2015
2016
annual report

Office of the
HEALTH
OMBUDSMAN

Listen. Respond. Resolve.

about **this report**

The ***Office of the Health Ombudsman annual report 2015–16*** is an integral part of the office's commitment to open and accountable governance. The report keeps the community and the office's stakeholders, including health consumers, health professionals, educators, regulatory partners, government leaders and the broader community informed and aware of the office's activities, current performance and future plans to continue to:

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

Structure of this report

The ***Introduction*** of this report contains background information about the agency and a helpful resource explaining who complaints can be made by and about, and the types of concerns raised by complainants.

The ***Year in review*** section provides reflections and an outlook from the Health Ombudsman, a performance summary and the office's key achievements for the year. For the first time ever, this section also contains commentary on the trends and profile of health service complaints made to the office.

Following this, a detailed ***Our performance*** section analyses the operational performance of the service areas of the office—reviewing timeframes, volumes, quality measures, trends, improvements and initiatives put in place to manage and deliver on the office's purpose. To provide context and complement the operational performance, insight into the office's community and stakeholder-focused practices are provided in the ***Our stakeholders*** section. This section also covers reflections and commentary of the deep inter-dependence required of the co-regulatory system of healthcare governance in Queensland.

The report then shifts its focus to the office's visions and plans for ***Our future***. In this section, opportunities and challenges of the operating and strategic environment are reviewed along with priorities for the year ahead and how these have been shaped or informed by sector trends, consumer healthcare experiences and the office's operational capability.

In the latter half, this report also includes statutory reporting and legislative information which can be found in the ***Our governance*** section, details of the office's human face and people practices and, finally, the office's financial performance.

Theme of this report

Being the second year of operation for the office, the focus of this annual report has been on highlighting the momentum and efficiencies achieved. The 2015–16 year was one of development for the office as the effects of transitional and start up matters began to stabilise.

Office of the Health Ombudsman Annual Report 2015-16

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Accessibility

Interpreter

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Office of the HEALTH OMBUDSMAN
Listen. Respond. Resolve.

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133 OHO (133 646)

7th September 2016

The Honourable Cameron Dick MP
Minister for Health
GPO Box 48
BRISBANE QLD 4001

Dear Minister

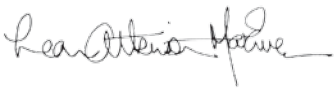
I am pleased to present the *Office of the Health Ombudsman annual report 2015–16* and financial statements.

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*
- the detailed requirements set out in the *Annual report requirements for Queensland Government agencies.*

A checklist outlining the annual reporting requirements can be found at pages 111 and 112 of this report.

Yours sincerely



Leon Atkinson-MacEwen
Health Ombudsman

about **us**

The Office of the Health Ombudsman is Queensland's health service complaints management agency. It is the one place people should go if they have a complaint about a health service provider or any aspect of a health service provided in Queensland.

Complaints can be made about both the health service organisation and registered and unregistered practitioners in their individual capacity.

In addition to receiving and acting on complaints and systemic issues, the office monitors the performance of the Australian Health Practitioner Regulation Agency (AHPRA) and the national boards in their functions relating to the health, conduct and performance of registered health practitioners in Queensland.

The *Health Ombudsman Act 2013* came into effect on 1 July 2014 and replaced the *Health Quality and Complaints Commission Act 2006*. The office has powers under the *Health Practitioner Regulation National Law (Queensland)* and Queensland is the only state or territory to share co-regulatory functions and powers under the National Law. The office also applies the *National Code of Conduct for Health Care Workers (Queensland)* in fulfilling its duties. For full details of the difference in powers and new functions introduced by the *Health Ombudsman Act 2013*, please review the *Office of the Health Ombudsman annual report 2014–15*.

The Health Ombudsman is a statutory position and must act independently, impartially and in the public interest. The 2015–16 financial year was the second full year of operation for the office under the leadership of Mr Leon Atkinson-MacEwen. During this time, the office continued to build and refine the platform on which it delivers its **vision:**

To be the cornerstone of a transparent, accountable and fair system for effectively and quickly dealing with complaints and other healthcare matters in Queensland.

To achieve this, the office plays many roles and in all practices, the office is guided by its **purpose**:

To protect the health and safety of the public and instil confidence in the Queensland health system by investigating, resolving or prosecuting complaints about healthcare.

A helpful resource explaining who complaints can be made about, the types of concerns they could relate to and various people informing the office of their concerns has been developed and is presented on page 4 and 5.

types of
health service complaints

Health consumer complaints

Health consumers and on behalf of health consumers

Complaints can be made by a health consumer, or on behalf of a health consumer. Before making a complaint, it is best to discuss issues with the health service provider—this is often the quickest and easiest way to have concerns addressed. Where this approach is not appropriate or the issue remains unresolved, the office can be contacted online, in writing, over the phone, or in person at its Brisbane office.

Complaints can be made against

Individual health practitioners

Registered health practitioners

- Doctors, nurses, dentists, physiotherapists, chiropractors, occupational therapists, optometrists, and osteopaths.

Unregistered health practitioners

- Nutritionists, masseuses, naturopaths, homeopaths, dieticians, social workers and speech pathologists.

Health service organisations

- Public, private and not-for-profit healthcare facilities
- Ambulance services
- Hospitals
- Health education services
- Pharmacies
- Mental health services
- Natural health clinics
- Community health services.

Complaints can be about any aspect of a health service, such as:

- diagnosis or care
- sharing information without permission
- inappropriate behaviour by a provider
- quality of the health service provided
- how a provider has dealt with a complaint.

Notifications

Health practitioners, employers or educators

Practitioners, employers and education providers are required by law (or the National Code of Conduct for Health Care Workers in the case of unregistered practitioners) to notify the Health Ombudsman if they believe another practitioner has behaved in a way that constitutes notifiable conduct. This is conduct that may arise from the health, conduct or performance of a health practitioner, or an impairment for a student. Notifications are to be made as soon as practicable. This type of conduct may present a risk to public health and safety.

Mandatory notifications

Mandatory notifications must be made when a practitioner or student has behaved in a way that constitutes 'notifiable conduct' which places the public at substantial risk of harm. Examples include:

- practising while intoxicated by alcohol or drugs
- engaging in sexual misconduct with a patient
- having a health impairment that places patients or the public at risk of substantial harm
- placing the public at risk by practising the profession in a way that deviates significantly from accepted professional standards.

Voluntary notifications

Grounds for voluntary notification about a health practitioner include:

- poor professional conduct
- sub-standard knowledge, skill, judgement or care
- not being considered a fit and proper person to hold registration
- having an impairment
- contravening the national law
- contravening a condition of their registration or an undertaking given to a national board
- improperly obtaining registration.

Self notifications

Like 'voluntary notifications', however the individual practitioner notifies the office about their own conduct—as opposed to a colleague, employer or education provider.

Referrals

Other organisations

Referrals from another organisation happen when matters they are dealing with raise concerns with the healthcare provision of a practitioner. Referrals can be made from agencies such as the:

- Queensland Police Service
- Office of the State Coroner
- Medicines Regulation and Quality unit of Queensland Health.

Own-motion investigation

The Health Ombudsman

A small number of investigations are initiated directly by the Health Ombudsman in the absence of a formal complaint. These matters can be identified through media reports or during the course of another investigation. For example:

- A systemic investigation into a health facility may be required as the risk is broader than a specific individual being investigated.
- Additional practitioners are identified during an investigation that may also pose a risk to the public or may have breached their code of conduct.
- A complainant withdraws their complaint but there is a high level of risk to the public.

health ombudsman's **review**

Our second year of operation has been even busier than we expected. With a 28 per cent increase in complaints handled by the office in 2015-16 compared to 2014-15, staff have risen magnificently to the challenges posed by this significant increase in complaint numbers. Along with dealing with a higher number of complaints, we have also used the year to consolidate our processes and to reflect on what we have learnt and achieved, with an eye to even more effective action to protect Queenslanders.

There is also a great sense of momentum in the office. Processes have been refined, systems improved, significant advances made in our case management system to ensure that staff are very well supported to do their work effectively and efficiently. Undoubtedly the rise in complaint numbers has posed a challenge, not the least in ensuring that there are appropriate levels of staff in place to deal with matters in our statutory timeframes. While more work needs to be done to ensure adequate staffing levels, particularly if we continue to see large year-on-year increases in complaint numbers, we are using the flexibility of action afforded by the *Health Ombudsman Act 2013* to identify appropriate pathways for dealing with complaints as quickly as possible.

We have also continued to analyse and report on our own performance as well as the performance of AHPRA and the national boards. This has resulted not only in the greatest levels of transparency and accountability ever seen in the health complaints management system in Queensland, but has seen AHPRA adopt a number of new transparency measures across the country. With two years worth of data, we have also been in a much better position to provide information and feedback to various areas of the health sector, particularly Hospitals and Health Services, about the trends and issues that the data reveal. This has provided me with an opportunity this year to discuss common themes as well as individual issues with the boards and senior executives of a range of Hospitals and Health Services, and to do so frankly and in a manner that is reflective of data rather than anecdote. These discussions will continue into 2016-17.

Even though we have made greater use of translator and interpreter services this year, and despite the ability to access our website in a number of the most commonly used languages other than English, I remain concerned about our ability to engage meaningfully with those Queenslanders who are over-represented (by head of population) as users of the health system but under-represented as complainants.

We also clearly need to do more work to ensure that our services are accessible in the most appropriate way to Aboriginal and Torres Strait Islander communities and to those who are accessing mental health and disability services in Queensland.

Queensland is a co-regulatory jurisdiction and our key partners in protecting the health and safety of Queenslanders are AHPRA and the national boards. Our fundamental approach in working with these keys partners has been, and remains, sharing information efficiently and making effective decisions about which agency is best placed, and legislatively equipped, to deal with health service complaints about registered health practitioners. As Health Ombudsman, I also have a role in oversighting and reporting on the performance in Queensland of AHPRA and the national boards. Apart from regular monitoring and reporting—which is published on our website— I also meet with boards to discuss issues, for example, around how best to manage serious and non-serious issues of health, conduct and performance, as well as managing issues of conflict of interest and the use of expert clinical advisors in informing decision-makers.

Given the genesis of the *Health Ombudsman Act 2013*, I believe it is important that the decision-making of all those engaged in dealing with health service complaints is robust, accountable and transparent.

While the unprecedented increases in complaints have placed strains on the resources of the office, and have resulted in legislative timeframes not being met in every instance, actions have been, and continue to be, taken to improve the performance of the office. There are also a number of potential legislative changes that will improve the operation of the health complaints management system, such as:

- correcting 'deficiencies' in the legislation
- providing clarity around timeframes and legislative requirements
- providing additional flexibility in dealing with the issues arising from complaints
- removing uncertainty or barriers to the effective sharing of information.

These potential legislative changes have been raised with the Minister for Health for consideration.

Finally, I would like to thank all the staff of the Office of the Health Ombudsman. It is a privilege to walk around the office every day and speak with such dedicated and high-quality individuals. Your dedication, perseverance and good humour is a credit to you all.

