health quality and complaints commission

Opportunities for **improvement**

Annual report 2012-13

health quality and complaints commission

9 September 2013

The Honourable Lawrence Springborg MP
Minister for Health
GPO Box 48
BRISBANE QLD 4001

Dear Minister

I am pleased to present the *Annual report 2012-13* and financial statements for the Health Quality and Complaints Commission.

I certify that this annual report complies with:

- the prescribed requirements of the *Financial Accountability Act 2009* and the *Financial and Performance Management Standard 2009*, and
- the detailed requirements set out in the *Annual report requirements for Queensland Government agencies*.

A checklist outlining the annual reporting requirements can be found on page 127 of this annual report and on our website, www.hqcc.qld.gov.au

Adjunct Professor Russell Stitz
Commissioner

About this report

This report records our achievements in improving the safety and quality of healthcare in Queensland during 2012-13. Our performance is measured against the objectives and targets in our strategic plan. The report also sets out our financial position for the year.

Our report theme, *Opportunities for improvement*, reflects our aim to promote healthcare improvement through our work in managing complaints and investigations and monitoring safety and quality. We also seek continuous improvement in our own operation.

Each chapter of the report analyses our performance, the challenges we faced, the improvements we made and the outlook for the year ahead.

The report is a key accountability document and the principal way in which we report on our activities to Parliament and the Queensland community.

Our annual reports are available on our website at www.hqcc.qld.gov.au/Resources/Pages/Annual-reports.aspx

Printed copies of the report are available on request.

Translation service

We are committed to providing accessible services to Queenslanders from all culturally and linguistically diverse backgrounds. If you need help to understand our annual report, please telephone (07) 3120 5999 or free call 1800 077 308 (outside Brisbane) and we will arrange an interpreter to share the report with you.

Feedback

We invite your feedback on our report. Please contact our community engagement team, telephone (07) 3120 5999 or free call 1800 077 308 (outside Brisbane), fax (07) 3120 5998, email engage@hqcc.qld.gov.au or complete our survey at www.hqcc.qld.gov.au/Resources/Pages/Annual-reports.aspx

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About us

The Health Quality and Complaints Commission is an independent statutory body dedicated to the management of health complaints and monitoring and improving the safety and quality of healthcare in Queensland. We regulate health services under the *Health Quality and Complaints Commission Act 2006* (HQCC Act).

Who we are

Established on 1 July 2006, following a key recommendation of the 2005 Health Systems Review (Forster Review), we are Queensland's independent health watchdog and quality champion.

We contribute to the Queensland Government's blueprint, *Getting Queensland back on track: Statement of objectives for the community* (Pledge 5: We will restore accountability in government) and the *Statement of Government Health Priorities* by providing Queenslanders with independent and impartial healthcare complaint management and quality monitoring services to maintain accountability in the health system.

Our 2012-16 strategic objectives were to:

- drive healthcare safety and quality improvement
- increase community involvement in improving healthcare safety and quality
- strengthen HQCC's leadership and independence
- strengthen business operations.

We have updated our objectives for 2013-17 (see page 17).

Our offices are located at 53 Albert Street, Brisbane.

Vision

Quality healthcare for Queenslanders.

Goal

To improve the safety and quality of healthcare in Queensland.

Values

Independence – we are courageous, engage in robust debate and question the status quo.

Integrity – we are honest, transparent and impartial; we use sound evidence, research and reasoning to inform decisions.

Respect – we actively listen to and support our clients and stakeholders.

Client-centred – we put our clients at the centre of all of our decisions.

Learning – we continuously improve our processes to influence quality improvement in healthcare.

What we do

We work with healthcare providers, consumers and other organisations to improve the safety and quality of health services in Queensland. To prevent patient harm and improve healthcare quality we:

- manage healthcare complaints
- investigate serious and systemic issues and recommend quality improvement
- monitor, review and report on healthcare quality
- identify healthcare risks and recommend action
- share information about healthcare safety and quality
- promote healthcare rights.

An independent and impartial health watchdog enables Queenslanders to have confidence that health services are safe and of high quality.

Our stakeholders

We work closely with our stakeholders towards better healthcare for Queenslanders. Stakeholders include:

- healthcare providers – public and private, licensed and unlicensed health services, including hospitals, general practitioners, allied health professionals and alternative healthcare practitioners
- healthcare consumers – the people who use health services, and their families and carers
- healthcare industry organisations, associations, colleges and educational institutions
- Parliament, Health and Community Services Committee, Minister for Health and the Queensland Government
- related jurisdictions
- community organisations
- the media.

How we work

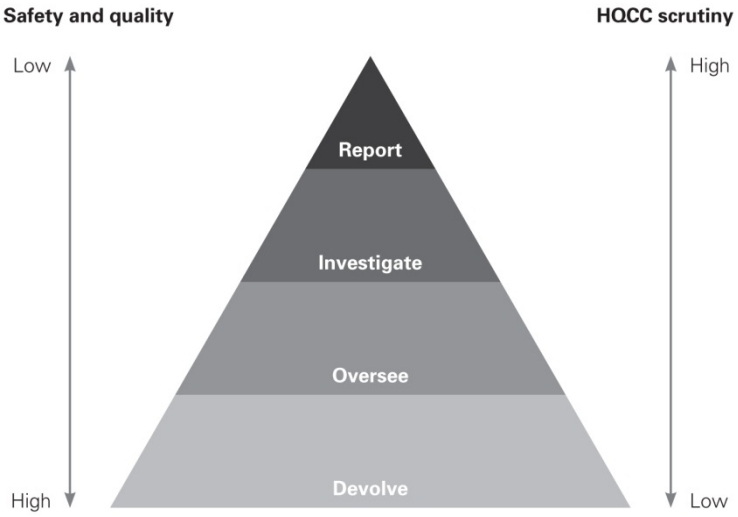
We are independent, impartial and act in the public interest, observing natural justice and working as quickly and with as little formality and technicality as possible.

Our work is underpinned by a 'responsive regulation' model, which moves beyond the traditional regulation roles of deterrence and compliance.

In enacting responsive regulation, we apply greater scrutiny and more powerful interventions to healthcare providers who are assessed as having lower levels of safety and quality or who fail to demonstrate improvement.

Most healthcare providers are represented at the base of our responsive regulation pyramid – they deliver safe, high quality care, have a positive attitude to improvement, and may never come to our attention.

Our responsive regulation model



References

Model modified from Walshe 2003/Ayres & Braithwaite 1992.
Walshe, K, Regulating healthcare: a prescription for improvement? State of health series. 2003, Maidenhead: Open University Press. xii, 262 p.
Ayres, I and J Braithwaite, Responsive regulation: transcending the deregulation debate. Oxford socio-legal studies. 1992, New York: Oxford University Press. vii, 205 p.

Highlights

Managed 3419 complaints this year, a 5% increase from 2011-12	page 8
Improved client service with our new triage and early resolution team, which streamlined referrals and helped resolve complaints quickly	page 8
Significantly reduced the number of open investigations that exceeded 12 months, from 34 investigations to five	page 25
Made or endorsed and monitored 200 investigation recommendations and 26 quality monitoring recommendations for healthcare improvement	page 26, 54
Expanded our reportable events monitoring to strengthen reporting and healthcare improvement	page 52
Monitored 46 healthcare providers to drive healthcare safety and quality improvement	page 53, 58
Published 12 safety and quality submissions, five safety and quality reports and four position statements	page 55
Reviewed our strategic plan in light of the introduction of the *Health Ombudsman Bill 2013*	page 17, 78
Welcomed a new Assistant Commissioner, Allied Health	page 78
Reduced supplies and services spending by $112,535	page 93

Financial snapshot

Our operational budget for 2012-13 was $10.170 million plus $461,249 in retained rollover funds, totalling $10,631,249.

This budget comprised:

- $9.898 million in recurrent funds
- $272,000 for payroll and finance system transition
- earned revenue of $130,681 of which $126,897 was earned from interest bearing accounts.

We ended the year with retained rollover funds of $1,166,393.

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 $9.934 million in 2012-13 against a forecast of $10.301 million.

Employee expenses accounted for 73.5% of our spending at $7.302 million, a decrease of $421,004 on 2011-12. Our second largest expenditure item was supplies and services, accounting for 22% of our spending at $2.170 million.

What we own

As at 30 June 2013, our assets totalled $3.215 million and comprised:

- $1.439 million – property, plant and equipment, including leasehold improvements, furniture and equipment
- $1.166 million – cash in bank
- $456,817 – intangibles, software
- $78,829 – pre-payments
- $74,531 – receivables.

What we owe

Our liabilities for 2012-13 totalled $1.545 million. These included $146,943 in accounts payable to suppliers and $618,846 in accrued employee benefits, with $779,380 in lease incentives.

Key financial statistics

	2008-09	2009-10	2010-11	2011-12	2012-13
Financial performance					
Total income	$10,598,975[1]	$9,437,433	$10,246,247	$10,377,354	$10,300,681
Total expenditure	$11,032,457	$9,596,764	$9,990,750	$10,557,272	$9,933,689
Operating surplus/(deficit)	($433,482)	($159,331)	$255,497	($179,918)	$366,992
Financial position					
Total assets	$4,420,977	$4,109,534	$3,204,002	$2,968,113	$3,215,534
Total liabilities	$3,033,851	$2,881,739	$1,720,710	$1,664,740	$1,545,169
Total equity	$1,387,126	$1,227,795	$1,483,292	$1,303,373	$1,670,365
Cash held at 30 June	$1,108,655	$1,013,628	$693,415	$461,249	$1,166,393

[1] We received $1.271 million in non-recurrent funds from Queensland Treasury to complete our relocation to new offices in March 2009.

Outlook

In 2013-14, we will continue to efficiently and economically manage complaints and drive healthcare improvement while working towards a smooth transition to the Health Ombudsman (see page 35). Current HQCC staff are not guaranteed positions with the Office of the Health Ombudsman and some staff have left the HQCC to secure their own futures. It is also natural that recruiting new staff has become more difficult.

We have made preparations, as best we can, and are in a strong financial position to continue to deliver services against our strategic plan until the Health Ombudsman is fully operational. As we move closer to the transition date to the Health Ombudsman, recruiting and retaining staff will become an increasing challenge.

Major events

2012

July	**Legislation updated** Amendments to the *Health Quality and Complaints Commission Act 2006* came into effect.	page 71
	Healthcare safety and quality research report released The HQCC published its report, *Checking the pulse: Perceptions and experiences of healthcare in Queensland, volume 1.*	page 55
	Public interest disclosure report tabled The Parliamentary Crime and Misconduct Committee's *Report on the Crime and Misconduct Commission's assessment of a public interest disclosure (Report No. 87)* tabled in Parliament. The report followed a public interest disclosure from Ms Jo-Anna Barber about the conduct, regulation, registration and discipline of medical practitioners in Queensland. The committee's report included the report of Mr Richard Chesterman AO RFD QC, who independently assessed Ms Barber's public interest disclosure.	page 31
September	**Hospital monitoring conducted** The HQCC required Queensland acute and day hospitals to report for the final time on compliance with its healthcare standards version 2.0 for 1 July 2011 to 30 June 2012.	page 49
	Dental care complaints report released The HQCC released its report, *Teething problems: A spotlight report on complaints about dental care in Queensland*.	page 55
November	**Memorandum of understanding signed** The HQCC and the Australian Competition and Consumer Commission signed a protocol to guide the working relationship between the two agencies.	page 34
December	**Hospital standards compliance reported** The HQCC released its report, *Standards of care: A report on Queensland acute and day hospital self-assessed compliance with healthcare standards.*	page 55
	Queensland hospital credentialing update tabled The HQCC's special report on credentialing and defining the scope of clinical practice for doctors working in Queensland hospitals, *Doctor Right, volume 3*, was tabled in Parliament.	page 55, 59

2013

January	**New assistant commissioner appointed** Mr Kos Sclavos was appointed Assistant Commissioner, Allied Health.	page 78
	New working protocol signed The HQCC and the Commission for Children and Young People and Child Guardian signed a protocol to guide the working relationship between the two agencies.	page 34
February	**Blueprint signals redesign of health complaints system** Queensland Premier, the Honourable Campbell Newman MP, and Minister for Health, the Honourable Lawrence Springborg MP launched the Queensland Government's *Blueprint for better healthcare in Queensland.* The blueprint detailed the Government's intention to introduce legislation to improve the response to allegations of medical malpractice.	page 31

	Position statements published The HQCC published position statements on ensuring correct patient, site, side and procedure; appropriate use of surgical antibiotic prophylaxis; hand hygiene; and dental health services.	page 55
April	**Medical practitioner case review reports tabled** Two reports on reviews of medical practitioners who had a complaint/notification dealt with by the Medical Board of Queensland, the Queensland Board of the Medical Board of Australia and the Australian Health Practitioner Regulation Agency tabled in Parliament: • *Chesterman report recommendation 2 review panel report (Forrester report)* - review panel members Dr Kim Elizabeth Forrester, Professor Elizabeth Anne Davies and Adjunct Professor James Henry Houston • *Review of files held by the Medical Board of Queensland, Queensland Board of the Medical Board of Australia and the Australian Health Practitioner Regulation Agency (Hunter report)* – Mr Jeffrey Hunter SC.	page 31
	New Health Ombudsman legislation announced Minister for Health, the Honourable Lawrence Springborg MP, announced new legislation to create a Health Ombudsman in Queensland as the lynchpin of a new and accountable complaints reporting system which would be introduced before July 2013.	page 31
	Parliamentary committee tables oversight report The Health and Community Services Committee tabled its report, *Oversight of the Health Quality and Complaints Commission (Report No. 21)*, in which it made three recommendations and 10 comments about the HQCC's performance of its functions.	page 73
	Cosmetic procedures report released The HQCC released its report *Great expectations: A spotlight report on complaints about cosmetic surgical and medical procedures in Queensland*.	page 55
May	**Legislation updated** Amendments to the *Health Quality and Complaints Commission Act 2006* came into effect.	page 71
	Liaison agreement signed The HQCC and the Queensland Ombudsman signed a liaison agreement to guide the working relationship between the two agencies.	page 34
	Advisory committee appointments extended The tenure of the HQCC's consumer and clinical advisory committee members was extended from 30 June 2013 to 31 December 2013, in light of the Queensland Government's intention to redesign the health complaints system.	page 71, 85
	Annual health check published The HQCC published its *Annual health check 2012*, a data report about managing healthcare complaints and monitoring the quality of health services in Queensland.	page 55
June	***Health Ombudsman Bill 2013* introduced** The *Health Ombudsman Bill 2013* was introduced to the Legislative Assembly by the Minister for Health, the Honourable Lawrence Springborg MP. The Bill was referred to the Health and Community Services Committee, which was asked to report to the Legislative Assembly by 12 August 2013.	page 31

The year in review

Our seventh annual report showcases our continued work in identifying opportunities for improvement in healthcare quality through complaint management and quality monitoring activities, as major changes were flagged to the health complaints management system in Queensland.

Driving healthcare safety and quality improvement

Our role is to manage complaints and oversee the safety and quality of health services in Queensland. We are the only health complaints entity in Australia tasked with this dual role.

In 2012-13, 3419 people contacted us with concerns about their healthcare, a 5% increase on the previous year. Since we were established in 2006, complaints have increased on average 3.6% per year. From July 2009, complaints received increased by 52.5%.

Our new triage team streamlined referrals and determined the best resolution pathway for complaints. We focused our efforts on resolving less serious complaints quickly and encouraging clients to raise their concerns directly with their healthcare provider.

Our investigations team concentrated on more complex and serious cases, and significantly reduced the number of long running, open investigations that exceeded 12 months, from 34 investigations to five.

We made or endorsed 200 investigation recommendations in 41 of 71 investigations completed in 2012-13. Sometimes, when the quality of care was reasonable and appropriate, or the healthcare provider had already taken corrective action, we did not issue recommendations.

We also monitored 26 recommendations for healthcare improvement as a result of quality monitoring activities.

On 1 July 2012, we expanded our approach to reportable events monitoring and implemented a process to monitor all reportable events that occurred, not just reportable events where healthcare providers conducted a root cause analysis (RCA). We reviewed 248 reports for healthcare safety and quality issues and to determine if further action or intervention was required. We will publish a report on reportable events in 2013-14.

Increasing community involvement in improving healthcare safety and quality

As Queensland's independent health watchdog and quality champion, complainants and healthcare providers give us unique information about the health system. By sharing lessons learned, we aim to spark discussion, drive improvement and prevent the same mistakes from recurring.

This year, we published five reports and four position statements about healthcare safety and quality and provided 12 submissions to peak bodies in the health sector about a range of state and national safety and quality issues.

We asked our clients to tell us what they thought about our complaint service and outcomes.

Since 2011-12, we have improved on our timeliness and keeping our clients informed. Review of our feedback last year indicated these were two areas we needed to work on and we are pleased to be able to report they have improved as a result of the actions we implemented.

We will continue to look to improve in all areas of client experience.

Strengthening our leadership and independence

Our quality oversight functions are unique among health complaint entities in Australia, and enable us to use the information from complaints, investigations and quality monitoring to identify healthcare risks and drive improvement in health services.

Our independence is paramount in ensuring complaints about healthcare safety and quality are managed fairly and appropriately.

We monitor community perception of our independence through our client experience survey. This year, 73% believed the HQCC was independent, an increase from 66% in the previous year.

We sought legislative amendments to secure independent funding, reporting and functional arrangements and submitted these to the Minister for Health for consideration in September and December 2012.

Our legislative amendment proposal was considered as part of the development of new health complaints management legislation.

The passing of the *Health Ombudsman Bill 2013* in the Legislative Assembly on 20 August 2013, will lead to significant changes to Queensland's health complaints management system. Our governing legislation, the *Health Quality and Complaints Commission Act 2006* will be repealed and replaced by the *Health Ombudsman Act 2013* at a time to be advised, with the full functions of the Office of the Health Ombudsman expected to commence in July 2014.

Strengthening business operations

We implemented two strategic initiatives in 2012-13.

The expansion of our reportable events monitoring process was designed to gather information about how serious incidents occur and help healthcare providers implement solutions to prevent them happening again and to strengthen healthcare safety and quality.

We also implemented a paper light project to increase the efficiency of workflows across the office and minimise costs associated with paper-based processes.

Each quarter we monitored our compliance with organisational government and risk management standards, and took action where we achieved only partial compliance with legislative requirements.

Since our establishment, we have relied on rollover monies to cover operational costs. This year we achieved a surplus of $366,992. We achieved efficiencies in our supplies and services spending as well as a reduction in employee expenses.

Outlook

We will continue in our current role pending the establishment of the Health Ombudsman.

No staff member is guaranteed a position with the Office of the Health Ombudsman. Several staff have left the organisation for other permanent positions, while some are signalling their intentions to seek alternative employment because of the uncertain environment. Recruiting skilled staff to replace those who have left may be a challenge.

We began to prepare for the changes to the health complaints management system when they were announced in February 2013 and are in a strong financial position to continue to deliver services against our strategic plan until the Health Ombudsman is fully operational.

However we have concerns about meeting our strategic plan targets for 2013-14 if significant personnel losses occur. The HQCC hopes that the Health Ombudsman, once appointed, will expedite the process of defining the Health Ombudsman structure and staff requirements to minimise further potential loss of experienced staff.

Acknowledgements

Our achievements in managing healthcare complaints and investigations, monitoring health services and driving improvement in the safety and quality of the Queensland health system would not have been possible without the support of the thousands of healthcare consumers and providers who worked with us. We thank the people who brought their healthcare concerns to us and the providers who worked towards resolving complaints and improving their services.

We also thank our Assistant Commissioners for their leadership; our advisory committees for their guidance; and our in-house and external clinical advisers for their expertise.

Finally, we thank our dedicated and hardworking staff, who continue to rise to every challenge. We applaud your commitment to client service and better healthcare for Queenslanders. It is our privilege to be part of your achievements.

2013-14 will be a challenging year. We look forward to working with our stakeholders to ensure a smooth transition to the new Health Ombudsman.

Adjunct Professor Russell Stitz
Commissioner

Adjunct Professor Cheryl Herbert
Chief Executive Officer

Performance report card

Our *Strategic plan 2012-16* sets out our objectives and strategies to improve the safety and quality of healthcare in Queensland.

We measured our success against clear key performance indicators (KPIs) and challenging targets to drive continuous improvement across four strategic objectives:

1. Drive healthcare safety and quality improvement.
2. Increase community involvement in improving healthcare safety and quality.
3. Strengthen HQCC's leadership and independence.
4. Strengthen business operations.

Our performance report card shows our progress in delivering our *Strategic plan 2012-16*. Overall performance is based on the achievement or progress against each KPI.

To enable easy comparison, our report card lists our strategies, KPIs, annual targets, last year's performance (where applicable), this year's performance, and status (target achieved, on track, closely monitor, action required).

Brief commentary on any variances and trends is provided, together with page references for more detailed analysis of our performance. Where a KPI has been measured in previous years, trending graphs provide an 'at a glance' view of our performance against the KPI over time.

Objective 1
Drive healthcare safety and quality improvement

Strategies

- Manage healthcare complaints effectively.
- Identify opportunities for reducing healthcare risks.
- Investigate healthcare issues for systemic improvement.
- Analyse and share information about healthcare quality.

Key performance indicator 1.1	Target	2011-12	2012-13	Status
Percentage of investigations that result in recommendations for healthcare improvement	80%	46%	58%	Closely monitor

Investigations resulting in recommendations for healthcare improvement

Forty-one of the 71 investigations we finalised in 2012-13 resulted in recommendations to healthcare providers, a small increase in performance against our target compared with 2011-12.

We made recommendations when we identified opportunities for improvement through our investigation. In some cases, our investigation of a complaint followed the healthcare provider's own internal investigation or review and therefore opportunities for improvement had been identified and actioned by the provider prior to finalisation of our investigation. In other cases, our investigation concluded that the treatment was of an appropriate standard and therefore no recommendation was made. Preliminary investigations undertaken on behalf of the Coroner sometimes did not include recommendations.

In some investigations, we chose not to make specific recommendations but to require healthcare providers to comply with their duty to improve the quality of their health service under section 20 of the HQCC Act. Use of the section 20 provision is not captured by this KPI, but does result in healthcare improvement. See page 24 for more information about investigations and our recommendations for improvement.

We have revised this KPI in our *Strategic plan 2013-17* to be more outcomes focused (see page 17).

Key performance indicator 1.2	Target	2011-12	2012-13	Status
Percentage of investigations recommendations implemented by healthcare providers	80%	72%	89%	Target achieved

Percentage of investigations recommendations implemented by healthcare providers

We commenced monitoring healthcare provider implementation of our investigation recommendations in 2009. Recommendation implementation timeframes were agreed with healthcare providers prior to finalising our reports, with a maximum timeframe of two years for complex recommendations. According to prescribed timeframes, providers reported to us on their progress in implementing recommendations until complete.

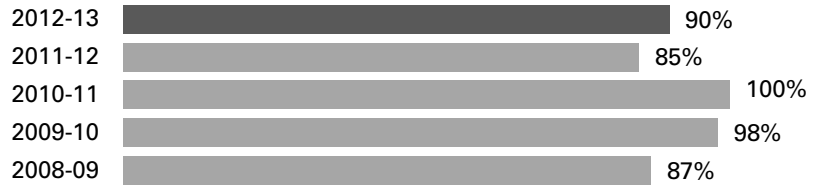
In July 2011, we introduced a new method to calculate this KPI. In previous annual reports, we calculated the cumulative percentage of all investigation recommendations fully implemented by healthcare providers out of all investigation recommendations made by the HQCC since 1 July 2006. Since 2011-12, we have calculated this KPI as the percentage of investigation recommendations fully implemented by healthcare providers out of those recommendations due to be completed in the financial year. This methodology allows us to better monitor provider implementation of recommendations over time.

Some 126 recommendations were fully implemented by providers out of a total of 142 recommendations due to be implemented. Ten recommendations were partially implemented, a further four were due to be implemented but no outcome had yet been reported, and two recommendations were not implemented. See page 26 for more information about investigations recommendation monitoring.

Key performance indicator 1.3	Target	2011-12	2012-13	Status
Percentage of *Healthcare quality analysis and sharing plan*[1] implemented	100%	85%	90%	On track

[1] In past annual reports, we reported on the percentage of our stakeholder engagement plan delivered. The stakeholder engagement plan was this year superseded by the *Healthcare quality analysis and sharing plan*, which includes our stakeholder engagement activity.

Percentage of *Healthcare quality analysis and sharing plan* implemented



Engaging our stakeholders in improving the safety and quality of healthcare is integral to our success. Since 2008-09, we have planned, measured and reported on our engagement activity. Following the successful introduction of our *Healthcare quality analysis and sharing plan* in 2011-12, this year's plan continued to focus on the sharing of lessons learned from our work in managing complaints and investigations, and monitoring healthcare quality.

In addition to our annual report, we produced five public reports and four position statements in 2012-13. Eighteen of the 20 projects in the plan were achieved or on track at year end. Two projects were cancelled during the year. See page 55 for more information about our *Healthcare quality analysis and sharing plan.*

Objective 2
Increase community involvement in improving healthcare safety and quality

Strategies

- Communicate healthcare improvement opportunities and improvements made by healthcare providers.
- Deliver quality client service.
- Preserve and promote healthcare rights.

Key performance indicator 2.1	Target	2011-12	2012-13	Status
Report(s) published by June 2013, and then annually, on improvements made by healthcare providers in response to opportunities identified by the HQCC	Published by 30 June 2013	New measure	Report in final draft	On track

All Queensland healthcare providers have a legal duty to establish, maintain and implement reasonable processes to improve the quality of their health services, under section 20 of the HQCC Act. This year we prepared a special report showcasing our role in driving healthcare improvement in Queensland through 10 case studies and case examples.

Due to resource constraints, we were unable to complete the report in 2012-13. We expect to provide it to the Minister for Health for tabling in Parliament later in 2013. See page 55 for more information about our *Healthcare quality analysis and sharing plan*.

Key performance indicator 2.2	Target	2011-12	2012-13	Status
Percentage of client satisfaction with complaint service	75%	64%	72%	On track

Client satisfaction with the way the complaint was handled

Since 2009-10, we have measured how well we meet the expectations of complaint service clients through a survey. We received an increased response this year, with 383 clients completing the survey (2011-12: 233 clients).

Clients indicated on a five point scale their level of agreement with the statement, 'Overall, I was satisfied with the way the complaint was handled'. To establish the percentage satisfaction with our service, we combined the two highest scale ratings ('strongly agree' and 'agree').

We achieved a service satisfaction rating of 72% (275 clients), slightly below target but an improvement on the 64% rating achieved in 2011-12. Based on our analysis of quantitative and qualitative data from the survey, the time taken to manage complaints impacted on this measure, as well as the fact we do not discipline healthcare providers. See page 29 for more information about our client experience survey results.

Key performance indicator 2.3	Target	2011-12	2012-13	Status
Percentage of client satisfaction with complaint outcome	60%	54%	62%	Target achieved

Client satisfaction with the complaint outcome

Since 2010-11, we have measured client satisfaction with the complaint outcome. The target of 60% recognises that we cannot meet client outcome expectations that are outside our jurisdiction, for example we cannot take disciplinary action against a healthcare practitioner or force a healthcare provider to supply treatment. Clients indicated on a five point scale their level of agreement with the statement, 'I was satisfied with the outcome of the complaint'. To establish the percentage satisfaction with our service, we combined the two highest scale ratings ('strongly agree' and 'agree'). We achieved a service satisfaction rating of 62% (237 clients), slightly above our target and an improvement on the 54% rating achieved in 2011-12.

Key performance indicator 2.4	Target	2011-12	2012-13	Status
Percentage of clients who believe their complaint has led to healthcare improvement	Establish baseline by 30 June 2013	New measure	40%	Target achieved

We introduced a new client experience measure to our survey in 2012-13. We asked clients to indicate on a five point scale their level of agreement with the statement, 'I believe this complaint has led to healthcare improvement'. To establish the percentage agreement, we combined the two highest scale ratings ('strongly agree' and 'agree').

Some 40% (152 clients) reported agreement. We hope to build on this baseline in the year ahead and have set ourselves an ambitious target of 60% for this KPI in 2013-14.

Objective 3
Strengthen HQCC's leadership and independence

Strategies

- Build reputation as Queensland's independent health watchdog.
- Secure independent funding, reporting and functioning.
- Retain a quality monitoring function following transition to *National safety and quality health service standards.*

Key performance indicator 3.1	Target	2011-12	2012-13	Status
Independent funding, reporting and functional arrangements implemented	Achieved by 30 June 2013	In progress	Arrangements partially implemented	Partial achievement

In 2012-13, we engaged a legislative policy officer to draft potential amendments to the HQCC Act identified as a result of the introduction of the national registration and accreditation scheme on 1 July 2010 and the HQCC's internal organisational review. These amendments were submitted to the Minister for Health for consideration in September and December 2012. The Queensland Government's February 2013 announcement of its plans to redesign the health complaints system resulted in our legislative amendment proposal being considered as part of the development of new health complaints management legislation.

We achieved improvements in the independence of our funding arrangements, with our Cabinet Budget Review Committee submission for additional funding being presented directly to the Minister for Health, rather than through the Department of Health, as was the process in previous years.

We continued to report to the Minister for Health. See page 8 for more information about our independence.

Key performance indicator 3.2	Target	2011-12	2012-13	Status
Quality monitoring function retained in future legislative amendments	Achieved in legislative amendment	Quality monitoring function retained	Quality monitoring function retained	Target achieved

The HQCC Act defines the organisation's main objects as the 'oversight and review of, and improvement in, the quality of health services, and independent review and management of health complaints'. Our quality oversight functions are unique among health complaint entities in Australia, and enable us to use the information from complaints, investigations and quality monitoring to identify healthcare risks and drive improvement in health services.

National and state health reforms did not impact on this function in 2012-13. However, following the introduction of the *Health Ombudsman Bill 2013* in June 2013, significant changes to Queensland's health complaints management system lie ahead.

See page 31 for more information about the redesign of the health complaints management system in Queensland and the *Health Ombudsman Bill 2013*.

Objective 4
Strengthen business operations

Strategies

- Realign resources, structure and processes to the strategic plan.
- Invest further in staff and system development.
- Streamline and enhance legislative powers and functions.
- Maintain financial sustainability.

Key performance indicator 4.1	Target	2011-12	2012-13	Status
Percentage of strategic initiatives implemented	100%	97%	100%	Target achieved

Strategic initiatives implemented

We implemented two strategic initiatives in 2012-13.

We commenced monitoring of hospital and healthcare provider reportable events (adverse healthcare incidents which resulted in patient deaths or serious harm). In 2013-14, we will prepare and release a report on the outcomes of our first year of reportable events monitoring. See page 52 for more information about reportable events monitoring.

We also implemented a paper light project to increase the efficiency of workflows across the office and minimise costs associated with paper-based operations. See page 70 for more information about paper light project outcomes.

Key performance indicator 4.2	Target	2011-12	2012-13	Status
Percentage of staff training and development plans implemented	100%	100%	100%	Target achieved

Staff training and development plans implemented

While we significantly reduced our learning and development expenditure in 2012-13, all staff members completed one or more training and development activity during the year. Our learning and development program focused on the core skills and competencies required by staff to do their jobs. See page 67 for more information about staff learning and development.

Key performance indicator 4.3	Target	2011-12	2012-13	Status
Compliance with organisational governance and risk management standards	Full compliance	Partial compliance	Partial compliance	Monitor closely

We achieved full compliance with governance and risk management standards related to our *Governance road map* and *Risk register*.

We achieved partial compliance with the:

- HQCC Act sections 49E (early resolution - individual registrants), 53 (early resolution - all other health service providers), 54 (notice of decision to assess health service complaint), 58 (time limit on assessment) and 214 (relating to the preservation of confidentiality)
- *Information Privacy Act 2009* privacy principle 11 limits on disclosure.

See page 83 for more information about meeting our legislative obligations.

Key performance indicator 4.4	Target	2011-12	2012-13	Status
Percentage of actual expenditure against recurring budget	100%	103%	96.4%	On track

Actual expenditure against recurring budget

We recorded a surplus of $366,992 in 2012-13. Since our establishment, we have relied on retained rollover monies to cover operational costs. In line with Queensland Government directives, we continually seek ways to reduce the cost of our operations while maintaining a high quality service to the Queensland community.

See our financial snapshot on page 5 or the financial report from page 93 for more information about our financial performance.

