant Commissioner, Consumer and Consumer Advisory Committee representative

Appendix 2
Freedom of information applications

Table 18: Applications received and processed

	2006–07	2007–08	2008–09
Applications carried over from previous year	6 (from HRC)	9	9
Number of applications received	30	67	44
Applications received under s.51 (consultation as an affected third party)	n/a	n/a	0
Applications withdrawn or deemed withdrawn	n/a	n/a	2
Number of applications requiring a decision	n/a	n/a	44
Applications carried over to next year	9	9	6

Table 19: Outcomes of applications finalised in 2008–09

Application type	Number of applications	Number of documents considered	Access in full	Access in part	Access refused	% of documents released in full or part
Non-personal	5	1164	982	68	114	90%
Personal	39	6894	6636	177	81	99%

Table 20: Exemptions invoiced in 2008–09

		Number of times
29B	Refusal to deal with application – previous application for same documents	1
39(1)	Disclosure could reasonably be expected to prejudice the conduct of an investigation by the HQCC	4
41(1)	Disclosure of an obtained opinion, advice or recommendation	0
42(1)(b)	Disclosure of the identity of a confidential source	323
43(1)	Would violate legal professional privilege	5
44(1)	Would disclose someone else's personal affairs	137
45(1)(c)	Would disclose someone's trade secrets, business affairs or research	4
46(1)(a)	Disclosure could bring an action for breach of confidence	711
46(1)(b)	Potential prejudice for future supply of information	388
50(b)(ii)	Contempt of Parliament or contempt of court	1

Of these, there were three applications for internal review and one application for external review.

A total of $470.90 was collected for non-personal application fees and photocopy charges.

Appendix 3: Presentations 2008–09

This year we travelled around the state and Australia to share information about our work with healthcare providers, consumers and others interested in improving health service safety and quality.

Date	Audience	Topic	Location
9/7/09	National Blood Authority fellows and staff	Influencing change in clinical practice	Canberra
12/7/08	RACSQ Annual State Meeting	Role of the HQCC (panel)	Sunshine Coast
15/7/08	Princess Alexandra Hospital	HQCC Prevention of venous thromboembolism standard	Brisbane
23/7/08	Bundaberg Health Community Council and Bundaberg Base Hospital staff	Role of the HQCC	Bundaberg
24/7/08	HQCC Brisbane information session for Queensland healthcare providers	Role of the HQCC	Brisbane
29/7/08	Health Community Council, Cairns and Cairns Base Hospital staff	Role of the HQCC	Cairns
30/7/08	HQCC Townsville information session for Queensland healthcare providers	Role of the HQCC	Townsville
5/8/08–8/8/08	Central Queensland Health Service District —staff from Biloela Hospital, Banana Hub, Gladstone Hospital and the Central Area Health Service Patient Safety and Quality Unit, Emerald Hospital, Central Highlands Hub, Rockhampton Hospital	Role of the HQCC	Central Queensland
15/8/08	National Health and Medical Research Council Centre for Research Excellence in Patient Safety executive staff	Credentialling—an HQCC perspective	Adelaide
20/8/08	Clinical and administrative hospital staff	HQCC—Regulation and beyond	Brisbane
20/8/08	University of Queensland School of Medicine Colloquium—medical students	Opening address	Brisbane
20/8/08	Northern and Southern Downs Health Community Councils	Role of the HQCC	Toowoomba
26/8/08	Fraser Coast region—Maryborough Hospital and Hervey Bay Hospital staff	Role of the HQCC	Fraser Coast
27/8/08	Queensland Nursing Council professional seminar for nurses	Role of the HQCC in investigations	Brisbane
27/8/08	Bundaberg Health Community Council	Complaint management	Bundaberg
10/9/08	Queensland Medical Superintendents' Conference	HQCC and the role of medical managers	Brisbane
18/9/08	IIR Clinical Governance Conference	Improving safety and quality—implications for clinical governance	Sydney
24/9/08	Wide Bay Health Service District—Bundaberg Base Hospital, Bundaberg consumer groups, Gin Gin Hospital and Friendly Society Private Hospital (Bundaberg)	Role of the HQCC	Bundaberg
26/9/08	Health Community Council	Complaint management	Gold Coast

appendices

Date	Audience	Topic	Location
6/10/08	Griffith University postgraduate students enrolled in Health Services Management, Leadership and Change	Change and improvement	Gold Coast
7/10/08	James Cook University occupational therapy and physiotherapy students	Complaint management	Townsville
13/10/08	Visiting medical practitioners, Sunshine Coast Private Hospital	HQCC—What do visiting medical practitioners need to know	Sunshine Coast
13/10/08	Queensland Nurses Union professional seminar	Complaint management	Townsville
22/10/08	Toowoomba Base Hospital—Junior Medical Officers	Role of the HQCC	Toowoomba
23/10/08	Queen Elizabeth II Hospital—operating suite staff	Surgical standards, clinician requirements and role of the HQCC	Brisbane
24/10/08	Centre for Medicine and Oral Health Griffith University—students	Role of the HQCC	Gold Coast
28/10/08	Queensland Nurses Union professional seminar	Complaint management	Rockhampton
28/10/08	7th Annual Resolve User Group	Data application features unique to the HQCC	Canberra
29/10/08	National Forum on Safety and Quality in Health Care	Why do we pay people for their errors?—panel discussion	Adelaide
29–31/10/08	National Forum on Safety and Quality in Health Care	Poster presentations	Adelaide
29/10/08	Office of the State Coroner	Review of hospital-related deaths standard and role of the HQCC	Brisbane
6/11/08	National Blood Authority National Blood Sector Conference	Achieving sustainable change	Sydney
13/11/08	Clinical Excellence Commission	Quality reporting in Queensland	Sydney
13/11/08	Hypnotherapists Association	Role of the HQCC	Brisbane
19/11/08	Australian College of Health Service Executives Breakfast	HQCC—Regulation and beyond	Cairns
25–26/11/08	Pioneer Valley Private Hospital (Mackay) management and executive, Medical Practitioners and General Practitioners	Role of the HQCC	Mackay
27/11/08	Perioperative Nurses Association Queensland Conference	Role of the HQCC	Sunshine Coast
1/12/08	Disability Services Queensland—Complaints Management Quality Committee	Role of the HQCC	Brisbane
4/12/08	Cape York Health Service District—Clinical Governance Workshop	Role of the HQCC	Cairns
12/12/08	University of Queensland Medical Registrants Breakfast	Role of the HQCC	Brisbane