Leon Atkinson-MacEwen
Health Ombudsman

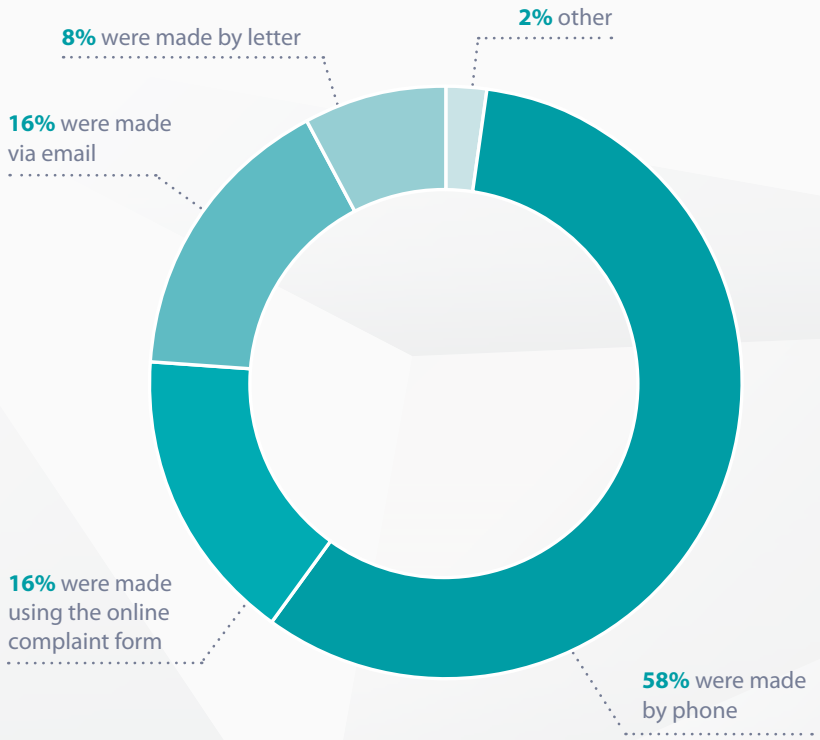
Processes have been refined, systems improved and significant advances made in our case management system to ensure that staff are very well-supported to do their work effectively and efficiently.

trends in health service complaints **made in queensland**

The overview of Queensland health service complaints presented on pages 4 and 5 is a useful reference to understand the context of these trends.

How we were contacted

The office received **9351** contacts this year, of which:



Out of these **9351** contacts:

3911 were enquiries

5435 were complaint contacts

73% were accepted as complaints

Who is contacting us

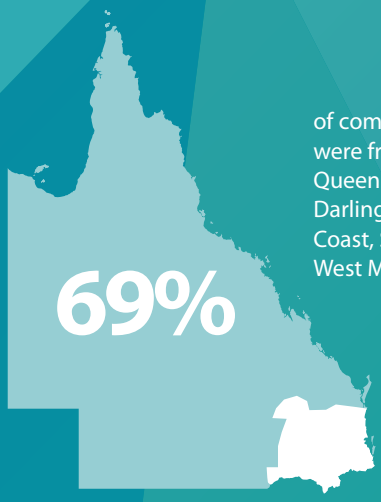
80% of complaints were from health consumers, of which:

40% Male **60%** Female

- **8%** under 18yrs old
- **18%** 18–34yrs old
- **33%** 35–54yrs old
- **25%** 55–74yrs old
- **11%** over 75yrs old

18% were from health employers, practitioners or AHPRA—12% mandatory notifications, 4% voluntary notifications and 2% self-notifications.

2% were referred from AHPRA



of complainants were from South-East Queensland (Brisbane, Darling Downs, Gold Coast, Sunshine Coast, West Moreton).

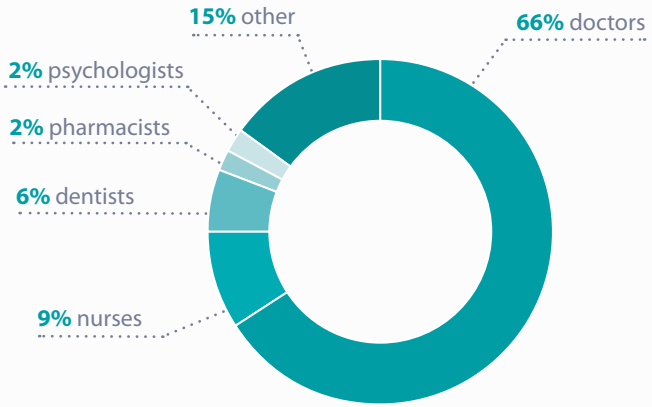
What are complaints about*

Individual practitioners

- 57% of issues raised in complaints were about an individual practitioner.

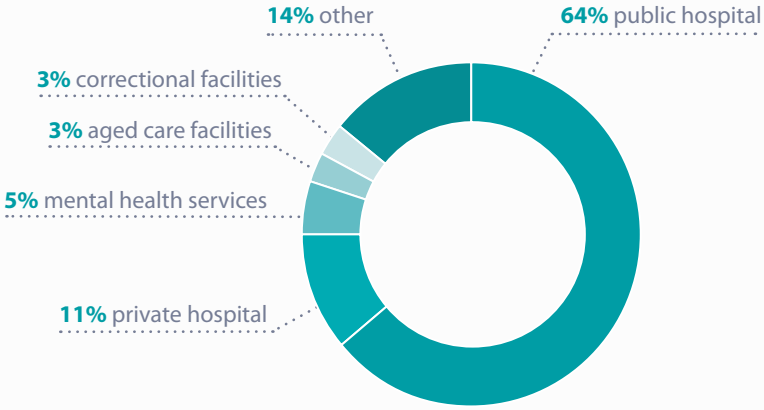
Of individual practitioner complaints:

- 94% were registered practitioners and
- 6% were unregistered.



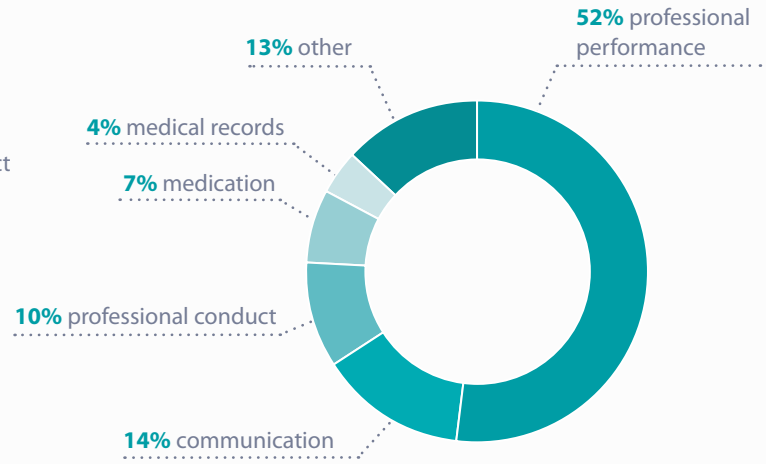
Health service organisations

- 43% of issues raised in complaints were about health service organisations.

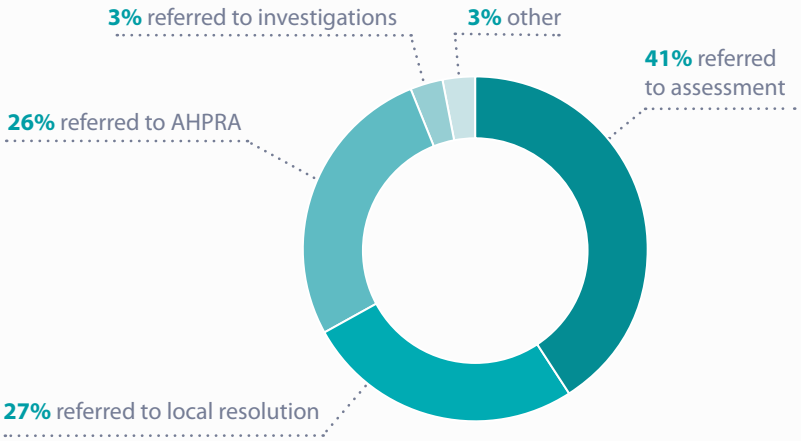


Most common issues raised in complaints

- **professional performance**—inadequate/unexpected treatment, outcome or complication, incorrect diagnosis or inadequate care
- **communication**—attitude or manner, inadequate, incorrect or misleading information
- **professional conduct**—competence, boundary violations, illegal practice
- **medication**—prescribing, administering, dispensing, storage
- **medical records**—record keeping, access and transferring records.



What happens when we accept a complaint



*For all matters that completed assessment.

Nationwide comparisons

Queensland's health complaints system is unique in Australia. The jurisdiction of the Health Ombudsman covers both registered and unregistered practitioners, the management of serious matters previously performed by AHPRA, monitoring of the performance of AHPRA and the national boards, and a range of additional powers. This broad jurisdiction can make it difficult to compare certain Queensland data with health complaints agency data from other states and territories.

The Health Ombudsman works with health complaint commissioners across Australia to discuss trends and changes in health complaints data. Bi-annual meetings for the Health Complaint Commissioners from each state and territory also provide a formal opportunity to facilitate this exchange.

Staff from the office also work with other state and territory health complaint agencies to ensure as much consistency as possible, given each jurisdiction's own legislation and system functions.

Implications of these insights for the office

While complaints management is the core function of the office, there is also an awareness of the office's unique sector-wide position as a regulator for healthcare in Queensland. From that position, it is possible to discern apparent trends in the delivery of healthcare across the state.

However, trends considered in isolation can be deceiving and misdirect focus away from less obvious, but more serious risks. To manage complaints effectively, the office invests time in gathering and tracking this information to understand where the greatest risks to the health and safety of the public are occurring.

These insights are used to instigate systemic investigations and inform recommendations made by the office to improve the standards for service delivery and healthcare practice. In the year ahead the office will be using data analysis and collaborative exchanges of data to inform stakeholders of areas where system wide improvements can be made.