Deleted key performance indicators

The following proposed 2012-13 key performance indicators were reported in our *Annual report 2011-12* but deleted during the year:

Objective 1 Drive healthcare safety and quality improvement

Proposed KPI	Percentage of early resolution complaints that result in identified healthcare improvements
	Percentage of assessed complaints that result in identified healthcare improvements
	Percentage of conciliated complaints that result in identified healthcare improvements
Reason for deletion	Due to resource constraints and competing priorities, we were unable to enhance our complaints and investigations case management system to capture this data for reporting purposes. This work is scheduled for 2013-14 and the KPIs will be reported in our 2013-14 annual report

Objective 3 Strengthen the HQCC's leadership and independence

Proposed KPI	Percentage of Queensland healthcare providers who are aware of the HQCC
	Percentage of Queensland healthcare providers (who are aware of the HQCC) who believe the HQCC is independent
Reason for deletion	To reduce discretionary expenditure, we decided not to proceed with independent research to measure these KPIs

Objective 4 Strengthen business operations

Proposed KPI	Percentage of staff identified in cultural survey as 'engaged'
Reason for deletion	Since 2007, we have monitored cultural change and identified opportunities for improvement through an annual cultural survey of our employees, which has been administered on our behalf by an independent research organisation. To reduce discretionary expenditure, we decided not to proceed with our usual survey in 2013 and instead participated in a public service-wide survey of all staff engaged under the *Public Service Act 2008* and other employing legislation. Some 65.6% of our staff completed the survey, which was coordinated by the Public Service Commission. As the survey results had not yet been released at the time of writing this report and are unlikely to be comparable with the results of our previous surveys, we decided to remove this KPI for 2012-13

Service standards

Our service standards set a benchmark for the efficiency and effectiveness of our service delivery. Service standard targets are based on an appropriate level of performance that we expect to achieve within available resources.

Service standards are part of the Queensland Government's *Performance Management Framework*. They enable the Queensland community and the Government to assess whether or not agencies are delivering services to acceptable levels of efficiency and effectiveness. Estimated actual performance against the targets is reported in the annual *State Budget Service Delivery Statements* (budget papers prepared by agencies reporting to each Minister and the Speaker).

Our service standards report card shows our 2012-13 targets, the estimated actual reported in the Service Delivery Statements, actual 2012-13 performance and our targets for 2013-14.

Service standards	2012-13 target	2012-13 estimated actual	2012-13 actual performance	2013-14 target
Percentage of client satisfaction with complaint service:				
• ease of access	75%	76%	77%	75%
• staff	75%	76%	78%	75%
• timeliness	75%	72%	74%	75%
• quality	75%	74%	76%	75%
• outcome	60%	61%	62%	60%
• overall	75%	74%	75%	75%
Percentage of complaints in early resolution closed within 30 days	100%	73%	77%[1]	100%
Percentage of complaints in assessment closed within 90 days	100%	93%	93%[1]	100%
Percentage of complaints in conciliation closed within 12 months	60%	53%	58%[2]	100%
Percentage of investigation recommendations implemented by healthcare providers	80%	91%	92%[3]	80%
Percentage of quality monitoring recommendations implemented by healthcare providers within agreed timeframes	75%	100%	100%	Discontinued[4]
Percentage of monitored healthcare providers who do not receive a subsequent related complaint or report[4]	[4]New measure	N/A	N/A[4]	75%

Notes:

[1]Effectively managing complaints within legislated timeframes of 30 days for early resolution and 90 days for assessment is an ongoing challenge, particularly given the continued increase in complaints received during 2012-13. Resolution was not completed within the statutory timeframes, in circumstances where a complainant or provider was not contactable until the end of the statutory timeframe, essential information was unable to be provided by parties to the complaint or independent clinical advisers within the timeframe, or where a provider requested an extension to adequately address the complaint issues.

[2]The 2013-14 target for this service standard has been increased to 100% following the introduction of a new conciliation policy on 29 January 2013, which requires conciliation cases accepted under the policy to be completed within 12 months.

[3]The wording of this service standard was amended to exclude the term 'within agreed timeframes'. The amendment reflects our experience that the effective implementation of healthcare quality improvement recommendations arising from investigation may exceed the initial specified timeframes due to factors outside a healthcare provider's control.

[4]The service standard *Percentage of quality monitoring recommendations implemented by healthcare providers within agreed timeframes* has been discontinued and replaced with a new quality monitoring measure, which will help to better assess the HQCC's monitoring outcomes.

Strategic outlook

Our *Strategic plan 2013-17* was endorsed by our governing Commission in August 2013. The plan sets out our objectives, strategies, and key performance indicators (KPIs), along with targets for the 2013-14 year. This plan and our service standards will form the basis of our performance report card for 2013-14.

The plan was prepared on the understanding that our organisation would be replaced by a new Health Ombudsman, as outlined in the *Health Ombudsman Bill 2013*, which was introduced to the Queensland Parliament in June 2013.

We will work towards a smooth transition to the new agency.

Objective 1
Drive healthcare safety and quality improvement

Strategies

- Manage healthcare complaints effectively.
- Identify opportunities for reducing healthcare risks.
- Investigate healthcare issues for systemic improvement.
- Analyse and share information about healthcare quality.

Key performance indicators	2013-14 targets
Percentage of complaints that result in identified healthcare improvements	Establish baseline by 30 June 2014
Percentage of investigation recommendations implemented by healthcare providers	80%
Percentage of *Healthcare quality analysis and sharing plan* implemented	100%

Objective 2
Increase community involvement in improving healthcare safety and quality

Strategies

- Communicate healthcare improvement opportunities and improvements made by healthcare providers.
- Deliver quality client service.
- Preserve and promote healthcare rights.

Key performance indicators	2013-14 targets
Report on improvements made by healthcare providers in response to opportunities identified by the HQCC	Published by 30 June 2014
Percentage of client satisfaction with complaint service	75%
Percentage of client satisfaction with complaint outcome	60%
Percentage of clients who believe their complaint has led to healthcare improvement	60%
Quality improvement function *(Providers' duty to improve the quality of health services)* retained in future legislative amendments	Achieved in legislative amendment

Objective 3
Strengthen business operations

Strategies

- Direct resources to maintain high quality service during transition to the Health Ombudsman.
- Invest further in staff and system development.
- Maintain financial sustainability.

Key performance indicators	2013-14 targets
Percentage of strategic initiatives implemented (transition to Health Ombudsman)	100%
Percentage of staff developed in line with business strategy	100%
Percentage of compliance with organisational governance and risk management standards	100%
Percentage of actual expenditure against recurring budget	100%

Chapter 1
Managing healthcare complaints and investigations

Highlights

- We managed 3419 complaints this year, a 5% increase.
- We significantly reduced the number of open investigations that exceeded 12 months, from 34 investigations to five.
- We recorded a successful outcome for 74% of all complaints referred to our conciliation team.
- We reduced the average number of days taken to assess a complaint by five days by improving the efficiency of complaint assessment and resolution.
- We established four dedicated early resolution roles and developed a new workflow, policies and procedures to support the timely resolution of less serious complaints.
- We appointed a new triage team to improve client service and achieve more efficient case allocation.
- We launched an online complaint form.
- We improved client satisfaction with our timeliness to 74%.

Overview

This year, we received 3419 (2011-12: 3244) complaints about healthcare organisations and individuals in Queensland, representing an increase of 5%. Since our inception in 2006, we have handled more than 33,000 complaints and enquiries about health services in Queensland.

Overall, 4828 Queenslanders contacted us with concerns about the safety and quality of their healthcare, a 12% decrease (2011-12: 5489) from last year. This decrease is due to a substantial reduction in enquiries received.

We worked hard to improve our client service and complaint management timeframes this year.

We appointed a dedicated triage team to be the first point of contact for complainants. This resulted in better client service, increased referrals to our early resolution team and fewer enquiries, due to more rigorous and consistent case decision-making.

The average number of days taken to assess a complaint was reduced by five days in 2012-13 and we had 147 fewer cases open in assessment at 30 June 2013 than at the same time last year.

In January 2013, we implemented a new conciliation policy to improve our efficiency in managing complaints through this process. Our new policy focused on increasing cooperation between parties, working towards achievable outcomes and limiting compensation to out-of-pocket expenses or corrective treatment costs.

Our investigations team focused on finalising a number of long-standing investigations, reducing the number of open investigations exceeding twelve months at 30 June 2013 from 34 to five.

Performance

Answering client enquiries

An enquiry is a matter raised with us by a client that is not eligible as a complaint, for example, a request for information about how we work or a complaint that falls outside our jurisdiction.

Most people contacted us by telephone, but we also received enquiries from people who visited our office as well as written enquiries (email, facsimile and letter). We answered people's questions, provided information and talked them through options for resolving their concerns. If a complaint was outside our jurisdiction, we referred the client to another agency that could help. Most enquiries were managed immediately.

There was a 37% drop in the number of enquiries received compared with the previous year. This decrease is likely due to improvements in our triaging of enquiries and complaints, which resulted in more enquiries becoming complaints. It may also reflect greater consumer understanding of our role and jurisdiction and improvements in local complaint resolution.

Table 1: Healthcare enquiries received and closed

	2008-09	2009-10	2010-11	2011-12	2012-13
Enquiries received	2177	2240	2403	2245	1409
Enquiries closed	2107	2225	2393	2285	1401

Managing healthcare complaints

A complaint is any expression of dissatisfaction or concern about a health service made by an eligible complainant about an identifiable healthcare provider. Concerns may be raised orally, by telephone or in person, or in writing, by letter, email or facsimile.

There was a 5% increase in the number of complaints we received in 2012-13, which followed a 28% increase in 2011-12.

Table 2: Healthcare complaints received and closed

	2008-09	2009-10	2010-11	2011-12	2012-13
Complaints received	2534	2241	2525	3244	3419
Complaints closed	2563	2134	2312	3445	3444

We accepted two kinds of complaints – health service complaints and health quality complaints.

We received 3355 health service complaints in 2012-13. Health service complaints were made by healthcare consumers, or someone acting on a consumer's behalf, about a healthcare provider. These complaints must be made within one year of the incident, or within one year of the complainant becoming aware of a problem.

We received 64 health quality complaints. These complaints can be made by anyone, including current or former staff or other healthcare providers. They can be about one health service or a problem found in multiple health services. There is no time limit on making a health quality complaint.

Table 3: Complaint type

	2012-13		2012-13
Health service complaints received	3355	Health quality complaints received	64
Health service complaints closed	3365	Health quality complaints closed	79

Our triage officers made a preliminary assessment of all complaints and decided the best complaint management pathway – direct resolution, early resolution, assessment or investigation.

Encouraging direct resolution

We encouraged complainants with less serious complaints, to approach their healthcare provider first and raise their concerns. We call this direct resolution.

We suggested direct resolution of 601 complaints in 2012-13, compared to 807 in 2011-12. Complainants were advised to formalise their complaint to us in writing if their attempt at direction resolution was unsuccessful.

Our legislation requires oral complaints to be confirmed in writing by the complainant unless we are satisfied there is good reason for the person not to do so. Some 1010 matters were not confirmed in writing, or otherwise progressed, in 2012-13 (2011-12: 1044).

Unless the oral complaint was of sufficient severity and detail for us to consider initiating our own action or indicated a risky pattern of provider practice, complaints not confirmed in writing were closed. All enquiries and complaints were kept on record to help us identify patterns of provider practice and complaint trends, or more widespread system issues.

Resolving concerns quickly

We facilitated resolution of less serious complaints through our early resolution process.

Complaints were referred for early resolution when:

- we considered it likely that we could help resolve concerns relatively quickly
- the complainant agreed to the process
- the complaint was not of a serious nature.

We helped complainants and healthcare providers try to work through their problems and concerns.

We attempted to resolve 599 complaints through early resolution this year, compared to 375 in 2012-13. The 60% increase reflects our renewed focus on early resolution and appointment of dedicated early resolution officers to resolve appropriate complaints quickly and efficiently. Of 599 early resolution cases managed during the year, 493 were resolved to the satisfaction of our agency and 106 were unresolved and referred for assessment. At 30 June 2013, 50 cases were open in early resolution (30 June 2012: 18).

The average number of days a complaint spent in early resolution this year was 26, compared with 19 in 2011-12. We met our legislated 30-day timeframe for the early resolution of complaints in 77% of cases, down from 91% in 2011-12. This was due to a number of reasons, including the resources required to establish a dedicated early resolution team, recruit and train experienced resolution officers and develop and implement policies and procedures.

Table 4: Early resolution – average time complaint completed

Mean days spent in ER	26
ERs completed within 30 days	77%

Table 5: Early resolution – time spent waiting for allocation

No. of days	No of cases.
0–10 days	101
11–20 days	88
21–30 days	282
31–40 days	74
41–50 days	26
51–60 days	11
61–70 days	11
71–80 days	5
81–90 days	3
91–100 days	6
>101 days	4

Table 6: Early resolution – average waiting time

Fiscal quarter 1: Jul – Sep 2012	Fiscal quarter 2: Oct – Dec 2012	Fiscal quarter 3: Jan – Mar 2013	Fiscal quarter 4: Apr – Jun 2013
10 days	17 days	21 days	16 days

Deciding on appropriate action

We formally assessed written complaints about more serious healthcare issues and complaints not resolved through early resolution to help us decide whether action was required.

We examined the complainant's concerns, relevant healthcare records and clinical notes and the healthcare provider's response to the complaint. In clinical complaint cases, we also obtained informal clinical advice on the key issues from an independent clinician. Occasionally, we required a formal clinical opinion in order to make our assessment decision and/or resolve the complaint (see page 33).

We made assessment decisions based on our review of all the information gathered. We may have decided no action was needed and closed the complaint or taken any, or all, of the following actions:

- conciliated the complaint
- investigated the complaint
- referred the complaint to another agency that had the authority to deal with it
- referred the complaint to a practitioner registration board through the Australian Health Practitioner Regulation Agency (AHPRA) or the Office of the Health Practitioner Registration Boards.

Table 7: Assessment decisions

	2008-09	2009-10	2010-11	2011-12	2012-13
Complaint closed – no further action required	423	548	493	703	815
Complaint referred to conciliation service	121	102	89	92	65
Complaint referred to investigation service	57	63	77	30	12
Complaint referred to healthcare practitioner registration board	159	90	41	93	166
Complaint referred to external agency	73	54	44	27	53

We met our legislated 90-day complaint assessment timeframe in 93% of cases. We achieved the same result in 2011-12. In some cases, healthcare providers not complying with s56 of the HQCC Act affected our ability to meet the legislated timeframe. The average number of days taken to assess a complaint was 64, compared to 69 in 2011-12. The 90-day assessment timeframe excludes time taken to consult with registration boards on complaints about registered healthcare practitioners (see page 30). At 30 June 2013, 262 complaints were open in assessment (30 June 2012: 409).

As with oral complaints, all written complaints were kept on record to help us identify patterns of provider practice and complaint trends, or more widespread system issues. We analysed complaint information and published reports to drive healthcare safety and quality improvement (see page 55).

The average time between the receipt of a complaint and its allocation to an assessment officer was 23 days. This figure was calculated from 705 assessment cases and excluded reviews and complaints referred from early resolution.

Conciliating resolution

Conciliation is a privileged and confidential process, which allows complainants and healthcare providers to speak freely about complaint issues. We conciliated complex complaints, such as those involving a claim of negligent treatment, or those requiring detailed explanation or confidential dispute resolution.

We accepted fewer complaints for conciliation than in previous years due to the introduction of a new conciliation policy in January 2013, which limited compensation in conciliation to out-of-pocket expenses and/or corrective treatment costs paid (see page 32).

Table 8: Conciliations accepted, closed, and open at 30 June

	2008-09	2009-10	2010-11	2011-12	2012-13
Accepted conciliations	121	102	89	92	75
Closed conciliations	108	122	102	101	98
Conciliations open	150	118	116	92	69

We closed 58% of conciliation cases within 12 months, just shy of our 60% target. More than three quarters (78%) of conciliation cases were closed within 18 months (2011-12: 72%).

The average case timeframe was 369 days, (2011-12: 422 days).

Table 9: Timeliness of conciliations closed

	2010-11	2011-12	2012-13
Less than 6 months	32	29	31
6-12 months	28	24	26
12-18 months	19	20	19
18-24 months	17	9	15
24-30 months	5	9	4
30-36 months	1	6	0
36-42 months	0	4	1
42-48 months	0	0	2

Table 10: Time between the date of the notice of assessment decision and the date the conciliation closed

	2012-13	%
Less than 6 months	23	26%
6-12 months	27	31%
12-18 months	17	20%
18-24 months	14	16%
24-30 months	3	3%
30-36 months	0	0%
36-42 months	1	1%
42-48 months	2	2%
Total	**87[1]**	**100%[2]**

[1] Most cases enter conciliation from assessment, however cases can be referred to conciliation from other sources. See Table 11 for a breakdown of sources of referral.
[2] Total <100% due to rounding.

Table 11: Source of referral to conciliation (closed cases)

	2012-13
Assessment	87
Investigation	3
Referred to board[1]	7
Referral to external agency[1]	1
Total	98

[1]Some conciliations were referred to a board or external agency before being accepted into our conciliation service.

Table 12: The time between the date the conciliation is allocated to a conciliator and the date the conciliation closed

	2012-13	%
Less than 6 months	34	35%
6-12 months	27	28%
12-18 months	17	17%
18-24 months	14	14%
24-30 months	3	3%
30-36 months	0	0%
36-42 months	1	1%
42-48 months	2	2%
Total	**98**	**100%**

Table 13: Timeliness of open conciliations

	2012-13	%
Less than 6 months	20	29%
6-12 months	21	30%
12-18 months	13	19%
18-24 months	8	12%
24-30 months	3	4%
30-36 months	2	3%
36-42 months	1	1.5%
42-48 months	0	0%
48-54 months	1	1.5%
Total	**69**	**100%**

More than half (53%) of conciliations accepted in 2012-13 have been in conciliation less than six months.

Table 14: Timeliness of accepted conciliations[1]

	2012-13	%
Less than 6 months	40	53%
6-12 months	35	47%
Total	**75**	**100%**

There were 73 successful conciliation cases. An explanation of events was the most common outcome, followed by financial settlement. When conciliation was unsuccessful, the most common reason was that the complainant withdrew from the process, followed by failure to progress by one or both parties.

Table 15: Conciliation outcomes

	2011-12	2012-13
Successful	**62**	**73**[1]
Explanation provided	29	28
Financial settlement	19	24
Apology given	7	16
Reimbursement of costs	4	2
Policy/procedure change	4	0
Remedial care provided	1	0
Unsuccessful	**39**	**49**[2]
Complainant withdrew	10	16
Failure to progress	13	13
Provider withdrew	5	11
No agreement reached	13	8
Public interest matter identified	0	3

[1,2] The total number of conciliation outcomes (122) exceeds the total number of conciliations closed (98) because conciliations can result in more than one outcome, for example a successful conciliation may result in an explanation and a financial settlement.

We are obliged to consider and action any public interest issues that may arise during conciliation. Three public interest issues (2011-12: 2) were identified in conciliation in 2012-13. Two were referred to the Australian Health Practitioner Regulation Agency for action and one was referred to our investigation team.

Investigating for improvement

We investigate systemic problems and serious event outcomes that impact on all types of health services. We also investigate health services that have, or could, put patient safety at risk.

An investigation involves gathering evidence and information to help us identify and analyse the cause/s of an adverse health incident or systemic issue.

Table 16: Investigations accepted, closed, and open at 30 June

	2008-09	2009-10	2010-11	2011-12	2012-13
Accepted investigations	78	85	83	39	54
Closed investigations	104	61	70	59	71
Open investigations	35	59	70	44	27

We started the year with 44 investigations and accepted a further 54 cases – 38 referrals from our triage, assessment and conciliation services and 15 referrals from external agencies. We initiated one investigation.

Table 17: Type of investigations accepted, closed and open at 30 June

	2009-10	2010-11	2011-12	2012-13
Health service complaints				
Accepted	35	55	15	35
Closed	30	35	32	35
Open	Data not available	Data not available	Data not available	20
Health quality complaints				
Accepted	50	28	24	19
Closed	31	35	27	36
Open	Data not available	Data not available	Data not available	7

We accepted 35 health service complaints and 19 health quality complaints for investigation in 2012-13.

Table 18: Source of referred investigations accepted and closed

	2009-10		2010-11		2011-12		2012-13	
	Accepted	Closed	Accepted	Closed	Accepted	Closed	Accepted	Closed
Office of the State Coroner	6	3	2	4	5	6	7	5
Minister for Health	5	2	0	3	0	2	1	2
Queensland Health	3	1	0	2	1	3	0	1
Commission for Children, Young People and Child Guardian	3	1	0	0	3	2	1	3
Medical Board	2	2	1	1	0	1	1	2
Nursing and Midwifery Board	0	0	0	1	0	0	2	2
Queensland Ambulance Service	0	0	1	0	0	1	3	3
Department of Community Safety	0	0	0	1	0	0	0	0
Corrective Services	0	0	1	0	0	0	0	0
Other public authority	3	3	0	0	0	0	0	1

As well as investigating complaints made by healthcare consumers, we accepted cases referred by other agencies, healthcare providers or the Minister for Health.

We accepted 15 referrals and finalised 21 referred investigations.

Table 19: Timeliness of investigations closed

	2009-10	2010-11	2011-12	2012-13
Less than 6 months	35	41	9	35
6-12 months	14	7	16	6
12-18 months	6	10	13	9
18-24 months	2	5	11	4
24-30 months	4	7	7	11
30-36 months			0	3
36-42 months			1	3
42-48 months			0	0
48-54 months			2	0

This year was our first full twelve months operating under a reviewed investigation acceptance criteria. The criteria ensured we employed our limited resources to investigate more serious healthcare complaints. Our reviewed case management processes also enabled more timely finalisation of investigations.

We closed 71 investigations within an average timeframe of 361 days or just short of 12 months (2011-12: 16 months). Two long-running investigations of more than two years' duration impacted on the average investigation timeframe. We focused on finalising more complex lengthy investigations, with just under half (42% or 30) of investigations closed taking more than one year to complete, and 17 running over more than two years.

Table 20: Status of open investigations

Of the 27 open cases at 30 June 2013, five had been open for more than 12 months (2011-12: 34 cases). This is a significant reduction in our timeframes for completing investigations.

	30 June 2013
Less than 6 months	19
6-12 months	3
12-18 months	2
18-24 months	1
24-30 months	1
30-36 months	0
36-42 months	0
42-48 months	1
48-54 months	0
Total	**27**

Table 21: Investigation recommendations for improvement

	2008-09	2009-10	2010-11	2011-12	2012-13
Number of closed investigations	104	61	70	59	71
Number of recommendations made/endorsed	58	54	84	158	200

Through investigation, we identified opportunities for health service improvement and made or endorsed 200 recommendations for action.

We made or endorsed recommendations in 58% (41) of investigations closed in 2012-13 (2011-12: 46%). Our recommendations were based on sound evidence and independent clinical opinion. Sometimes we endorsed recommendations made as part of a healthcare provider's internal review of an adverse incident. In many cases, opportunities for improvement were actioned by the provider prior to finalisation of our investigation.

Recommendations generally included changes in individual and organisational practice, and specific initiatives to address identified failings.

Of the 200 investigation recommendations made, 151 were directed to public healthcare providers (mainly hospitals) and 38 were directed to private hospitals. The remaining 11 recommendations were directed to other services, such as nursing services, specialised health services and administrative services.

It is not our role to find fault or apportion blame, decide negligence or award compensation; nor do we prosecute or discipline healthcare providers.

Table 22: Status of investigation recommendations made/endorsed in 2012-13

	2011-12	2012-13
Fully implemented	78	126
Partially implemented	40	10
Not yet due to be implemented	39	58
Not yet implemented but overdue	Data not available	4
Not implemented	1	2
Total		**200**

We monitored healthcare provider implementation of all investigation recommendations made or endorsed. Recommendation implementation timeframes were agreed prior to finalising our investigation reports. We allow a maximum timeframe of two years for complex recommendations.

Providers were required to report regularly to us on their progress in implementing recommendations until complete. In some investigations, we chose not to make specific recommendations but to require healthcare providers to comply with their duty to improve the quality of their health service under section 20 of the *Health Quality and Complaints Commission Act 2006.* We monitored action taken by providers to meet their section 20 obligations until we were satisfied any safety and quality concerns had been addressed.

We calculated the percentage of investigation recommendations fully implemented by healthcare providers within agreed timeframes against those recommendations due to be completed in the financial year.

One hundred and twenty-six or 89% of 142 investigation recommendations (2011-12: 72%) due to be complete in 2012-13 were fully implemented by healthcare providers within agreed timeframes.

Our decisions

If a client is dissatisfied with a decision we made about a complaint, they can apply to have the decision reviewed. Our review process ensures our decision making processes are fair, open and transparent.

Clients may request a review on the basis of:

- new and relevant information being provided (i.e. information not available or provided at the time of the original decision) and/or
- concerns about the validity, fairness, or impartiality of the original decision and assessment outcome.

Clients who remained dissatisfied following our review were able to make a complaint to the Queensland Ombudsman.

Table 23: Decision review requests

	2010-11	2011-12	2012-13
Review requests received	54	113	**166**
Requests declined (no valid grounds for review)	31	85	**75**
Requests withdrawn	1	0	**0**
Requests accepted (valid grounds for review)	12	19	**42**
Original decision upheld	2	5	24
Original decision revoked	3	14	18
Review requests pending at 30 June	10	9	**49**
Cases being re-assessed at 30 June	7	6	5

We received 166 review requests (2011-12: 113), an increase of 47%. Valid grounds for review were identified in 42 requests.

Our original decision was upheld in 24 cases, revoked in 18 cases and five cases were being re-assessed at 30 June 2013. Some 49 review requests were pending at year end.

Measuring client satisfaction

Since 2009-10, we have measured how well we meet the expectations of complaint service clients through an experience survey.

Following case closure, we invited complainants and healthcare providers who had received our early resolution, assessment and conciliation services to complete a survey indicating on a five point scale their level of agreement with a series of 19 performance measures. We combined the two highest scale ratings ('strongly agree' and 'agree') to establish the percentage agreement.

We set a target of 75% for measures 1 to 17 and 60% for measure 18 *(I was satisfied with the outcome of the complaint)*. The target was adjusted for measure 18 to recognise that we cannot meet client outcome expectations that are outside our jurisdiction. For example, we cannot take disciplinary action against a healthcare practitioner or force a healthcare provider to supply treatment.

We received an increased response this year, with 383 clients completing and returning the survey (2011-12: 233 clients). Of the 383 responses, 50% were received from complainants, 42% from healthcare providers, and in the remaining 8% of surveys the respondent type was unknown.

We met or exceeded our targets for 12 measures but achieved slightly below target ratings for six measures. All but one of the six measures under our target improved from the previous year's results. We introduced a new measure *(19 - I believe this complaint has led to healthcare improvement)* this year and established a baseline for future reporting.

Client satisfaction with the timeliness of our service improved from 61% in 2011-12 to 74% in 2012-13. We also improved in keeping people informed about the progress of their complaint (up from 68% in 2011-12 to 74% in 2012-13), meeting people's expectations about the complaint process (up from 59% in 2011-12 to 67% in 2012-13) and providing overall satisfaction about the way the complaint was handled (up from 64% in 2011-12 to 72% in 2012-13).

Where there was more than one measure under a service area, we averaged performance across measures to produce our service standards results for that service area. The overall satisfaction rating reported in the service standards is the average satisfaction across all 19 measures (see page 16).

Client experience survey results

Table 24: Client experience survey results

		Percentage of clients who agreed or strongly agreed			
		2009-10	2010-11	2011-12	2012-13
Access to our service					
1.	The complaint service was easy to access	[1]	80%	88%	77%
Our staff					
HQCC staff members:					
2.	- were polite	84%	82%	94%	84%
3.	- were professional	85%	81%	90%	81%
4.	- were prompt in responding to my communications	74%	73%	77%	73%
5.	- listened to what I had to say	78%	74%	80%	75%
Timeliness of our service					
6.	The complaint was managed in a timely manner	[1]	64%	61%	74%
Quality of our service					
7.	The complaint process was clearly explained to me	79%	80%	82%	81%
8.	The role of the HQCC was clearly explained to me	81%	78%	83%	80%
9.	My view was heard in a fair and unbiased way	78%	71%	73%	75%
10.	I was kept informed about the progress of the complaint	70%	69%	68%	74%
The information I received was clear and easy to understand:					
11.	- telephone calls	75%	73%	83%	78%
12.	- letters/emails	83%	79%	82%	78%
13.	I felt the complaint was taken seriously	81%	76%	72%	77%
14.	I was given clear reasons for the decision made about the complaint	79%	74%	74%	75%
15.	My expectations of the complaint process were met	[1]	60%	59%	67%
16.	I believe the HQCC is independent	[1]	68%	66%	73%
Our service					
17.	Overall, I was satisfied with the way the complaint was handled	80%	71%	64%	72%
Outcome of the complaint					
18.	I was satisfied with the outcome of the complaint	[1]	61%	54%	62%
19.	I believe this complaint has led to healthcare improvement	[2]	[2]	[2]	40%

[1] Questions 1, 6, 15, 16 and 18 were added to our client experience survey in 2010-11.
[2] Question 19 was added to our client experience survey in 2012-2013

Challenges

Managing a growing workload

Sometimes after we have received a written complaint, we are unable to immediately start work on it due to significant demand for our complaint resolution and assessment services.

We redesigned our complaint case management system to create a case stage for complaints where a triage decision has been made but the case has not yet been allocated to an officer for early resolution or assessment. The creation of the 'waiting allocation' case stage allowed case officers to easily identify and monitor complaint cases awaiting allocation and enable accurate reporting on waiting times.

We increased complaint through-put and improved customer service by reducing staff caseloads from 30 to 25. This was in line with a KPMG review conducted on our assessment team in 2009.With slightly reduced caseloads, officers found they could spend more time with complainants and healthcare providers discussing complaint issues, resulting in a more focused and efficient case management process.

If a complaint is about a serious issue and involves a vulnerable person, and/or matters that require immediate action, and/or is in the public interest, we may bypass the waiting list and allocate the case immediately.

We implemented an easy way for complainants to check on our progress in allocating complaint cases for early resolution and assessment.

On our website, under the Complaints section, complainants can click on a section called *My complaint* to check where we are up to in allocating received complaints.

We contact complainants as soon their case is assigned to an officer. The website is updated weekly to ensure case allocation dates are available to complainants waiting for the case to be allocated to an officer.

In 2013-14 we plan to increase transparency and better manage complainant expectations of our services by improved communication with complainants about waiting times (see page 34).

Liaising with AHPRA

We notified the relevant national board through the Australian Health Practitioner Regulation Agency (AHPRA) of all complaints about registered practitioners and gave AHPRA copies of complaints and associated information. We then consulted with APHRA as to whether each complaint should be dealt with by our agency or the national board. If agreement could not be reached, the most serious action proposed (open to our agency in the case of a complaint or the national board in the case of a notification) was taken.

The AHPRA consultation period, in particular the time taken by AHPRA to respond, dropped significantly this year. The consultation period was three months or less for 61% of complaints, compared to 41% in 2011-12.

Table 25: Timeliness of AHPRA consultations

	Number of complaints	
	2011-12	2012-13
Under one month	54	247
1–2 months	71	184
2–3 months	121	109
3–4 months	152	90
4–5 months	85	56
5–6 months	45	52
6 months or more	73	142
Total	**601**	**880**

Table 26: Average days at AHPRA per month

2012-13	Average no. of cases	Average days at AHPRA
Jul	57	70
Aug	40	73
Sep	106	67
Oct	65	81
Nov	84	75
Dec	48	98
Jan	104	125
Feb	39	57
Mar	42	97
Apr	68	89
May	64	80
Jun	74	17

We worked closely with AHPRA to reduce consultation times this year. We met with leaders from AHPRA to explore ways the two organisations could work together to manage healthcare complaints and notifications more efficiently. A small working group was formed to progress the improvements, with the aim of minimising duplication between the organisations and speeding up processes.

We also quickly established an efficient working relationship with the Queensland Medical Interim Notifications Group (QMING) after the Medical Board of Australia delegated interim powers to the group to deal with notifications about practitioners' conduct and performance.

With an aim to reduce time-consuming 'back-and-forth' discussions about consultations where agreement could not be reached, we met face-to-face with QMING members as required to resolve issues and reach decisions.

Ensuring client privacy

We identified and addressed 33 breaches (2011-12: 10) of the *Information Privacy Act 2009* Information Privacy Principle 11 in accordance with our Privacy Policy (see page 84).

Scrutinising health complaint management

The management of healthcare complaints came under scrutiny in 2012-13, in particular the management of concerns about medical practitioners.

In April 2012, the Parliamentary Crime and Misconduct Committee (PCMC) received a public interest disclosure about alleged issues relating to the conduct, regulation, registration and discipline of medical practitioners in Queensland.

The PCMC referred the disclosure to the Crime and Misconduct Commission (CMC), which appointed retired Supreme Court Judge, Mr Richard Chesterman AO RFD QC to undertake an independent assessment of the allegations. This assessment was completed on 11 July 2012 and provided to CMC Chairperson Ross Martin SC, who provided the report to the PCMC and relevant Ministers. The PCMC tabled *Report No. 87 – A report on the Crime and Misconduct Commission's assessment of a public interest disclosure* on 23 July 2012.

Mr Chesterman made four recommendations to the Minister for Health following his assessment, including that there be a review of all the cases of misconduct or alleged misconduct by medical practitioners, dealt with by the Medical Board or in which Australian Health Practitioner Regulation Agency (AHPRA) had recommended disciplinary action against a medical practitioner. This included cases in which the Notification Advisory Committee and/or Queensland Board of the Medical Board of Australia (QBMBA) rejected a recommendation by AHPRA to take disciplinary action.