Date	Audience	Topic	Location
19/12/08	Griffith University Medical Registrants Breakfast	Role of the HQCC	Gold Coast
4/2/09	Royal Australasian College of Physicians Queensland State Committee Meeting	Role of the HQCC	Brisbane
19/2/09	Australasian Commissioners' Meeting	HQCC vision, recent investigations and community engagement	Auckland
3/3/09	Human Factors in Healthcare Conference	Role of the HQCC and human factors issues	Sydney
11/3/09	Avant medico-legal forum	Complaint management	Brisbane
27/3/09	Grand Rounds, Mater Hospital	HQCC—the story so far and future directions	Brisbane
27/3/09	Perinatal Mortality Committee	HQCC—the story so far and future directions	Brisbane
6/4/09	External Advisory Council, Faculty of Nursing & Midwifery, University of Queensland	Challenges related to unregistered providers and quality reporting in Queensland	Brisbane
17/4/09	Leadership Program, Australian Centre for Clinical Leadership	Clinical leadership, reform and regulation	Gold Coast
23/4/09	Australian Commission on Safety and Quality in Health Care Meeting	Safety and quality risk mapping	Sydney
18/5/09	GE Medical Grand Rounds, Royal Brisbane & Women's Hospital	The medical profession and role of the HQCC	Brisbane
25/5/09	Clinical Senate Data to Inform Clinical Practice	Queensland experience of statistical process control reports	Adelaide
28/5/09	Better Workplace Forum 2009, Queensland Health	Keynote address—clinician leadership	Brisbane
29/5/09	Queensland Centre for Health Data Services	Analysing routinely collected health data	Brisbane
29/5/09	Multicultural health officers in training at the Ethnic Community Council	Role of the HQCC	Brisbane
17/6/09	Queensland Police Service Far Northern Region	Joint agency investigations and role of the HQCC	Cairns
20/6/09	Mental Health Review Tribunal	Role of the HQCC	Brisbane
22/6/09	Spiritus clients	Role of HQCC and complaint management	Brisbane
25/6/09	Far North Queensland Rural Division of General Practice	HQCC standards and compliance	Cairns
25/6/09	Cairns Private Hospital and Cairns Day Surgery Visiting Medical Officers	HQCC standards and compliance	Cairns
30/6/09	Toowoomba Base Hospital—doctors	The medical profession and role of the HQCC	Toowoomba

glossary

ACSQHC	Australian Commission on Safety and Quality in Health Care
ADCQ	Anti-Discrimination Commission Queensland
AMI	Acute Myocardial Infarction (heart attack)
CAC	Consumer Advisory Committee
CCYPCG	Commission for Children Young People and Child Guardian
CLAC	Clinical Advisory Committee
CMC	Crime and Misconduct Commission
CGRG	Clinical Governance Reference Group
CHRISP	Centre for Healthcare Related Infection Surveillance and Prevention
eDRMS	electronic Document Records Management System
FoI	Freedom of Information
HCC	Health Community Council
HQCC	Health Quality and Complaints Commission
HRC	Health Rights Commission (the HQCC replaced the HRC in July 2006)
ISQua	International Society for Quality in Health Care
MBQ	Medical Board of Queensland
MOU	Memoranda/um of Understanding
NRAC	National Registration and Accreditation Scheme
PHAQ	Private Hospitals Association of Queensland
PLO	Patient Liaison Officers
PWC	Positive Workplace Committee
QGAP	Queensland Government Agency Program
QH	Queensland Health
QPLON	Queensland Patient Liaison Officer Network
QPS	Queensland Police Service
RCA	Root Cause Analysis
SSQ	Smart Service Queensland
StaRT	Standards Reporting Tool
SV&HS	St Vincent's and Holy Spirit Health
UQ	University of Queensland
VTE	Venous Thromboembolism

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Suzanne Gogolin supports our information and communication technology systems.

David McKenzie is a senior member of our Investigations team.

Carli Rowlands works in our standards verification team and Kim Nash coordinates our Root Cause Analysis process.

Megan Fairweather is our General Counsel, providing legal advice and support.

Andrea Doyle coordinates our learning and development program.

Leah Milburn-Walker is the administrator of our complaint and investigation case management system.

We value your feedback

Thank you for taking the time to read our 2008–09 Annual Report. We hope you enjoyed sharing our year with us.

To help us improve, we invite your comments or suggestions about the content or design of the report.

DESIGN AND PRODUCTION Double P Design Group **PHOTOGRAPHY** Lime – Corporate and Advertising Pictures
Some photographs in this report were taken by members of our team, John Marquess, Richard Stevens and Emma Gumbleton.

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