Insights greatly strengthen the office's ability to fulfil its role to:

performance **summary**

Spotlight on 2015-16

Received **9351** contacts

17% more than last year

Accepted **3961** health service complaints

27% more than last year

49% of decisions on how to proceed made within 7 days

Completed **1897** assessments

32% within legislated timeframes

Completed **1242** local resolutions

80% more than last year

90% within legislated timeframes

Reached agreement in **75%** of matters that started conciliation

Completed **163** investigations

Issued **11** immediate registration actions

Issued **24** interim prohibition orders

5 matters referred *to QCAT*

3121 non-serious matters referred for management *to AHPRA*

12 serious investigations requested *from AHPRA*

key achievements

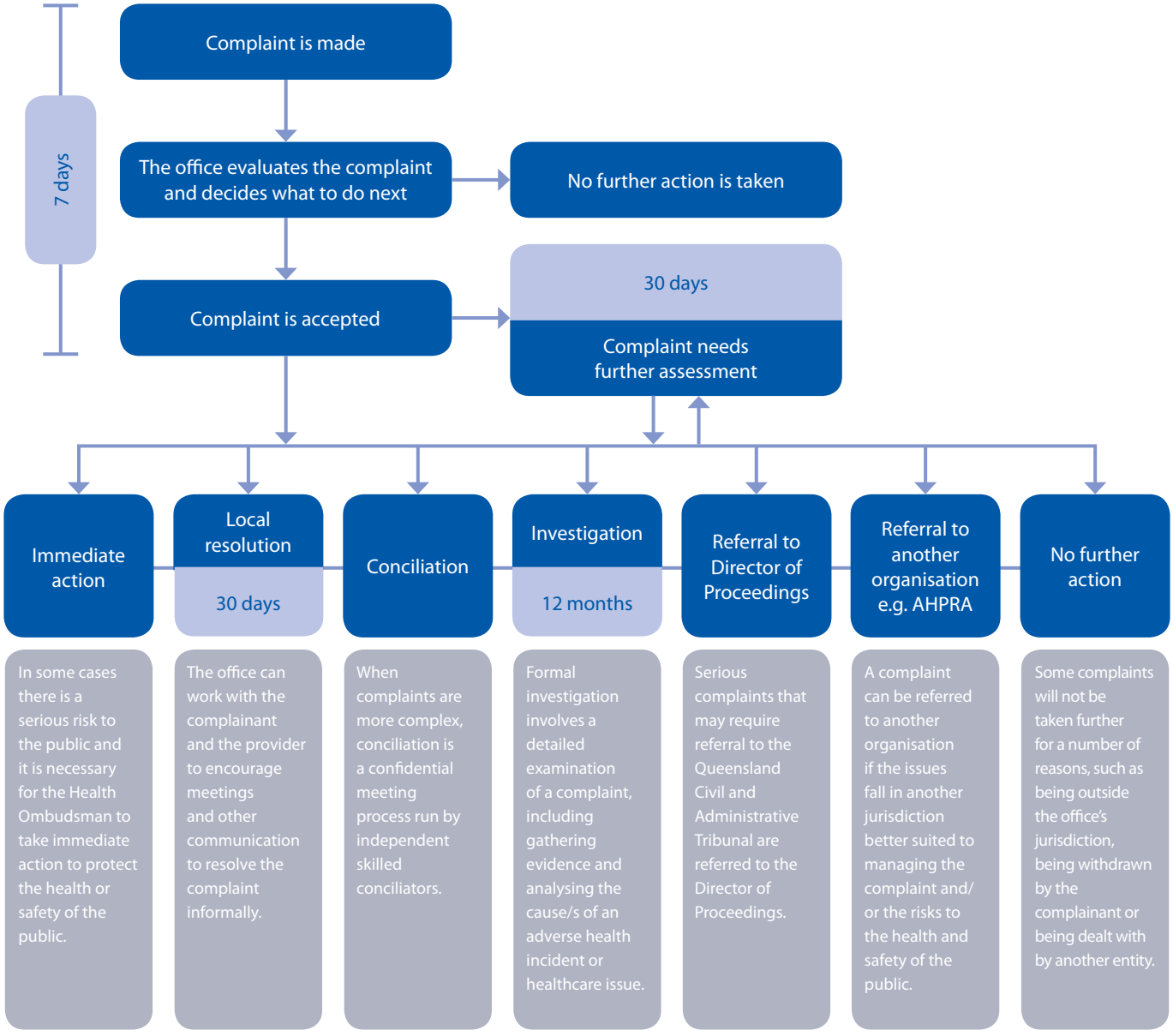
Below is a snapshot of the key achievements the Office of the Health Ombudsman has delivered in 2015–16. These achievements are measured against objectives outlined in the office's strategic plan, of which further detail can be viewed on page 49 of this report.

Objectives	Key achievements
Protect the health and safety of the public.	▪ A robust and effective health service complaints management system has been established with a focus on continual improvement ensuring complaints are received and acted upon efficiently to protect public health and safety and bring about systemic change. ▪ The Health Ombudsman has taken immediate action to protect the health and safety of the public on a number of occasions, issuing 11 immediate registration actions and 24 interim prohibition orders. ▪ Five matters have been referred by the Director of Proceedings to Queensland Civil and Administrative Tribunal (QCAT) for prosecution.
Promote professional, safe, competent practice and high standards of service delivery from health practitioners and health service organisations.	▪ The office has established a collaborative relationship with AHPRA to ensure an effective co-regulatory system. ▪ The office uses best-practice case management and investigative methodologies to achieve quality and timely outcomes. ▪ The office commenced several investigations into systemic issues within the health system in Queensland that will identify and make recommendations for overarching improvements. ▪ By working with health service providers throughout the health complaints process, the office has educated providers and highlighted the improvements needed for positive change.
Maintain public confidence in the management of complaints and other matters relating to the provision of health services.	▪ The office received and actioned high volumes of contacts and managed a 28 per cent increase in complaints in a thorough and impartial way. ▪ The office resolved 86 per cent of matters referred for local resolution and conciliated 75 per cent of matters that started conciliation. ▪ A robust mechanism for accessing advice from expert clinicians has been established, ensuring matters are reviewed by suitably qualified and experienced health practitioners with an appropriate understanding of the situational and work environments in which matters take place. ▪ The office established an open and transparent reporting regime by publishing on its website: – monthly, quarterly and yearly performance reports – various investigation reports – investigations that have been open for more than 12 months – all prohibition orders and certain immediate registration actions. ▪ Public hearings with the Health Ombudsman by the Health, Communities, Disability Services and Domestic and Family Violence Prevention parliamentary committee are broadcast live to the public on the Queensland Parliament website www.parliament.qld.gov.au. ▪ The Health Ombudsman gave more than 8 formal presentations to stakeholders and other interested parties to explain his role and that of the office. He also participated in many more meetings and discussions with a wide range of organisations regarding his responsibilities.
Create strong business operations and a culture of continual improvement.	▪ Best-practice technology and record keeping mechanisms have been put in place, underpinning the office's operations and supporting productivity in the workplace. ▪ Extensive process mapping and refinement was used to enable the office to improve its efficiency, improve its ability to meet legislative requirements and deliver on its objectives. ▪ The office grew its workforce of dedicated specialists with expertise in a range of key areas and the flexibility to deliver quality outcomes while managing high workloads.

the office's **management of complaints**

Managing complaints is a dynamic process. While this diagram attempts to show the relationships between various stages, in reality it is rarely straightforward. For example, complaints can be split or combined, returned for further assessment or investigated by multiple teams and other government agencies in tandem. The office takes great care in determining appropriate pathways for complaints and makes a conscious effort to maintain flexible processes that ensure the health and safety of the public remains the focus above all else.

When a complaint is made, the office has a legislated timeframe of seven days to evaluate it and decide what to do next. If the complaint is accepted, it will either be sent for further assessment or referred to another area of the office for review and further action. It may also be evident upfront, or at any stage as the complaint progresses, that the complaint requires no further action by the office or should be referred to another organisation. Extensive information around the circumstances of these decisions is provided in this section of the report.



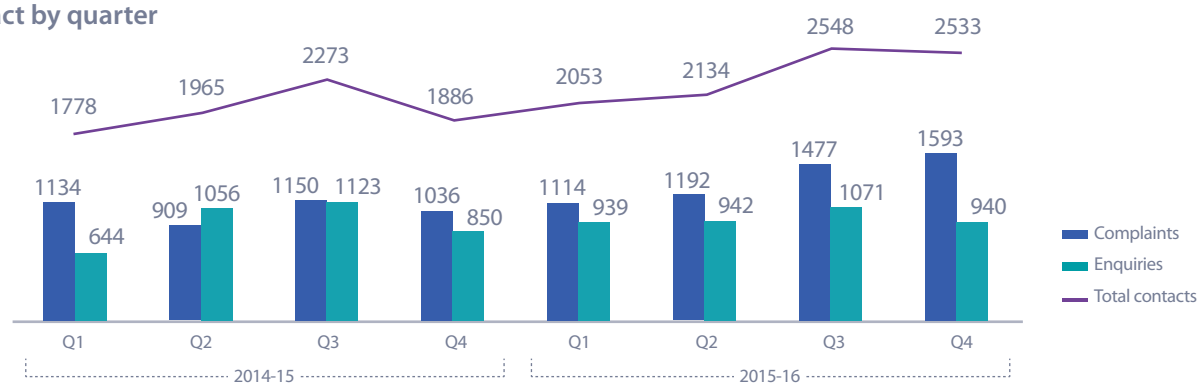
complaint **contacts**

During 2015–16, the office received 9351 contacts, of which 5435 were complaints and 3911 were enquiries. This was a 17 per cent increase in contacts from last year. Of these, the number of enquiry contacts increased slightly—up 6 per cent from last year. However, of greater significance, there was a 28 per cent increase in the number of complaint contacts received—up from 4229 in 2014–15 to 5435 in 2015–16.

While an increase was expected this year, the size of the increase was not. Although a number of factors could have contributed to this, the most likely reason is external awareness of the office, its functions and its ability to assist in resolving health complaints increased during the office's second year. As the office continues to actively engage with various key stakeholders, and further cement its place in the Queensland health sector, it can be expected that confidence in the health complaints system in Queensland will continue to increase in the coming financial year. This will bring further increases in complaint numbers, although possibly not by as much as the 28 per cent seen this year.

As a result of these significantly higher numbers of complaint contacts, the number of decisions made about how to deal with a complaint also increased year-on-year—up 40 per cent from 3546 in 2014–15 to 4970 in 2015–16. Of these, the number of complaints accepted increased 27 per cent—up from 3109 in 2014–15 to 3961 in 2015–16.

Type of contact by quarter



Decision timeframes

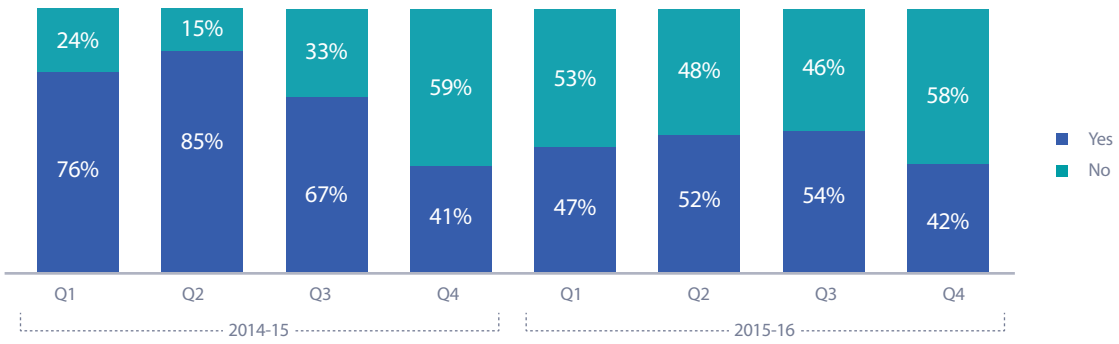
This increase in volume affected the office's ability to meet the legislated seven calendar day timeframe in which to decide how to deal with complaints. This reduced from 67 per cent in 2014–15 to 49 per cent in the 2015–16 reporting year.