In December 2012, the Minister for Health, the Honourable Lawrence Springborg MP, announced the appointment of a panel comprising Dr Kim Forrester, Adjunct Professor James Houston and Professor Elizabeth Davies to undertake this review. The panel was asked to determine whether the QBMBA had made timely and appropriate responses to the complaints.

Mr Springborg also announced the appointment of senior legal practitioner Mr Jeffery Hunter SC to investigate whether criminal charges should be laid against doctors who had been disciplined in the past five years following the death or serious bodily harm of a patient. Mr Hunter was asked to review Medical Board of Queensland (MBQ), QBMBA and AHPRA case files.

In February 2013, the Queensland Government released its *Blueprint for better healthcare in Queensland*. The blueprint signalled the redesign of the health complaints management system in Queensland and stated that legislation would be introduced to improve the response to allegations of medical malpractice.

On 16 April 2013, the Hunter and Forrester review reports were tabled and the Minister announced new legislation would be introduced before July to create a Health Ombudsman as the lynchpin of a new and accountable complaints reporting system in Queensland.

While the reviews focused on the role and actions of the MBQ, QBMBA and AHPRA, as Queensland's independent health complaints entity, our agency was impacted.

The Forrester review found the cross jurisdictional referral and consultation obligations, in relation to complaints/notifications, resulted in substantial delays and inconsistencies in the processing and outcomes of complaints.

The panel was also concerned by the number of complaints/notifications the HQCC recommended for referral to be dealt with by the Board which were either rejected by the Board or, if accepted by the Board, resulted in an NFA (no further action) decision.

Mr Hunter's report identified a number of cases involving six medical practitioners where, in his view, there should be an investigation into whether or not criminal offences had been committed.

The Queensland Government's decision to establish a new statutory position of Health Ombudsman to manage health complaints in Queensland will see our organisation replaced. The stated aim is to remove role confusion between complaints entities by requiring all health complaints to be made to the Health Ombudsman, rather than being split between our agency and the national health practitioner registration boards.

On 4 June 2013, the Minister for Health, the Honourable Lawrence Springborg MP, tabled the *Health Ombudsman Bill 2013* (the Bill) in the Queensland Parliament.

We participated in preliminary consultation on the draft Bill and made a formal submission to the Health and Community Services Committee following the referral of the Bill for the committee's consideration. While we support any move to strengthen the health complaints management system in Queensland, we noted significant concerns about three areas we believe to be critical to the effective operation of the Health Ombudsman:

1. Ensuring public accountability
    - Enshrining the independence of the Health Ombudsman in the legislation
    - Ensuring consumer and clinical advice and input at all levels of the Health Ombudsman's governance and operations.
2. Measuring and managing healthcare risks
    - Maintaining the legislated duty of all healthcare providers in Queensland to improve the quality of health services as the cornerstone of the legislation
    - Empowering the Health Ombudsman to proactively monitor patterns of healthcare provider practice, complaint trends and other healthcare performance data to identify health service safety and quality issues early and prevent another health system failure such as the one that occurred in Bundaberg in 2005.
3. Safeguarding service levels
    - Ensuring complaint management service standards and continuity in the transition from the HQCC to the Health Ombudsman
    - Maintaining a skilled and experienced complaint management and investigation workforce.

The Bill was passed by the Legislative Assembly on 20 August 2013.

Improvements

Making it easier to complain

We launched our online complaint form in June 2013. Complainants can choose to make their complaint online at any time, making it easier for people to share their concerns.

The online complaint form ensures appropriate information is collected to help us efficiently manage complaints.

As at 30 June 2013, six complaints and three enquiries had been made online.

Efficiently triaging complaints

Following a six-month trial in 2011, four triage staff were appointed in July 2012 to serve as the first point of contact for complainants and triage incoming complaints. A permanent triage team supervisor was appointed in September 2012.

The appointment of a dedicated triage team resulted in:

- better client service, as staff now have more capacity to assist complainants and are better informed on referral options, where a client's concern is outside our jurisdiction
- increased referrals to our early resolution service, and fewer enquiries, due to more rigorous and consistent case decision-making
- improved case management, ensuring complaint information was accurately captured and recorded
- an increased number of serious, oral complaints being confirmed in writing, allowing us to progress the issues raised
- an improved ability to capture data and report in more detail on complaints and enquiries during triage.

In July 2012, we introduced an automated phone answering service which directed all new complainants to our triage staff, while other calls were directed to our receptionist.

During the year we documented new triage policies and procedures and prepared new correspondence templates to support our staff to ensure a high quality service. A new complaint and investigation case management system workflow was designed and implemented to enable us to better document and report on complaint triage.

We also followed up with complainants who contacted us with serious concerns, but who did not then formalise their complaints in writing. We encouraged these complainants to put their concerns in writing, so we could progress their matter. We offered some clients our help to write their complaints.

Resolving concerns informally

With a renewed focus on resolving less serious complaints informally, we established four dedicated early resolution roles and appointed to these positions in March 2013.

To support these staff and improve our capture and collection of data, we developed an early resolution process workflow in our complaint and investigation case management system, which was implemented in June 2013. The workflow is supported by updated policies and procedures and new templates for client correspondence.

Deciding on action

We worked hard to improve the efficiency of complaint assessment, at times with depleted resources due to staff movements. We completed 46% of assessments within 60 days, and 93% in 90 days for complex complaints. Improvements in timeframes were made through achieving a full complement of assessment staff, which allowed more complaints to be resolved.

During the year we documented new assessment policies and procedures and prepared new correspondence templates to support our staff, meet legislative requirements and ensure a high quality service.

We moved to electronic records and correspondence where possible, and encouraged complainants to supply an email address to us so we could process their complaint more efficiently. Wherever possible, we arranged with healthcare practitioners to send us electronic copies of medical records and other documentation.

For complainants without a messaging service, we contacted them by SMS (direct from our email), which let them know we were trying to get in touch. This reduced the time spent by our officers attempting to contact complainants, and increased the time officers could spend helping to resolve complaints.

Conciliating resolution

To improve the efficiency of our service and better support healthcare consumers and providers to resolve healthcare complaints, we implemented a new conciliation policy, effective from 29 January 2013.

The key improvements made to our conciliation service were:

- an emphasis on direct involvement by, and cooperation between, the parties to encourage complaint resolution within prescribed directions and timelines
- resolution outcomes focused on achievable personal outcomes such as apology, explanation, refund and/or fee waiver
- compensation outcomes were limited to out-of-pocket expenses and/or corrective treatment costs paid.

The policy will enable us to conciliate complaints in most cases within a maximum of six months and clearly focus the conciliation service on its legislated functions of improving the quality of health services and reviewing and managing healthcare complaints.

Complaints must satisfy the following criteria to be suitable for conciliation:

- We consider the complaint can be resolved in conciliation.
- The complaint raises issues of substance and is not frivolous or trivial (this will involve a consideration of whether the treatment complained of was reasonable).
- The parties consent to the conciliation process.
- The parties agree in good faith to strictly comply with directions and timelines during the conciliation.
- The parties acknowledge resolution outcomes are limited to apology, explanation, refund and fee waiver.
- The parties acknowledge that compensation is limited to out-of-pocket expenses and/or corrective treatment costs.

The following complaints are considered unsuitable for conciliation:

- complaints that highlight problems of a systemic nature
- complaints that raise concerns about professional conduct
- complaints where a complainant is seeking compensation beyond out-of-pocket expenses and/or corrective treatment costs
- complaints where a complainant demonstrates an unwillingness to satisfactorily cooperate with attempts made to resolve the complaint with the provider.

At 30 June 2013, no complaints had been conciliated under the new policy. We expect the policy to have an impact in 2013-14.

Finalising long-running investigations

We continued to concentrate on finalising major investigations, particularly those more than 12 months old. These investigations involved multiple issues, including systemic matters, and were complex and resource-intensive.

During 2012-13, we significantly reduced the number of investigations exceeding 12 months. At 30 June 2013, there were five ongoing investigations more than 12 months old.

An independent review of our investigation process (undertaken by KPMG as part of our internal audit program), measured our performance against 23 Australian Government Investigation Standards (AGIS) benchmarks. The review found our investigation process was 'to a very high standard when compared to the AGIS'. Of the 23 benchmarks measured against, 20 were deemed to be better practice or approaching better practice, and three were at the accepted standard level.

The review 'found a robust complaints management framework that is well implemented'. It recommended we establish an investigations management team, through which all matters referred for investigation are considered against specific acceptance and prioritisation criteria, and oversee the progress of all investigations.

We initiated fortnightly meetings involving the investigation team manager, the CEO and the Commissioner, to focus on decisions involving potential investigations.

We also developed investigation prioritisation criteria after reviewing similar models adopted by other complaint agencies to assist in prioritising the investigation workload. The criteria have also helped us to improve case management timeframes.

Most investigations are allocated as a standard investigation and have standard priority. Some standard investigations may be allocated a higher priority level designated as intermediate. Investigations which meet the criteria for a major investigation are dealt with as high priority.

Completion times for investigations reflect the fact that more complex investigations, i.e. more serious matters, require longer timeframes to complete.

Table 27: Investigation prioritisation criteria

Investigation	Priority	Target timeframe
Standard	Standard	0-200 days
Standard	Intermediate	0-300 days
Major	High	0-300+ days

Securing the best clinical advice

To manage healthcare complaints, we rely on independent clinical advice and opinion to help us determine whether the healthcare provided was reasonable and appropriate.

Consistently obtaining a high level of quality clinical advice in a cost-efficient and timely manner was challenging. Our dedicated clinical team coordinated and sourced advice from our internal in-house clinicians and external specialists.

Our four in-house clinicians provided 635 informal clinical advices (2011-12: 944) during the year at a cost of $72,284 (2011-12: $164,934). We contracted external specialist clinicians to provide 49 clinical opinions (2011-12:82) on assessment, conciliation and investigation cases, at a cost of $102,150 (2011-12: $109,659).

We reviewed and restructured the clinical advice model this year to significantly improve the efficiency and quality of our clinical advice and progressively rolled it out from January 2013.

The model uses a series of filters to ensure appropriate clinical advice is sought for each complaint.

Complaint officers and their peers, many of whom have experience and knowledge in relation to common complaint themes and issues, significant skill in analysing available documentation and information and

clinical backgrounds or clinical qualifications, examined the complaint to determine if clinical advice was warranted.

Targeted training of complaint staff in 2012-13 about how and when to seek clinical advice has seen a more efficient and appropriate use of this service.

Our Principal Clinical Consultant, who is a qualified health professional with an extensive clinical background assisted complaint officers where necessary to understand medical terminology, interpret records and results and analyse issues and submissions. The Principal Clinical Consultant acted as a second 'filter' to determine if a higher level of clinical advice was needed.

For more complex cases, in-house medical and dental clinicians provided advice as requested. Our extensive panel of external experts were sought to provide formal opinion on complex matters or complaints that were referred for conciliation or investigation.

The new model helped us to provide a more efficient and cost-effective clinical advice service.

Streamlining our processes with interagency collaboration

On 2 November 2012, with our state and territory health complaint agency counterparts, we signed a memorandum of understanding (MOU) with the Australian Competition and Consumer Commission (ACCC).

The MOU demonstrates a renewed spirit of cooperation between agencies which share responsibility for protecting health consumers and ensures they enjoy the benefits of consumer protection and fair trading.

The formal agreement outlines how agencies can mutually assist each other with exchanges of information and referral of appropriate healthcare matters.

The MOU sets out the framework for communication, cooperation and coordination between the agencies so they can both collectively and within their own jurisdictions, effectively resolve and/or investigate complaints about health service providers in relation to consumer protection issues.

On 3 January 2013, we signed a working protocol with the Commission for Children and Young People and Child Guardian.

On 4 May 2013, the Queensland Ombudsman formalised a liaison agreement with us.

Given our common interests, these three agreements were designed to prevent duplication of complaint management and investigative effort between agencies, improve timeliness and enable easy referral of matters between jurisdictions. They also encouraged the sharing of information to benefit the complaint resolution process, within the legislative requirements of the agencies regarding the disclosure of information.

Outlook

Following up direct resolution clients

To continue to offer an efficient and responsive service to our clients, we propose to send an automated text message and/or email to complainants who we have recommended attempt direct resolution of their concerns with their healthcare provider. The text/email will encourage complainants to proceed with a formal written complaint if their attempt to resolve their concerns directly with the provider has been unsuccessful.

This method of follow-up requires enhancements to our complaint and investigation case management system, which at the time of writing this report are in the planning stages. Once developed, this automated messaging system will also be used to help us keep complainants informed of case progress, in addition to personal contact made by case officers.

Publicly reporting on healthcare improvement

We planned to publicly report on healthcare improvements achieved through our complaint process by 30 June 2013. The draft report has been prepared.

However, due to resource constraints, this special report will now be released later in 2013.

Increased communication with complainants

We plan to improve our communication with complainants and better manage their expectations by implementing SMS and email updates on complaint waiting times.

Complainants who have provided mobile telephone and/or email contact details to us will receive a fortnightly automated SMS or email communication while waiting for their case to be allocated.

If due to service demand waiting times exceed 90 days, complainants will receive the following information in writing:

- advice that due to a continued high volume of complaint cases, we have been unable to allocate their case to an officer
- our apologies for the delay
- advice that we will be in touch as soon as we assign the case to an early resolution/assessment officer
- the date their written complaint was received and the date received range for cases we are currently working on
- the website address for them to check on complaint case allocation progress.

Preparing for legislative change

On 4 June 2013, the Minister for Health, the Honourable Lawrence Springborg MP, introduced the *Health Ombudsman Bill 2013* to the Queensland Parliament. The Bill establishes a new statutory position of Health Ombudsman to manage health complaints in Queensland.

The Bill provides that the main objects of the Act are:

- to protect the health and safety of the public
- to promote professional, safe and competent practice by health practitioners
- to promote high standards of service delivery by health service organisations and
- to maintain public confidence in the management of complaints and other matters relating to the provision of health services.

In September and December 2012 we submitted two legislative development proposals to the Minister for Health resulting from an internal review of our governing legislation and the introduction of the National Registration and Accreditation Scheme for healthcare practitioners.

Certain proposals have been included in the *Health Ombudsman Bill 2013,* including:

- the timeframe for which the health complaints entity can exercise discretion to accept a health complaint has been extended from one year to up to two years from the time of complaint or knowledge of the complaint
- regulation of unregistered health service providers
- a good faith negotiation requirement in relation to conciliation.

The *Health Ombudsman Act 2013* will repeal and replace the *Health Quality and Complaints Commission Act 2006* and the *Health Practitioners (Disciplinary Proceedings) Act 1999* and amend the *Health Practitioner Regulation National Law Act 2009.*

The Bill was referred to the Health and Community Services Committee, which reported to the Legislative Assembly by 12 August 2013. The Bill was passed on 20 August 2013 in the Legislative Assembly.

We will continue in our current role pending the Health Ombudsman being established and will work towards a smooth transition to the new agency.

Current HQCC staff are not guaranteed positions with the Office of the Health Ombudsman and some staff have left to secure their own futures. As we move closer to the transition date to the Health Ombudsman, recruiting and retaining appropriately skilled staff will become increasingly difficult.

Chapter 2
Complaint profile 2012-13

Who complained

Complainant gender

We received more complaints from women (1990, 58%) than men (1390, 40%) in 2012-13. This gender distribution is in line with previous years. The gender of complainants may be unknown (39, 1%) because we received the complaint in writing and the client's gender was unclear or because this data was not recorded in our complaint and investigation case management system at the time of writing this report.

Complainant age

Almost half (46%) of complaints were made by people aged between 35 and 54 years.

Table 28: Age of complainants

Age range	Complaints	%[1]
18–24 years	67	4%
25–34 years	293	17%
35–44 years	403	23%
45–54 years	396	23%
55–64 years	307	18%
65–74 years	206	12%
75 years +	82	5%

[1] Total >100% due to rounding.

Complainant region of origin

We recognise it is not always easy to complain, especially if you speak little or no English or you come from a different culture.

In 2012-13, 390 or 11.4% of complainants were born outside Australia. This percentage excludes people whose country of origin was not stated (see complaints from culturally and linguistically diverse people, page 45).

Table 29: Complainant region of origin

Region	2011-12	2012-13
Australia	2381	2827
Europe	187	202
New Zealand and Pacific Islands	112	65
Asia	42	51
Africa	32	35
Middle East	20	11
North America and Canada	15	17
South America	3	9
Unknown region	452	202

What people complained about

Client concerns about treatment were again the most common issue of complaint (53%), followed by communication and information problems (17%).

Complaints may be about more than one of the 13 issues we categorise against. Generally, the number of complaints about each issue remained steady, except for an increase in complaints people made about grievance processes. There was a decrease in the number of complaints about medication and professional conduct.

Complaint issue categories

Table 30: Number of complaint issues

Issue category	2010-11[1]	2011-12[1]	2012-13 n=	2012-13 %
Treatment	1751	2464	2327	53%
Communication and information	437	830	737	17%
Access	115	289	281	6%
Medication	192	397	236	5%
Fees and costs	93	179	208	5%
Professional conduct	290	460	127	3%
Grievance processes	11	25	108	2%
Environment/management of facilities	56	103	86	2%
Discharge and transfer arrangements	37	95	83	2%
Consent	48	109	78	2%
Medical records	34	115	77	2%
Reports/certificates	39	57	37	1%
Enquiry service only	4	3	2	<1%
Total	**3107**	**5126**	**4387**	**100%**

[1] Since preparing the *Annual report 2011-12*, we discovered an error in the automated calculations behind the generation of the 2010-11, and 2011-12 complaint issue categories data. The correct data is presented here and in the table below.

We further categorised the 13 complaint issue categories in the table below.

Breakdown of complaint issues

Table 31: Number of complaint issues – sub-categories

	2010-11	2011-12	2012-13
Treatment total	**1751**	**2464**	**2327**
Attendance	2	4	1
Coordination of treatment	59	76	57
Delay in treatment	83	97	90
Diagnosis	300	393	287
Excessive treatment	25	51	29
Experimental treatment	6	8	3
Inadequate care	217	259	245
Inadequate consultation	60	95	21
Inadequate prosthetic equipment	66	105	59
Inadequate treatment	369	697	877
Infection control	43	38	23
No/inappropriate referral	22	29	46
Rough and painful treatment	57	69	47
Unexpected treatment outcome/ complications	302	397	369
Withdrawal of treatment	16	10	66
Wrong/inappropriate treatment	123	135	107
Communication and information total	**437**	**830**	**737**
Attitude/manner	245	480	412
Inadequate information provided	114	219	218
Incorrect/misleading information provided	60	117	95
Special needs not accommodated	18	14	12
Access total	**115**	**289**	**281**
Access to facility	9	15	9
Access to subsidies	1	2	7
Refusal to admit or treat	55	102	155
Service availability	17	56	55
Waiting lists	31	109	55

Medication total	**192**	**397**	**236**
Administering medication	38	74	45
Dispensing medication	66	102	53
Prescribing medication	79	205	129
Supply/security/storage of medication	9	16	9
Fees and costs total	**93**	**179**	**208**
Billing practices	54	105	109
Cost of treatment	23	17	33
Financial consent	16	57	66
Professional conduct total	**290**	**460**	**127**
Assault	13	40	22
Boundary violation	18	24	10
Breach of condition	1	8	1
Competence	42	114	12
Discriminatory conduct	2	9	6
Emergency treatment not provided	0	0	4
Financial fraud	1	7	9
Illegal practice	38	35	2
Impairment	75	64	5
Inappropriate disclosure of information	29	68	30
Misrepresentation of qualifications	6	11	6
Registration/licensing	37	49	2
Scientific fraud	0	0	1
Sexual misconduct	28	31	17
Grievance processes total	**11**	**25**	**108**
Inadequate/no response to complaint	11	22	97
Information about complaints procedures not provided	0	0	3
Reprisal/retaliation as result of complaint lodged	0	3	8
Environment/management of facilities total	**56**	**103**	**86**
Administrative processes	7	32	43
Cleanliness/hygiene of facility	25	22	20
Physical environment of facility	13	25	12
Staffing and rostering	6	18	8
Statutory obligations/accreditation standards not met	5	6	3
Discharge and transfer arrangements total	**48**	**109**	**83**
Delay	10	7	4
Inadequate discharge	28	86	66
Mode of transport	3	8	8
Patient not reviewed	7	8	5
Consent total	**37**	**95**	**78**
Consent not obtained or inadequate	26	51	43
Involuntary admission or treatment	7	12	25
Uninformed consent	4	32	10
Medical records total	**34**	**115**	**77**
Access to/transfer of records	19	64	54
Record keeping	9	45	20
Records management	6	6	3
Reports/certificates total	**39**	**57**	**37**
Accuracy of report/certificate	23	33	21
Refusal to provide report/certificate	5	13	11
Report written with inadequate/no consultation	4	5	0
Timeliness of report/certificate	7	6	4
Cost of report/certificate	0	0	1
Enquiry service only total	**4**	**3**	**2**
Request for information – Commission	2	1	0
Request for information – complaint mechanisms	0	1	0
Request for information – health service	1	0	1
Request for information – other	1	1	0
Resources	0	0	1

Who people complained about

Most complaints are dealt with directly between the consumer and healthcare provider. We encourage people to raise their concerns directly with their healthcare provider in the first instance, as this is often the quickest and most effective way to resolve concerns.

Of the complaints that do reach us, the majority are about hospitals and doctors. This generally reflects more complex and higher risk health services delivered by these healthcare providers.

Complaints about healthcare organisations

Table 32: Number of complaints about healthcare organisations

	2008-09	2009-10	2010-11	2011-12	2012-13
Public hospital	707	731	841	1102	996
Correctional facility	27	28	12	85	211
Medical centre	197	119	121	110	171
Licensed private hospital	133	118	147	147	147
Mental health service	87	64	50	57	96
Dental service	38	37	53	49	67
Public health service	61	51	53	61	39
Specialised health service	20	32	39	31	32
Community health service	5	6	10	16	30
Pharmaceutical service	14	26	18	21	27
Aged care facility	25	16	35	26	23
Allied health service	16	8	7	7	23
Ambulance service	14	9	14	19	23
Health service district	20	16	14	4	23
Laboratory service	16	10	10	14	22
Other support service	4	6	4	10	9
Other government department	4	0	1	2	8
Administrative service	0	3	3	1	4
Residential care service	9	0	3	8	4
Licensed day hospital	0	0	0	0	2
Other organisation	0	0	0	2	2
Nursing service	0	0	0	2	0
Welfare service	0	0	0	1	0
Total				**1775**	**1959**

Slightly more than half (51%) of the complaints made about healthcare organisations in 2012-13 were about public hospitals (2011-12: 63%).

Correctional facilities accounted for 11% (2011-12: 5%) of complaints. We have seen a notable increase in complaints from detainees over the past two years. This increase in complaints can be attributed to a greater awareness among detainees of their ability to make a complaint to us through the free telephone service provided in correctional centres.

We also took steps to improve our processes when managing complaints from detainees. We worked with correctional facilities to improve our knowledge of their processes, advise them of our internal processes and developed a new policy that reflected the change in responsibility for health services from the Department of Corrective Services to individual Hospital and Health Services. This led to a more efficient management of these complaints.

Complaints about healthcare practitioners

Table 33: Number of complaints about healthcare practitioners

	2010-11	2011-12	2012-13
Medical practitioner	693	862	968
Dentist	185	190	226
Alternative practitioner/unregistered practitioner	Data not available	127	50
Nurse/midwife	11	16	36
Dental prosthetist	29	24	30
Pharmacist	10	7	15
Psychologist	13	11	14
Podiatrist/chiropodist	4	2	8
Optometrist	9	6	5
Chiropractor	10	9	4
Physiotherapist	4	5	4
Occupational therapist	2	2	2
Dental therapist	0	1	2
Speech pathologist	0	1	2
Dental hygienist	0	1	0
Medical radiation technologist	5	0	0
Osteopath	0	0	0
Unknown (provider pending)	Data not available	132	110*
Total	**975**	**1396**	**1476**

*At the time of this report, 110 (7%) of complaints did not have a provider type recorded. In most cases, this is because we were waiting for further information from the complainant about the practitioner and their profession.

Doctors accounted for 66% of complaints about healthcare practitioners (2011-12: 68%), followed by dentists with 15% (2011-12: 15%).

Alternative practitioners or unregistered practitioners accounted for 3% (2011-12: 10%) of complaints.

Complainants' desired outcomes

People make healthcare complaints for many reasons but one of the most common thing complainants tell us is, 'I just don't want this to happen to someone else'.

We record, manage and monitor complaints about healthcare and help complainants to raise their concerns with providers. Acknowledgements, apologies, explanations and policy, process or practice changes are common outcomes of our service. Sometimes clients receive refunds or more rarely, compensation. Some people just want their concerns to go on record.

We have no powers to force resolution. We are not a disciplinary body and we cannot require a provider to waive or refund fees, pay compensation or meet the cost of remedial treatment. Nor can we influence healthcare waiting lists or waiting times.

Every complaint is important to us. We keep all complaints on record to help us identify patterns of provider practice and complaint trends, or more widespread system issues.

Table 34: Complainants' desired outcomes (closed cases)

	2011-12	2012-13
Explanation	1100	1444
Acknowledgement	276	1056
Apology	501	1026
Compensation	742	812
Healthcare provider policy, process and/or practice change	750	732
Disciplinary action	475	602
Refund	305	386
Treatment or health service (including change in treatment)	329	234
Records – access, amendment, transfer to another healthcare provider	118	57
Fees waived or reduced	90	47
Complaint recorded or independently reviewed	154	41
Remedial treatment	85	36
Access to health service	147	24
Information or advice	32	12
Ongoing or remedial treatment costs to be paid by the healthcare provider	76	11
Healthcare provider training and education	35	10
Healthcare provider to be advised of and/or respond to the complaint	60	2
Other outcomes[1]	537	612

[1] Some complainants were unsure of the outcomes they were seeking at the time of making a complaint to us. Some outcomes were specific to a complainant's personal circumstances and therefore unable to be categorised.

Distribution of complaints

More than one third (35.5%) of complainants in 2012-13 lived in the Greater Brisbane region (2011-12: 35%). Gold Coast residents accounted for 12% of complaints, with Ipswich and Wide Bay residents making up 9.5% and 9% of complainants respectively.

Table 35: Distribution of complaints by location of complainant

	2010-11	2011-12	2012-13	%
Cairns	99	122	144	4.5%
Darling Downs	66	70	88	2.5%
Gold Coast	325	359	395	12%
Greater Brisbane	871	1148	1162	35.5%
Ipswich	159	253	310	9.5%
Mackay	63	72	89	3%
Outback Queensland	39	56	71	2%
Rockhampton	96	118	103	3%
Sunshine Coast	161	210	195	6%
Toowoomba	61	64	89	3%
Townsville	88	130	155	5%
Wide Bay	207	271	313	9%
Unknown[1]	290	371	305	5%
Total	**2525**	**3244**	**3419**	**100%**

[1] The geographic region of the complainant is unknown because their suburb and postcode are not recorded in our complaint management system. This may be because all communication with the complainant was via email or because the complainant chose to remain anonymous.

Some 43% (2011-12: 43%) of complaints received in 2012-13 were about healthcare providers in the Greater Brisbane region.

It is evident from the data that people who live outside the region are making complaints about Greater Brisbane healthcare providers. This concentration of complaints reflects the higher density of health services in the capital and its status as a tertiary referral centre.

Table 36: Distribution of complaints by location of healthcare provider

	2010-11	2011-12	2012-13	%
Cairns	110	127	140	4%
Darling Downs	30	47	40	1%
Gold Coast	341	373	414	12%
Greater Brisbane	1063	1389	1460	43%
Ipswich	108	128	257	7.5%
Mackay	55	80	74	2%
Outback Queensland	28	44	59	2%
Rockhampton	95	89	102	3%
Sunshine Coast	165	208	206	6%
Toowoomba	90	100	125	4%
Townsville	96	121	168	5%
Wide Bay	161	188	216	6%
Unknown[1]	183	350	158	4.5%
Total	**2525**	**3244**	**3419**	**100%**

[1] The geographic region of the healthcare provider is unknown because their suburb and postcode are not recorded in our complaint management system. This may be because all communication with the provider was via email.

Complaints from Indigenous peoples

Our experience shows Aboriginal and Torres Strait Islander peoples are less likely to complain about their healthcare. We recognise the importance of these complaints in helping to improve healthcare for Queenslanders.

Table 37: Enquiries from Indigenous peoples

	2009-10	2010-11	2011-12	2012-13
Aboriginal	20	25	21	15
Torres Strait Islander	3	1	8	0
Aboriginal and Torres Strait Islander	7	12	1	0
Total	30	38	30	15

Table 38: Complaints from Indigenous peoples

	2009-10	2010-11	2011-12	2012-13
Aboriginal	39	47	83	67
Torres Strait Islander	4	6	13	8
Aboriginal and Torres Strait Islander	16	21	8	12
Total	59	74	104	87

In 2012-13, 2.5% of complaints (2011-12: 4.4%) and 1% of enquiries (2011-12: 3.6%) were made by people who identified as Aboriginal, Torres Strait Islander or both. Australian Bureau of Statistics 2011 census data shows Aboriginal and Torres Strait Islander peoples account for 3.6% of Queensland's population.

Table 39: Issues of complaint from Indigenous peoples

	2011-12	2012-13
Treatment	74	44
Communication and information	24	19
Medication	22	10
Access	13	14
Discharge and transfer arrangements	9	6
Professional conduct	7	5
Medical records	5	2
Consent	2	1
Environment/management of facilities	1	0
Fees and costs	1	1
Reports/certificates	0	0
Grievance processes	0	2
Enquiry service only	0	0
Total	**158**	**104**

Common issues of complaint were concerns about treatment and communication and information, which align with the general population.

We promoted our complaint service at the NAIDOC Family Fun Day in Musgrave Park, Brisbane, in July 2012 and at other events during the year. We also produced posters and postcards featuring artwork by Indigenous artists and distributed them to a range of healthcare providers and organisations throughout the year.

Complaints from culturally and linguistically diverse people

People who speak little or no English or who come from different cultures face unique challenges when raising concerns about a health service. Providing accessible and culturally appropriate services is at the foundation of our service.

Table 40: Enquiries from people born overseas and/or whose preferred language is other than English

	2009-10	2010-11	2011-12	2012-13
Born overseas[1]	91	150	122	47
Preferred language other than English[2]	14	21	9	7
Preferred language other than English and born overseas	Data not available	Data not available	Data not available	3

[1] Includes English-speaking countries.
[2] Includes people whose country of origin was Australia.

Table 41: Complaints from people born overseas and/or whose preferred language is other than English

	2009-10	2010-11	2011-12	2012-13
Born overseas[1]	113	190	411	361
Preferred language other than English[2]	12	25	36	5
Preferred language other than English and born overseas	Data not available	Data not available	Data not available	28

[1] Includes English-speaking countries.
[2] Includes people whose country of origin was Australia.

In 2012-13, 11.5% (394) of complainants (2011-12: 12.7%) and 4% of enquirers (2011-12: 5.3%) were born outside Australia or spoke a preferred language other than English or both.

These percentages exclude people whose country of origin was not stated.

Australian Bureau of Statistics 2011 census data shows people born overseas account for 26.3% of Queensland's population.

We recognise that culturally and linguistically diverse complainants and enquirers may be born in Australia but are not identified in our complaint management data collection or that complainants and enquirers born overseas or whose preferred language is not English may not share this information with us.

Table 42: Issues of complaint for people born overseas or whose preferred language is a language other than English

	2009-10		2010-11		2011-12		2012-13	
	Born overseas[1]	Preferred language OTE[2]	Born overseas[1]	Preferred language OTE[2]	Born overseas[1]	Preferred language OTE[2]	Born overseas[1]	Preferred language OTE[2]
Treatment	114	15	140	17	381	35	299	27
Communication and information	16	2	40	6	121	8	93	10
Medication	2	0	3	0	34	3	22	1
Access	0	0	14	4	26	0	22	4
Discharge and transfer arrangements	4	1	10	2	25	2	9	1
Professional conduct	5	1	3	1	24	2	11	2
Medical records	0	0	3	1	13	1	6	0
Consent	1	0	3	0	14	1	10	1
Environment/ management of facilities	0	0	2	0	11	0	13	2
Fees and costs	2	0	2	1	8	0	31	1
Reports/certificates	0	0	2	0	6	0	2	0
Grievance processes	0	0	0	0	5	0	21	0
Enquiry service only	0	0	1	0	0	0	0	0
Total	**144**	**19**	**223**	**32**	**668**	**52**	**539**	**49**

[1] Includes English-speaking countries.
[2] Includes people whose country of origin was Australia.

Issues of complaint are broken down by the complainant's country of birth and preferred language in the following tables.

Table 43: Issues of complaint by complainant's country of birth

	2012-13													
	Treatment	Communication and information	Access	Medication	Fees and costs	Professional conduct	Discharge and transfer	Consent	Environment/ management of facilities	Reports/certificates	Medical records	Grievance processes	Enquiry service only	Total
Argentina	2	0	0	1	0	0	0	0	0	0	0	0	0	3
Austria	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Brazil	1	1	0	1	1	1	0	0	0	0	0	0	0	5
Cambodia	1	1	0	0	0	0	0	0	0	0	0	0	0	2
Canada	6	2	0	0	0	0	0	0	0	0	0	0	0	8
China	4	0	0	0	2	0	0	2	0	0	0	1	0	9
Croatia	6	2	0	0	0	0	0	0	0	0	0	0	0	8
Czech Republic	4	1	0	0	0	0	0	0	0	0	0	0	0	5
Denmark	1	1	0	0	0	0	0	0	0	0	0	0	0	2
Ecuador	2	2	0	0	0	0	0	0	0	0	0	0	0	4
Egypt	1	0	1	0	1	0	0	0	0	0	0	1	0	4
Estonia	0	1	0	0	0	0	0	0	0	0	0	0	0	1
Ethiopia	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Fiji	10	2	0	0	2	0	0	0	1	0	0	1	0	16
Finland	1	0	0	0	0	0	0	0	0	0	0	0	0	1
France	2	0	2	0	1	0	0	0	1	0	0	0	0	6
Germany	12	4	1	4	0	0	1	1	0	0	0	2	0	25
Greece	3	1	0	0	0	0	0	0	0	0	0	0	0	4
Hong Kong	1	0	0	0	1	0	0	0	0	0	0	0	0	2
Hungary	4	3	0	0	1	1	0	0	0	0	0	0	0	9
India	8	5	0	0	1	0	0	0	0	0	0	0	0	14
Iran	7	2	0	0	1	0	0	0	0	0	0	0	0	10
Iraq	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Ireland	7	2	0	0	1	0	0	1	0	0	0	1	0	12
Italy	3	2	0	0	1	0	0	0	0	0	0	0	0	6
Japan	2	0	0	0	0	0	0	0	0	0	0	0	0	2
Kazakhstan	4	4	0	0	0	0	0	0	0	0	0	0	0	8
Kenya	2	0	0	0	0	0	0	0	0	0	0	0	0	2
Korea, Republic of	3	1	0	0	0	0	0	0	0	0	0	0	0	4
Lebanon	1	0	1	0	0	0	0	0	0	0	0	0	0	2
Macedonia	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Malaysia	4	0	1	0	0	0	0	0	1	0	0	0	0	6
Malta	3	1	0	1	0	0	1	0	0	0	0	0	0	6
Mauritius	0	1	0	0	0	0	0	0	0	0	0	0	0	1
Netherlands	5	0	1	0	0	0	1	0	0	0	0	1	0	8
New Zealand	41	11	0	2	4	1	1	1	1	1	2	3	0	68
Norway	0	1	0	0	0	0	0	0	0	0	0	0	0	1
Papua New Guinea	1	0	0	0	0	0	0	0	0	0	0	0	0	1

Philippines	2	2	0	2	1	1	0	0	0	0	0	1	0	9
Poland	4	1	1	1	0	0	0	0	0	0	0	0	0	7
Romania	5	0	0	0	1	0	0	0	0	0	0	0	0	6
Russian Federation	5	1	0	0	1	0	0	0	1	0	0	0	0	8
Samoa	2	0	0	0	0	0	0	0	0	0	0	0	0	2
Saudi Arabia	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Scotland	3	0	3	1	0	0	0	0	1	0	0	1	0	9
Singapore	3	0	0	0	1	0	0	0	0	0	0	0	0	4
Slovenia	1	0	0	0	0	0	0	0	0	0	0	0	0	1
South Africa	16	2	2	2	2	0	0	0	0	1	0	0	0	25
Sri Lanka	3	2	0	0	1	0	0	0	0	0	0	0	0	6
Sudan	2	0	0	1	0	0	0	0	0	0	0	0	0	3
Sweden	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Thailand	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Tonga	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Turkey	0	0	0	0	1	0	0	1	0	0	0	0	0	2
United Kingdom	75	25	4	3	5	7	3	3	2	0	3	4	0	134
United States	5	3	1	2	1	0	0	0	2	0	1	1	0	16
Unknown	1	1	1	0	0	0	0	0	0	0	0	0	0	3
Uruguay	0	0	0	0	0	0	0	0	1	0	0	0	0	1
Vietnam	3	1	1	0	0	0	0	0	0	0	0	1	0	6
Wales	4	1	0	0	0	0	1	0	1	0	0	1	0	8
Yugoslavia	1	0	0	0	0	1	0	1	0	0	0	0	0	3
Zambia	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Zimbabwe	6	3	0	1	0	0	0	0	1	0	0	1	0	12

Table 44: Issues of complaint by complainant's preferred language (excludes English)

	2012-13													
	Treatment	Communication and information	Access	Medication	Fees and costs	Professional conduct	Discharge and transfer	Consent	Environment/ management of facilities	Reports/certificates	Medical records	Grievance processes	Enquiry service only	Total
Arabic	2	1	1	1	0	0	0	0	0	0	0	0	0	5
Chinese (Cantonese and Mandarin)	1	0	0	0	0		0	0	0	0	0	0	0	1
Croatian	4	2	0	0	0	0	0	0	0	0	0	0	0	6
Filipino (Tagalog)	0	1	1	0	0	0	0	0	0	0	0	0	0	2
German	4	4	0	0	0	0	0	0	0	0	0	0	0	8
Greek	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Hindi	3	0	0	0	0	0	0	0	0	0	0	0	0	3
Italian	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Japanese	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Not stated	4	0	0	0	0	0	0	0	1	0	0	0	0	5
Other	5	2	2	0	1	2	1	1	0	0	0	0	0	14
Russian	1	0	0	0	0	0	0	0	1	0	0	0	0	2

Translation and interpreter services were used on 35 occasions (2011-12: 45), assisting us to manage complaints in languages such as Arabic, Indonesian, Korean, Macedonian, Mandarin, Portuguese and Tamil. Total expenditure for translation and interpreter services in 2012-13 was $3,707.33 (2011-12: $3,781.90).

Our language services policy ensures our services are inclusive of people who are not proficient in English or have a hearing impairment.

We promoted our complaint service at the World Refugee Day Community Festival at Annerley, Brisbane in June 2013, including our complaint brochure which is translated into twenty languages - Amharic, Arabic, Burmese, Chinese (simplified and traditional), Dari, Dinka, Hindi, Italian, Japanese, Korean, Persian, Punjabi, Samoan, Somali, Spanish, Thai, Tongan, Torres Strait Creole/Yumplatok and Vietnamese.

Chapter 3
Monitoring and improving healthcare safety and quality

Highlights

- We achieved 92% compliance with our healthcare standards.
- We implemented our *Standards transition plan*.
- We expanded our reportable events monitoring to strengthen reporting and healthcare improvement.
- We received and reviewed 248 reportable event reports.
- We monitored 46 healthcare providers to drive healthcare safety and quality improvement.
- We monitored the implementation of 26 recommendations for quality improvement.
- We published five reports on healthcare safety and quality.
- We issued four position statements.
- We made 12 healthcare safety and quality submissions.
- We reviewed and updated our *Provider profiling policy* for individual practitioners.

Overview

This year, there were substantial changes to the national and state healthcare environment that changed the way we monitored and reported healthcare quality improvement.

The introduction of the *National safety and quality health service standards* (the national standards) on 1 January 2013 saw us retire six of our healthcare standards in recognition of the significant overlap between the two sets of standards. We retained three of our healthcare standards and removed the requirement for hospitals to report on self-assessed compliance.

We expanded our oversight of reportable events after a decline in the number of root cause analysis (RCA) reviews conducted by healthcare providers. From 1 July 2012, we established a process to monitor all reportable events that occur, not just reportable events where healthcare providers conducted an RCA. We received and examined 248 reviews of reportable events and monitored 13 healthcare providers for safety and quality improvements identified through this process.

We continued to publicly share our analysed data to help drive healthcare improvement, publishing one special report, two spotlight reports, two data reports and four position statements. We also made 12 submissions to healthcare organisations and peak bodies to influence safety and quality improvement.

Performance

Healthcare standards monitoring, reporting and transition

Our healthcare standards aim to set achievable and consistent benchmarks to drive safety and quality improvement in key clinical and governance areas. They were introduced on 1 July 2007 (version 1.0) and received a major update on 1 July 2010 (version 2.0).

The standards and associated reporting requirements apply to all Queensland public and licensed private hospitals and day hospitals. The standards also apply to individuals working in and/or for hospitals.

All 224 Queensland public and licensed private acute and day hospitals reported for the tenth time in September 2012 (for the period 1 July 2011 to 30 June 2012). This was the second time hospitals reported against our updated healthcare standards.

This was the final reporting round against our healthcare standards due to the introduction of national healthcare standards (see page 51).

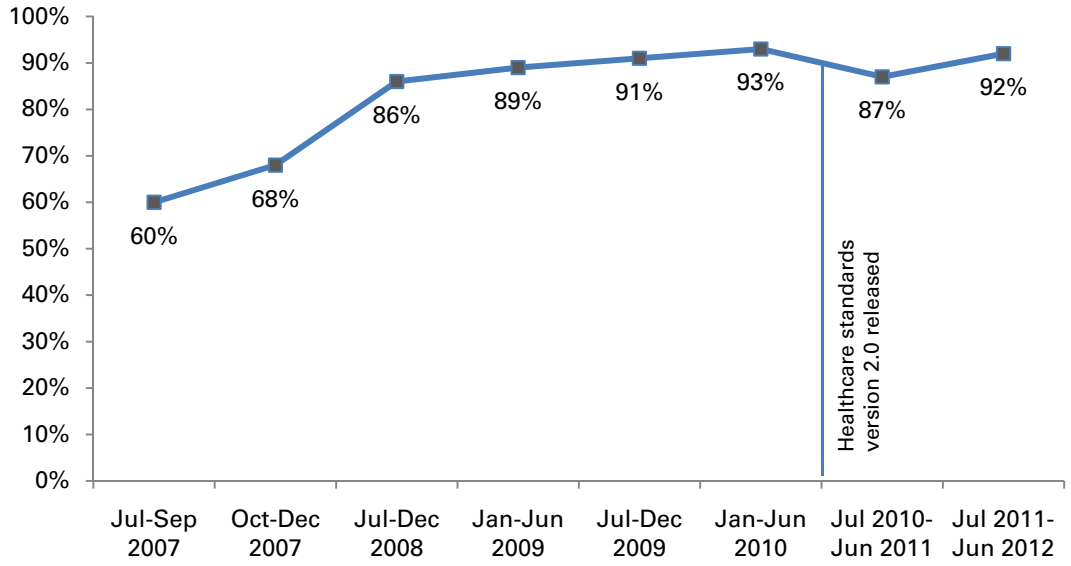
In December 2012, we released a report *Standards of care: a report on Queensland acute and day hospital self-assessed compliance with healthcare standards,* detailing Queensland hospitals' compliance against each of our standards for the tenth reporting round. The report examines changes in performance since the standards were introduced in 2007 and highlights improvements in performance since the standards were updated in July 2010.

Queensland hospital performance against updated healthcare standards

The state-wide average percentage of self-reported standards compliance for the period 1 July 2011 to 30 June 2012 was 92%, up from 87% in June 2011.

When we expanded the scope of some of our standards in 2010, we expected a decrease in compliance. We are pleased that this year most hospitals returned to a level of compliance similar to that which they reported under version 1.0 of the standards.

Figure 1: Hospital self-assessed compliance average across all standards (July 2007 to July 2012)



Queensland hospital healthcare standards compliance trends

There has been an overall increase in the reported level of hospital self-assessed compliance with our nine healthcare standards since their introduction in 2007.

For each of our standards, at least eight out of 10 hospitals reported in September 2012 that their process is fully compliant with all of the criteria for that standard (see Table 45).

Table 45: Hospital self assessed compliance with our healthcare standards, reporting periods 1, 8, 9 and 10

		Reporting period			
		1[1]	8[1]	9[2]	10[2]
Code	**Standard**	**Jul-Sep 2007**	**Jan-Jun 2010**	**Jul 2010-Jun 2011**	**Jul 2011-Jun 2012**
PDI	Providers' duty to improve health services	69%	95%	88%	93%
CRE	Credentialing and scope of clinical practice	84%	96%	91%	100%
COM	Complaints management	78%	100%	96%	93%
ROD	Review of hospital-related deaths	37%	94%	94%	99%
AMI	Management of acute myocardial infarction on and following discharge or transfer	28%	81%	92%	91%
VTE	Reducing the risk of venous thromboembolism	26%	82%	67%	80%
CCC	Ensuring correct patient, site, side and procedure	75%	99%	78%	92%
HHG	Hand hygiene	88%	100%	92%	95%
SSA	Appropriate use of surgical antibiotic prophylaxis	41%	91%	86%	87%

[1] Version 1.0 of our healthcare standards.
[2] Version 2.0 of our healthcare standards.

After the September 2012 reporting round, we identified opportunities for further improvement in compliance with four of our healthcare standards.

Blood clot prevention (VTE)
Hospitals reported low compliance with our *Reducing the risk of venous thromboembolism standard*. While the reported proportion of surgical patients receiving a VTE risk assessment has increased substantially since the 2011 reporting period, the proportion of medical patients receiving a VTE risk assessment decreased substantially. Overall, hospitals reported that 67% of surgical patients undergo a VTE risk assessment, while only 37% of medical patients receive a VTE risk assessment. We expect all adult in-patients to have a documented VTE risk assessment.

Hand hygiene (HHG)
While hand hygiene compliance increased, hospitals reported that only 72% of hospital staff cleaned their hands at critical times. The Hand Hygiene Australia average hand hygiene compliance rate at the time of reporting (June 2012) exceeded 75%.

Post heart attack care (AMI)
There was no increase in overall compliance with our *Management of acute myocardial infarction on and following discharge or transfer standard*. Hospitals reported that only half of all patients recovering from type 1 AMI received a discharge care plan that included medication information, a chest pain action plan, a referral to cardiac rehabilitation and lifestyle advice.

Complaints management (COM)
Seven percent of Queensland hospitals reported they do not meet all the criteria of our *Complaints management standard*. Complainant satisfaction declined from 2011 to 2012, both with the process of managing complaints (down 12%) and the outcome (down 10%). This decline was mainly reported by public hospitals.

The future of our healthcare standards

On 1 January 2013 the Australian Commission for Safety and Quality in Health Care's 10 *National safety and quality health service standards* (the national standards) came into effect. All hospitals are required to be accredited against the national standards.

In recognition of significant overlap between our standards and the national standards, we retired six of our standards on 31 December 2012. These were:

- Providers' duty to improve health services (PDI)
- Credentialing and scope of clinical practice (CRE)
- Complaints management (COM)
- Ensuring correct patient, site side and procedure (CCC)
- Hand hygiene (HHG)
- Appropriate use of surgical antibiotic prophylaxis (SSA).

We retained three healthcare standards, with a view to retire these by 31 December 2014:

- Review of hospital-related deaths standard (ROD)
- Management of acute myocardial infarction on and following discharge or transfer standard (AMI)
- Reducing the risk of venous thromboembolism standard (VTE).

We no longer require acute and day hospitals to report on self-assessed compliance with our three remaining healthcare standards. We will monitor hospital compliance with our remaining standards and the national standards through:

- analysis of healthcare complaints
- analysis of reportable events
- random audits of compliance with a specific standard or responsive audits where we have concerns about a health service provider's compliance
- our Annual Quality and Activity Return (AQAR) process (see page 60).

Monitoring reportable events

On 1 July 2012, we expanded our approach to reportable events monitoring. We established a process to monitor all reportable events that occur, not just reportable events where healthcare providers conduct a root cause analysis (RCA).

Our reportable events monitoring applies to all public and private sector health service facilities and the Queensland Ambulance Service.

'Reportable events' are serious, unforseen events that resulted in the serious harm or death of a patient. Reportable events are defined in section 29 of the *Hospital and Health Boards Regulation 2012* and in section 36A of the *Ambulance Service Act 1991*. Reportable events are relatively rare and represent a small, but serious, subset of patient harm incidents.

For all reportable events that occurred, healthcare providers sent us either a copy of the RCA summary report or a reportable event summary review form (when an alternative form of review to an RCA is conducted).

The primary objective of our monitoring of reportable events is to analyse aggregated reportable events data and any associated coronial investigations at a system-wide level and publicly share lessons learned with the Queensland community in order to drive improvement in the safety and quality of healthcare.

We also review each reportable event report we receive to determine whether any further regulatory action or intervention is required. If a reportable event highlights significant safety and quality concerns that are not being adequately dealt with by the health service or another entity, we may escalate the issue (see page 53).

Results of monitoring reportable events

During 2012-13, we received 248 summary review reports of reportable events – 241 from public and private health service facilities and seven from the Queensland Ambulance Service (2011-12: 141).

The Queensland Ambulance Service use one reportable event review methodology. Public and private health service facilities use several methods. Root cause analysis (RCA) was the most commonly used incident review method.

Table 46: Incident review methods used by public and private health service facilities

	No. of reports	%
Root cause analysis	169	70%
Human Error and Patient Safety (HEAPS) analysis	36	15%
Clinical reviews	16	6%
Mortality and morbidity case reviews	10	4.5%
Other	10	4.5%
Total	**241**	**100%**

The number and type of reportable events reported to us by public and private health service facilities in 2012-13 is shown in Table 47. The most frequent reportable event type reported was *death of a person, or an injury suffered by a person, that was not reasonably expected to be an outcome of the health service provided to the person,* accounting for more than half of all reportable event review reports we received.

It is important to note that not all reportable events are the result of errors or mistakes. Incidents are usually the result of a complex set of contributory factors including organisational, environmental, staff, patient, equipment, and communication factors.

Good clinical incident management which leads to improved healthcare safety and quality requires healthcare providers to recognise, review, and report on all serious clinical incidents, to understand what happened and to take corrective actions to prevent the recurrence of a similar event. The focus of reportable event reviews is not to judge or blame, but to understand what happened and to implement solutions to strengthen healthcare safety and quality.

We will conduct further analysis of our reportable events data and publish a report on the results of this work by January 2014 to share information, optimise learning opportunities and drive improvements in the safety and quality of healthcare.

Table 47: Reportable event types (public and private health service facilities)

Reportable event type	Public	Private	Total
Any other death of a person, or an injury suffered by a person, that was not reasonably expected to be an outcome of the health service provided to the person	97	33	130
The suspected suicide of a person with a mental illness who is under the care of a provider of mental health services while residing in the community	54	2	56
The wrong procedure being performed on a person, or a procedure being performed on the wrong part of a person's body, resulting in the death of the person or an injury being suffered by the person	6	7	13
The retention of an instrument, or other material, in a person's body during surgery that requires further surgery to remedy the retention	6	6	12
The suspected suicide of a person receiving inpatient health care	5	7	12
Maternal death or serious maternal morbidity associated with labour or delivery	8	2	10
The death of a person associated with the incorrect management of the person's medication	5	1	6
The death of a person, or neurological damage suffered by a person, associated with an intravascular gas embolism	1	-	1
The death of a person, or an injury suffered by a person, associated with a haemolytic blood transfusion reaction resulting from the wrong blood type being used for the person during a blood transfusion	-	1	1
Total	**182**	**59**	**241**

Notes:
1. Reportable events as prescribed under section 29 of the *Hospital and Health Boards Regulation 2012.*
2. Reference to an injury is a reference to an injury that is likely to be permanent.
3. For definition of mental illness, see the *Mental Health Act 2000*, section 12.
4. These figures are preliminary at time of preparing this report and may be subject to change.
5. The number of reportable events received by us in 2012-2013 may not equal the number of reportable events which occurred in the same period, for example due to the time lag between the date of the incident and the date the review report was submitted to us.

Monitoring healthcare providers

We reviewed 248 reportable event reports we received to identify patterns, trends and improvement opportunities.

We monitored 13 healthcare providers for safety and quality improvements identified through our reportable events management processes.

Safety and quality concerns identified and monitored included:

- deficiencies in pre-operative and operative checks, in particular inadequate patient identification and procedure matching practices
- inadequate falls management practices, in particular post-falls assessment and management
- deficiencies in documentation, assessment and management of pressure injuries and wounds
- inadequate management of patients with a mental illness, including poor documentation of mental health status and care plans in the patient medical record and failure to use standardised mental health forms, procedures and care pathways.

We will publish a report on the results of our analysis of our reportable events data by January 2014 to share information, optimise learning opportunities and drive improvements in the safety and quality of healthcare.

Driving healthcare safety and quality improvement

Recommending quality improvement

In 2012-13, we monitored the implementation of 26 recommendations as a result of our quality monitoring activities. These recommendations are separate to recommendations made during our investigations. See page 26 for investigation recommendations and monitoring.

Table 48: Quality monitoring recommendations due for completion in 2012-13

Source of recommendations	Number of recommendations	Implementation status as at 30 June 2012
Monitoring reportable events about maternity services	6	6 recommendations fully implemented within agreed timeframes
Quality review of hospital maternity services	15	13 recommendations fully implemented within agreed timeframes 2 recommendations appropriately discontinued
Monitoring reportable events about mental health services	5	4 recommendations fully implemented within agreed timeframes 1 recommendation awaiting funding with satisfactory risk mitigation strategies in place

100% (26 out of 26) of quality monitoring recommendations due for completion in 2012-13 were implemented by healthcare provides within agreed timeframes.

This is the last year we will report on this service standard. It has been discontinued and replaced with a new quality monitoring measure (see page 16).

Healthcare quality analysis and sharing plan

This year we continued to publicly share our analysed data to help drive healthcare improvement. Patterns and trends, along with opportunities for improvement are shared with healthcare providers and the broader community in public reports, alerts and position statements. Program publications include:

- **Special reports** are prepared under section 173 of the *Health Quality and Complaints Commission Act 2006* (HQCC Act) and provided to the Minister for Health for tabling in Parliament. Special reports may include information, opinion and recommendations disclosing details of:
  - health complaints or contraventions of the HQCC Act
  - the quality of health services
  - results of investigations into health complaints or contraventions of the HQCC Act
  - systemic health service quality issues.

We cannot include information that identifies a complainant or healthcare consumer unless the person consents or the person's identity as the complainant or consumer is publicly known. If we make adverse comment about an entity identifiable from our report, we give them an opportunity to respond before finalising the report. We review and reflect their responses in our reports prior to publication.

- **Spotlight reports** highlight a healthcare safety and quality issue and explore what healthcare consumers, families and carers have told us through our complaint process about problems with health services. We analyse complaint data and provide case studies and excerpts from client complaints to illustrate the issues. Sometimes spotlight reports may contain analysis of other data sources, such as reportable event reports.

- **Data reports** present data and commentary about our work. They feature graphs and imagery to help make information easy to understand.

- **Position statements** are issued to communicate our position on key healthcare safety and quality matters.

In 2012-13 we produced one special report, two spotlight reports, two data reports and four position statements (see Table 49). Publications were distributed widely to key stakeholders, promoted at events and through the news media and made available on our website, www.hqcc.qld.gov.au/Resources/Pages/Publications.aspx

Table 49: Reports on healthcare safety and quality

Release date	Publication name	Report type
23 May 2013	Annual Health Check 2012: A snapshot of our work in resolving health complaints and monitoring the quality of health services in Queensland	Data report
8 April 2013	Great expectations: A spotlight report on complaints about cosmetic surgical and medical procedures in Queensland	Spotlight report
21 December 2012	Doctor Right Volume 3: A special report on credentialing and defining the scope of clinical practice for doctors working in Queensland hospitals	Special report
10 December 2012	Standards of care: a report on Queensland acute and day hospital self-assessed compliance with healthcare standards	Data report
28 September 2012	Teething problems: A spotlight report on complaints about dental care in Queensland	Spotlight report
5 July 2012[1]	*Checking the pulse: Perceptions and experiences of healthcare in Queensland, Volume 1*[1]	*Data report*[1]

[1] Our *Checking the pulse* report was completed in 2011-12 but released in the 2012-13 financial year. It is not included in our 2012-13 report data.

Table 50: Position statements issued

Release date	Publication type	Publication name
21 February 2013	Position statement	Dental health services
11 February 2013	Position statement	Ensuring correct patient, site, side and procedure
11 February 2013	Position statement	Appropriate use of surgical antibiotic prophylaxis
11 February 2013	Position statement	Hand hygiene

Our healthcare analysis and sharing priorities are based on emerging safety and quality issues arising from our complaints data and other information sources and existing safety and quality priorities (for example, as defined by the World Health Organization or the Australian Commission on Safety and Quality in Health Care). We also consider the:

- impact (frequency and severity of problem)
- improvability (opportunity to make or leverage improvements), and
- inclusiveness (size of benefit, the reach or significance of the health gain).

We regularly review our analysis and sharing program, based on the feedback of our Commission and clinical and consumer advisory committees.

Submissions on safety and quality issues

By providing feedback on proposed changes to legislation, standards, guidelines, policies and procedures we continued to inform safety and quality improvement measures at a local, state and national level.

Government healthcare providers and health sector peak bodies invited us to participate in their consultation processes and activities.

We applied selection criteria to ensure submissions we made were consistent with our legislative functions and strategic directions.

We consulted with our consumer and clinical advisory committees for their views when preparing submissions.

During 2012-13 we made 12 healthcare safety and quality submissions.

Table 51: Healthcare safety and quality submissions

Submission requested by	Submission title
Australian Commission on Safety and Quality in Health Care	Review of National Open Disclosure Standard
Department of Health, Victoria	Victoria's health complaints legislation, review of the *Health Services (Conciliation and Review) Act 1987*
National Health Performance Authority	National Health Performance Authority Strategic Plan
Australian Commission on Safety and Quality in Health Care	*National Safety and Quality Health Service Standards* - draft resources
Queensland Health, Health Service and Clinical Innovation Division	Consultation Paper: Legislative Proposal re Maternal Mortality Reporting
Consumers Health Forum Australia	Project on informed consent and informed financial consent
Health Consumers Queensland	Health Consumers Queensland - Transition project survey
Australian Health Practitioner Regulation Agency	Nursing and Midwifery Board of Australia National Competency Standards for the Nurse Practitioner
Medical Board of Australia	Proposed changes to the competent authority pathway and specialist pathway for international medical graduates
Australian Health Practitioner Regulation Agency	Targeted consultation on international criminal history checks
Queensland Health, Patient Safety Unit	Draft Patient Safety Health Service Directive
Health and Community Services Committee	Submission on the *Health Ombudsman Bill 2013*

Supporting research to promote safety and quality improvements

We supported the development and sharing of new knowledge through research to improve healthcare safety and quality.

Our research priorities in 2012-13 were:
- analyse our complaints data to drive effectiveness and efficiency and identify areas for improvement
- identify systemic safety and quality issues that emerged from our complaints and healthcare monitoring information.

We publicly shared complaint management and quality monitoring information in a variety of publications (see page 55).

In our *Annual report 2011-12*, we signalled our intention to develop a research plan to map actual hospital compliance with state-wide regulatory standards and invite a sample of Queensland acute care hospital to be part of a pilot study on VTE. In response to changed priorities within our organisation and in recognition of the national and state health reforms, we did not progress the VTE standard outcomes research as planned.

We were approached by independent researchers and organisations asking to access our data for research or related purposes.

To facilitate good governance and appropriately manage data requests we updated our *Data access and research governance framework*. The framework outlines a consistent and transparent approach, including principles, decision pathways and standardised documents for managing data access requests.

Requests to access our data are assessed and managed via one of two pathways depending on the nature and complexity of the request:

- the **streamlined pathway** - for straightforward data access requests which do not involve research or do not have significant resource implications
- the **research pathway** - for data access requests which involve research or have substantial ethical or resource considerations.

In line with the strict confidentiality provisions of our Act, we do not provide access to information which identifies an individual or organisation.

During 2012-2013 we supported the following research projects with data access:

Table 52: Data access

Data access arrangement	Name of research/project	Contact	Status at 30 June 2013
Deed of confidentiality	Development of a risk, safety and performance indicator set for hospital management	Mark Avery University of Queensland	Two progress reports received in 2012-13
Australian Research Council grant	Resolving patients' complaints about hospitals: responsive regulation by health ombudsmen	Professor Merrilyn Walton, Australian National University Professor Jeffrey Braithwaite, University of NSW Jennifer Smith-Merry, University of Sydney	Two progress reports received in 2012-13
Data access agreement	Complaint-prone medical practitioners in Australia	Marie Bismark David Studdert and Matt Spittal, University of Melbourne	Two progress reports received in 2012-13 Project completed April 2013.

Challenges

Communicating with a changing system

The Queensland health system underwent significant changes in 2012-13.

There were major reforms to the Queensland health system when 17 Hospital and Health Services were established as statutory bodies to provide health services, overseen by the Department of Health as system manager.

Ongoing restructures and changes to primary contact staff disrupted communication pathways and continuity of service providers accountable for quality improvements. To overcome this, we improved the quality, volume and timing of our communications, and where required granted extensions for delivery of information.

We retired six of our healthcare standards and retained three, in December 2012. This change occurred at the same time that 10 national standards came into force and hospitals were adjusting to new accreditation arrangements. This caused some uncertainty in hospitals about their reporting requirements and implications for their service.

We communicated regularly with hospitals about changes to our standards and clearly outlined ongoing reporting and compliance obligations with our remaining healthcare standards. We provided a dedicated helpdesk to answer enquiries about our *Annual quality and activity return (AQAR)* – our new healthcare quality reporting process (see page 60).

We expect to continue to provide a high level of ongoing communication support to hospitals when we request information via our AQAR for the first time in September 2013.

Expanded approach to reportable events

On 1 July 2012, we expanded our approach to reportable events monitoring. We requested information from public and private health service facilities and the Queensland Ambulance Service about all reportable events that occur, not only those reportable events for which healthcare providers conduct a root cause analysis (RCA). We requested this information under section 21 of the HQCC Act.

Healthcare providers submitted either an RCA, or provided information on our *Reportable event summary review form* (RESR form). We found healthcare providers sometimes did not provide sufficient detail on the RESR form about the incident or about measures implemented to prevent recurrences. We helped healthcare providers on a case-by-case basis to improve the information provided in the report. We reviewed the RESR form to clarify our requirements, and ensured information on our website was clear and easy to understand.

Despite our expanded approach, it is likely not all reportable events, as defined in legislation, are submitted to us via an RCA or our RESR form.

To measure the difference between the number of reportable events we receive and with those that actually occur, we will ask hospitals to tell us the number of reportable events which occurred for the year, and compare them with the number of event reviews completed in the year in our *Annual quality and activity return*.

We expect the number of reviews completed in the year to match or closely match the number of reportable event reviews we receive. Healthcare providers will be asked to provide information on material discrepancies in the number and types of reportable events.

Managing resources

During 2012-13, some positions allocated to quality services were redirected to investigations to address the high investigations workload.

Leave absences and natural attrition saw staff resources dedicated to monitoring quality improvement and monitoring greatly reduced.

The organisation has implemented more efficient ways to deliver services to ensure that quality monitoring functions can continue at a high level.

Improvements

Identifying opportunities to improve

All Queensland healthcare providers have a legal duty to establish, maintain and implement reasonable processes to improve the quality of their health services, under section 20 of the HQCC Act.

During 2012-13 we strengthened our capability to monitor a provider's duty to improve by developing a more efficient and effective process for applying s20 of the HQCC Act within our complaints management system.

Previously, our Devolution Officer monitored all recommendations for improvements made by assessment officers, along with complaints that had been devolved back to the healthcare provider to investigate. We split this function and the monitoring of improvements recommended under s20 was handed over to our quality services team.

Complaint officers who identified opportunities for improvement under s20 during early resolution or assessment of a complaint referred these matters for monitoring under our new, streamlined *Monitoring for safety and quality procedure.* We monitor these improvement plans until we are satisfied the healthcare provider has taken reasonable steps or implemented reasonable processes to improve the quality of their health service.

Our renewed focus on s20 resulted in a more efficient and effective application of this section of our Act and drove healthcare improvement. Forty-six healthcare providers' quality improvement activities were monitored in 2012-13. Thirty-three of these healthcare providers were identified during our complaints management process and 13 were identified during our reportable events monitoring activities.

At 30 June 2013, 23 of 46 matters (50%) were closed after we were satisfied that the healthcare provider had implemented reasonable processes to improve the quality of their health services.

In conjunction with the new procedure, we developed a data management solution to more effectively measure our monitoring activities.

In 2013-14, we plan to further integrate this solution with our complaint management system to enable us to quickly and easily identify patterns, trends and improvement opportunities.

Improving monitoring of reportable events

There was a 30% increase in reviews of reportable events we received due to our expanded approach.

There continues to be a significant swing away from using root cause analysis (RCA) as a methodology for reviewing reportable events and serious clinical incidents. We estimate that, on average, RCA reports account for about 60% of all reportable events which occur in Queensland. Relying on RCA reviews alone would only provide a partial picture of systemic issues identified in reportable events.

We systematically examined the 248 reportable event review reports we received against our escalation checklist. This enabled us to examine each reportable event review report in a fair, consistent and transparent way.

We examined the reports for multiple system failures, compliance issues and identifiable patterns of previous, similar incidents. If we identified evidence that met our escalation checklist criteria, and the matter was not being dealt with by another agency or entity, we escalated the matter to a 'watching brief' (with an internal monitoring plan) or took further action.