To address this reduction and help improve the office's performance in this area, a number of initiatives were implemented throughout the year, including:

- structural changes to the team to more effectively manage incoming complaints
- improved processes for quickly identifying and escalating complaints that identify serious risks to the health and safety of the public—such as taking immediate action or investigating
- refined case management processes
- expanded performance reporting to increase visibility over whether complaint management is progressing appropriately and to enable any obstacles to progressing a complaint to be addressed quickly
- team capability improvements from on-the-job experience and structured training programs.

Work will continue on refining processes, further developing the office's electronic case management system and identifying the necessary level of resourcing to enable the office to meet the seven calendar day statutory timeframe. The office will also continue to work with AHPRA to obtain timely and comprehensive information about registered practitioners.

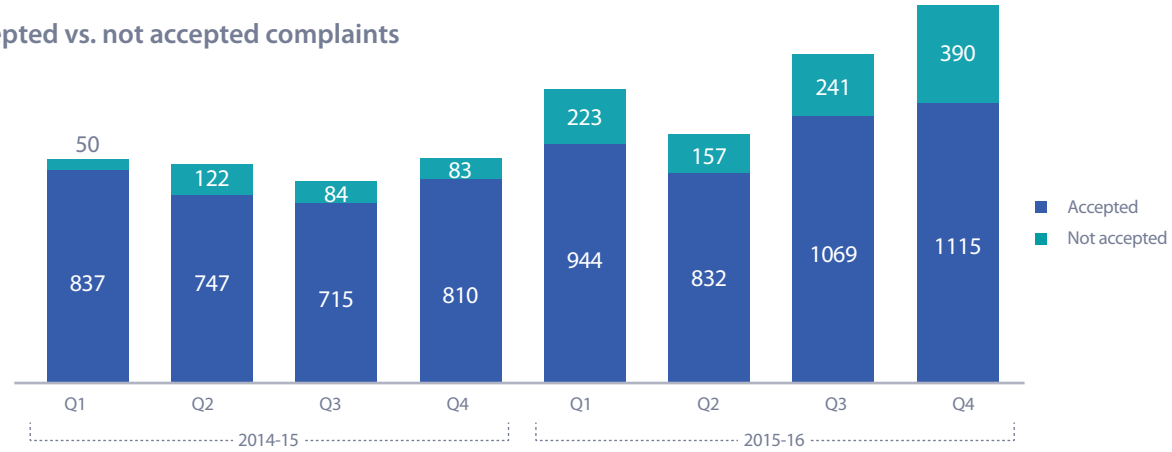
Decisions made within seven days



Complaint contact decisions

In 2015–16, 3961 complaint contacts were accepted as health service complaints (80 per cent), while no further action was taken on 1009 (20 per cent). The decision to take no further action can occur as a result of a complaint lacking substance; a complaint being, or having been, adequately dealt with by the office or another organisation, or a complaint being frivolous, vexatious or not being made in good faith (of which there are very few).

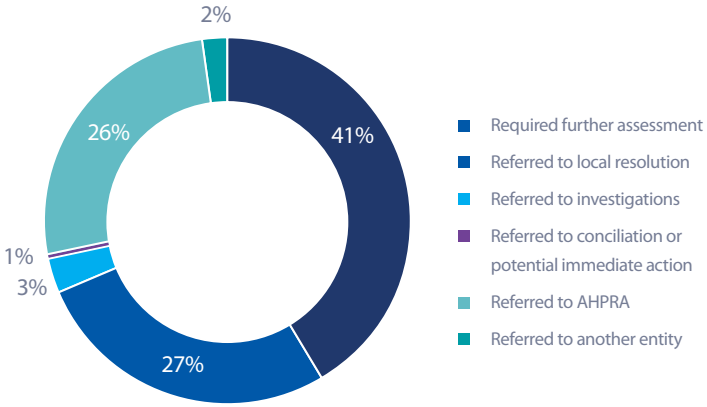
Number accepted vs. not accepted complaints



Complaints that are accepted by the office progress for further action. These can be actions within the office—such as, investigation, immediate action, assessment, local resolution or conciliation—or the complaint may be referred to another agency—such as AHPRA, the Queensland Police Service or a Hospital and Health Service. Multiple actions can be taken for each accepted complaint.

This year, 41 per cent of accepted complaints required further assessment, 31 per cent were referred directly for actions within the office and 28 per cent were referred directly to AHPRA or another entity without needing to undergo further assessment.

Accepted complaint decisions



Case study

The office received a mandatory notification from a hospital raising concerns about an employee's performance. The employer also noted that the practitioner had pre-existing Board imposed supervision conditions on their registration relating to other matters and was being monitored by the Australian Health Practitioner Regulation Agency (AHPRA). This new notification related to allegations that the practitioner had failed to appropriately obtain consent from a patient for a surgical procedure.

In response, the office and AHPRA conducted a co-regulatory face-to-face consultation to discuss the complexities of the matter and plan the most appropriate pathway forward. It was noted during this consultation that the practitioner was about to undergo a Board directed performance assessment for the previous matter. In noting a potential pattern of conduct, and that the new matter would not amount to professional misconduct under the Health Ombudsman Act, the matter was referred to AHPRA for the Board to manage the practitioner's performance in its entirety.

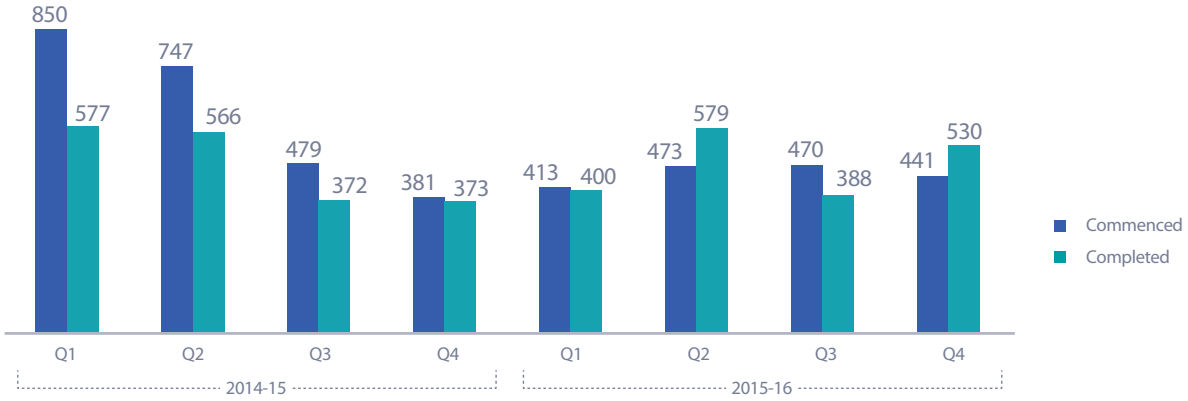
assessment

Complaints are referred for assessment if they are complex and require further information and analysis to determine the full scope of the complaint and the most appropriate way to deal with it. In 2015–16, the office's assessment team commenced 1781 assessments and completed 1897. The development and implementation of more efficient processes has enabled earlier identification of matters appropriate for referral directly to local resolution, investigation, immediate action or AHPRA without undergoing an assessment. Earlier referral has produced more timely consideration of options to resolve complaints, more timely risk assessment and escalation of complaints and more cost-effective complaint management. Additional process improvements that have resulted in the completion of more assessments included:

- refining co-regulatory processes to allow for quicker referral of appropriate matters from the office to AHPRA, including the establishment of a dedicated referrals officer—who handles referrals to AHPRA and other organisations—and a secure, online referrals portal between the office and AHPRA to create a quick and transparent means of transferring referral matters
- enhancing internal reporting to improve caseload management, performance, training and development needs
- establishing triage teams dedicated to assessing aged and complex matters.

As at 30 June 2016, 430 complaints remain open for assessment with an average age of 83 days.

Assessments commenced and completed



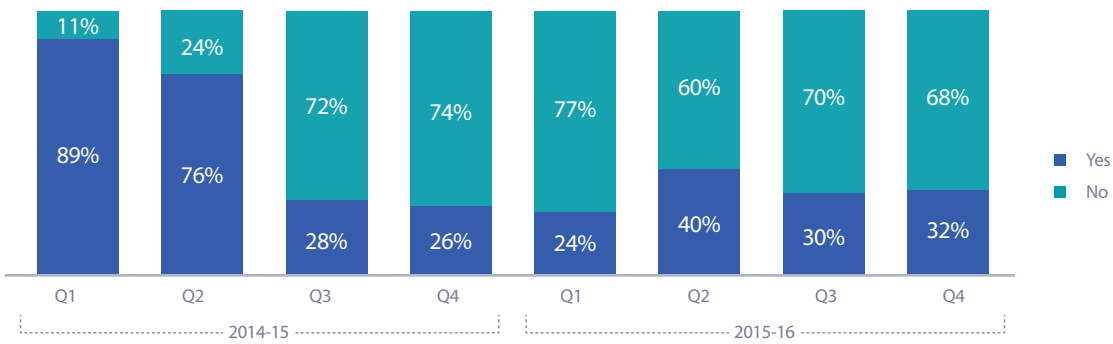
Assessment timeframes

The office has 30 days to complete an assessment, although this may be extended for an additional 30 days for more complex matters or where more time is required to receive necessary information. In 2015–16, 32 per cent of assessments were completed within legislated timeframes—that is either within 30 days, or within 60 days when granted an extension.

The nature of the assessment process and its potential for complexity and expanded scope makes the assessment process for the office different from many other similar agencies. Assessment of a single complaint about one practitioner and one issue may identify multiple issues about multiple practitioners, with each issue and practitioner requiring further assessment to identify how to deal with it. In other words, a single complaint can generate multiple assessment processes—exponentially increasing the work required to manage the complaint effectively. Independent clinical advice may be sought from a clinical advisor if a complaint or issue raises complex clinical questions. Clinical advice may also inform whether a complaint or issue is appropriate for referral for conciliation or local resolution. Obtaining clinical advice can also impact on the time within which an assessment can be completed.

The process improvements and initiatives mentioned above have been implemented to address the timeframes in which assessments are completed, while factoring in the complexity and the need to ensure quality in the assessment process and the decisions that are made.

Assessments completed within legislative timeframes



Assessment outcomes

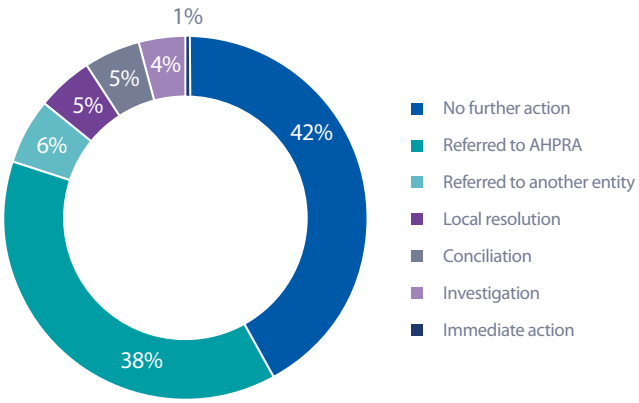
At the conclusion of an assessment, a decision is made on how to best deal with a matter. There are a number of alternative actions available. Of the 1897 completed assessments in 2015–16, 903 matters (42 per cent) were closed with no further action being taken and 811 matters (38 per cent) were referred to AHPRA for management. The remaining 20 per cent were either referred to another entity, local resolution, conciliation, investigation or immediate action.