We took further action with 13 healthcare providers, advised them of our concerns and requested they provide us with information on actions taken to prevent similar incidents from occurring. We monitored these improvement plans until we were satisfied the healthcare provider had implemented reasonable processes to improve the quality of their health service.

Profiling hospitals and individual practitioners

We developed complaint information profiles for all Hospital and Health Services and private hospital groups, combining the unique information we held about complaints received, root cause analysis summary reports, quality improvement activities and healthcare standards compliance.

During 2012-13 we tested these profiles with three Hospital and Health Services and obtained feedback on the profile's content, format and usefulness. The three test sites found the group profiles helpful and felt their value could be increased by:

- highlighting 'hotspots' where a health service or hospital substantially differs from its peers
- providing data that is unique to HQCC and not already available to them
- including narrative on data limitations.

Stakeholders told us they planned to use the data for the education of clinicians about how to handle complaints and improve communication with their patients, and improve local complaint management processes. Our aim is to develop these profiles further based on the feedback from stakeholders, bearing in mind the introduction of other hospital performance monitoring systems at a state and national level.

Progress on the revised profiles was put on hold with the introduction of the *Health Ombudsman Bill 2013* and reduced resources within the quality services team.

We reviewed and updated our provider profiling (individual practitioner) policy in light of new research. A study conducted by the University of Melbourne examined medical practitioners with multiple complaints lodged with Australian complaint organisations/ Commissions[1] showed that the number of prior complaints medical practitioners had received was a strong predictor of subsequent complaints.

Compared to doctors with one prior complaint, doctors with four complaints had four times the risk of recurrence. This research also showed that there was high risk of recurrence of complaints within two years (>60%) among doctors with as few as four complaints.

Taking steps to identify individual practitioners at high risk of attracting recurrent complaints and intervening early will have considerable potential to advance the quality and safety of health services.

Our *Provider profiling policy* states when an individual practitioner with four or more complaints receives an additional complaint, the complaint cannot be referred for direct resolution. We manage these complaints through our early resolution or assessment process.

This year we reviewed and updated our policy to ensure alignment with latest research and to clarify scope, including definition of complaints for inclusion. Our updated policy was published in July 2013.

Working toward 100% compliance with our credentialing standard

Queenslanders want to be sure their care is provided by 'Doctor Right' - that is, the right doctor, with the right skills, doing the right task, with the right support, in the right place. The process of credentialing and defining the scope of clinical practice helps ensure safe care.

Doctor Right Volume 3, published on 21 December 2012, was the third in a series which examined credentialing and defining the scope of clinical practice for doctors working in Queensland hospitals.

Doctor Right Volume 3 examines progress made by Queensland hospitals since the publication of *Doctor Right Volume 1: A special report on credentialing and defining the scope of clinical practice for doctors employed by Queensland Health* and *Doctor Right Volume 2: A special report on credentialing and defining the scope of clinical practice for doctors working in*

[1] Bismark M, Spittal M, Gurrin L, Ward M, Studdert D. *Identification of doctors at risk of recurrent complaints: a national study of healthcare complaints in Australia.* Quality and Safety in Healthcare. 2013; 0:1-9.

licensed private acute and day hospitals in Queensland, tabled in Queensland Parliament in April and June 2012 respectively.

All Queensland hospitals reported to us in September 2012 that they have a process for credentialing and defining the scope of clinical practice that includes all the criteria of our C*redentialing and scope of clinical practice standard*, increasing from 84% in 2007 to 100% in 2012. This demonstrates improvement in hospitals' ability to ensure their doctors are appropriately credentialed and have a defined scope of clinical practice. We retired our *Credentialing and scope of clinical practice standard* on 31 December 2012 due to strong alignment with the national standard.

However, hospitals reported that not all of the eligible doctors in public and private hospitals were credentialed in 2012. Less than 1% of all eligible doctors were not credentialed. We expect 100% of all eligible doctors in public and private hospitals to be credentialed with a defined scope of clinical practice at all times.

We will publicly report on progress made since publication of *Doctor Right Volume 3*, including the Department of Health and Hospital and Health Services' implementation of the agreed action plan on recommendations from *Doctor Right* and on the credentialing auditing practices or results of credentialing audits in a selected sample of hospitals.

Outlook

Monitoring hospital improvement

We will finalise the implementation of our *Standards transition plan* and review our three remaining healthcare standards, with the expectation they will be retired. This review was scheduled for December 2014, or earlier if required. The review has been brought forward in light of the *Health Ombudsman Bill 2013*.

We will monitor hospitals' statutory duty to improve the quality of their health services through our complaints, reportable events monitoring and our *Annual quality and activity return* (AQAR) process.

Hospitals will answer a series of questions about the quality of their health services. All Queensland hospitals are required to submit information to us via the AQAR. We will use this information to monitor and drive healthcare quality improvement.

Hospitals will report against three modules:

- Complaints, activity and reportable events (CARE)
- Accreditation (ACC)
- Implementation of the Queensland Health and Hospital and Health Service (HHS) action plan on recommendations from *Doctor Right Volume 1* (DRR).

All Queensland hospitals will submit their AQAR in September 2013.

Reportable event monitoring

We will publish a report on the results of our aggregate analysis of twelve months of expanded reportable events data by January 2014.

We plan to report on state-wide patterns and trends including:

- types of reportable events
- clinical settings
- contributory factors which led to these events
- actions taken to reduce and/or prevent recurrence of similar events
- effectiveness of preventative actions.

Our aim is to share information, optimise learning opportunities and drive improvements in the safety and quality of healthcare.

We will commence reporting on our new quality measure, *Percentage of monitored healthcare providers who do not receive a subsequent related complaint or report* (see page 16).

This new measure will help us better assess our quality monitoring outcomes.

Sharing lessons learned

We will share our complaints and reportable event information with consumers and healthcare providers.

As part of our *Healthcare quality analysis and sharing plan*, in 2013-14 we will finalise and publicly share the results of our analysis of:

- clinical deterioration
- mental health services
- maternity and prenatal care
- review and follow up of test results.

We will publicly report the outcomes of our credentialing review, in our *Doctor Right Volume 4* special report, including the Department of Health and Hospital and Health Services' implementation of the agreed action plan.

Health Ombudsman Bill 2013

On 4 June 2013, the Honourable Lawrence Springborg MP, Minister for Health, tabled the *Health Ombudsman Bill 2013* in Queensland Parliament.

The Bill establishes a new statutory position of Health Ombudsman to manage health complaints in Queensland.

The draft bill has removed the legislated duty to improve provisions for healthcare providers that currently exist in the HQCC Act.

We see this as a major retrograde step for Queensland. Any move back to a reactive complaint management model, with a focus on individual practitioners rather than investigating systemic failures again puts the community at greater risk of another health system failure such as the one that occurred in Bundaberg in 2005.

We recommended to the Health and Community Services Committee that the main objects of the Bill be expanded to include oversight and review of, and improvement in, the quality of health services as is currently in the HQCC Act.

This includes maintaining the legislated duty of all healthcare providers in Queensland to improve the quality of health services (section 20, HQCC Act) and empowering the Health Ombudsman to proactively gather information and monitor patterns of healthcare provider practice, complaint trends and other healthcare performance data (such as reportable events) to identify health services safety and quality issues early and prevent another health system failure.

We will continue to work with the Minister for Health and Queensland Parliament to find ways to appropriately monitor and manage healthcare risks.

Chapter 4
Our people

Highlights

- We invested $17,188 invested in staff learning and development.
- We had a permanent staff retention rate of 81.66%.
- 65.6% of staff shared their views in the Working for Queensland Employee Opinion Survey administered by the Public Service Commission.

Overview

Our people are our greatest asset.

In a period of major operational change following the completion of our internal organisational review in December 2011, we encouraged our staff to seize the opportunities presented by change.

The review resulted in some internal staff movements as we realigned our human resources to achieve the objectives of our strategic plan.

We supported our staff in managing an increasing number of complaints by making efficiencies and improvements.

New policies and procedures were drafted in all business areas to ensure we provided consistent, high quality services to clients and stakeholders.

We worked hard to develop and retain our skilled and experienced workforce and to attract capable new employees when vacancies occurred. Permanent staff turnover continued to be low. We recruited seven permanent and five temporary staff during the year. Eighty-five percent of permanent jobs are occupied.

We planned for career progression and retirement by integrating succession planning into our performance development process. We achieved our strategic key performance indicator, with 100% of staff training and development plans implemented.

In strengthening business processes, we fostered a positive workplace culture, encouraged open communication, and offered flexible work conditions to help our people maintain a healthy work life balance.

Our staffing establishment

As at 30 June 2013, our permanent staffing establishment was 71, with 59.4 actual staff on hand.

Following our internal organisational review and the decision to move to a matrix management approach, and to allow direct comparison with last year's figures, we have continued to report positions by function rather than business unit.

Staff were deployed across nine functional areas, with the core product and service delivery function positions in complaint management, quality, business intelligence and analysis, clinical support, and community engagement accounting for 50.8 positions or 78% of the actual staff on hand at 30 June 2013.

Table 53: Establishment positions by function as at 30 June 2013

	Permanent establishment positions	Actual staff on hand		
		Permanent staff	Temporary staff	Total
Business intelligence and analysis	4	3	0	3
Chief/senior executive	3	1	0	1
Clinical support	2	0.8	0	0.8
Community engagement [1]	3	1	2	3
Complaint management [2]	43	31.5	7.5	39
Corporate support [3]	6	4.6	0	4.6
Information technology	2	2	0	2
Legal/right to information	2	2	0	2
Quality	6	4	0	4
Total	**71**	**49.9**	**9.5**	**59.4**

[1]Community engagement position responsibilities included communications, public affairs and media relations. Communication of our services is essential to encourage people to raise health service concerns and to keep healthcare providers and the community informed about the outcome of investigations and reviews of the safety and quality of health services, as well as opportunities for healthcare improvement identified by our agency.
[2]Complaint management includes triage, early resolution, assessment, conciliation, investigation and complaint support positions.
[3]Corporate support includes human resources, finance, record management and administration positions.

Our staff profile

To give a complete picture, our staff profile is based on the number of staff on our payroll as at 30 June 2013, rather than our permanent staffing establishment positions or actual staff on hand.

The total number of staff employed reduced to 65 (2011-12: 75). This total is greater than the number of staff on hand as we have counted part-time and job-sharing employees, and staff on parental leave and long service leave.

Staff employment as at 30 June 2013

Over three quarters (86%) of our workforce were permanent employees (2011-12: 76%). Most (90%) of our staff worked full-time (2011-12: 95%), with five employees working part-time. Some 73% of our workforce were women, up from 69% in 2011-12.

Table 54: Distribution of staff by classification and gender as at 30 June 2013

	M	F	Total	%
Permanent full-time	14	36	50	77%
Permanent part-time	0	6	6	9%
Temporary full-time	4	4	8	13%
Temporary part-time	0	1	1	1%
Total	**18**	**47**	**65**	**100%**

Table 55: Distribution of staff by function as at 30 June 2011, 2012 and 2013

	2010-11	2011-12	2012-13
Business intelligence and analysis	0	3	3
Chief executive	1	1	1
Clinical support	2	2	1
Community engagement	3	3	4
Complaint management	42	45	42
Corporate support	7	7	5
Information technology	3	2	2
Legal/right to information	2	4	2
Quality	15	8	5
Total	**75**	**75**	**65**

Staff are employed across a range of functions, with complaint management staff accounting for 65% of the total. As we moved to function-based reporting in last year's annual report, we have included 2010-11 and 2011-12 data to enable comparison.

Following our internal organisational review, our functions were restructured to achieve our new service delivery model. The creation of triage and early resolution teams, the establishment of a business intelligence and analysis team within the information management team, an increase in the investigation team and a re-sizing of the quality services team were key changes.

Table 56: Distribution of staff by function and age range as at 30 June 2013

	16–20 yrs	21–30 yrs	31–40 yrs	41–50 yrs	51–60 yrs	61+ yrs	Total
Business intelligence	**0**	**0**	**1**	**2**	**0**	**0**	**3**
CEO	**0**	**0**	**0**	**0**	**1**	**0**	**1**
Clinical support	**0**	**0**	**0**	**1**	**0**	**0**	**1**
Community engagement	**0**	**0**	**2**	**1**	**1**	**0**	**4**
Complaint management	**0**	**2**	**12**	**14**	**11**	**3**	**42**
Corporate services	**0**	**1**	**0**	**2**	**2**	**0**	**5**
Information technology	**0**	**1**	**0**	**1**	**0**	**0**	**2**
Legal	**0**	**1**	**1**	**0**	**0**	**0**	**2**
Quality	**0**	**0**	**3**	**2**	**0**	**0**	**5**
Total	**0**	**5**	**19**	**22**	**15**	**3**	**65**
Proportion of total	**0**	**8%**	**30%**	**35%**	**23%**	**4%**	**100%**

The average age of our staff at 30 June 2013 was 44.41 years (2011-12: 42.32 years) – 43.33 years for men (2011-12: 39.34 years) and 44.83 years for women (2011-12: 43.63 years). Less than half of our employees (48%) are younger than the average age (2011-12: 53%), and 27% are over the age of 50 years (2011-12: 25%).

Table 57: Distribution of staff by age and gender as at 30 June 2013

Classification	Base Salary Range	Female		Male	
	$	Number	%	Number	%
AO3	54,274-60,496	6	9%	0	0%
AO4	64,133-70,519	0	0%	0	0%
AO5	74,326-80,778	16	25%	3	5%
AO6	85,270-91,237	8	13%	10	15%
AO7	95,422-102,312	11	17%	3	5%
AO8	105,727-111,811	3	5%	1	1%
SO	114,889-126,044	2	3%	1	1%
CEO	contract	1	1%	0	0%
Total overall salaries		47	73%	18	27%
* based on total payroll at 30 June 2013 Totals rounded					

Classification key
AO – Administrative Officer
SO – Senior Officer
CEO – Chief Executive Officer

We had a predominantly female staff (73%), however there was a higher proportion of women in management and executive management, with women holding 6 of the 8 management roles (AO8 and above) at 30 June 2013.

Under the *Industrial Relations Act 1999*, our recruitment process aims to prevent discrimination and ensure equal remuneration for men and women. Our human resource management and associated policies comply with the *Public Service Act 2008* and the *Anti-Discrimination Act 1991*, providing for the rights and obligations of employees, and equal employment opportunity.

Table 58: Distribution of staff by function and classification as at 30 June 2013

	AO3	AO4	AO5	AO6	AO7	AO8	SO	CEO	Total
	$54,274-$60,496	$64,133-$70,519	$74,326-$80,778	$85,270-$91,237	$95,422-$102,312	$105,727-$111,811	$114,889-$126,044	Contract[1]	
Business intelligence and analysis	0	0	0	0	2	0	1	0	3
Chief executive	0	0	0	0	0	0	0	1	1
Clinical support	0	0	0	0	1	0	0	0	1
Community engagement	0	0	0	2	1	0	1	0	4
Complaint management	6	0	13	13	8	2	0	0	42
Corporate support	0	0	3	1	0	1	0	0	5
Information technology	0	0	1	1	0	0	0	0	2
Legal/right to information	0	0	1	0	0	0	1	0	2
Quality	0	0	1	1	2	1	0	0	5
Total	6	0	19	18	14	4	3	1	65
Proportion of total	**9%**	**0%**	**29%**	**28%**	**22%**	**6%**	**5%**	**1%**	100%[2]

[1] See Financial report on page 93.
[2] Rounded total

More than three quarters (79%) of our staff were employed at the AO5 to AO7 classification levels.

The Chief Executive Officer's remuneration is by contract and is not included in this table. See *Financial report, page 93.*

Performance

Workforce planning

Our workforce plan for the year focused on attracting, developing, caring for and retaining staff.

Building staff capability in line with the Queensland Public Service Capability and Leadership Framework is central to our organisation's achievement of strategic objectives.

Our plan ensured alignment between organisational goals and staff skills and capability development.

Workforce retention

From 2011-12, retention and separation data for the HQCC was supplied by the Public Service Commission through the Workforce Analysis and Collection Application information sheet. In previous years, the HQCC calculated this information manually.

One employee accepted an offer of voluntary early retirement in 2012-13 at a cost of $151,000 to the organisation.

Table 59: Permanent retention and separation rate

Year	Permanent retention rate	Permanent separation rate
2009-10	90%	10%
2010-11[1]	86%	14%
2011-12[2]	88.33%	5.46%
2012-13[2]	81.66%	11.77%

[1] The permanent retention rate for 2010-11 reported in our *Annual report 2011-12* was erroneous. The correct figure is 86%.
[2] Data for 2011-12 and 2012-13 is provided by the Public Service Commission.

Flexible working arrangements

We encouraged our staff to maintain a healthy work life balance. Our *Work life balance guide* details the range of options available to staff, including part-time work, job sharing and telecommuting.

Work life balance initiatives

Almost half (45%) of staff were approved for home-based telecommuting either on a regular or ad hoc basis.

Table 60: Work life balance initiatives

Initiative	2010-11	2011-12	2012-13
Staff working part-time (at 30 June)	5	4	**6**
Staff in job sharing arrangement	2	2	**2**
Staff approved for home-based telecommuting	23	34	**24**
Staff taking extra leave for proportionate salary	2	1	**0**
Staff taking career break	0	0	**0**
Staff taking parental leave	2	1	**4**
Staff accessing independent employee assistance scheme	4	4	**4**
Staff receiving study and research assistance	3	1	**2**

We offered leave arrangements such as extra leave for proportionate salary, career break, parental leave and family responsibility leave to help our people balance their work and personal commitments. Where the personal circumstances of a staff member temporarily changed, we offered a short-term reduction in work hours or a change in rostered hours.

We also provided access to carer facilities in a family-friendly work space.

An independent external counselling service was available to all staff to help resolve personal and/or work-related problems, with four staff accessing the service during the year.

To support staff to continue their professional development, we provided leave to two staff members to undertake personal study or research relevant to our work.

Employee performance management

We continued to review and refine our employee performance management framework.

The framework covers the 'hire to retire' model, including our employee induction program, performance development program, succession planning and employee reward and recognition.

New staff participated in an induction program led by their supervisor, with a follow-up formal induction session for recent recruits held in September 2012 and March 2013.

All employees prepared performance development plans in conjunction with their supervisor, with reviews every six months. We achieved our strategic key performance indicator, with 100% of staff training and development plans implemented.

Industrial and employee relations

We managed our staff under government industrial directives and circulars, supported by internal policies and procedures.

Staff were employed under the *Public Service Act 2008* and the Queensland Public Health Sector Certified Agreement (No.8) 2011.

On 8 May 2012, the Queensland Industrial Relations Commission certified the Queensland Public Health Sector Certified Agreement (No. 8) 2011 (EB8). The agreement cancelled the Queensland Public Health Sector Certified Agreement (No. 7) 2008 (EB7). It will operate until its nominal expiry on 31 August 2014.

Queensland Health was the lead agency in the negotiation of this agreement and we were a party to the agreement. Staff were given the opportunity, through their union representation, to participate in the ballot on the proposed agreement.

We contributed 12.75% of each employee's salary to their QSuper managed superannuation account. Our standard employee contribution was 5% and staff also had the option to salary sacrifice a range of approved benefit items.

In 2012-13, one dispute was lodged with the Queensland Industrial Relations Commission. This matter was resolved during the year. No matters were lodged with the Anti-Discrimination Commission.

Cultural survey

Growing a healthy, productive and client-centred workplace culture is an important element to achieving our strategic objectives.

To monitor our cultural change and identify opportunities for improvement, an independent research organisation has surveyed our staff in April each year. However, in 2012-13, we chose to participate in the Queensland Government *Working for Queensland Employee Opinion Survey*, conducted by the Public Service Commission in lieu of an agency-specific survey.

Some 65.6% of our staff shared their views in the 2012-13 survey (2011-12: 91%). The results for 2012-13 were not available at the time of writing this report and will be included in our *Annual report 2013-14*.

In the past, employees were asked to share their views of our organisational culture, including staff engagement, conditions of employment, communication, organisational strategy and management skills.

Learning and development

In discussion with their supervisor, every employee prepared a learning and development plan as part of their annual performance development plan.

Learning and development focused on the core skills and competencies required by staff to do their jobs.

All staff completed one or more training and development activity in 2012-13 and we achieved our KPI target, with 100% of staff training and development plans implemented. However, due to the all-of-government directive to reduce training and development costs, the amount of external training and conference attendance was significantly reduced.

We invested $17,188 in staff training (2011-12: $88,219).

All staff participated in public sector writing to improve our written communication with clients and stakeholders. Other learning and development areas included complaint management, mediation training, records management, investigation training and software training. We also supported training for first aid officers, and a fire safety adviser role.

One staff member registered for a conference in 2012-13—the National Mediation Conference (September 2012).

While we are a small organisation, we have a diverse range of roles, including investigators, assessment officers, quality analysts, policy writers, mediators and conciliators, communicators, ICT specialists, finance and human resource officers and business support officers. In 2013-14, we will continue to identify specific training opportunities for professional groups as part of ongoing professional development.

Challenges

Managing staff through uncertainty

In February 2013, the Queensland Government signalled the redesign of the state's health complaints management system with the *Blueprint for better healthcare in Queensland*.

In April 2013, two reports were tabled in the Legislative Assembly and the Minister for Health announced new legislation would be introduced to create a Health Ombudsman.

With significant changes to our operating environment foreshadowed, we focused on supporting our staff and keeping them current with all developments.

At our regular staff meetings, we invited employees to raise any concerns and ask questions about the proposed changes.

Staff were further informed through meetings with the Commissioner and Assistant Commissioners, representatives of the Public Service Commission and the Department of Health.

Relevant documents and information were shared with staff as they came to hand.

Recruiting staff

Recruitment of suitable candidates to vacancies continued to be challenging in 2012-13.

We employed seven permanent and five temporary staff in the financial year.

Arranging temporary secondments from other government agencies proved difficult at times as other government agencies were not in a position to release resources.

Candidate selection followed the whole-of-government recruitment directive and appointments were based on merit through an open and transparent process.

While some positions attracted a high number of applicants, other roles proved more difficult to fill because of the nature of the skill set required.

Team leaders and managers were responsible for the induction of new staff, with guidance from our human resource advisers. Only one induction workshop was required due to the minimal number of new staff, covering all key aspects of organisational policies and procedures and mandatory workplace health and safety information and evacuation procedures. New staff received on-the-job training within their work teams.

Improvements

Improvements for our staff this year included:

- staff access to our performance measures via the Sharepoint portal and the information-sharing and reporting benefits Sharepoint provided
- the Positive Workplace Committee's Wellness program, which encouraged a healthy lifestyle
- the flatter management structure, which gave greater complaints representation on the executive team resulting in a better understanding of complaints management.

Implementing our organisational review

As well as their core role, all staff now have responsibilities in information collation, analysis and sharing. We are using the information gathered through managing complaints and investigations and monitoring healthcare quality to identify opportunities for positive change at the practitioner, organisation and system levels.

Lessons learned are shared with healthcare providers and the broader community in public reports and through associated engagement campaigns (see page 55). We set key performance indicators for our *Healthcare quality analysis and sharing plan* to measure our impact and ensure we are making a difference.

Organisational review outcomes which we reported last year we would implement in 2012-13 were to:

- offer greater support to clients to confirm their complaints in writing (see page 32)
- increase our focus on identifying opportunities for health service improvement in early resolution and assessment (see page 32)
- introduce formal recommendations for health service improvement and associated monitoring in conciliation. (During the review of our conciliation policy during the year, we decided not to proceed with these activities.)
- enhance our quality assurance audit program to support continuous quality improvement (see page 33 and 83)
- review and simplify our complaint and investigation case management system to improve data collection, quality and reporting (see page 32).

Supporting ethical behaviour

Our staff are educated about the behaviour expected of them as integrity agency employees on commencement and more formally at biannual workshops. Our human resource management procedures and practices align with the *Code of Conduct for the Queensland Public Service*.

All staff completed mandatory online ethics training in August 2012 to meet our responsibilities under the *Public Sector Ethics Act 1994*. Ethical behaviour continues to be covered in our induction program and individual staff performance development plans, which provide the opportunity for staff and managers to address any ethical behaviour issues.

There was one reported breach of misconduct under the *Crime and Misconduct Act 2001*.

Promoting a safe and healthy workforce

To ensure a safe and healthy workplace and prevent injury or illness under the *Work Health and Safety Act 2011*, we reviewed our policies on fire and emergency evacuation, personal security, duress alarm response, unannounced visitors and workplace rehabilitation.

Following the introduction of the *Work Health and Safety Act 2011*, we added work health and safety as a standing agenda item for our Positive Workplace Committee. Our Audit and Risk Governance Committee reviewed work health and safety compliance reports quarterly.

We are committed to being responsive and accessible to all complainants who contact us and allocate our resources fairly across all the complaints we receive. However, as some complainants place unreasonable demands on our staff, we introduced the *Unreasonable complainant conduct policy* in January 2013 to ensure their health, safety and security.

The policy enables us to take proactive steps to manage any complainant conduct that negatively and unreasonably affects us.

We categorised unreasonable conduct as:

- unreasonable persistence
- unreasonable demands
- unreasonable lack of cooperation
- unreasonable arguments
- unreasonable behaviours.

The policy outlines clear guidelines and appropriate responses to manage any unreasonable conduct.

We trained four new first aid officers and 34 staff participated in an annual influenza vaccination clinic. We also trained one staff member as a fire safety adviser and a further staff member is completing workplace health and safety officer training.

Staff also participated in a number of joint information sessions with other co-located complaint agencies. Topics included heart health, personal self-defence, superannuation and salary sacrificing.

Revitalising our values

Following our review and as part of our *Cultural improvement plan*, we revitalised our organisational values.

As part of the 2012 survey, we asked our staff to share what they would tell a new staff member about the 'dos and don'ts' of working in our agency. This information was used to check whether any changes needed to be made to our values and to define the behaviours we expect of our staff.

In light of the many service improvements we continue to make as a result of our organisational review, we replaced our value of 'responsiveness' with 'client-centred'. The new values wheel was created in July 2012 to reflect this change and to reinforce our cultural values to all staff. Executive staff promoted it to their teams internally and the values were included on the agenda for all-of-staff meetings and the Positive Workplace Committee. The values wheel is displayed prominently throughout our office.

Building a better workplace

Our Positive Workplace Committee supported cultural and workplace improvement through innovative and inclusive initiatives and social activities aligned to our strategic plan and cultural improvement plan.

The committee, made up of staff members from across the organisation and the CEO, met monthly. It provided a forum for issues and changes relating to staff health and safety and general welfare to be discussed, actioned and resolved.

In 2012-13, the committee:

- coordinated the organisation's sponsorship of a World Vision child
- arranged Christmas and Melbourne Cup events
- developed a Healthy Workers' Initiative program including a regular walking club
- collected donations for 139 Club (a Brisbane drop-in centre and refuge for the homeless)
- organised staff raffles and other activities in support of Jeans for Genes Day, Men's Health Week, Mental Health Week, National Bandana Day (CanTeen), Australia's Biggest Morning Tea (Cancer Council), Harmony Day, World Health Day and Movember (supporting men's health programs).

This year, we planned to roll out management development training to emerging leaders across the organisation and to provide human resource management training to those staff with line management responsibility.

Due to the announcement of the transition of our functions to the Health Ombudsman, we decided to discontinue these plans but continued to support emerging leaders and those who assumed greater supervisory roles with internal mentoring.

Building an intranet

In February this year, Sharepoint was provided to staff as a gateway to our business intelligence. It is easily accessible by staff as their website home screen, and lists our organisational KPIs, which are updated monthly.

Sharepoint includes a calendar tool to help teams manage team member attendance.

It has also been a valuable tool for members of our clinical advice team who now manage their caseload and share case information with each other on this platform.

Business information at our fingertips

All team policies and procedures are stored in our electronic records and documents management system and are easily accessible by all staff.

Staff were kept current with important whole-of-organisation information in regular staff meetings and via daily email broadcasts. They were encouraged to share their knowledge of sector news, events and professional development opportunities through these broadcasts.

Any changes to policies and procedures were addressed in regular team meetings.

Outlook

Going paper light

To increase the efficiency of administrative procedures and minimise costs, we moved closer to becoming a 'paper light' office in 2012-13.

Paper records are still maintained in line with our retention and disposal schedule but wherever possible, email has been introduced as our preferred channel for written communication.

Routine correspondence is largely being produced on electronic HQCC letterhead and where appropriate electronic signatures are used, saving time with scanning and printing, and paper and print costs.

All Commission, advisory committee and internal team meetings are now being conducted electronically, i.e. agendas and minutes are emailed; no hard copies of documents/reports are available for delegates; delegates are encouraged to either print off their own copies of paperwork or bring laptops/tablets to meetings; documents are projected onto the screen for viewing during the meetings.

Learning and developing

Unless they are already accredited, we will provide mediation training for all early resolution and assessment staff towards their accreditation with the *National Mediation Accreditation Standards* and to consolidate existing skills.

As recommended by the KPMG review into our investigations processes and procedures, we will provide training for our investigations team in Certificate IV, Government (Investigations) and Certificate IV, Government (Fraud control).

Safeguarding service levels

We acknowledge the vital need to maintain complaint management service standards and continuity during the transition from the HQCC to the Health Ombudsman.

While the *Health Ombudsman Bill 2013* stipulates that the Health Ombudsman is the legal successor of the HQCC, the Bill makes no provision for the transition of HQCC staff to the Health Ombudsman. Rather, we have been advised that the Health Ombudsman will determine the staffing of the new organisation at a time yet to be announced.

This presents us with considerable challenges in terms of maintaining a skilled and experienced complaint and investigation management workforce when there is no job certainty for staff. We have lost five key personnel since the Health Ombudsman was announced, with more staff since signalling their intention to seek permanent positions outside the organisation due to lack of staff transition arrangements and employment certainty.

The implications for service standards and continuity are significant, with the risk that we will no longer be able to meet community demand for our services or our legislated and strategic targets for the effective and efficient management of complaints and investigations. There are clear risks to public safety if the HQCC is not adequately resourced to deliver its legislated functions.

The loss of specialist staff expertise will also have a major impact on the Health Ombudsman when it comes time to recruit to the new organisation, given the requirement for specialist skill sets.

In June this year, the HQCC recommended to the Health and Community Services Committee that it review the transition arrangements outlined in the Bill to mitigate the risk of the loss of a skilled and experienced complaint management and investigation workforce and ensure service standards and continuity are maintained during the transition period.

We will help our staff manage the change and provide them with job-seeking support. We will continue to promote the Employee Assistance Program (EAP), a confidential professional counselling service to help them resolve any personal concerns resulting from any uncertainty surrounding the transition.

We will work with the transition team to address any skills shortages and recruit temporary contractors on a needs basis to address shortfalls.

Chapter 5
Corporate governance

Highlights

- We welcomed new Assistant Commissioner, Allied Health, Kos Sclavos.
- We reviewed our strategic plan in light of the *Health Ombudsman Bill 2013.*
- The Minister for Health and Assistant Minister toured our offices and met with us in August 2012.
- Our governing legislation was amended to reflect changes to national legislation concerning registration of select practitioners and the launch of the Hospital and Health Services.

Overview

Our approach to corporate governance reflects our commitment to meeting our statutory obligations and delivering an open and transparent healthcare complaint management and quality improvement service. Our Commission, and governance and advisory committees worked with the Office of the Commission to drive quality healthcare for Queenslanders.

Our corporate governance is based on the values that underpin our everyday operation to ensure 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.

Due to the future transition to the Health Ombudsman the Commission decided to extend all current clinical advisory and consumer advisory committee member terms to 31 December 2013.

We continued to report to the Health and Community Services Committee (HCSC), the bi-partisan parliamentary committee charged with monitoring and reviewing our performance. We attended two public hearings on the oversight of the HQCC and responded to the committee's first report (*Report No.21 Oversight of the Health Quality and Complaints Commission)*, which was tabled in the Legislative Assembly in April 2013.

The Commissioner and CEO met with the Minister for Health, the Honourable Lawrence Springborg MP three times during the year. The Minister and Assistant Minister for Health, Dr Christopher Davis, also toured our office in August 2012 and met with the Commission and staff.

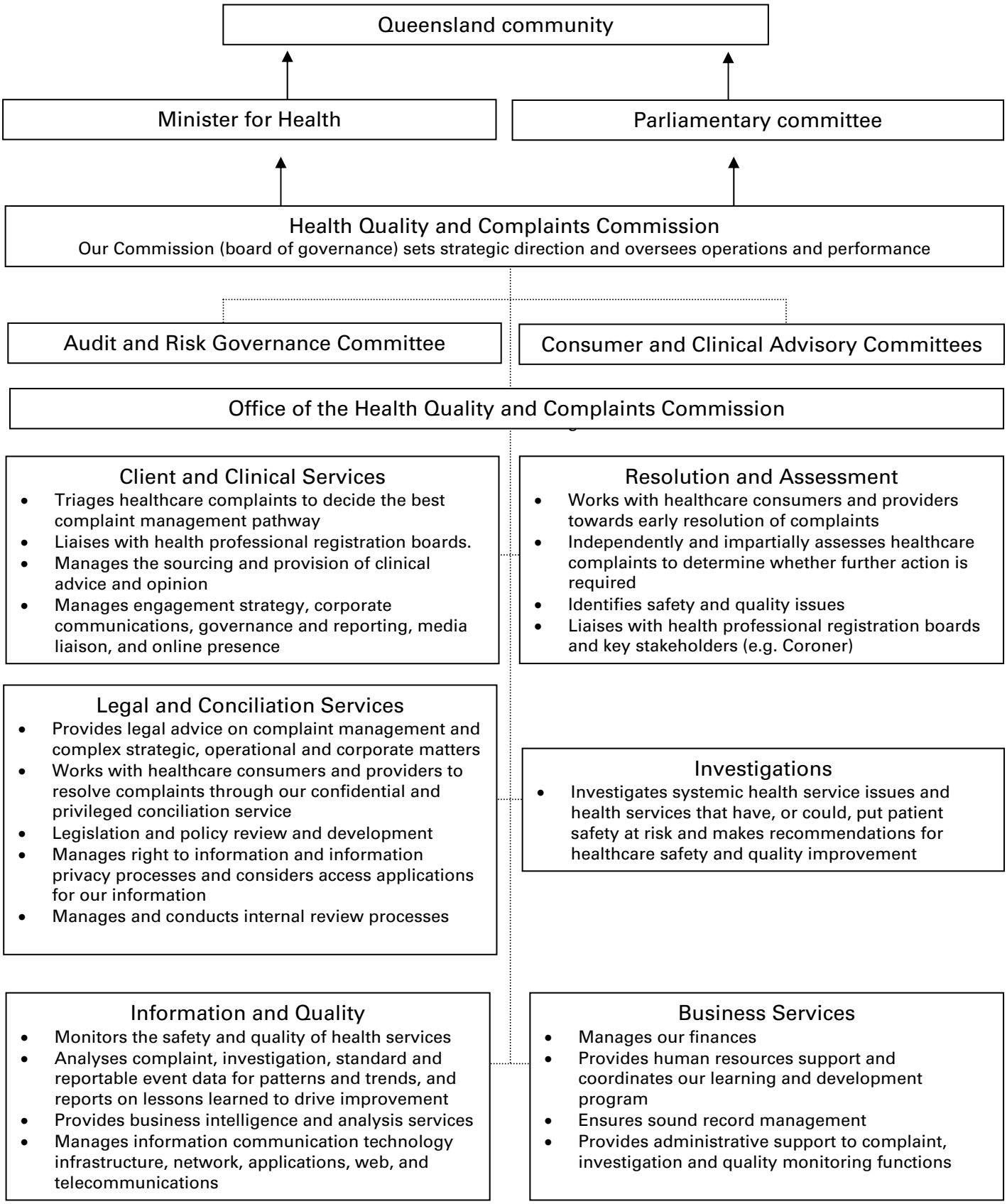
Key achievements during the year included:
- renewed governance framework ensuring effective planning, measurement and monitoring of results and public reporting in line with the Queensland Government's *Performance management framework*.
- revision of our strategic plan as a result of the announcement of the *Health Ombudsman Bill 2013*
- a reduction in supplies and services costs including savings on telephone costs, consultancy costs, travel costs, stationery, printing and postage and administrative expenses.

2012-13 was a year of major reform in our health system, with the introduction of Hospital and Health Services, the move to mandatory accreditation against the *National safety and quality health service standards* and the continued rollout of the Medicare Locals network. We formed working relationships with the new healthcare organisations to drive safety and quality improvement.

The executive coordinated project management within the agency through regular Program Control Board meetings, until this group was retired in May 2013 due to the future transition to the Health Ombudsman. The opportunity to recall the group remained open should future projects require its attention.

From 1 July 2012, our governing legislation was amended to reflect changes to the *Health Practitioner Registration and Other Legislation Amendment Act 2012,* which abolished the Queensland registration scheme for dental technology and speech pathology practitioners. Amendments were also made to the HQCC Act as a consequence of the Health and Hospital Service network commencing on 1 July 2012. During the year we undertook a legislative review project to consider further amendments to strengthen the HQCC Act. These were subsequently considered during the development of the draft *Health Ombudsman Bill 2013*, which was introduced to the Legislative Assembly in June 2013.

Organisational chart



Reporting to our community

We are accountable to Parliament and the Queensland community. Our corporate governance framework ensures we are transparent, responsible and ethical in the way we operate, make decisions, and report to stakeholders.

Minister for Health

Our independent statutory body is funded by the Queensland Government and reports to Parliament through the Minister for Health.

Under our legislation, the Minister for Health may direct us to investigate serious healthcare issues. We received one Ministerial referral in 2012-13 and closed two investigations referred by the Minister in previous years.

The Commissioner and CEO met with the Minister for Health, the Honourable Lawrence Springborg MP, in October 2012 and January and May 2013. The Minister and Assistant Minister for Health, Dr Christopher Davis, toured our office in August 2012 and met with the Commission and staff.

Parliamentary committee

In addition to the Ministerial reporting responsibilities, our agency is also overseen by a bi-partisan parliamentary committee. The Health and Community Services Committee (HCSC) has oversight responsibility for the HQCC. The committee's role is to:

- monitor and review the performance by the HQCC of its functions
- report to the Legislative Assembly on:
  - any matter concerning the HQCC, its functions or the performance of its functions
  - any changes to the functions, structures and procedures of the HQCC that are desirable for more effective operation of the HQCC or the HQCC Act
- examine the annual report of the HQCC and, if appropriate, comment on any aspect of the report.

We appreciate the importance of our accountability to Parliament and the Queensland community and take seriously our responsibilities to provide clear and transparent information to the committee about our role and work.

At 30 June 2013, the Health and Community Services Committee comprised:

- Chair Mr Trevor Ruthenberg MP, Member for Kallangur (Chair from November 2012)
- Deputy Chair Mrs Jo-Ann Miller MP, Member for Bundamba
- Ms Ros Bates MP, Member for Mudgeeraba
- Mr Steve Davies MP, Member for Capalaba
- Dr Alex Douglas MP, Member for Gaven
- Mr John Hathaway MP, Member for Townsville
- Mr Dale Shuttleworth MP, Member for Ferny Grove.

Previous committee members and terms:

- Mr Peter Dowling MP, inaugural HCSC chair, Member for Redlands (18 May to 27 November 2012)
- Mr Aaron Dillaway MP, Member for Bulimba (18 May to 29 November 2012)
- Mrs Desley Scott MP, Member for Woodridge (18 May 2012 to 12 February 2013)
- Mr Michael Trout MP, Member for Barron River (18 May to 27 November 2012)

The Chair, Mr Peter Dowling, and Deputy Chair, Mrs Jo-Ann Miller visited the HQCC on 20 September 2012 and met with the Commission.

During the year, the HCSC held two public hearings on the oversight of the HQCC. The first, on 1 August 2012, was attended by our Commissioner and Chief Executive Officer (CEO). The second, held on 22 May 2013, was attended by our CEO and Assistant Commissioner, Patient Safety Dr John O'Donnell.

The Commissioner and CEO also attended the Health and Community Services Committee Estimates Committee hearing on 17 October 2012.

The HCSC tabled its first report on the oversight of the HQCC (*Report No.21 Oversight of the Health Quality and Complaints Commission)* in the Legislative Assembly on 26 April 2013. The report was informed by:

- evidence given by the HQCC Commissioner and CEO at a public hearing on 1 August 2012 and at a Budget Estimates hearing on 17 October 2012
- the HQCC's 6 July 2012 response to pre-hearing questions on notice
- the HQCC's 20 December 2012 response to the committee's request for information and comment
- HQCC annual reports
- the HQCC's *Annual health check 2011*
- other HQCC special reports
- the HQCC's *Organisational review report 2011*.

The HCSC's report commented on issues raised by its predecessor, the Health and Disabilities Committee, gave an overview of the HQCC's performance of its functions, and remarked on the HQCC's *Annual report 2011–12.*

The HCSC made three recommendations and 10 comments, which are listed below together with the Minister for Health's response. The Minister's response was tabled in the Legislative Assembly on 26 July 2013.

Recommendation 1

The committee recommends that the Health Quality and Complaints Commission measure and report on the timeliness of conciliation closure as the time between the date a decision is made to conciliate a complaint and the date the conciliation is closed.

Recommendation supported.

The HQCC has advised that in future annual reports, it will measure and report on the timeliness of conciliation closure as follows:

- the time between the date of the notice of assessment decision and the date the conciliation is closed; and
- the time between the date the conciliation is allocated to a conciliator and the date the conciliation is closed.

Recommendation 2

The committee recommends that, in light of HQCC's decision not to conciliate claims for damages - elements of which HQCC identified as causes of delay in conciliation, the HQCC:

- review its current performance target of completing 60 per cent of conciliations within 12 months, and
- consider a performance target which aims to close a higher proportion of conciliations within 12 months, or to close conciliations in a period of less than 12 months.

Recommendation supported for 2013-14.

The HQCC has advised that the Commission has implemented a new conciliation policy, effective from 29 January 2013.

The key improvements the HQCC reports have been made to the conciliation service include:

- an emphasis on direct involvement by, and cooperation between, the parties to encourage complaint resolution within prescribed directions and timelines;
- resolution outcomes focused on achievable personal outcomes such as apology, explanation, refund and/or fee waiver; and
- compensation (limited to out-of-pocket expenses and/or corrective treatment costs paid).

The HQCC has advised that this policy will enable it to conciliate complaints in most cases within a maximum of six months and focus the conciliation service on improving the quality of health services and reviewing and managing healthcare complaints, as set out in the *Health Quality and Complaints Commission Act 2006* (the Act).

The HQCC has yet to finalise any conciliations accepted under the new policy. Consequently, it reports that the 2012-13 target of 60% of complaints in conciliation closed within 12 months remains unchanged, and performance against this target will be reported in the 2012-13 annual report.

The HQCC has advised that it has revised its 2013-14 conciliation performance targets as follows:

- 70% of complaints in conciliation closed within six months
- 85% of complaints in conciliation closed within nine months
- 100% of complaints in conciliation closed within 12 months.

Performance against these targets will be reported in the 2013-14 annual report.

Committee comment 1

The committee notes that despite a reduced number of complaints referred for investigation in 2011–12 and more investigators, the time taken to complete investigations increased, contrary to the HQCC's expectations. The committee remains concerned about the length of time taken to complete investigations. The increased period for completion of investigations in 2011–12 is of significant concern to the committee. The committee will continue to monitor the number and type of complaints that are investigated, and the time taken to complete investigations, as the new investigation prioritisation criteria are applied and new processes for management of investigations are implemented.

Comment noted.

The HQCC reports that in 2011-12, its efforts were focused on finalising major investigations, particularly those more than 12 months old. The HQCC advised that these investigations involved complex issues, which were resource intensive, with three senior investigators assigned to manage major cases, which were investigated simultaneously, and one of the senior investigators concentrated solely on finalising a long-term, multi-jurisdictional major investigation.

The HQCC also advised that investigation resources were required to assist in an internal organisational review and an external KPMG review of the investigation team. Both reviews considered the timeliness of investigations and how delays could be minimised. Following a recommendation of the KPMG, the HQCC established a fortnightly investigations management team meeting involving the investigation team manager, the CEO and the Commissioner, to oversight HQCC investigations.

In 2012-13, the HQCC reports that is has continued to focus on finalising major and long-standing investigations, while managing new investigations as efficiently as possible. The HQCC claims it has significantly reduced the number of investigations open for more than 12 months, and anticipates that most of these matters will be finalised by the end of July 2013, with other ongoing investigations being under 12 months old.

Two additional temporary investigation officers were appointed in early 2012. The investigation unit also reviewed and commented on Australian Health Practitioner Regulation Agency preliminary investigation reports and regularly reviewed registration board notifications, assessment cases, complaint reviews and other information as required.

The HQCC reports that due to staff attrition and resource demands across the HQCC, the planned increased allocation of staff for the investigation team in real terms was never fully realised.

Committee comment 2

The committee would be concerned if the identification of delays in an HQCC investigation caused by another organisation or individual led to the HQCC reducing its performance target for the timeliness of investigations.

Minister's response: comment noted.

The HQCC claims that it is committed to ensuring all investigations are managed in a timely way and that investigators have worked hard to finalise complex and lengthy cases while continuing to manage new investigations.

All identified delays that are unable to be resolved are documented and progressed by the unit manager with the Commissioner and CEO at the investigations management team meetings. Actions from the meeting are then implemented by staff.

The HQCC reports that is has implemented investigation prioritisation criteria after reviewing similar models adopted by other complaints agencies. Application of these criteria means that investigations are initially allocated a standard priority. Some standard investigations may be allocated a higher priority level and designated as intermediate. Investigations that meet the criteria for a major investigation are dealt with as high priority.

The HQCC has advised the following target completion times for investigations (Table 61):

Table 61: Investigation prioritisation criteria

Investigation	Priority	Target timeframe
Standard	Standard	0-200 days
Standard	Intermediate	0-300 days
Major	High	0-300+ days

Note 1: Priority lists and timeframes may be amended by the HQCC executive management team as required.

Note 2: The HQCC advises that case complexity may be relevant to the level of priority of an investigation, but it is not necessarily the only determining factor.

The HQCC reports that due to the number and diversity of investigations that can be conducted under Section 86 of the Act, the priority rating is subject to revision and can change according to emerging factors such as:

- new information identified during the investigation
- risk to public safety
- public interest factors
- referring external agency requirements
- resource implications, and
- direction from the Minister for Health under the Act.

The HQCC claims that application of the criteria has resulted in an increase in the number of older investigations being finalised, as well as an increase in the number of investigations being finalised within 12 months.

The Commission has resolved to retain its target of 70% of investigations closed within 12 months for the 2012-13 year. The HQCC reports that continued concentration on investigation cases open for 12 months or more has meant that as at 18 June 2013, it had finalised 35 out of 62 investigations within 12 months.

The HQCC has set its 2013-14 investigation performance targets as follows:

- 40% of investigations closed within nine months
- 70% of investigations closed within 12 months
- 100% of investigations closed within 24 months.

Committee comment 3

The committee will continue to monitor the number and type of complaints that are devolved to health providers, and the outcomes of those complaints.

Minister's response: comment noted.

The HQCC reports that investigations are devolved where it is determined issues would be best addressed by referring them back to healthcare facility/healthcare provider to conduct an internal review and report to the HQCC. In making a decision to devolve a matter, the HQCC has advised that the Commission considers the nature and seriousness of the complaint, the public interest, and the capacity of the provider to respond effectively.

The HQCC has advised that the process is managed by an investigation officer, who is also responsible for the monitoring and follow up of the implementation of recommendations arising from HQCC investigations, outstanding coronial matters, and matters referred to other agencies, such as the Crime and Misconduct Commission and Department of Health's Ethical Standards Unit.

Management and monitoring of investigations devolved to health providers by the HQCC for internal review and action includes:

- requests for further information and/or recommendations for improvement under section 20 of the Act
- review of responses to requests for further information, and actions towards implementation of recommendations, to assess provider progress towards fulfilment of section 20 obligations to demonstrate improvement in the quality of health services provided
- ensuring provider responses and action are delivered within agreed timeframes, including negotiation of extensions if required
- (based on provider responses and/or actions) the development of internal recommendations about case progression or closure for management approval.

Recommendation 3

The committee recommends that the HQCC:

- publish corrected data on issues in complaints for 2010–11 and 2011–12 in its Annual Report for 2012–2013, and
- ensure that the data remains comparable over time so that trends in complaint issues can be identified.

Minister's response: supported.

The HQCC reports the data presented on complaint issue categories on pages 36-38 of the HQCC's *annual report 2011-12* was collected using the same methodology that was used in 2010-11. However, in reviewing this data for the committee, the HQCC discovered an error in the automated calculations behind the generation of the 2010-11 and 2011-12 data. The corrected data for both years was provided to the committee in December 2012 and will be reported, together with 2012-13 data, in the HQCC's 2012-13 annual report to enable comparison and identification of trends in complaint issues.

Committee comment 4
The committee will continue to monitor developments in national safety and quality standards for health services and the standards made by the HQCC, including transition arrangements and HQCC resourcing.

Minister's response: comment noted.

Primary responsibility for making health care standards and reporting on compliance has been transferred to the Australian Commission for Safety and Quality in Health Care (ACSQHC). As part of the transition to the national safety and quality health service standards and the proposed introduction of a health ombudsman in Queensland, the HQCC will no longer require acute and day hospitals to report on self-assessed compliance with the HQCC's three healthcare standards.

In the interim, the HQCC will continue to monitor compliance with these standards by:

- monitoring healthcare complaints
- monitoring reportable events; and
- conducting random audits of compliance with a specific standard or responsive audits where we have specific concerns about a hospital's compliance.

Committee comment 5
The committee notes the HQCC's expansion of its monitoring of reportable events and suggests that the HQCC include in its Annual Reports the results relevant to safety and quality in health services and the HQCC resources allocated to this work.

Response: comment noted.

The HQCC advises that it will include a report in its 2012-13 annual report on the results of its activities in monitoring reportable events. The HQCC also intends to prepare a public report on reportable events.

Committee comment 6
In 2011, the HQCC agreed to provide the former Health and Disabilities Committee (HDC) with six-monthly updates on the engagement strategies implemented and the nature of complaints received from each of the different culturally and linguistically diverse (CALD) communities. Six-monthly reporting will continue for this Committee. Reporting on CALD enquiries and complaints is now also reflected in the HQCC's annual reporting.

Response: comment noted.

The HQCC has advised that it will continue to provide the Committee with six-monthly updates on the engagement strategies implemented and the nature of complaints received from CALD communities. The next update will be provided in the HQCC's 2012-13 annual report.

Committee comment 7
The committee will continue to monitor client satisfaction with the HQCC's complaint service and the outcomes of the HQCC's improvement action plan.

Response: comment noted.

The HQCC reports that it will continue to use client experience survey information to improve its service, as well as to report publicly on client satisfaction in its annual report and annual health check publications.

Committee comment 8
The former HDC recommended that it has reviewed the workforce retention data in its 2011-12 annual report and identified that the 2010-11 data included in the report is erroneous. Information reported in the 2010-11 annual report is correct. To correct the public record, the HQCC has confirmed that it will report the error in its 2012-13 annual report and include permanent retention rate and permanent separation rate data for the past three financial years.

Response: comment noted.

Committee comment 9
The Committee commends the HQCC for some improvements to reporting in response to the former HDC's recommendations about the provision of clear, consistent and transparent information about complaints in its annual report. The committee, however, notes that further work is required to ensure that the HQCC's reporting is clear, consistent and transparent. In particular, the committee considers that more consistent and transparent reporting on the total time for management of complaints to completion (including any time awaiting allocation) and other performance measures is required. Other areas for improvement include the issues raised in complaints, and ensuring this data is comparable over time. The committee suggests that the HQCC should use the refining of its complaints and investigations case management system as an opportunity to improve the usefulness of the data captured, as well as its presentation. The HQCC should also ensure that its ability to consider data trends over time is not compromised by changes to data capture, making arrangements for historical data to be recategorised if necessary to ensure comparability across years.

Minister's response: comment noted.

We strive to provide clear, consistent and transparent information about our work in managing healthcare complaints and monitoring healthcare safety and quality. The HQCC advises that during 2013 it is refining its complaints and investigations case management system to enable the capture and reporting of more detailed information on complaint management, including case allocation waiting times.

The HQCC claims that these changes will enable the comparison of data over time (see page 21).

Committee comment 10

The committee notes that meaningful reporting of performance measures requires improvement, in particular for the conciliation process, and that information on the time taken to manage complaints should be more comprehensive.

Minister's response: comment noted.

The HQCC has advised that future annual reports will include the following information on the timeliness of conciliation processes:

- the time between the date of the notice of assessment decision and the date the conciliation is closed, and
- the time between the date the conciliation is allocated to a conciliator and the date the conciliation is closed.

The HQCC claims that this will enable the Commission to report timeliness in a way that is consistent with a complainant's or respondent's experience of complaint management, as well as to report actual time taken in active complaint management (and increase the transparency of the waiting times for conciliation).

Following improvements to its complaint and investigation case management system, the HQCC has advised that the Commission will be able to report more detailed information on case allocation waiting times in our 2013-14 annual report.

Further information about the HCSC is available on the Queensland Parliament website, www.parliament.qld.gov.au/work-of-committees/committees/HCSC

Reporting to the community

Annual reports are key accountability documents and the principal way we report on our activities to Parliament and the Queensland community.

Our *Annual report 2011-12* was tabled in Parliament by the Minister for Health, the Honourable Lawrence Springborg MP, on 28 September 2012.

Our Commission

With wide-ranging and specialist expertise, the Commission sets our strategic direction and oversees operations and performance.

The Commission was established under Chapter 10 of the HQCC Act. The Commission's role is to:

- set strategic direction
- establish annual health priorities, milestones, and timeframes for completion
- identify emerging health issues and ensure these are acted upon
- determine whether health issue inquiries should be conducted
- review the completion 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 our progress and performance against stated goals.

The proposed reform of the health complaints management system in Queensland signalled by the Queensland Government's *Blueprint for better healthcare in Queensland* was high on the Commission agenda in 2013. Challenges included managing an increasing complaint caseload with limited resources and preparing the organisation for significant change in the year to come. Achievements included the implementation of our *Standards transition plan*, a full review and update of our governance framework, the revision of our strategic plan in light of the *Health Ombudsman Bill 2013*, and the continued implementation of our *Healthcare quality analysis and sharing plan*.

In December 2012, we farewelled Assistant Commissioner, Allied Health Professor Michele Clark and Assistant Commissioner, Public Service Mr Rodney Metcalfe. We thank Michele and Rodney for their leadership and valuable contribution to our organisation. In particular, we thank Michele for her service as Assistant Chair of our Consumer Advisory Committee and Rodney for his leadership of our Complaint Services Governance Committee.

In January 2013, we welcomed new Assistant Commissioner, Allied Health Mr Kos Sclavos. We decided not to fill the position of Assistant Commissioner, Public Service (which is not required by the HQCC Act), in line with Government directives to continually look for ways to reduce the cost of our operations while maintaining a high quality service to the Queensland community.

Meet our Commission

Adjunct Professor Russell Stitz AM, RFD MBBS, FRACS, FRCS Eng, FRCS Ed (Hon), FCSHK (Hon), FRCST (Hon), ASDA
Commissioner
First appointed Assistant Commissioner, Medical in January 2011. Appointed Commissioner in January 2012.
Now serving two-year term to 31 December 2013.

Russell is a senior colorectal surgeon at the Royal Brisbane and Women's Hospital (RBWH) and at the Wesley Hospital. He is Chair of the National Lead Clinicians Group, a member of the Health Care Committee of the National Health and Medical Research Council (NHMRC) and an Adjunct Professor at the University of Queensland. He also chairs the Specialist Connect Board and is an Honorary Member of the American Society of Colon and Rectal Surgeons, the Association of Coloproctology of Great Britain and Ireland and the Section of Coloproctology of the Royal Society of Medicine. He has been President of the Royal Australasian College of Surgeons, Chair of the Committee of Presidents of Medical Colleges (CPMC) and a Director of the Australian Medical Council.

Russell has been a pioneer in the development of laparoscopic colorectal surgery and has published and presented on many aspects of colorectal disease. He has a major interest in training, particularly in advanced laparoscopic surgery. He has also had a long career in the Army Reserve holding the rank of Colonel (Ret.) in the Royal Australian Army Medical Corps.

Professor Michele Clark PhD, B OccThy (Hons), BA, Grad Cert Health Econ
Assistant Commissioner, Allied Health
First appointed January 2008.
Completed final three-year term to 31 December 2012.

With a background in occupational therapy and community health, Michele is Director of Research Training in the Faculty of Health at QUT. In 2000, she was the Inaugural Director of the Australian Centre for Prehospital Research and was Foundation Professor of Rehabilitation Sciences and Head of the Occupational Therapy Unit at James Cook University. In 1998-99 she worked on the International Year of Older Persons for the United Nations in New York.

Mr Rodney Metcalfe LLB, Solicitor
Assistant Commissioner, Public Service
First appointed January 2008.
Completed final three year term to 31 December 2012.

Rodney comes from a successful career in local government, with 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. Rodney is also a member of the Conduct Review Panel for Councillors.

Adjunct Professor John O'Donnell MBBS, Dip RACOG, MHP, FRACMA, FACHSM, FAICD, FAIM
Assistant Commissioner, Patient Safety
First appointed 31 March 2011.
Now serving three year term to 31 December 2013.

John is a medical graduate of the University of Adelaide and has been managing public and private hospitals since 1984. John is a Master of Health Planning and a Fellow of the Royal Australasian College of Medical Administrators, the Australian Institute of Management and the Australian Institute of Company Directors. John has been Chief Executive Officer of the Mater Hospitals in Brisbane since November 2001. He is also a director of the Mater Foundation, and the Health Round Table Ltd. John is an Adjunct Professor, School of Medicine, University of Queensland and Adjunct Professor, Griffith Business School.

Dr John Rivers BSc (Med), MBBS, FRACP, FCSANZ, Grad Dip AFI, GAICD
Assistant Commissioner, Medical
First appointed June 2012.
Now serving 18-month term to 31 December 2013.

John is a consultant physician (cardiology) with more than 20 years' specialist practice across public, private and research sectors. He is the former chair of the St Andrew's Medical Institute and a Director of the Queensland Cardiovascular Group. John's work in clinical outcomes research has been widely published in peer-reviewed publications and at conferences.

Mr Kos Sclavos DUniv, BPharm, GradDipClinPharm, AdvDipCommPharmMgmt, FAIPM (HC), FACPP, FIPharmM, FAIM, FAICD, AACPA, MPS
Assistant Commissioner, Allied Health
First appointed January 2013.
Now serving a two-year term to 31 December 2014.

Kos has served as the National President of the Pharmacy Guild of Australia since 2005. Kos was also the Queensland Guild Branch President for nine years, and spent six years as the National President of the Australian Institute of Pharmacy Management. Trained as a clinical pharmacist, Kos was a driving force behind eHealth and industry initiatives, including Project Stop, tracking sales of pseudoephedrine, the development of a unique electronic prescriptions system called eRx prescription and the Quality Care Pharmacy Program. In 2008, Kos was awarded an honorary doctorate by Griffith University for services to pharmacy. The Pharmaceutical Society of Australia (PSA) Young Pharmacist of the Year in 1999, Kos has also received the PSA Bowl of Hygeia Award, which recognises exceptional individual service to the profession, and Epilepsy Australia's Allied Health Education Worker of the Year Award.

Mr Mark Tucker-Evans
Assistant Commissioner, Consumer Issues
First appointed January 2011.
Now serving three year term to 31 December 2013.

Mark is the Chief Executive of COTA (Council on the Ageing) Queensland. He is also chair of Health Consumers Queensland, an Executive Member of the Queensland Clinical Senate, a Director of Check Up Australia, member of the State-wide Older Persons Health Clinical Network, and a member of the University of Queensland School of Medicine Consultative Council, the Public Panel of Assessors, the Queensland Civil and Administrative Tribunal, and the Advisory Council to the Energy and Water Ombudsman Queensland. He is vice president of the QCOSS (Queensland Council of Social Service).

Professor Catherine Turner RN, BA, GradDip Ed, MN, PhD
Assistant Commissioner, Nursing
First appointed January 2011.
Now serving three-year term to 31 December 2013.

With a background in nursing, education and population health, Cathy is Professor and Head of the School of Nursing and Midwifery at the University of Queensland. Cathy has been the recipient of a Fulbright Scholarship and a National Health and Medical Research Council (NHRMC) Research Fellowship. She has published more than 100 peer-reviewed journal publications and conference presentations and, as the lead investigator, attracted more than $5 million in competitive Australian Research Council, National Health and Medical Research Council (NHMRC), and industry grant funding within the past seven years.

Commission meeting attendance

Table 62: Commission meeting attendance

Name	Eligibility to attend	Meetings attended	Jul	Aug	Sep	Oct	Nov	Dec	Feb	Mar	Apr	May	Jun
Adjunct Professor Russell Stitz	11	11	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Professor Michele Clark	6	6	✓	✓	✓	✓	✓	✓					
Mr Rodney Metcalfe	6	6	✓	✓	✓	✓	✓	✓					
Professor John Devereux	11	9	✓	x	✓	✓	✓	x	✓	✓	✓	✓	✓
Professor Catherine Turner	11	8	✓	✓	x	✓	✓	x	✓	✓	✓	x	✓
Mr Mark Tucker-Evans	11	10	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	✓
Dr John O'Donnell	11	9	✓	✓	✓	✓	✓	x	✓	x	✓	✓	✓
Dr John Rivers	11	11	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mr Kos Sclavos	5	4							✓	x	✓	✓	✓

Table 63: Strategic planning meeting – Commission attendance

Strategic planning meeting	Feb 2013
Adjunct Professor Russell Stitz	✓
Professor John Devereux	✓
Professor Catherine Turner	✓
Mr Mark Tucker-Evans	✓
Dr John O'Donnell	✓
Dr John Rivers	✓
Mr Kos Sclavos	✓

Table 64: Commission remuneration 2012-13

	Remuneration
Commissioner	$106,587
Assistant Commissioner	$ 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).

The total remuneration paid to the Commission in 2012-13 was $270,983.31(2011-12: $282,436.68).

Advice and scrutiny

Our corporate governance framework demands that we effectively mitigate risk, seek advice to improve, regularly scrutinise our performance, decisions and processes, and comply with legal requirements.

Governance committees

In 2012-13, two governance committees reported to the Commission.

Audit and Risk Governance Committee

The Audit and Risk Governance Committee reports to and advises our Commission. The committee provided independent assurance and assistance on risk, control and compliance frameworks, and external accountability responsibilities prescribed in the HQCC Act.

The committee met in July and September 2012 and in February 2013. At the September meeting, the Commission agreed to reduce the frequency of Audit and Risk Committee meetings from quarterly to six-monthly, meeting in February to review the July to December financial statements and risk register. Quarterly reports were provided to the Commission.

The committee observed its terms of reference and had due regard to *Queensland Treasury Audit Committee Guidelines – improving accountability and performance,* December 2009.

The committee comprised three members of the Commission and an external member. The CEO is an ex officio member.

2012-13 achievements included oversight of:

- preparation of quarterly and annual financial statements
- quarterly legislative compliance reports
- quarterly risk register review and internal audit of risk management
- review of delegations manual
- review of *Financial Management Practice Manual*
- review of Building Owner Incentive to match the life of the building lease
- review of *Absentee policy* and procedures
- engagement of an internal auditor for two years (July 2012 to June 2014)
- the October 2012 review by KPMG of our investigations processes and procedures (see page 33).

Chair
Adjunct Professor John O'Donnell - Assistant Commissioner, Patient Safety

Membership
Adjunct Professor Russell Stitz - Commissioner
Mr Rodney Metcalfe - Assistant Commissioner, Public Service (to December 2012)
Mr Kos Sclavos - Assistant Commissioner, Allied Health (from January 2013)
Mr Len Scanlan - external member. Mr Scanlan was the former Auditor General of Queensland from 1997 to 2004.
Adjunct Professor Cheryl Herbert - Chief Executive Officer (ex officio).

Mr Scanlan received remuneration of $2175 (2011-12: $3450).

Complaint Services Governance Committee

In 2012-13, we retired our Complaint Services Governance Committee and replaced it with a regular meeting of the complaint services management team and the CEO, which considered case management efficiency and effectiveness, staffing issues and quality improvement initiatives, such as the development of updated policies and procedures and new workflows for triage and early resolution (see page 32).

In addition, following a recommendation of the KPMG review of our investigations processes and procedures, we established a fortnightly investigations management team meeting involving the investigation team manager, the CEO and the Commissioner. This year, the team focused on improving investigation timeframes. All identified delays in investigations which were unable to be resolved at the unit level were documented and progressed by the unit manager with the Commissioner and CEO. Actions arising from the meeting were then implemented by staff.

To assist in prioritising the investigation workload, we developed and implemented our own investigation prioritisation criteria based on similar models adopted by other complaint agencies.

Auditing our performance

Our strategic internal audit plan and annual internal audit plans set out how we check the effectiveness and efficiency of our internal control systems and compliance with legislation, policies and procedures. These plans were approved by the Commission.

The Audit and Risk Governance Committee monitored the plans in line with the Queensland Treasury Audit *Committee Guidelines – improving accountability and performance*, December 2009.

In June 2012, we invited three suppliers to submit a quotation and proposal for the internal audit function, and following review of the proposals in line with Queensland Government procurement guidelines, we reappointed KPMG for a further two years to June 2014. This reappointment provides continuity to our internal audit approach.

Following a core business process internal audit, KPMG reported to the July 2012 Audit and Risk Governance Committee meeting. At the time, risk control processes were tested and approved. We have since acted on their findings which required us to:

- enhance the business process to notify our information management team of new and terminated employees
- develop a termination checklist
- update bank signatories list regularly.

We have a termination policy and conduct exit interviews, which exceeds requirements.

In 2012-13, KPMG conducted a risk register review in February 2013 and a review of our investigations processes and procedures (see page 33).