The office may take no further action when:

- the assessment process provides information to the complainant which resolves the complaint
- assessment indicates that the complaint was being adequately dealt with by another entity
- assessment shows the health service provided was appropriate and reasonable in the circumstances
- the complaint is not made in good faith
- the complaint is withdrawn
- the complainant fails to cooperate with requests for information.

The office may identify issues in complaints that are appropriately dealt with by AHPRA and will refer those issues to AHPRA for management. AHPRA has the ability to deal with certain issues, such as health impairment, by putting in place health assessment and monitoring programs—options not available to the office. When the office transfers a matter, AHPRA is provided with all relevant information about the complaint to enable ongoing management as part of the co-regulatory partnership in Queensland.

Assessment outcomes



Case study

The office received a complaint from a female complainant about a maternity service provided to her by a doctor at a private hospital.

The complainant raised a number of issues about the adequacy of the treatment she received during her pregnancy and birth of her child which resulted in an unexpected hysterectomy after a caesarean section.

After receiving the complaint, the office completed an assessment taking into account medical records for the complainant, a written submission from the hospital and practitioner, medical imaging reports, and independent clinical advice from a suitably qualified health practitioner.

In this instance, the Health Ombudsman decided to take no further action as there was no evidence to suggest that the complainant received inadequate or inappropriate care from the health provider or practitioner.

Ultimately, while the outcome was not the one the complainant was looking for, it is important to provide an opportunity for certainty and an examination of the facts of the case. This can also contribute to identifying possible trends and systemic issues that may be present in the healthcare sector.

Case study

A complaint was made to the office by a patient who had received treatment for a leg ulcer at their local hospital. During the hospital admission, a practitioner noted that near the patient's ulcer was an area of skin that appeared suspicious. This was documented in the notes but no treatment plan or follow-up occurred and the patient was discharged from the hospital.

Several months later, the patient's condition deteriorated and they were seen by their general practitioner who identified the suspicious area of skin, conducted a biopsy and received results that confirmed that the lesion was a malignant melanoma.

As part of the assessment process the office obtained independent clinical advice to understand whether earlier detection of the melanoma in this case would have prevented unnecessary pain and suffering for the patient. The independent clinical advice was critical of the lack of diagnosis and follow up by a practitioner at the hospital. Based on this independent evidence, the office referred the practitioner to the Australian Health Practitioner Regulation Agency and progressed the matter on for conciliation regarding the patient's dispute of subsequent treatment costs.

local **resolution**

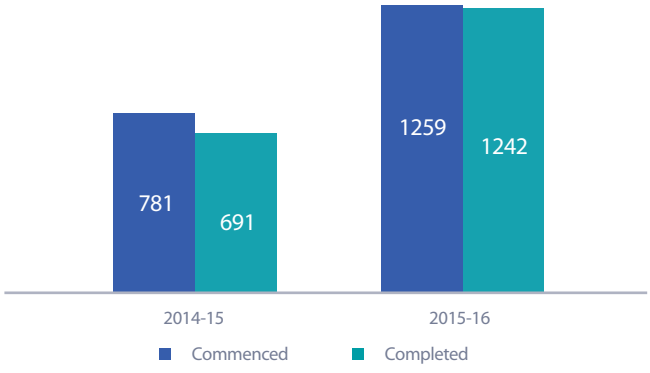
The local resolution process helps parties to resolve a complaint in an informal, simple and quick way. This is achieved by helping parties to discuss suitable solutions to achieve resolution.

Local resolution can be helpful for a range of complaints such as negotiations on less complex clinical issues, communication breakdowns, access to health services or financial settlements such as out-of-pocket expenses or corrective costs.

In 2015–16, 1259 local resolutions were started, 61 per cent more than last year (781), while 1242 local resolutions were completed, an increase of 80 per cent from 2014–15 (691). These significant increases are largely due to process improvements which allow for earlier identification of complaints suitable for direct referral to local resolution and a greater awareness within the office of what local resolution may achieve for complainants. Direct referral means the office can work with the parties involved in a complaint sooner to try and resolve the matter as quickly and easily as possible.

The office was able to manage this significantly higher volume effectively by re-allocating available resources, and implementing process efficiencies. These strategies not only resulted in the management of the increased volume but also resulted in a corresponding increase in the percentage of local resolutions able to be closed.

Local resolutions commenced and completed

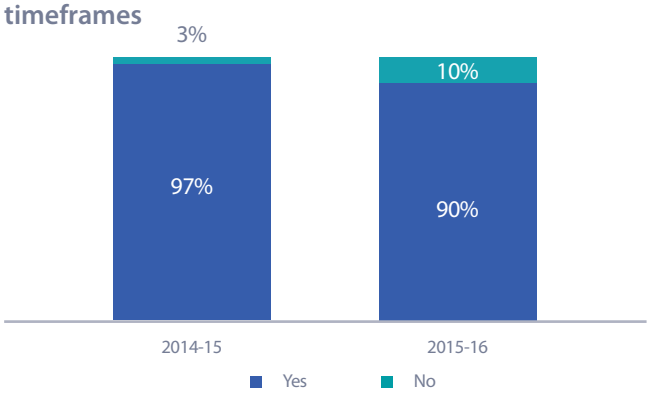


Local resolution timeframes

Local resolution is required to be completed within 30 days. However, this may be extended for an additional 30 days if necessary information has not been received or the Health Ombudsman believes the complaint may be resolved within the extended period.

Despite the significant increase in the volume of complaints moving into local resolution, 90 per cent of resolutions (1115) were completed within legislative timeframes—that is within 30 days, or within 60 days when granted an extension.

Local resolutions completed within legislative timeframes



Local resolution outcomes

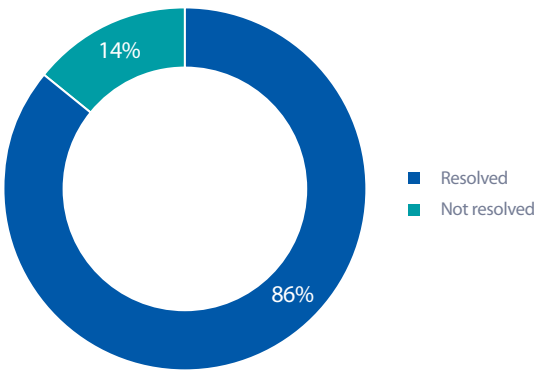
In 2015–16, 86 per cent of completed local resolutions were resolved. This is a significant achievement given the increased volume of complaints and the proportion that were completed within statutory timeframes.

As local resolution is a voluntary process, the outcomes that can be achieved are varied and are tailored to the circumstances of each complaint. Potential outcomes include an apology, policy or process improvements and refunds of out-of-pocket expenses or corrective costs.

Often the health consumer may require ongoing healthcare, making the local resolution process an important step in rebuilding trust and confidence in the relationship. This may be achieved by sharing information regarding the care received, improving the understanding of clinical treatment or administration procedures and developing communication protocols for the future.

The majority of local resolutions finalised without achieving resolution were closed with no further action to be taken. The reasons why a matter is not resolved vary but could include the complaint being withdrawn by the complainant, either party not participating in the voluntary process or matters being resolved without the involvement of the office. The remainder of matters were either referred to AHPRA, assessment, conciliation or another agency for further action.

Local resolution outcomes



Case study

A complaint to the office was made by a young woman who attended the health service provider under a 72 hour involuntary treatment order. During the treatment period, the patient was placed in a seclusion room due to safety concerns and her clothing and underwear were removed by a nurse with the assistance of three male security guards. This caused the complainant distress and embarrassment. During this process, the patient advised staff that she suffered from incontinence and asked for her underwear not to be removed. Despite this, she was left for a period of at least eight hours with no means to manage her incontinence.

After an initial assessment, the matter was referred for local resolution. The office managed negotiations between the parties in order to find a suitable pathway to resolve the complaint.

As a result of these interactions, the provider acknowledged the distress and embarrassment caused by the situation and apologised. In addition, the hospital placed an alert on the patient's medical record identifying the incontinence so that in future this can be managed appropriately. The hospital also provided an explanation regarding the use of male security guards, along with a commitment to explore the possibility of arranging female security guards to manage these situations.

Case study

A complaint was made to the office by a woman on behalf of her mother, who after undergoing surgery, was left alone in a transit area for around four hours. The complaint alleged the patient's family was not notified of the transfer and no assistance was offered to the patient, including providing any food or water or assistance to go to the toilet. In addition, it was reported that staff made comments such as 'you're too healthy to be here' and showed no compassion for her severe disability.

The matter was referred for local resolution, and as a result of negotiations, the hospital explained that changes had been made to ensure patients had a better transition experience and were better supported while they were in the transfer unit. The hospital also acknowledged how the comments could have been perceived and confirmed that the issue had been discussed with all staff involved.

The complainant said she found it gratifying that her complaint was taken seriously and that changes were made to ensure that future patients would be better supported.

conciliation

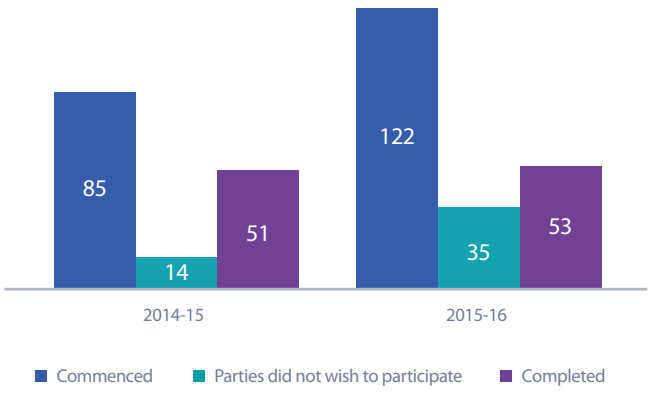
Conciliation is a voluntary process used for more complex or sensitive complaints. In conciliation, an independent and impartial conciliator works with the parties involved to reach agreement.

The conciliator works with parties to gather information, identify issues, clarify misunderstandings and provide explanations. A variety of different methods such as teleconferences or face-to-face conciliation meetings are used with all parties to try to negotiate the issues and reach agreement.

In order for the conciliation process to operate effectively, conciliators ensure that the parties engage in good faith. This means that parties must reasonably comply with the arrangements made by the conciliator and remain focussed on resolving the complaint.

In 2015–16, 88 conciliations were completed, an increase of 35 per cent from last year. The number of conciliations started also increased dramatically, up from 85 in 2014–15 to 122 in 2015–16—a 44 per cent increase—leading to 54 conciliations remaining open at year's end. However, of these open matters, 13 are currently on hold and have not been able to commence conciliation until the process of another agency, such as AHPRA or a Hospital and Health Service, has been finalised.