Auditing our finances

In addition to the internal audit plan, the Queensland Audit Office undertook its annual audit of our financial documentation – both source documents and electronic systems – to ensure the accuracy and fairness of our reporting under the *Financial Accountability Act 2009*.

We met 2012-13 deadlines for the preparation of financial reports. For the independent auditor's report, see page 126.

The 2011-12 financial audit identified three areas for improvement:

Moderate risk:

- out-dated delegations list
- excessive annual leave balances of more than six weeks.

Low risk:

- poor cash control of monies received as payment for computers sold through staff auction.

We took corrective action on all identified risks, updating our delegations list, working with staff to reduce annual leave balances of more than six weeks, and reviewing and revising cash handling procedures.

On 17 October 2012, the Commissioner and CEO attended the Health and Community Services Committee Estimates Committee hearing for scrutiny of our financial and non-financial performance (both current and future) as part of the Queensland Government budget process.

Managing risk

Risk management is an integral part of our decision-making, planning and service delivery, and we reviewed and reported our progress quarterly.

Our risk management process is modelled on the *Australian/New Zealand Standard for Risk Assessment AS/NZS 4360* and overseen by our Audit and Risk Governance Committee, which reported to the Commission.

In December 2012, we reviewed and revised our *Business continuity plan* and ensured the plan was operable over the mandatory Christmas closure period.

Meeting our legislative obligations

Under our legislative compliance program, we conducted quarterly reviews of our compliance with the 68 applicable mandatory obligations of the HQCC Act.

Our audits indicated we were 100% compliant with 62 of these 67 provisions.

At 30 June 2013, the audit showed we had achieved only partial compliance with:

- Section 49E(3)(b)
  Early resolution (individual registrants)
- Section 53
  Early resolution (all other health service providers)
- Section 54
  Notice of decision to assess health service complaint
- Section 58
  Time limit on assessment
- Section 214
  Preservation of confidentiality

Sections 49E(3)(b), 53, 54 and 58 relate to the management of healthcare complaints within set timeframes.

A continued increase in the number of complaints received meant new written complaints could not always be allocated to an officer for immediate early resolution or assessment, due to existing caseloads.

Complaints which presented an immediate patient safety risk or immediate healthcare issue were allocated immediately.

Depending on new complaint numbers and available staffing, case allocation waiting times ranged from immediate allocation to up to 12 weeks during the year.

Resourcing issues also impacted on our ability to notify healthcare providers within the required 14 days that we intended to assess complaints about them. We achieved 98% compliance with this provision.

While we aimed for 100% compliance with legislated timeframes for complaint management, we closed 77% of early resolution complaints within 30 days from commencement and 93% of complaint assessments within 90 days of commencement.

Partial compliance related to managing complaints within set timeframes occurred due to a variety of reasons including:

- staff movement which resulted in some cases having to be reassigned, reviewed and actioned by other officers
- resolution was likely and imminent (e.g. if a complainant or provider had been difficult to contact or where a provider requested an extension to adequately address the complaint issues)
- less than a full complement of early resolution and assessment staff until March/April 2013
- an occasional administrative processing error which recorded a delay where a delay had not actually occurred
- a delay in a complainant, provider or external independent clinician responding to our requirement for information
- the impact of the Christmas closure and holiday period on staff absences and complainant, provider or clinical adviser availability.

To address issues within our control, we:

- ceased authorising any extensions for early resolution, and cases were immediately referred to assessment for action
- moved staff between teams to share the caseload, however acknowledge we are not always able to control staff movements
- streamlined processes and procedures to provide more efficient complaint management
- provided refresher training in administrative processes which support complaint timeframe management
- plan to supplement our existing panel of independent clinical advisers
- employed additional early resolution and assessment staff to manage the growing caseload.

Both teams are now at full complement.

Partial compliance relating to the preservation of confidentiality section occurred due to:

- identifying information being included in a draft report provided to a number of health organisations for review
- correspondence being sent to the wrong practice or practice where a provider was no longer employed
- an emailed letter being sent to the wrong person or wrong address (e.g. provider with the same surname, or practice which was assumed to be within a hospital)
- incorrect administrative procedures (i.e. filing a complaint against an unrelated case), which resulted in the wrong provider receiving a letter
- a transcript being attached to an unrelated case in error.

Actions following privacy breaches complied with our Privacy Policy requirements.

To mitigate future privacy breaches, reports will be checked for any identifying information before being circulated to any steering committee or review groups. New processes ensure our complaint and investigation case management system is updated more frequently with correct contact details and staff have been asked to ensure all provider details are current and correct before sending correspondence. Additionally, staff are required to open and check all attachments before sending an email. To avoid confusion over providers who share the same surnames, staff are required to contact the provider in question by telephone before sending confidential correspondence and to also check the provider register on the AHPRA website.

The legislative compliance program also involved quarterly reviews of our compliance with other legislation. A compliance management framework and policy set out our obligations, accountabilities, reporting and audit mechanisms.

At 30 June 2012, we achieved full compliance with governance and risk management standards related to our *Governance road map*, *Risk register* and the *IS18 Information security standard.* We reviewed and updated our corporate governance framework to ensure effective planning, measurement and monitoring of results and public reporting in line with the Queensland Government's *Performance Management Framework*.

Ensuring client privacy

Client privacy and confidentiality are core values of our service.

Unfortunately, in 2012-13 we identified 33 privacy breaches (2011-12: 10) involving the inadvertent unauthorised disclosure of an individual's personal information contrary to Information Privacy Principle 11.

On each occasion, we took steps to contain the breach (such as retrieving the documents/information disclosed), advised the individual concerned about the privacy breach, apologised for the error and provided information on their right to make a complaint to the Privacy Commissioner.

We also put in place improved processes to prevent breaches from happening again, such as regular updates of healthcare providers' contact details in our complaint and investigation case management system and double-checking the contact details of a healthcare provider before sending any correspondence.

Legislative amendments

On 20 May 2013, the *Health Practitioner Registration and Other Legislation Amendment Act 2013* abolished the Queensland registration scheme for dental technology and speech pathology practitioners.

Consequential amendments were made to the HQCC Act omitting references to these state registered professions and deleting provisions relating to management of complaints about state registered professions.

Amendments were also made to the HQCC Act as a consequence of the Hospital and Health Services network commencing on 1 July 2012.

Keeping excellent records

Sound recordkeeping practices underpin good corporate governance.

We use an electronic document and records management system (eDRMS) to help us make, manage and keep full and accurate records of our activities, as required by the *Public Records Act 2002*.

All new employees received records management and eDRMS training and access to ongoing internal support.

Our Corporate Records Committee, with representatives from each business unit, met bi-monthly to discuss recordkeeping issues and information security.

We did not identify any serious breach of our information security in 2012-13.

Advisory committees

To ensure the Commission kept in touch with grassroots consumer concerns and the latest clinical issues, we consulted with two advisory committees.

Our consumer and clinical advisory committees are established under section 169 of the HQCC Act. They are a highly valued part of our organisation, providing essential consumer and clinical insight, advice and feedback on healthcare issues, as well as supporting our work in improving the safety and quality of healthcare.

The consumer and clinical advisory committees each comprised two members of the Commission and members from a variety of specialties and backgrounds. Members serve two-year terms and the committees met twice, in July and December 2012. We suspended meetings in 2013 until more was known about the impact of changes to the health complaints management system in Queensland.

We had planned to renew committee membership this year, but again, due to the transition to the Health Ombudsman, in May 2013 the Commission decided to extend all current committee member terms to 31 December 2013.

During the year, each committee provided advice on our *Healthcare quality analysis and sharing plan* and our draft reports prior to publication, contributed to submissions on healthcare safety and quality issues, and raised issues of concern to healthcare consumers and clinicians.

Between meetings, committee members were kept informed by email. To minimise costs, we decided to hold only one face-to-face meeting during the year and to trial teleconferencing for members based outside Brisbane.

Advisory committee member remuneration is set according to the *Remuneration of Part-time Chairs and Members of Government Boards, Committee and Statutory Authorities* policy administered by the Department of Justice and Attorney-General. Members may claim $141 for a meeting of less than four hours and $281 for a meeting of more than four hours.

The total cost of the advisory committees in 2012-13 was $8253.28:

- Consumer Advisory Committee – $4081.19
- Clinical Advisory Committee – $4172.09

These costs included meeting sitting fees as outlined above, travel and accommodation costs for members from regional Queensland, and catering.

Attendance record

12 July 2012
Consumer Advisory Committee meeting

Attendance:

- Assistant Commissioner Mr Mark Tucker-Evans (Chair)
- Assistant Commissioner Professor Michele Clark (Assistant Chair)
- Ms Helena Lake
- Ms Louise Judge
- Ms Lynette Moyle
- Ms Marie Pietsch
- Mr Terry Lees.

Apologies:

- Ms Rebecca Kok
- Commissioner Adjunct Professor Russell Stitz.

24 July 2012
Clinical Advisory Committee meeting

Attendance:

- Assistant Commissioner Professor Catherine Turner (Chair)
- Commissioner Adjunct Professor Russell Stitz
- Dr Derek Lewis
- Adjunct Associate Professor Stephanie Fox-Young
- Dr Cameron Bardsley
- Dr John Rivers
- Dr John North.

4 December 2012
Joint advisory committees meeting

Attendance in person:

- Assistant Commissioner Professor Catherine Turner (Chair)
- Dr Derek Lewis
- Adjunct Associate Professor Stephanie Fox-Young
- Dr John North
- Assistant Commissioner Mr Mark Tucker-Evans
- Ms Rebecca Kok.

Attendance by teleconference:

- Dr Cameron Bardsley
- Dr John Rivers
- Ms Helena Lake
- Ms Louise Judge
- Ms Lynette Moyle
- Ms Marie Pietsch
- Mr Terry Lees.

Apologies:

- Assistant Commissioner Professor Michele Clark.

Consumer Advisory Committee

Chair

Mr Mark Tucker-Evans - Assistant Commissioner, Consumer Issues
Appointed January 2011.
Now serving three-year term to 31 December 2013.

Assistant Chair

Professor Michele Clark - Assistant Commissioner, Allied Health
First appointed January 2008.
Served three-year term to 31 December 2012.

Membership

Mrs Louise Judge

Appointed June 2011.
Now serving 30-month term to 31 December 2013.

Louise is a community worker in South Burnett and brings to the committee her wealth of experience in community and rural health. Currently the coordinator of Centacare South Burnett, Louise is a member of the Queensland Council of Social Service board, the Kingaroy Health Consultative Committee and the Australasian Centre for Rural and Remote Mental Health – Rural and Remote Mental Health Advisory Group. Louise was named South Burnett Citizen of the Year in 2010 and has a strong interest in identifying the needs and challenges specific to regional areas.

Ms Rebecca Kok

Appointed June 2011.
Now serving 30-month term to 31 December 2013.

Rebecca is Manager, Advocacy Services with QADA (Queensland Aged and Disability Advocacy Inc.) Rebecca holds a Bachelor of Social Work and has experience working with youth, families, people with disabilities and the elderly. Rebecca has strong networks with healthcare consumers within the aged and disability sectors and is passionate about assisting vulnerable people in the community.

Ms Helena Lake

Appointed June 2011.
Now serving 30-month term to 31 December 2013.

Helena is an experienced consumer representative, who brings her personal experience as a carer to the committee. Helena was a member of the now disbanded Health Community Council at Royal Brisbane and Women's Hospital and participated in the review of Root Cause Analysis legislation for the Department of Health's Patient Safety and Quality Improvement Service. Helena's current serving positions include senior consumer representative on the Appeals and Monitoring Committees for Medicines Australia; Queensland Bedside Audit (QBA), Open Disclosure, and Patient Experience with the Department of Health's Patient Safety and Quality Improvement Service; and governance roles on the Consumer & Community Engagement, Clinical Handover, and Recognition and Management of the Deteriorating Patient Committees at the Royal Brisbane and Women's Hospital.

Mr Terry Lees

First appointed in July 2009.
Now serving 30-month term to 31 December 2013.

Terry's background is in spiritual ministry, social services, consulting, media, and business development. In 2006, Terry contributed to the establishment of the Centre for Rural and Remote Mental Health Queensland and now serves as a Director on the Board of the Australasian Centre for Rural and Remote Mental Health. He participates in various health-related network groups in northwest Queensland and has held numerous board and directorship positions, including six years as a director and chair of Australian Rotary Health.

Mrs Lynette Moyle

Appointed June 2011.
Now serving 30-month term to 31 December 2013.

Lynette has more than 30 years' experience as a consumer health representative. As an inaugural member of the Innisfail District Kidney Dialysis Support Group, she successfully lobbied for a dialysis unit at Innisfail Hospital. Lynette was also a founding member of the Diabetes Support Group and organised the first diabetes seminar in Innisfail. Lynette is an experienced medical receptionist and is currently a member of the Innisfail Hospital Consumer Group and Innisfail Breast Cancer Support Group. Lynette is also a member of Friends of the Far North Queensland Hospital Foundation Volunteer Group in Innisfail.

Mrs Marie Pietsch

First appointed to the Consumer Advisory Committee in October 2008.
Now serving a 30-month term to 31 December 2013.

Marie's tireless work in representing health consumers earned her a 2003 Centenary Medal and a 2005 Australia Day Medal. Marie is chairperson of the local Community Advisory Network and a community member of the Inglewood Multipurpose Health Service Management Committee.

Clinical Advisory Committee

Chair

Professor Catherine Turner - Assistant Commissioner, Nursing
Appointed January 2011.
Now serving three-year term to 31 December 2013.
Chair of the Clinical Advisory Committee from July 2012.

Assistant Chair

Dr John Rivers - Assistant Commissioner, Medical
Appointed June 2012.
Now serving 18-month term to 31 December 2013.

Membership

Dr Cameron Bardsley MBBS, DRANZCOG adv, FRACGP, FACRRM
First appointed October 2006.
Now serving 30-month term to 31 December 2013.

Cameron has worked as a doctor for the past 20 years, most of that time at St George Hospital, where he is 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.

Adjunct Associate Professor Stephanie Fox-Young
RN, BA(Hons) (Qld), GradDipEd (Canberra CAE), MEd (CCAE), PhD (QUT), FACN (DLF)
First appointed October 2008.
Now serving 30-month term to 31 December 2013.

Stephanie is on the Board of the Australian College of Nursing and until her recent retirement, she had more than 30 years' experience in clinical practice, education and regulation roles. She is an adjunct Associate Professor with the School of Nursing and Midwifery at the University of Queensland. Her work has been published in nursing and medical journals.

Dr Derek Lewis BDSc (Qld) FICD FADI FPFA
First appointed October 2006.
Now serving 30-month term to 31 December 2013.

Derek has been a dental practitioner in Queensland for more than 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.

Dr John North MBBS, FRACS, FAOrthA
First appointed in June 2012.
Now serving two-year term to 30 June 2014.

John is a consultant orthopaedic surgeon with more than 38 years' specialist practice across the public and private sectors. He is a senior visiting orthopaedic surgeon at Princess Alexandra and Mt Isa Hospitals. He chairs the QComp Orthopaedic Assessment Tribunals and is the Clinical Director of the Queensland Audit of Surgical Mortality as well as a past President of the Australian Orthopaedic Association.

Our office

Our executive team provides leadership and direction to our staff and ensures we meet our strategic priorities and legislative responsibilities in a way that is open, accountable, ethical and responsible.

The executive team met fortnightly to improve operational performance and drive continuous improvement. Major achievements for the year included the oversight and coordination of strategic projects (see paper light, page 70 and reportable events, page 54), a significant reduction in supplies and services costs (see page 93) and improvements in complaint and investigation management (see page 32) and quality monitoring (see page 58).

Staff movements in the first half of the financial year resulted in a smaller and flatter executive structure, with the new team comprising:

- CEO Adjunct Professor Cheryl Herbert
- Manager, Client and Clinical Services Ms Liz Kearins
- Manager, Resolution and Assessment Services Ms Leah Milburn-Walker
- General Counsel, Legal and Conciliation Services Ms Brooke Roberts
- Manager, Investigations Mr David McKenzie
- Manager, Corporate Services, Information and Quality Mr Shaun Nesbitt
- Manager, Business Services Ms Julie Imber.

Meet our executive team

Adjunct Professor Cheryl Herbert RN, RM, DipAppSc, BAppSc, FRCNA
Chief Executive Officer
First appointed September 2006.
Reappointed September 2011.
Now serving five-year term to 25 September 2016.

Cheryl is our founding CEO, joining us in September 2006 after 10 years as CEO of Spiritus (formerly St Luke's Nursing Service), which she transformed to be one of Queensland's largest not-for-profit community organisations. As a registered nurse and midwife, Cheryl has worked in community, aged care and acute settings, as well as in academic and management positions.

Cheryl is an Adjunct Professor of the Faculty of Health Sciences at the University of Queensland. She holds positions on various boards and committees including Wound Management Innovation CRC Pty Ltd, Greater Metro South Brisbane Medicare Local, Lives Lived Well Pty Ltd, Peachtree Perinatal Wellness Inc and Advisory Committees for the Australian Council on Healthcare Standards (ACHS) and Queensland University of Technology Faculty of Health.

The CEO is appointed by the Governor in Council for a five-year term

Ms Liz Kearins Cert Journalism, DipBusStud, MPRIA, AFAIM
Manager, Client and Clinical Services
Commenced May 2008.

Liz has extensive experience in public/private sector community engagement, communications, marketing, media and journalism. She has worked in her native New Zealand, the United Kingdom and Australia. Before joining us, Liz held senior communication roles in the resources, local government, environment, tourism and health sectors. Liz's role includes executive leadership of our complaint triage, healthcare professional registration board liaison, clinical advice and opinion, and community engagement teams.

Client and Clinical Services triages healthcare complaints to decide the best complaint management pathway; liaises with health professional registration boards on complaint handling; sources and provides clinical advice and opinion; and manages our engagement strategy, corporate communications, governance and reporting, media liaison, and online presence.

Ms Leah Milburn-Walker BBus, BEd
Manager, Resolution and Assessment Services
Commenced November 2007.

Leah was appointed Manager, Resolution and Assessment Services in August 2010. She is a qualified quality management practitioner and auditor. Leah has more than 25 years' experience in government undertaking roles in complaint management system development, implementation and review, business analysis and process mapping, quality management system review and auditing, policy and procedure development, provision of training and education, complaint resolution and strategic management roles. She was previously awarded a Queensland Police Service medal for ethical and diligent service.

Resolution and Assessment Services works with healthcare consumers and providers towards early resolution of complaints, where appropriate, and independently and impartially assesses healthcare complaints to determine whether action is required and identifies safety and quality issues.

Ms Brooke Roberts LLB
General Counsel, Legal and Conciliation Services
Commenced July 2010.

Admitted as a Barrister at Law of the Supreme Court of Queensland in 1999, Brooke joined us from the former Medical Board of Queensland, where she managed the in-house legal service including disciplinary proceedings and litigation. Brooke has also held positions with the former Department of Primary Industries and Fisheries, Crown Law and the Office of the Director of Public Prosecutions, developing extensive experience in public administration and governance within the Queensland Government. Brooke's role includes executive management of our legal and conciliation teams.

Legal and Conciliation Services provides legal advice on complaint management and other matters; works with healthcare consumers and providers to resolve complaints through our confidential and privileged conciliation service; manages applications for access to our information; and considers complaint decision review requests.

Mr Dave McKenzie BA Justice Admin, AdvDip Public Safety, AdvDip Investigative Practices, Dip Policing
Manager, Investigations from December 2009. Commenced September 2008.

Dave has more than 26 years' experience in the investigation and management of complaint processes for a number of government agencies. He was formerly in charge of the Queensland Police Service Detective Training Program and is a certified workplace trainer and assessor for a number of nationally recognised qualifications. Dave is a member of the International Investigative Interviewing Research Group, the Institute for Learning Practitioners and the Corruption Prevention Network Queensland.

Our investigation team conducts in-depth examinations of systemic health service issues and health services that have, or could, put patient safety at risk and makes recommendations for healthcare safety and quality improvement.

Mr Shaun Nesbitt BSc (GeoI, ApplGeoI), PGDip Bus Mgmt, MBA
Manager, Corporate Services, Information and Quality
Commenced August 2009.

Shaun has wide-ranging experience in public/private sector information and communication technology (ICT). Since relocating from his native South Africa, he has worked with IBM and Telstra to develop and manage ICT process, architecture and strategy. Most recently, he was instrumental in developing a Queensland Government IT consolidation framework. Shaun's role includes executive leadership of our corporate services, information management and quality services teams.

Corporate Services, Information and Quality provides business intelligence and analysis services; and manages our information communication technology infrastructure, network, applications, web, and telecommunications. They also monitor the safety and quality of health services; analyse complaint, investigation, standard and reportable event data for patterns and trends; and report on lessons learned to drive improvement.

Ms Julie Imber BBus, GCertHlthMgmt, Dip Management
Manager, Business Services
Commenced November 2006.

Julie joined us in our first year of operation and has 25 years' experience in corporate services roles within the Queensland Government. Her skills include internal audit, risk management and policy development, workplace rehabilitation and work health and safety. Julie is also completing a Master in Business Administration, majoring in Human Resources.

Our business services team manages our finances, human resources, learning and development program, records management, and administrative support.

Former executive team members

Mr Peter Johnstone BCom, MBA
Executive Manager, Complaint Services
July 2007 to September 2012.

Peter joined us in our second year, having worked for 15 years in the dispute resolution field within the Department of Justice and Attorney General. During this time, Peter spent four years as Executive Manager of the Dispute Resolution Branch and received an Australia Day Award for service to government. Peter is a nationally accredited mediator and an adjunct lecturer with Griffith University's Law School.

Dr Alyson Ross EdD, PGradDipEd, BA (SocSc), DipBus (HRM)
Executive Manager, Quality Services
August 2009 to December 2012.

Alyson has a wealth of experience in large-scale reform, strategy and organisational development. Before coming to us, Alyson led the development of Gold Coast City Council's 30-year vision. She has held roles in the health and community sector and has worked with the National Health Service in England.

Outlook

Improving records management

The recordkeeping retention and disposal schedule will be reviewed in 2013-14 in consultation with Queensland State Archives. Specific, short-course training is planned for our recordkeeping staff on knowledge and information management. Staff will also be offered the opportunity to undertake a Certificate IV in Recordkeeping.

In 2013-14 we plan to audit all records to ensure compliance with Queensland State Archives protocols and to further consolidate the status of each complaint record, consistent with best practice recordkeeping.

Managing risk

We are mindful of the critical need for continuity of complaint management and investigation service delivery standards during the transition to the Health Ombudsman.

The challenge for the Office of the Commission is to maintain service standards with potentially fewer human resources. At 30 June 2013, five key personnel had already resigned due to uncertainty about their future employment. Other employees have advised they are considering their future with the HQCC due to the absence of staff transition arrangements in the *Health Ombudsman Bill 2013*.

We reviewed all positions and identified key roles that must remain filled to ensure service continuity. In the event of staff attrition, we will work with the Health Ombudsman transition team and use temporary contractors to address any shortfall.

If staff numbers reduce further, our strategic plan targets will be at risk and we may not be able to meet key performance indicators (KPIs). We will closely monitor our performance and keep the transition team and Minister for Health informed of any impacts of a reduction in our staff establishment. We will report on our performance against KPIs in our *Annual report 2013-14* with commentary on any variances.

When we are advised how transition will occur, we will help staff manage the change. By supporting the transition team, we will seek to achieve as seamless a transition as possible for the complainants and providers with whom we are working.

Financial overview

Highlights

- We reduced telephone costs by $29,094.
- We reduced consultancy costs by $140,913.
- We reduced travel costs by $18,647.
- We reduced stationery costs by $14,563.
- We reduced printing and postage costs by $26,996.
- We reduced administrative expenses by $99,628.

Overview

We continued to find efficiencies during 2012-13, with reductions in supplies and service spending ($112,535) including savings on telephone costs, consultancy costs, travel costs, stationery, printing and postage and administrative expenses.

We spent $9.934 million against a forecast of $10.301 million, ending the year with a budget surplus of $366,992.

Employee expenses accounted for almost three-quarters of our spending (73.5%) at $7.302 million, a decrease of $421,004.

We received additional funding of $272,000 from the Department of Health to continue to support the new payroll and finance systems implemented in 2011-12. No further funding will be received for payroll and finance systems from the Department of Health.

Outlook

As our human resources are impacted by the transition to the Health Ombudsman, we will continue to support appropriate staffing levels to ensure service quality does not decrease or is compromised.

Health Quality and Complaints Commission
Financial Statements

for the year ended 30 June 2013

Health Quality and Complaints Commission
Financial Statements 2012-13

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 info@hqcc.qld.gov.au, or visit the Commission's website www.hqcc.qld.gov.au.

Amounts shown in these financial statements may not add to the correct sub-totals or totals due to rounding.

Health Quality and Complaints Commission

STATEMENT OF COMPREHENSIVE INCOME

for the year ended 30 June 2013

	Notes	2013 $	2012 $
Income from Continuing Operations			
Grants and other contributions	2	10,170,000	10,078,000
Other revenue	3	130,681	299,354
Total Income from Continuing Operations		10,300,681	10,377,354
Expenses from Continuing Operations			
Employee expenses	4	7,302,420	7,723,424
Supplies and services	5	2,169,718	2,282,253
Depreciation and amortisation	6	434,311	451,336
Other expenses	7	27,240	100,259
Total Expenses from Continuing Operations		9,933,689	10,557,272
Operating Result from Continuing Operations		366,992	(179,918)

The accompanying notes form part of these statements.

Health Quality and Complaints Commission

STATEMENT OF FINANCIAL POSITION

as at 30 June 2013

	Notes	2013 $	2012 $
Current Assets			
Cash and cash equivalents	8	1,166,393	461,249
Receivables	9	74,531	276,762
Other current assets	10	78,829	61,734
Total Current Assets		1,319,753	799,745
Non Current Assets			
Intangible assets	11	456,817	605,316
Property, plant and equipment	12	1,438,964	1,563,052
Total Non Current Assets		1,895,781	2,168,368
Total Assets		3,215,534	2,968,113
Current Liabilities			
Payables	13	146,943	116,243
Accrued employee benefits	14	564,057	556,266
Other liabilities	15	139,311	139,311
Total Current Liabilities		850,311	811,820
Non Current Liabilities			
Accrued employee benefits	14	54,789	73,540
Other liabilities	15	640,069	779,380
Total Non Current Liabilities		694,858	852,920
Total Liabilities		1,545,169	1,664,740
Net Assets		1,670,365	1,303,373
Equity			
Accumulated surpluses		1,670,365	1,303,373
Total Equity		1,670,365	1,303,373

The accompanying notes form part of these statements.

Health Quality and Complaints Commission

STATEMENT OF CHANGES IN EQUITY

for the year ended 30 June 2013

	Accumulated Surplus/Deficit	
	2013	2012
	$	$
Balance as at 1 July	1,303,373	1,483,292
Operating Result from Continuing Operations	366,992	(179,918)
Balance as at 30 June	1,670,365	1,303,373

The accompanying notes form part of these statements.

Health Quality and Complaints Commission

STATEMENT OF CASH FLOWS

for the year ended 30 June 2013

	Notes	2013 $	2012 $
Cash flows from operating activities			
Inflows:			
Grants and other contributions		10,170,000	9,898,000
GST input tax credits from ATO		282,165	283,020
GST collected from customers		2,493	2,434
Interest receipts		126,792	288,899
Other		184,985	8,992
Outflows:			
Employee expenses		(7,316,634)	(7,626,914)
Supplies and services and other expenses		(2,322,664)	(2,560,399)
GST paid to suppliers		(260,269)	(287,362)
Net cash provided by operating activities	16	866,868	6,671
Cash flows from investing activities			
Outflows:			
Payments for property, plant and equipment		(161,724)	(80,617)
Payments for intangibles		(0)	(158,220)
Net cash (used in) investing activities		(161,724)	(238,837)
Net increase (decrease) in cash and cash equivalents		705,144	(232,166)
Cash and cash equivalents at beginning of financial year		461,249	693,415
Cash and cash equivalents at end of financial year	8	1,166,393	461,249

The accompanying notes form part of these statements.

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.

On 4 June 2013, the Minister for Health, the Honourable Lawrence Springborg MP introduced to Parliament the *Health Ombudsman Bill 2013* (the Bill). The primary policy objective of the Bill is to strengthen the health complaints management system in Queensland. The introduction of the Bill was signalled in the Queensland Government's Blueprint for Better Health Care in Queensland (released 27 February 2013) and follows three independent reports that highlighted fundamental deficiencies in the way the public is protected by the existing health complaints management system.

The main objects of the Bill are to protect the health and safety of the public; to promote professional, safe and competent practice by health practitioners; to promote high standards of service delivery by health service organisations; and to maintain public confidence in the management of complaints and other matters relating to the provision of health services. The Bill establishes a new statutory position of Health Ombudsman to manage health complaints, to be supported by the Office of the Health Ombudsman.

The *Health Ombudsman Act 2013* will repeal and replace the *Health Quality and Complaints Commission Act 2006* (HQCC Act) and the *Health Practitioners (Disciplinary Proceedings) Act 1999*, and to amend the *Health Practitioner Regulation National Law Act 2009* to ensure a seamless interaction with that law and the *Health Ombudsman Act 2013*. The Health Quality and Complaints Commission will continue to operate under its existing legislation until the HQCC Act is repealed.

At balance date, the Bill remains before the Parliament, having been referred to Health and Community Services Committee for consideration, and as such is subject to amendment before final passage into law. It is anticipated that all assets and liabilities of the Health Quality and Complaints Commission will be transferred to the Office of the Health Ombudsman at the values at which they will be held by Health Quality and Complaints Commission, the date of abolition. Refer to Note 19 for further detail.

1. Summary of Significant Accounting Policies

(a) Statement of Compliance

The Health Quality and Complaints Commission has prepared these financial statements in compliance with section 43 of the *Financial and Performance Management Standard 2009*.

These financial statements are general purpose financial statements and have been prepared on an accrual basis in accordance with Australian Accounting Standards and Interpretations. In addition, the financial statements comply with Queensland Treasury and Trade's Minimum Reporting Requirements for the year ending 30 June 2013, and other authoritative pronouncements.

1. Summary of Significant Accounting Policies (cont'd)

(a) Statement of Compliance (cont'd)

With respect to compliance with Australian Accounting Standards and Interpretations, the Commission has applied those requirements applicable to not-for-profit entities, as the Commission is a not-for-profit entity. Given the circumstances described in the Objectives and Principal Activities note above, management do not expect the Health Quality and Complaints Commission to continue in operational existence for the foreseeable future. Accordingly, the financial report has been prepared on a basis consistent with the going concern basis of preparation.

(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 outputs/major activities undertaken by the Commission are disclosed in Note 1(r).

(c) Administered Transactions and Balances

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

(d) Grants and Other Contributions

Grants, contributions, 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 grant revenue from Queensland Treasury and Trade through Department of Health.

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

(e) Other Revenue

Other revenue is principally interest derived from short term investments of surplus cash. This interest is recognised in the month that it is earned.

(f) Cash and Cash Equivalents

For the purposes of the Statement of Financial Position and the Statement of Cash Flows, 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 and Trade.

(g) Receivables

Trade debtors are recognised at the amounts due at the time of sale or service delivery. i.e. the agreed purchase/contract price. Settlement of these amounts is required within 30 days from invoice date.

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

1. Summary of Significant Accounting Policies (cont'd)

(h) Acquisitions of Assets

Actual cost is used for the initial recording of all non-current physical and intangible asset acquisitions. 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 architects' 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*.

(i) Property, Plant and Equipment

Items of property, plant and equipment 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 (including leasehold improvements)	$5,000

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

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

The carrying amounts for non-current physical assets and intangibles at cost do not materially differ from their fair value.

(k) Intangibles

Intangible assets with a cost or other value equal to or 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 straight line basis over the period of the expected benefit to the Commission, namely seven (7) years.

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

All intangible assets of the Commission have finite useful lives and are amortised on a straight line basis.

Property, plant and equipment (PP&E) is depreciated on a straight line (SL) 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.

1. Summary of Significant Accounting Policies (cont'd)

(l) Amortisation and Depreciation of Intangibles and Property, Plant and Equipment (cont'd)

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	14.00%

(m) 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 Statement of Comprehensive Income, 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.

1. Summary of Significant Accounting Policies (cont'd)

(n) Leases

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.

(o) 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.

(p) Financial Instruments

Recognition

Financial assets and financial liabilities are recognised in the Statement of Financial Position 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

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 financial instruments held by the Commission are included in Note 21.

(q) Employee Benefits

Wages, Salaries, Annual Leave and Sick Leave

Wages, salaries and recreation leave due but unpaid at reporting date are recognised in the Statement of Financial Position 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.

1. Summary of Significant Accounting Policies (cont'd)

(q) Employee Benefits (cont'd)

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.

The QSuper scheme has defined benefit and defined contribution categories. The liability for defined benefits is held on a whole-of-government basis and reported in those financial statements pursuant to AASB 1049 *Whole of Government and General Government Sector Financial Reporting*.

Key Management Personnel and Remuneration

Key management personnel and remuneration disclosures are made in accordance with the section 5 of the Financial Reporting Requirements for Queensland Government Agencies issued by Queensland Treasury and Trade. Refer to Note 4.

(r) 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 Commission. The legislation establishing the Commission was enacted on 29 May 2006, and came into force on 1 July of that year. Some of the key Commission 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;

1. Summary of Significant Accounting Policies (cont'd)

(r) Major Activities of the Health Quality and Complaints Commission (cont'd)

- 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.

(s) 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 respect of its obligations for employee compensation.

(t) Taxation

The Commission 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 (FBT) 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).

(u) 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 at the date of signing the Management Certificate.

(v) Accounting Estimates & 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:

Accrued Employee Benefits - Note 14

(w) Rounding and Comparatives

Amounts included in the Financial Statements are in Australian dollars and have been rounded to the nearest $1.

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

(x) New and Revised Accounting Standards

The Commission did not voluntarily change any of its accounting policies during 2012-13. Australian Accounting Standard changes applicable for the first time for 2012-13 have had minimal effect on the Commission's financial statements, as explained below.

1. Summary of Significant Accounting Policies (cont'd)

(x) New and Revised Accounting Standards (cont'd)

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 and Trade. Consequently, the Commission has not applied any Australian Accounting Standards and Interpretations that have been issued but are not yet effective. The Commission applies standards and interpretations in accordance with their respective commencement dates.

At the date of authorisation of the financial report, the expected impacts of new or amended Australian Accounting Standards with future commencement dates are as set out below.

AASB 13 *Fair Value Measurement* applies from reporting periods beginning on or after 1 January 2013. The new requirements will apply to all of the Commission's assets and liabilities (excluding leases) that are measured and/or disclosed at fair value or another measurement based on fair value. The potential impacts of AASB 13 relate to the fair value measurement methodologies used and financial statement disclosures made in respect of such assets and liabilities.

The Commission has commenced reviewing its fair value methodologies (including instructions to valuers, data used and assumptions made) for all items of property, plant and equipment measured at fair value to determine whether those methodologies comply with AASB 13. At this stage, no consequential material impacts are expected for the Commission's property, plant and equipment as from 2013-14.

A revised version of AASB 119 *Employee Benefits* applies from reporting periods beginning on or after 1 January 2013 and applied retrospectively. The only implications for the Commission are that the revised standard clarifies the concept of 'termination benefits', and the recognition criteria for liabilities for termination benefits will be different. If termination benefits meet the timeframe criterion for 'short-term employee benefits', they will be measured according to the AASB 119 requirements for 'short-term employee benefits'. Otherwise, termination benefits will need to be measured according to the AASB 119 requirements for 'other long-term employee benefits'. Under the revised standard, the recognition and measurement of employer obligations for 'other long-term employee benefits' will need to be accounted for according to most of the requirements for defined benefit plans.

The revised AASB 119 includes changed criteria for accounting for employee benefits as 'short-term employee benefits'. However, as the Commission is a member of the Queensland Government central scheme for long service leave, this change in criteria has no impact on the Commission's financial statements as the employer liability is held by the central scheme.

1. Summary of Significant Accounting Policies (cont'd)

(x) New and Revised Accounting Standards (cont'd)

AASB 1053 *Application of Tiers of Australian Accounting Standards* applies as from reporting periods beginning on or after 1 July 2013. AASB 1053 establishes a differential reporting framework for those entities that prepare general purpose financial statements, consisting of two Tiers of reporting requirements – Australian Accounting Standards (commonly referred to as 'Tier 1'), and Australian Accounting Standards – Reduced Disclosure Requirements (commonly referred to as 'Tier 2').

Queensland Treasury and Trade has advised that its policy decision is to require adoption of Tier 1 reporting by all Queensland Government departments and statutory bodies that are consolidated into the whole-of-Government financial statements. Therefore, the release of AASB 1053 and associated amending standards will have no impact on the Commission.

The following new and revised standards apply as from reporting periods beginning on or after 1 January 2014 –

- AASB 10 *Consolidated Financial Statements* ;
- AASB 11 *Joint Arrangements* ;
- AASB 12 *Disclosure of Interests in Other Entities* ;
- AASB 127 (revised) *Separate Financial Statements* ;
- AASB 128 (revised) *Investments in Associates and Joint Ventures* ; and
- AASB 2011 -7 *Amendments to Australian Accounting Standards arising from the Consolidation and Joint Arrangements Standards [AASB 1, 2, 3, 5, 7, 9, 2009-11, 101, 107, 112, 118, 121, 124, 132, 133, 136, 138, 139, 1023 & 1038 and Interpretations 5, 9, 16 & 17]* .

AASB 10 redefines and clarifies the concept of control of another entity, and is the basis for determining which entities should be consolidated into an entity's financial statements. Therefore, once the AASB finalises its not-for-profit amendments to AASB 10, the Commission will need to reassess the nature of its relationships with other entities, including entities that aren't currently consolidated.

AASB 11 deals with the concept of joint control and sets out new principles for determining the type of joint arrangement that exists, which in turn dictates the accounting treatment. The new categories of joint arrangements under AASB 11 are more aligned to the actual rights and obligations of the parties to the arrangement. Subject to any not-for-profit amendments to be made to AASB 11, the Commission will need to assess the nature of any arrangements with other entities to determine whether a joint arrangement exists in terms of AASB 11. If a joint arrangement does exist, the Commission will need to follow the relevant accounting treatment specified in either AASB 11 or the revised AASB 128, depending on the nature of the joint arrangement.

1. Summary of Significant Accounting Policies (cont'd)

(x) New and Revised Accounting Standards (cont'd)

AASB 1055 *Budgetary Reporting* applies from reporting periods beginning on 1 July 2014. From that date, based on what is currently published in the Queensland Government's Budgetary Service Delivery Statements, the Commission will need to include the original budgeted statements for the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Equity, and Statement of Cash Flows. These budgeted statements will need to be presented consistently with the corresponding (actuals) financial statements, and will be accompanied by explanations of major variances between the actual amounts and the corresponding budgeted financial statement.

AASB 9 *Financial Instruments* (December 2010) and AASB 2010-7 *Amendments to Australian Accounting Standards arising from AASB 9 (December 2010) [AASB 1, 3, 4, 5, 7, 101, 102, 108, 112, 118, 120, 121, 127, 128, 131, 132, 136, 137, 139, 1023 & 1038 and Interpretations 2, 5, 10, 12, 19 & 127]* become effective from reporting periods beginning on 1 January 2015. The main impacts of these standards are that they will change the requirements for the classification, measurement and disclosures associated with the Commission's financial assets. Under the new requirements, financial assets will be more simply classified according to whether they are measured at amortised cost or fair value.

The Commission has commenced reviewing the measurement of its financial assets against the new AASB 9 classification and measurement requirements. However, as the classification of financial assets at the date of initial application of AASB 9 will depend on the facts and circumstances existing at that date, the Commission's conclusions will not be confirmed until closer to that time. At this stage, and assuming no change in the types of transactions the Commission enters into, it is not expected that any of the Commission's financial assets will meet the criteria in AASB 9 to be measured at amortised cost. Therefore, as from the 2015-16 financial statements, all of the Commission's financial assets are expected to be required to be measured at fair value, and classified accordingly (instead of the measurement classifications presently used in Notes 1(p) and 21). The same classification will be used for net gains/losses recognised in the Statement of Comprehensive Income in respect of those financial assets. In the case of the Commission's current receivables, as they are short-term in nature, the carrying amount is expected to be a reasonable approximation of fair value.

The Commission will not need to restate comparative figures for financial instruments on adopting AASB 9 as from 2015-16. However, changed disclosure requirements will apply from that time. A number of one-off disclosures will be required in the 2015-16 financial statements to explain the impact of adopting AASB 9. Assuming no change in the types of financial instruments that the Commission enters into, the most significant ongoing disclosure impacts are expected to relate to investments in equity instruments measured at fair value through other comprehensive income.

All other Australian Accounting Standards and Interpretations with future commencement dates are either not applicable to the Health Quality and Complaints Commission's activities, or have no material impact on the Commission.

		2013 $	2012 $
2. Grants and Other Contributions			
Operational grant		10,170,000	10,078,000
Total		10,170,000	10,078,000
3. Other Revenue			
Interest earned		126,897	288,788
RTI application fees		1,215	936
Other		2,569	9,630
Total		130,681	299,354
4. Employee Expenses			
Employee Benefits			
Wages and salaries		5,648,110	5,856,690
Employer superannuation contributions	*	719,413	768,107
Long service leave levy	*	111,249	147,641
Annual leave expenses	*	447,455	516,296
Employee Related Expenses			
Payroll tax and fringe benefits	*	336,808	369,970
Workers' compensation premium	*	26,220	55,677
Other		13,165	9,043
Total		7,302,420	7,723,424

* Refer to Note 1 (q)

The number of employees including both full-time employees and part-time employees measured on a full-time equivalent basis is:

	2013	2012
Number of employees:	70	71

4. (cont'd)

a) Key Management Personnel

Position	Responsibilities	Current Incumbents	
		Contract classification and appointment authority	Date appointed to position
Chief Executive Officer	The Chief Executive Officer is responsible for the administration of HQCC	s122 contract; Governor in Council	Appointed 24 September 2006
Executive Manager, Quality Services	The Executive Manager, Quality Services is responsible for quality services which drives healthcare improvement by monitoring and reporting on safety and quality and setting healthcare standards.	SO3; Public Service Act 2008	Appointed 18 August 2009 Resignation 02 December 2012
Executive Manager, Complaint Services	The Executive Manager, Complaint Services is responsible for complaint services which provides an impartial, professional service in complaint management and resolution, conciliation and investigation.	SO2; Public Service Act 2008	Appointed 03 March 2008 Redundant 21 September 2012
Manager, Client & Clinical Services Previously known as Manager, Community Engagement	The Manager, Client & Clinical Services is responsible for the management of HQCC's communications and reporting; initial intake of health complaints and the provision of clinical advice.	SO3; Public Service Act 2008	Appointed 20 July 2009
Manager, Information & Quality Previously known as Manager, Information Management	The Manager, Information & Quality is responsible for the management of ICT infrastructure and communications; and quality monitoring functions.	SO3; Public Service Act 2008	Appointed 10 August 2009
General Counsel	The General Counsel is responsible for the management of the provision of legal services; and conciliation services.	SO2; Public Service Act 2008	Appointed 01 July 2010
Manager, Business Services	The Manager, Business Services is responsible for the management of corporate support services.	AO8; Public Service Act 2008	Appointed 06 November 2006
Manager, Resolution & Assessment	The Manager, Resolution & Assessment is responsible for the assessment and early resolution of health complaints.	AO8; Public Service Act 2008	Appointed 04 October 2010
Manager, Investigations	The Manager, Investigations is responsible for the management of health service investigations.	AO8; Public Service Act 2008	Appointed 21 December 2009

b) Remuneration

Remuneration policy for the agency's key management personnel is set by the Queensland Public Service Commission as provided for under the *Public Service Act 2008*. The remuneration and other terms of employment for the key management personnel are specified in employment contracts. The contracts provide for the provision of motor vehicles.

For the 2012-13 year, remuneration of key management personnel increased by 2.5% (CEO), 2.2% (SO), and 3% (AO).

4. (cont'd)

b) Remuneration (cont'd)

Remuneration packages for key management personnel comprise the following components:-

Short term employee benefits which include:

Base - consisting of base salary, allowances and leave entitlements paid for the entire year or for that part of the year during which the employee occupied the specified position. Amounts disclosed equal the amount expensed in the Statement of Comprehensive Income.

Non-monetary benefits – consisting of provision of vehicle together with fringe benefits tax applicable to the benefit.

Long term employee benefits include long service leave accrued.

Post employment benefits include superannuation contributions.

Redundancy payments are not provided for within individual contracts of employment. Contracts of employment provide only for notice periods or payment in lieu of notice on termination, regardless of the reason for termination.

1 July 2012 - 30 June 2013

Position	Short-term Employee Benefits		Long Term Employee benefits	Post Employment Benefits	Termination Benefits	Total Remuneration
	Base $'000	Non-monetary benefits $'000	$'000	$'000	$'000	$'000
Chief Executive Officer	347	13	7	38	0	405
Executive Manager, Quality Services	63	0	1	7	0	71
Executive Manager, Complaint Services	39	0	4	11	151	205
Manager, Client & Clinical Services	132	0	3	16	0	151
Manager, Information & Quality	137	0	3	16	0	156
General Counsel	108	0	2	13	0	123
Manager, Business Services	77	0	1	9	0	87
Manager, Resolution & Assessment	118	0	2	13	0	133
Manager, Investigations	115	0	2	14	0	131
Total Remuneration						**1462**

1 July 2011 - 30 June 2012

Position	Short-term Employee Benefits		Long Term Employee benefits	Post Employment Benefits	Termination Benefits	Total Remuneration
	Base $'000	Non-monetary benefits $'000	$'000	$'000	$'000	$'000
Chief Executive Officer	307	50	6	39	0	402
Executive Manager, Quality Services	121	0	2	15	0	138
Executive Manager, Complaint Services	130	0	2	16	0	148
Manager, Community Engagement	122	0	2	15	0	139
Manager, Information Management	124	0	2	16	0	142
General Counsel	109	0	2	13	0	124
Manager, Business Services	69	0	1	8	0	79
Total Remuneration						**1172**

c) Performance payments

There were no aggregate performance bonuses paid to any of the key management personnel in the 2011-12 and 2012-13 Financial years.

	2013 $	2012 $
5. Supplies and Services		
Administrative expenses	140,890	240,518
Finance expenses	179,262	181,866
Catering	7,473	5,406
Consultancy	195,026	335,939
Legal expenses	13,908	29,201
Maintenance costs	5,025	3,026
Motor vehicle - operating lease	-	15,170
Motor vehicle - other	11,395	19,875
Plant & equipment purchases <$5,000	41,851	7,361
Printing expenses and postage	25,687	52,683
Network support	412,810	279,800
Rent - operating lease	800,414	737,716
Software licences	18,703	9,255
Staff development	12,036	85,931
Stationery and office supplies	31,879	46,442
Telephone expenses	31,627	60,721
Temporary staff expenses	228,259	134,479
Translation services	3,707	8,451
Travel expenses	9,766	28,413
Total	2,169,718	2,282,253

	2013 $	2012 $
6. Depreciation and Amortisation		
Depreciation and amortisation were incurred in respect of:		
Plant and equipment	70,643	90,019
Leasehold improvements	215,168	215,168
Software purchased	148,499	146,149
Total	434,311	451,336
7. Other Expenses		
Insurance premiums - QGIF	4,740	3,520
Audit fees - external *	22,500	27,700
Audit fees - internal	-	61,550
Losses from disposal of plant & equipment	-	7,489
Total	27,240	100,259

* Total Queensland Audit office audit fees relating to the 2012-13 financial year are estimated to be $22,500 (2011-12: $22,500). There are no non-audit services included in this amount.

8. Cash and Cash Equivalents		
Cash at bank	14,659	6,574
Cash on hand	500	500
QTC 24 hour call deposits	1,151,234	454,175
Total*	1,166,393	461,249

* Refer to Note 1 (f)

Annual effective interest rate on cash held with the Queensland Treasury Corporation for 2012-13 was 3.63% (2011-12: 4.33%). Interest earned on cash held with the Commonwealth Bank was 3.20% in 2012-13 (2011-12: 2.53%). The Treasurer's approval has been obtained for these investments.

9. Receivables		
Trade debtors	373	181,574
	373	181,574
GST receivable	69,810	92,219
GST payable	(3,941)	(1,961)
	65,869	90,258
Accrued interest	401	296
Long service leave reimbursements	7,888	4,634
	8,289	4,930
Total	74,531	276,762

	2013 $	2012 $
10. Other Current Assets		
Prepayments	78,829	61,734
	78,829	61,734
11. Intangible Assets		
Software Purchased:		
At cost	1,040,068	1,040,068
Less: Accumulated amortisation	(583,251)	(434,752)
Total	456,817	605,316

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

	Software Purchased 2013 $	Software Purchased 2012 $	Total 2013 $	Total 2012 $
Carrying amount at 1 July	605,316	593,245	605,316	593,245
Acquisitions	-	158,220	-	158,220
Amortisation	(148,499)	(146,149)	(148,499)	(146,149)
Carrying amount at 30 June	456,817	605,316	456,817	605,316

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

	2013 $	2012 $
12. Property, Plant and Equipment		
Plant and equipment:		
At cost	541,166	379,442
Less: Accumulated depreciation	(324,075)	(253,432)
	217,091	126,010
Leasehold improvements		
At cost	2,152,866	2,152,866
Less: Accumulated depreciation	(930,993)	(715,824)
	1,221,873	1,437,042
Total	1,438,964	1,563,052

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

Property, plant and equipment (PP&E) is depreciated on a straight line (SL) 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. Refer to Note 1(l).

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 and Equipment 2013	Plant and Equipment 2012	Leasehold improvements 2013	Leasehold improvements 2012	Total 2013	Total 2012
Carrying amount at 1 July	126,010	142,901	1,437,042	1,652,210	1,563,052	1,795,111
Acquisitions	161,724	80,617	-	-	161,724	80,617
Disposals	-	(7,489)	-	-	-	(7,489)
Depreciation	(70,643)	(90,019)	(215,168)	(215,168)	(285,812)	(305,187)
Carrying amount at 30 June	217,091	126,010	1,221,874	1,437,042	1,438,964	1,563,052

13. Payables		
Trade creditors	108,860	58,709
Taxes, fees and fines payable	2,500	2,500
Accrued expenses	35,583	55,034
Total	146,943	116,243

	2013 $	2012 $
14. Accrued Employee Benefits		
Current Liability		
Annual leave liability	529,822	520,027
Parental leave liability	2,473	10
Long service leave levy payable	31,762	36,229
	564,057	556,266
Non-current Liability		
Annual leave liability	54,789	73,540
Total	618,846	629,806
15. Other Liabilities		
Current Liability		
Lease incentive	139,311	139,311
	139,311	139,311
Non-current Liability		
Lease incentive	640,069	779,380
Total	779,380	918,691
16. Reconciliation of Operating Result to Net Cash from/(used in) Operating Activities		
Operating surplus/(deficit)	366,992	(179,918)
Depreciation and amortisation expense	434,311	451,336
Loss on disposal of assets	-	7,489
Changes in assets and liabilities:		
(Increase)/decrease in GST input tax credit receivables	24,389	(1,908)
(Increase)/decrease in receivables	181,201	(181,574)
(Increase)/decrease in accrued interest	(105)	111
(Increase)/decrease in long service leave reimbursements	(3,254)	(289)
(Increase)/decrease in prepayments	(17,095)	(32,605)
Increase/(decrease) in payables	30,700	8,794
Increase/(decrease) in accrued employee benefits	(10,960)	96,799
Increase/(decrease) in Leasehold liability amortisation	(139,311)	(161,563)
Net cash from operating activities	866,868	6,671

	2013 $	2012 $

17. 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:

Not later than one year	982,669	940,350
Later than one year and not later than five years	4,393,223	4,204,043
Later than five years	701,190	1,873,039
Total	6,077,082	7,017,432

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) Other expenditure commitments

Other expenditure committed at the end of the period but not recognised in the accounts are as follows:

Payable:		
Not later than one year *	185,478	183,558
Later than one year and not later than five years	-	-
Later than five years	-	-
Total	185,478	183,558

*Service Level Agreement with Corporate Administration Agency for the year 2013-2014. Note, comparative was omitted from prior year financial statements.

(c) Capital expenditure commitments

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

18. Contingencies

There were no material contingent assets or liabilities as at 30 June 2013.

19. Subsequent Event

As outlined in Objectives and Principal Activities of the Health Quality and Complaints Commission, the *Health Ombudsman Bill 2013* was introduced into the Queensland Parliament on 4 June 2013 and was passed on 20 August 2013. Upon enactment and assent by the Queensland Parliament, the *Health Quality and Complaints Commission Act 2006* will be repealed. This is anticipated to occur by 30 June 2014. All assets, liabilities and financial commitments will be effectively transferred from the Health Quality and Complaints Commission to the Office of the Health Ombudsman. The Health Quality and Complaints Commission will be abolished. At the time of preparing this report, it is not known which employees will be offered redundancies and under what terms. Therefore, as at 30 June 2013, no liability can be recognised. It is anticipated at this time that any liability relating to staff redundancies or the office lease may be transferred to the Office of the Health Ombudsman.

20. Restricted Assets

There were no restrictions on the use of cash held as at 30 June 2013.

21. Financial Instruments

(a) Categorisation of Financial Instruments

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

Category	Note	2013 $	2012 $
Financial Assets			
Cash and cash equivalents	8	1,166,393	461,249
Receivables	9	74,531	276,762
Total		**1,240,924**	**738,011**
Financial Liabilities			
Financial liabilities measured at amortised costs:			
Payables	13	146,943	116,243
Total		**146,943**	**116,243**

(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

21. Financial Instruments (cont'd)

(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**	2013 $	2012 $
Cash	8	1,166,393	461,249
Receivables	9	74,531	276,762
Total		**1,240,924**	**738,011**

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 liabilities have been offset and presented net in the Statement of Financial Position.

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.

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

2013 Financial Assets Past Due But Not Impaired

			Overdue			
	Note	Less than 30 Days	30-60 Days	61-90 Days	More than 90 Days	Total
		$	$	$	$	$
Financial Assets						
Receivables	9	74,531	-	-	-	74,531
Total		**74,531**	-	-	-	**74,531**

21. Financial Instruments (cont'd)

(c) Credit Risk Exposure (cont'd)

2012 Financial Assets Past Due But Not Impaired

	Note	Overdue				
		Less than 30 Days	30-60 Days	61-90 Days	More than 90 Days	Total
		$	$	$	$	$
Financial Assets						
Receivables	9	276,762	-	-	-	276,762
Total		**276,762**	**-**	**-**	**-**	**276,762**

(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.

The following table sets out the liquidity risk of financial liabilities held by the Commission. It represents the contractual maturity of financial liabilities, calculated based on undiscounted cash flows relating to the liabilities at reporting date. The undiscounted cash flows in these tables differ from the amounts included in the Statement of Financial Position that are based on discounted cash flows.

		2013 Payables in			Total
		<1 year	1-5 years	>5 years	
	Note	$	$	$	$
Financial Liabilities					
Payables	13	146,943	-	-	146,943
Total		**146,943**	**-**	**-**	**146,943**

		2012 Payables in			Total
		<1 year	1-5 years	>5 years	
	Note	$	$	$	$
Financial Liabilities					
Payables	13	116,243	-	-	116,243
Total		**116,243**	**-**	**-**	**116,243**

21. Financial Instruments (cont'd)

(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. The Commission does not undertake any hedging in relation to interest risk and manages its risk as per the liquidity risk management strategy.

(f) Interest Rate Sensitivity Analysis

The following interest rate sensitivity analysis is based on a report similar to that provided to management, depicting the outcome on 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 $11,664 (2012: $4,612). This is attributable to the Commission's exposure to variable interest rates on interest bearing cash deposits.

Financial Instruments	Carrying Amount	2013 Interest rate risk			
		-1%		+1%	
		Profit	Equity	Profit	Equity
Cash	1,166,393	(11,664)	(11,664)	11,664	11,664
Potential Impact		(11,664)	(11,664)	11,664	11,664

Financial Instruments	Carrying Amount	2012 Interest rate risk			
		- 1 %		+1%	
		Profit	Equity	Profit	Equity
Cash	461,249	(4,612)	(4,612)	4,612	4,612
Potential Impact		(4,612)	(4,612)	4,612	4,612

(g) Fair Value

The Commission does not recognise any financial assets or financial liabilities at fair value.

The fair value of receivables and payables are assumed to approximate the value of the original transaction, less any provision for impairment.

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

Certificate of the Health Quality and Complaints Commission

These general purpose financial statements have been prepared pursuant to section 62(1) of the *Financial Accountability Act 2009* (the Act), relevant sections of the *Financial and Performance Management Standard 2009* and other prescribed requirements. In accordance with section 62(1)(b) 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 the Health Quality and Complaints Commission for the financial year ended 30 June 2013 and of the financial position of the Commission at the end of that year.

Adjunct Professor Russell Stitz
Commissioner

Date: 21.8.13

Shaun Nesbitt
Acting Chief Executive Officer

Date: 21/8/13

INDEPENDENT AUDITOR'S REPORT

To the Commissioner of the Health Quality and Complaints Commission

Report on the Financial Report

I have audited the accompanying financial report of the Health Quality and Complaints Commission, which comprises the statement of comprehensive income, statement of financial position as at 30 June 2013, statement of changes in equity and statement of cash flows for the year then ended, notes comprising a summary of significant accounting policies and other explanatory information, and certificates given by the Commissioner and Acting Chief Executive Officer.

The Commission's Responsibility for the Financial Report

The Commission is responsible for the preparation of the financial report that gives a true and fair view in accordance with prescribed accounting requirements identified in the *Financial Accountability Act 2009* and the *Financial and Performance Management Standard 2009*, including compliance with Australian Accounting Standards. The Commission's responsibility also includes such internal control as the Commission determines is necessary to enable the preparation of the financial report that gives a true and fair view and is free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on the financial report based on the audit. The audit was conducted in accordance with the *Auditor-General of Queensland Auditing Standards*, which incorporate the Australian Auditing Standards. Those standards require compliance with relevant ethical requirements relating to audit engagements and that the audit is planned and performed to obtain reasonable assurance about 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 the risks of material misstatement of 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 of the financial report that gives a true and fair view 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 used and the reasonableness of accounting estimates made by the Commission, as well as evaluating the overall presentation of the financial report including any mandatory financial reporting requirements 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 all authorised auditors. The Auditor-General is the auditor of all Queensland public sector entities and can be removed only 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.

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 relation to the establishment and keeping of accounts have been complied with in all material respects; and

  (ii) the financial report presents 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 2012 to 30 June 2013 and of the financial position as at the end of that year.

Emphasis of Matter – Abolition of the Health Quality and Complaints Commission

Without modifying my opinion, attention is drawn to the Objectives and Principle Activities of the Commission and Note 19 Subsequent Events in the financial report. These notes to the financial statements identify that legislative processes are currently in progress to abolish the Health Quality and Complaints Commission (the Commission). As at the date of issue of this financial report, legislation to give effect to the abolition of the Commission has yet to be enacted, but it is anticipated this will occur before 30 June 2014. As it is anticipated that the assets and liabilities of the Commission will be transferred to the Office of the Health Ombudsman at the values at which they are held by the Commission upon its abolition, the financial report has been prepared on a basis consistent with the going concern basis.

Other Matters - Electronic Presentation of the Audited Financial Report

Those viewing an electronic presentation of these financial statements should note that audit does not provide assurance on the integrity of the information presented electronically and does not provide an opinion on any information which may be hyperlinked to or from the financial statements. If users of the financial statements are concerned with the inherent risks arising from electronic presentation of information, they are advised to refer to the printed copy of the audited financial statements to confirm the accuracy of this electronically presented information.

D R ADAMS FCPA
(as Delegate of the Auditor-General of Queensland)

Queensland Audit Office
Brisbane

ATTACHMENT A – Compliance checklist

Summary of requirement		Basis for requirement	Annual report reference
Letter of compliance	• **A letter of compliance from the accountable officer or statutory body to the relevant Minister**	ARRs – section 8	Page i
Accessibility	• **Table of contents** • **Glossary**	ARRs – section 10.1	Page ii Page 131
	• **Public availability**	ARRs – section 10.2	Page i
	• **Interpreter service statement**	*Queensland Government Language Services Policy* ARRs – section 10.3	Page i
	• **Copyright notice**	*Copyright Act 1968* ARRs – section 10.4	Page i
	• **Information licensing**	*Queensland Government Enterprise Architecture – Information licensing* ARRs – section 10.5	Page i
General information	• **Introductory information**	ARRs – section 11.1	Page 1-3
	• **Agency role and main functions**	ARRs – section 11.2	Page 2, 3
	• **Operating environment**	ARRs – section 11.3	Page 4-9
	• **Machinery of Government changes**	ARRs – section 11.4	Not applicable
Non-financial performance	• **Government objectives for the community**	ARRs – section 12.1	Page 1
	• **Other whole-of-government plans/specific initiatives**	ARRs – section 12.2	Not applicable
	• **Agency objectives and performance indicators**	ARRs – section 12.3	Page 10-15
	• **Agency service areas, service standards and other measures**	ARRs – section 12.4	Page 16-18
Financial performance	• **Summary of financial performance**	ARRs – section 13.1	Page 5, 93
	• **Chief Finance Officer (CFO) statement**	ARRs – section 13.2	Not applicable
	• **Organisational structure**	ARRs – section 14.1	Page 72
	• **Executive management**	ARRs – section 14.2	Page 89-91
	• **Related entities**	ARRs – section 14.3	Not applicable
	• **Boards and committees**	ARRs – section 14.4	Page 78-82, 85-88

ATTACHMENT A – Compliance checklist

Summary of requirement		Basis for requirement	Annual report reference
	• ***Public Sector Ethics Act 1994***	*Public Sector Ethics Act 1994* (section 23 and Schedule) ARRs – section 14.5	Page 68
Governance – risk management and accountability	• **Risk management**	ARRs – section 15.1	Page 83
	• **External scrutiny**	ARRs – section 15.2	Page 71-77
	• **Audit committee**	ARRs – section 15.3	Page 82
	• **Internal audit**	ARRs – section 15.4	Page 83
	• **Public Sector Renewal Program**	ARRs – section 15.5	Page 66
	• **Information systems and recordkeeping**	ARRs – section 15.7	Page 70, 85, 92
Governance – human resources	• **Workforce planning, attraction and retention and performance**	ARRs – section 16.1	Page 66-67
	• **Early retirement, redundancy and retrenchment**	Directive No.11/12 *Early Retirement, Redundancy and Retrenchment* ARRs – section 16.2	Page 66
	• **Voluntary Separation Program**	ARRs – section 16.3	Not applicable
Open data	• **Open data**	ARRs – section 17	Page 129
Financial statements	• **Certification of financial statements**	FAA – section 62 FPMS – sections 42, 43 and 50 ARRs – section 18.1	See *Financial report*
	• **Independent Auditor's Report**	FAA – section 62 FPMS – section 50 ARRs – section 18.2	See *Financial report*
	• **Remuneration disclosures**	*Financial Reporting Requirements for Queensland Government Agencies* ARRs – section 18.3	See *Financial report*

FAA *Financial Accountability Act 2009*, FPMS *Financial and Performance Management Standard 2009*

ARRs *Annual report requirements for Queensland Government agencies*

Additional information

In line with the *Annual report requirements for Queensland Government agencies* (March 2013), the following additional information applicable to statutory bodies is reported on our website, see http://www.hqcc.qld.gov.au/resources/pages/annual-report-2012-13-additional-information.aspx

- Consultancies
- Overseas travel
- Multicultural.

Index

Glossary

ACSQHC Australian Commission on Safety and Quality in Health Care

AMI Acute myocardial infarction (heart attack)

AHPRA Australian Health Practitioner Regulation Agency

AQAR Annual quality and activity return

Assessment Our 60-day* complaint management process for more complex complaints which can't be resolved directly or through our early resolution process (*may be extended to 90 days in special circumstances)

CALD Culturally and linguistically diverse

Complaint management Comprises triage, early resolution, assessment, conciliation, investigation and complaint support positions

Conciliation Our free, confidential and privileged complaint management process for complaints which may require a detailed explanation or confidential dispute resolution

Consumer (healthcare) Patients and potential patients, carers and organisations representing consumers' interests

Direct resolution We encourage complainants with less serious concerns to try to resolve them directly with their healthcare provider

eDRMS Electronic document and record management system

Early resolution Our 30-day complaint management process for straightforward complaints we consider can be resolved with the agreement of the complainant and provider

HCSC Health and Community Services Committee (bi-partisan Parliamentary committee from 18 May 2012)

HDC Health and Disabilities Committee (bi-partisan Parliamentary committee prior to May 2012)

HHS Introduced on 1 July 2012, the Hospital and Health Services are statutory bodies with Hospital and Health Boards, accountable to the local community and the Queensland Parliament

HQCC Health Quality and Complaints Commission

HQCC Act *Health Quality and Complaints Commission Act 2006*

ICT Information and communication technology

KPI Key performance indicator

Medicare Locals In 2011, the Australian Government established local decision-making bodies, Medicare Locals (61), to plan and fund extra health services in Australian communities.

NAIDOC National Aborigines and Islanders Day Observance Committee (this committee was once responsible for organising national activities during NAIDOC Week and its acronym has since become the name of the week itself)

National Law *Health Practitioner Regulation National Law Act 2009*

NSQHS Standards Ten *National safety and quality health service standards*, developed by the Australian Commission on Safety and Quality in Health Care after extensive consultation. The primary aims of the standards are to protect the public from harm and improve the quality of health service provision.

RCA Root cause analysis (a type of review undertaken by a healthcare provider following reportable, adverse and unexpected healthcare incidents)

Reportable event An adverse or unexpected healthcare incident, including death, as defined under the *Hospital and Health Boards Regulation 2012* and the *Ambulance Service Act 1991*

Triage Our triage officers are the first point of contact for complainants and decide on the best complaint management pathway.