Conciliations commenced and completed



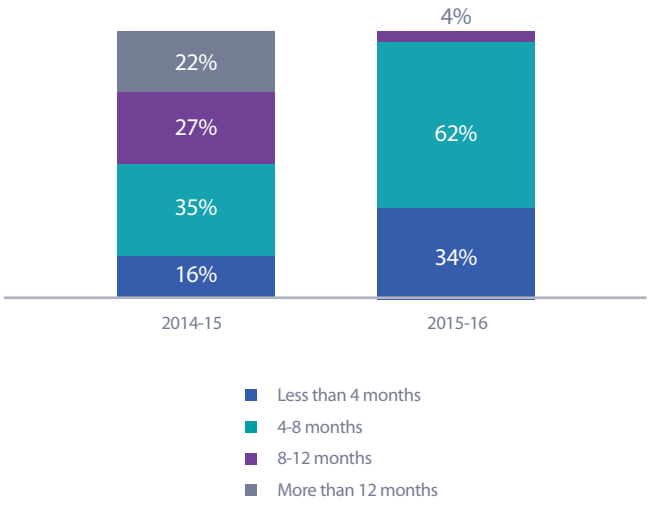
Conciliation timeframes

While the conciliation process does not have a legislated timeframe, the office has a conciliation timeframe target of four months to assess the viability of a successful conciliation. This ensures the conciliation process is being delivered within a reasonable timeframe.

Conciliation is a confidential and privileged process. This means any written or verbal information provided during conciliation cannot be used later by either party as evidence before a court, tribunal or disciplinary body—unless it raises a public interest issue.

Despite the increase in the number of conciliations completed in 2015–16, 34 per cent of matters that completed the conciliation process were finalised in less than four months. This is an improvement from last year in which 16 per cent of conciliations were completed in the same timeframe.

Completed conciliation timeframes



Conciliation outcomes

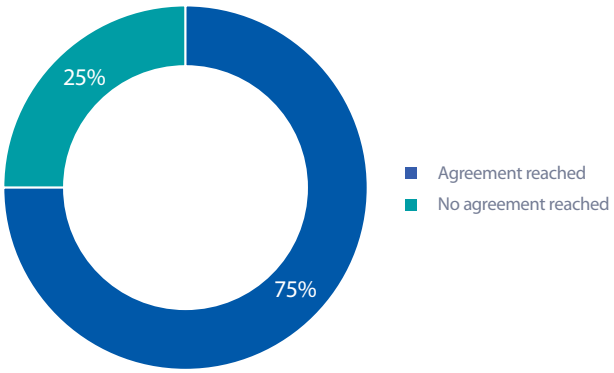
As conciliation is a voluntary process, parties cannot be compelled to participate. Of the 88 conciliations closed in 2015–16, 40 per cent were due to parties declining to participate in the process, an increase from 20 percent 2014–15. Reasons for this include:

- either party deciding to proceed with a legal personal injuries claim
- the type of compensation being sought is not available through conciliation—e.g. pain and suffering or economic loss
- one or both of the parties cannot see the benefit of participating in conciliation
- a perception by either party that the other party will not participate in good faith.

For conciliations where parties did choose to participate, 75 per cent were conciliated successfully. The outcomes ranged from acknowledgements, apologies and detailed explanations, through to reimbursement for out-of-pocket expenses, future treatment costs and ex-gratia goodwill payments.

For the 25 per cent of conciliations where agreement was not reached, the majority were closed as no further action for the same reasons outlined above.

Completed conciliation outcomes



Case study

A patient died in a hospital from a very rare condition that was untreatable. The patient's family were distressed and made a complaint because they believed the patient did not receive potentially life-saving treatment.

The office assessed the case and referred the matter to conciliation to help both parties to explain and understand the issues related to the patient's treatment and subsequent death. Both parties agreed to participate in conciliation and a confidential and privileged conciliation conference was held to enable the parties to jointly explore the issues.

During the conference, the family were empowered to ask questions and to explore in detail the treatment provided and the hospital was able to explain the complex medical issues confronting the patient and the hospital staff. The parties worked together to reach the understanding necessary to allow the family to obtain closure on the passing of their loved one.

Case study

A complaint was made to the office regarding an elderly patient who was admitted to hospital after suffering a fall at home. The patient was diagnosed with a fractured leg, but the surgery to address the fracture was delayed for 14 days with no reason provided for the delay. A week after the surgery, after further deterioration, the leg was amputated below the knee.

At the confidential and privileged conciliation meeting, complex clinical information was shared and explained, resulting in an understanding that the amputation was medically necessary and unavoidable.

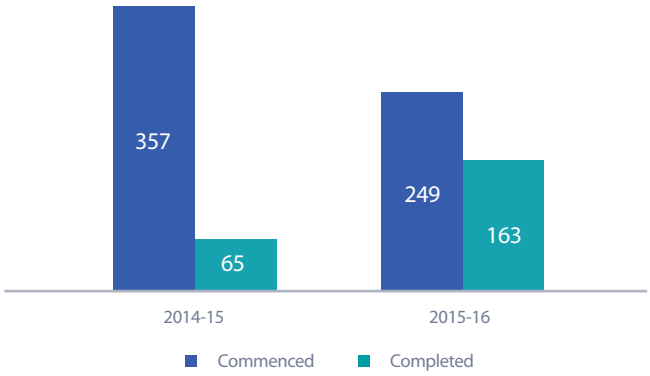
After the explanation was provided, the patient's family acknowledged that the medical treatment was appropriate and also that the hospital staff did their best in providing the necessary care. The hospital acknowledged to the family that there was a fundamental lack of communication with the patient and their family. The hospital apologised for the communication breakdown and advised that they had taken action to change internal procedures with a focus on improving communication.

investigation

Formal investigations are conducted into more serious matters and involve detailed planning, identification and sourcing of evidence based on a risk management framework.

The office commenced 249 investigations in 2015–16, and closed 163. This means for every three new investigations commenced in 2015–16, two investigations were closed. This is an improvement from the previous year which had an opened-to-closed ratio of more than five to one.

Investigations commenced and completed



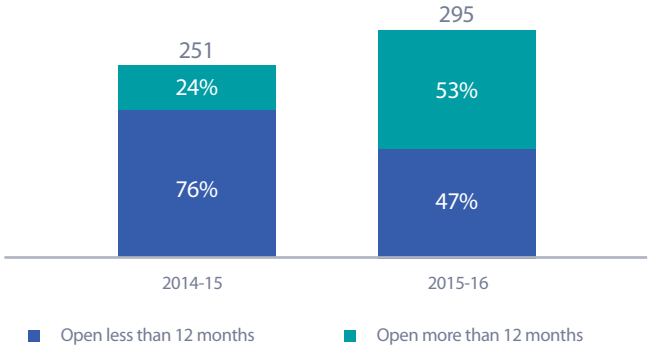
Open investigations

The number of open investigations increased by 18 per cent, from 251 at the end of 2014–15 to 295 at the end of 2015–16.

In reviewing the year-on-year average age of open investigations—excluding those that are paused—53 per cent were more than 12 months old. This is compared to 24 per cent in 2014–15.

All investigations that have been open for more than 12 months are published on the investigations register, available on the office's website **www.oho.qld.gov.au**.

Open investigations timeframes



Paused matters

In addition to the 251 open investigations at the end of this year, 77 matters were open, but paused. This means the office can't progress its investigation until another agency has completed its own investigation into the same individual. Commonly, this relates to matters of a criminal nature being investigated by the Queensland Police Service, but can also include matters under investigation by the Crime and Corruption Commission, Queensland Corrective Services, AHPRA or the Office of the State Coroner.

Once an agency has completed its action on a matter, the office is notified and commences its investigation, often using information gathered by the other agency to inform its decision.

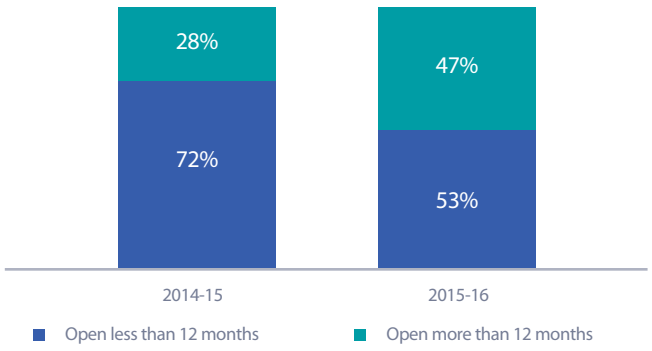
However, if a practitioner poses a serious enough risk to the health and safety of the public, the Health Ombudsman will prevent the practitioner from practising by taking immediate action against them prior to the matter being paused, even if another agency is investigating.

Investigation timeframes

Generally, investigations are to be completed within one year, although this may be extended due to the nature or complexity of a matter.

Of the 163 investigations completed in 2015–16, 53 per cent were finalised within 12 months, while 47 per cent were more than 12 months old. There are a number of factors contributing to closed investigations being older than 12 months.

Completed investigation timeframes



AHPRA transitional matters

Notably, 26 per cent of closed investigations were investigations originally started by AHPRA and transferred to the office in 2014–15 as part of the establishment of the new co-regulatory arrangement in Queensland. When looking just at closed investigations older than 12 months, this figure jumps to 49 per cent. These transferred matters created challenges during the office's first two years and have had a major impact on the office's investigations timeframes.

In 2014–15, the office commenced 124 investigations started by AHPRA, while in 2015–16 only 14 matters were transferred—this lower level of transfers is expected to continue in the future. The AHPRA matters transferred in 2014–15 were in varying stages of completion and required additional work by the office.

The disproportionate workload created by the unexpected number of matters transferred from AHPRA had a flow on effect in 2015–16, and coupled with new investigations being commenced by the office, created a backlog.

To address this, the office has established a temporary investigation team dedicated to these legacy matters, with a view to significantly reduce their numbers in 2016–17. The effect of this strategy can already be seen in Q4 of this year, with an increase in the number of investigations closed which were open for more than 12 months—increasing from an average of 14 in Q1–Q3 to 33 in Q4. As at 30 June 2016, 96 matters transferred from AHPRA remained open.

Establishment staffing levels

The staffing levels for investigations set prior to the commencement of the office have proven to be inadequate to meet the volume of matters being received by the office. Recruitment strategies to address resourcing deficiencies were implemented throughout the year, along with restructuring within the investigations division to better target existing resources to meet requirements. Additionally, process and system improvements were also implemented to streamline workflows and increase efficiency levels. These strategies will continue in 2016–17.

Complexity and seriousness of investigations

The office is responsible for all serious health service complaints in Queensland. Having all facts available for review is paramount to making well-informed and objective decisions, which, when dealing with complex matters that can involve multiple issues and practitioners, can take time to gather, evaluate and finalise. While the office strives to complete investigations as quickly as possible, it is important to ensure there is a balance between timeliness and the quality of decisions, particularly when dealing with more serious matters.

By their nature, the more serious matters require careful investigation and consideration. In 2015–16, 54 per cent of the office's investigations related to either illegal practice, sexual misconduct, other forms of misconduct, unauthorised prescription of medication or boundary violations.

Legislative requirement to investigate

The *Health Ombudsman Act 2013* requires that an investigation must be started when a matter reaches the threshold of a serious risk, or the conduct of a registered practitioner is considered to be professional misconduct or another ground exists which may lead to the practitioner's suspension or de-registration.

This is an important measure in protecting the health and safety of the public and ensuring appropriate rigour is applied to the investigation process. It also means, with such a broad scope, that a large number of investigations are started.

There are also a number of legislated administrative functions which can impact on the office's investigative capacity and subsequent timeframes, such as providing regular documented updates to providers, complainants and employers, and seeking quarterly extension approvals for all investigations more than 12 months old.

Case study

The office received a mandatory notification about a dentist which raised serious concerns regarding their performance and conduct.

The notification, which was made by a previous colleague of the dentist, specifically identified issues with:

- infection control measures such as washing hands and sanitising
- surgery arrangements such as reuse of single use equipment
- delegation of tasks to dental assistants beyond their qualification and experience
- use of adhesive bonding material for fillings purchased overseas and not approved for use by the Therapeutic Goods Administration in Australia
- supply of hydrogen peroxide in take home do-it-yourself teeth whitening kits at a concertation above ACCC rulings that can result in serious injuries.

In response, the office took immediate registration action against the dentist by imposing conditions on their practice.

The dentist admitted to the allegations and took steps to rectify failings and prevent repetition.

As the dentist's conduct was below the accepted standards, notifications were made to the:

- Chief Health Officer of Queensland—regarding infection control issues
- Therapeutic Goods Administration—regarding use of unapproved products, and
- Australian Health Practitioner Regulation Agency and the Dental Board of Australia.

In light of the breaches of the guidelines and evidence of professional misconduct, the Health Ombudsman chose to refer the matter to the Director of Proceedings.

Investigation outcomes

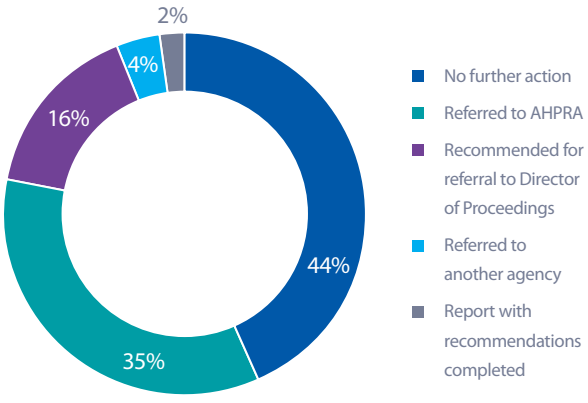
Of the 163 investigations completed in 2015–16, the majority of outcomes resulted in no further action being taken (53 per cent) or in the matter being referred to AHPRA (41 per cent). These outcomes occur when information and evidence gathered during an investigation shows that:

- a matter is not as serious as first thought and that further investigation, or prosecution, is not needed
- a practitioner no longer poses a risk to the public
- an issue is identified that makes the matter suitable for referral to AHPRA, such as the practitioner having a health impairment, or holding themselves out as a registered practitioner
- the matter has been appropriately dealt with by another agency.

Closed investigation reports are available on the office's website **www.oho.qld.gov.au**.

As a quality assurance exercise, the office followed up on 17 matters, relating to 14 practitioners that were closed as no further action—since the office's inception—in instances where practitioners surrendered, did not renew or withdrew their application for registration. Through a review of AHPRA's practitioner database, it was seen that in all cases the practitioners had not renewed their registration after the office's decision for no further action.

Completed investigation outcomes



Matters to be considered for referral to the Director of Proceedings

Notably, there was an increase in the number of matters considered appropriate for referral to the Director of Proceedings. In 2015–16, 24 matters relating to 18 practitioners were recommended to the Health Ombudsman for referral to the Director of Proceedings, up from 3 matters the previous year. This is expected to continue to increase in 2016-17.

Case study

The office received a complaint from the legal representative of a patient who, while on a four day interstate holiday to Queensland, was prescribed with medication by a doctor to treat chronic pain and pre-existing and severe depression and anxiety.

In the patient's home state, the patient had received regular psychiatric treatment and, as a result of their history, was not to receive controlled schedule 8 drugs.

The patient was assisted in obtaining the prescription by an acquaintance they made on the holiday who claimed painkillers could easily be accessed and that they had previously obtained hundreds of scripts and accumulated a large quantity of prescription medication.

When the patient returned home, they were admitted to hospital after becoming ill and losing consciousness from an alleged overdose of the painkillers prescribed by the doctor which they had mixed with their existing medication.

The complaint made against the doctor alleged the combination and dosage of the prescribed painkillers mixed with repeat scripts was inappropriate. Additionally, it was claimed insufficient assessment was completed to understand the patient's medical conditions and establish whether they had a therapeutic need for the painkillers.

The office investigated the matter in relation to both the patient and the acquaintance and found a history of schedule 8 medication abuse and overdoses. The office also found a number of misrepresentations and inconsistencies between the patient's report and the evidence. The investigation also found that in both cases—the patient and their acquaintance—the doctor had also checked the prescription shopper information service prior to prescribing and, in the case of the acquaintance, stopped prescribing. Additionally, the doctor had ordered a pain-related health assessment for the patient, which the patient did not attend.

As a result, the office concluded the doctor's conduct was unlikely to amount to professional misconduct. To confirm the decision, and given the adverse reaction suffered by the patient, independent clinical advice was sought which confirmed that the prescriptions, dosage and assessment completed by the doctor was appropriate. The office decided to take no further action in relation to the matter.

In the case of the acquaintance, the office referred this matter to the Australian Health Practitioner Regulation Agency for management. Although the doctor ceased prescription and only treated the friend a handful of times, there were high doses of medication prescribed and a lack of evidence of health investigations to support the therapeutic need for schedule 8 medicines.

referral to the **director of proceedings**

Serious complaints that may require referral to QCAT are referred to the Director of Proceedings. The decision to refer a matter to the Director of Proceedings is made by the Health Ombudsman.

In 2015–16, the Health Ombudsman referred 24 matters relating to 18 practitioners to the Director of Proceedings. The majority of these referrals were made in the last quarter of the year and this momentum is expected to continue into next year. Referrals made to the Director of Proceedings related to concerns of:

- fraud
- theft of medication or drugs
- self-administration of drugs
- working while intoxicated
- physical or sexual assault of patients
- poor infection control.

Further details on the functions of the Director of Proceedings can be reviewed on page 52 of this report.

Referral to Director of Proceedings outcomes

The health and safety of the public is the main consideration of the Director of Proceedings when deciding whether to refer a matter to QCAT. The Director of Proceedings also considers the seriousness of a matter, the likelihood of proving a matter before QCAT, the orders QCAT might make and anything else the Director of Proceedings considers relevant.

In 2015–16, five matters were referred by the Director of Proceedings to QCAT. The remaining 13 matters are in the process of being examined ahead of a final decision by the Director of Proceedings.

Developing best practice processes

The office strives to implement best practice in its dealings with practitioners and their legal representatives, complainants, third parties and QCAT during disciplinary proceedings.

The Director of Proceedings is mindful of the significant adverse impact that disciplinary proceedings may have on a practitioner, as well as the complainant and third parties.

As a result, the review of referrals, and subsequent proceedings before QCAT, are conducted in accordance with model-litigant principles to ensure the process is managed in an impartial, fair and independent manner and matters are dealt with as effectively and efficiently as possible.

As part of this approach, the office provides practitioners with a narrative of the matter—known as a statement of facts—and a full brief of evidence containing the materials the office intends to rely on in QCAT. By providing this material to the practitioner at an early stage, the office seeks to streamline the disciplinary process and facilitate meaningful discussions in order to reach agreement on as many issues as possible.

Outcomes of referrals to the Queensland Civil and Administrative Tribunal

Of the five matters referred to QCAT, one was decided on by QCAT in May 2016. The matter of *The Health Ombudsman v Costello* was the first matter referred by the Director of Proceedings to QCAT and involved a practitioner who sexually assaulted a vulnerable patient. In referring the matter to QCAT, the Director of Proceedings sought to prohibit the practitioner from providing any health services in the future, as an unregistered health practitioner. His Honour Judge Thomas prohibited the practitioner from providing any health service again.

The remaining four referrals are yet to be determined by QCAT.

Case study

Following a matter being referred to QCAT, the office provided the practitioner's legal representatives with an early brief of evidence. This avoided the need to have a compulsory conference in the matter, and both parties were able to file detailed joint submissions in QCAT using this material.

Less than two weeks after the joint submissions were filed, the practitioner was banned from ever providing a health service.

In deciding the matter, the Judge acknowledged as particularly helpful the joint submissions between the parties.

immediate **action**

In some cases, it is necessary for the Health Ombudsman to take immediate action to protect the health and safety of the public. This action is taken when there is a reasonable belief that a health practitioner's health, conduct or performance poses a serious risk to the public.

The Health Ombudsman took 38 immediate actions in 2015–16 relating to 26 individual practitioners, an increase from the 17 taken last year. Of these 38 immediate actions:

- 11 immediate registration actions were taken against registered practitioners to suspend or impose conditions on their registration
- 24 interim prohibition orders were issued to health practitioners, prohibiting or restricting their right to provide health services
- 3 corresponding interstate prohibition orders were issued to interstate practitioners preventing practise in Queensland, in accordance with prohibition orders issued in their home state.

In addition, the Health Ombudsman served 12 show cause notices to practitioners to alert them to the proposed action and invited them to make a submission within a stated period. This is an important step in providing procedural fairness for the practitioners involved.

These temporary measures are effective in protecting public health and safety while matters are further investigated or prosecuted—as was the case with the matter concerning Costello prior to the QCAT ruling.

Immediate registration actions may, and interim prohibition orders must, be published on the office website at **www.oho.qld.gov.au**. This is done to ensure the public and employers are aware of restrictions or conditions a practitioner has on their registration or practice.

A practitioner has a right to seek review of the Health Ombudsman's decision to take immediate action by applying to QCAT within 28 days of receiving the notice of immediate registration action or interim prohibition order. One practitioner made an application to review the Health Ombudsman's decision to impose an interim prohibition order in 2015–16. The outcome of their application is yet to be determined by QCAT.

Case study

A hospital made a mandatory notification to the office that a registered nurse had been charged with several violent, criminal offences.

Within four days of receiving additional relevant information, the Health Ombudsman issued an immediate action notice suspending the practitioner's registration.

The Health Ombudsman took immediate action because he believed the practitioner posed a serious risk to patients because of their criminal conduct and occupational role in treating, often vulnerable, patients dependent on the medical care provided by nursing staff.

Although the practitioner later sought to have the suspension removed after they had pleaded guilty to the criminal charges, the Health Ombudsman decided not to lift the suspension. This decision was made because the Health Ombudsman had formed the reasonable belief that the practitioner still posed a serious risk to the health and safety of the public and that it was still necessary to act to protect the health and safety of the public.

systemic **investigations**

In addition to managing health service complaints, the office carries out investigations into system-wide issues relating to health service provision and the effectiveness of components of Queensland's health system. The office provides recommendations to the health sector to assist in bringing about overarching improvements.

The office commenced 27 systemic and facility-based investigations in 2015–16. Selected systemic investigation reports outlining recommendations can be seen on the office's website at **www.oho.qld.gov.au**.

A number of systemic investigations initiated in 2014–15 were continued in 2015–16. One notable example was the office's investigation into the effectiveness of the Queensland regulatory system for scheduled medicines. In particular, the prescribing and dispensing of schedule 8 medications—the most tightly controlled medicines. The final report of this investigation will be published early in 2016–17 and will outline a number of recommendations under the themes of legislative complexity, agency roles and responsibilities, policies and procedures, communication and collaboration and real-time prescription monitoring.

Case study

The office received a complaint from family members of a deceased patient following his death in a Queensland hospital.

Concerns were raised about the availability of staff, pain management, hospital record keeping, discharge and transfer arrangements and the limited communication had with the patient's family.

The office commenced an investigation to understand whether the alleged practices led to the death of the patient and to what extent they may be affecting other patients at the hospital seeking treatment.

Detailed submissions from the family and hospital, medical records, protocols and policies, independent clinical advice and clinical incident reports were obtained and reviewed to inform the Health Ombudsman's conclusion.

The investigation revealed the patient's death was unavoidable due to a terminal illness prior to his admission to the hospital. However, concerns in the way the hospital managed the care of the patient and the sufficiency of their processes were substantiated.

To ensure the health and safety of the public is protected in the future and preventative measures are effective in mitigating reoccurrence, the office developed four recommendations in addition to the improvements already made by the hospital since the death of the patient.

The recommendations are now being monitored by the office and the first of three progress reports has been received.

Own-motion investigations

The Health Ombudsman can commence own-motion investigations without a complaint where there is an identified significant risk to the health and safety of the public. Following the collection of a year's worth of internal data, engagement with external stakeholders, media monitoring and issues emerging during the course of investigations, eight own motion systemic investigations were started in 2015–16.

These investigations focussed on medication management, failure to notify the health ombudsman of notifiable conduct, patient admission and transfer, and the quality of health service delivery in the areas of audiology, maternity services and correctional services. These investigations are due for completion in 2016–17.

monitoring and **quality assurance**

Australian Health Practitioner Regulation Agency and the national boards

One of the functions of the Health Ombudsman is monitoring the performance of AHPRA and the 14 national health practitioner boards. In particular, monitoring their oversight of the health, conduct and performance of registered health practitioners who provide health services in Queensland.

As part of fulfilling this function, the Health Ombudsman analyses data provided by AHPRA and publishes quarterly performance reports on the office's website. This is an important aspect of the co-regulatory system in Queensland as it:

- encourages transparency and accountability in relation to the functions of AHPRA and the national boards
- highlights areas for improvement in the performance of those functions
- provides information and assurance to the public about the performance of AHPRA and the national boards.

The office's monitoring functions of AHPRA differ to those performed by the Office of the National Health Practitioner Ombudsman and Privacy Commissioner. Under the National Law, the National Health Practitioner Ombudsman and Privacy Commissioner was established to receive complaints relating to the fairness of processes, outcomes and the manner in which personal information has been handled by AHPRA and the national boards.

Targeted assurance activity

In 2015–16, the office finalised an assurance framework to explore identified performance issues in more depth. An outcome of this work was the commencement of an assurance activity into the management of practitioners with impairments by AHPRA and the national boards.

Further assurance activity also continued on previous work undertaken by the office in 2014–15 whereby a practitioner, subject to AHPRA's monitoring program, was able to breach the imposed conditions on their registration more than 191 times. The review identified opportunities for improvement in AHPRA's processes and systems in place to monitor and manage the compliance of practitioners subject to conditions on their registration. The review made 10 recommendations and AHPRA advised the office in April 2016 that all recommendations had been implemented.

Recommendation monitoring

At the completion of an investigation into a health service provider, the Health Ombudsman may recommend improvements to aspects of the provider's health service delivery. The office monitors and reports on the implementation of these recommendations.

Recommendations generally relate to changes in organisational practice and specific initiatives to address identified failings.

The office made 19 recommendations relating to six providers. As at 30 June 2016, 11 recommendations were fully implemented, 1 was partially implemented and 7 were yet to be implemented.

In 2015–16, the office also monitored 61 recommendations made by other agencies, such as reviews or investigations undertaken by a health service provider or Office of the State Coroner. As at 30 June 2016, 45 recommendations were fully implemented, 7 were partially implemented and 9 were still to be implemented.

Practitioner compliance monitoring

The office monitors compliance with any restrictions imposed on practitioners in Queensland as a result of the Health Ombudsman taking immediate action. Monitoring practitioner compliance with conditions on their registration or restrictions on their practice is an important means of mitigating risk to the health and safety of the public.

As at 30 June 2016, 41 practitioners were being monitored—22 registered practitioners and 19 unregistered practitioners. Of these 41 practitioners, only one was identified as being likely to have breached conditions. The suspected breach of conditions may constitute professional misconduct, and as a result an investigation has been commenced to further explore the alleged breach.

As an outcome of monitoring, two registered practitioners had their conditions lifted because the Health Ombudsman was satisfied the immediate registration action was no longer necessary.

During 2015–16, the office continued to develop improved processes and consistent practices to support the monitoring of practitioner compliance, including the capacity to report on compliance status. The office notes the work done by AHPRA and the National Boards, with input from the Office of the Health Ombudsman, to create a National Restrictions Library and promote a consistent set of restrictions capable of being appropriately implemented and monitored.

Monitoring healthcare safety and quality

The office continued to develop its capacity to monitor emerging health service provision risks in Queensland by considering trends in healthcare complaints and investigations, and assessing information that comes to the office in the course of its work.

Reportable events

Reportable events are serious clinical events that result in death or serious or permanent harm which was not reasonably expected as the outcome of the health service.

A root cause analysis is a type of report that can be compiled following a serious clinical event in a public or private health facility or ambulance. A root cause analysis includes information about what happened, how and why it happened and what corrective actions have been identified to prevent it happening again.

A change to the *Hospital and Health Boards Act 2011* has made the selection of the root cause analysis process optional as opposed to mandatory. However, if a root cause analysis process is undertaken, the report must be supplied to the office—currently the only organisation that monitors all root cause analysis reports across the Queensland public and private health system.

During 2015–16, the office received and reviewed 159 root cause analysis reports.

Evidence suggests that fewer root cause analysis reports are being conducted, which means the office will have even less visibility of potential systemic risks and trends over time. This is a matter of concern and will be subject to further exploration in 2016–17 to ensure that emerging issues can be identified quickly.

business
support services

Clinical advice

Clinical advice is sought from appropriately qualified and experienced clinicians to assist the Health Ombudsman to assess whether the conduct or performance of a health service provider is appropriate in the circumstances. This independent technical advice ensures that decisions made by the office are appropriate, credible, robust and transparent. Input from these clinicians allows the office to assess complex clinical complaints. The office is grateful for the assistance provided by these high calibre professionals.

Clinical advice is used mainly for complaints relating to serious and complex matters involving the performance or conduct of a specific practitioner and systemic issues associated with practices in hospitals and in health services.

During 2015–16, the Health Ombudsman received 186 clinical advice reports from 52 different areas of speciality or sub-speciality. For example, a diagnostic radiologist in the sub-specialty of an interventional radiologist who specialises in the area of heart and vascular (arteries and veins) issues provided assistance.

On occasion, delays may be experienced in identifying an appropriately experienced and qualified clinician who can assist in a matter. For example, if there are only a limited number of practitioners in the area of sub-specialty. In these cases, an interstate clinical advisor may be sourced to ensure conflicts of interest are avoided.

Case study

A complaint was made to the office about the standard of care provided to a two-month old infant born with a heart defect which required surgical repair. The complaint specifically made reference to a resuscitation process and if the resuscitation process caused or contributed to an adverse outcome for the infant.

Three days after the surgery was completed, the infant was considered sufficiently stable for the removal of the RA line inserted as part of the surgery. However, shortly after the line was removed, the infant went into cardiac arrest. The infant was resuscitated but was later discovered to be suffering frequent brain seizures which resulted in long-term impairment of vision, cognition and motor skills.

Specialist clinical advice was sought to allow a comprehensive assessment to take place. While the clinical advisor indicated that some of the treatment may not have been required, no instances were identified where the professional practice was below a reasonable standard.

Legal services

The Health Ombudsman's in-house legal team assists in guiding the office in a complex health regulatory space. In 2015–16, 365 internal requests for expert legal advice were made relating to a variety of proceedings including:

- judicial review
- immediate actions
- disciplinary proceedings in QCAT—relating to statutory interpretation and jurisdiction
- right to information, privacy and information request issues
- managing external legal advisers
- assist with other government agency inquiries such as the Barrett Adolescent Centre Commission of Inquiry
- process management.

Under his jurisdiction, the Health Ombudsman did not commence any inquiries into any matters in 2015–16. However, the office did assist with other government agency inquiries such as the Barrett Adolescent Centre Commission of Inquiry.

Having an in-house legal team has brought about time and cost efficiencies for the office and its management of complaints. The immediate access to specialist legal advice has been instrumental in reducing risk and allowing for timely responses and management of complaints.

Developing capability

To further develop the capability of the office, a legal knowledge base was created in 2015–16 to improve the capture and sharing of the legal team's advice across the office. The legal knowledge base allows staff to request and track legal advice, search a database of existing legal advices, and consult a sanctions framework containing relevant QCAT health discipline decisions.

In addition, regular in-house training was conducted on matters ranging from co-regulation, QCAT outcome presentations, confidentiality, procedural fairness and intensive support in making lawful decisions. The office's lawyers are also engaging productively with external legal professionals. In 2015–16, the office provided presentations to external stakeholders at the Hospital and Health Service Lawyers Conference, QCAT, the Bar Association of Queensland and a specialist medical conference.

Internal reviews

If a person is concerned the Health Ombudsman has made an inappropriate decision or the complaint management process was flawed, they may request an internal review of that decision, provided there are grounds to justify a review.

The office is committed to this review process to ensure that parties are able to raise concerns if they believe management of their complaint, or the complaint about them, was not conducted appropriately. To ensure objectivity, an independent review officer who was not involved in the original matter examines all of the information to determine whether or not the decision or process was appropriate.

In 2015–16, the office's dedicated review team commenced 201 and finalised 216 review requests. Reviews were conducted for 162 (75 per cent) of the 216 finalised review requests. Following review, the original decision was upheld for 128 decisions (79 per cent) of matters. For the 25 per cent of requests which were closed without conducting a review, there were either no grounds identified for the review, it was not a reviewable decision or the review request was withdrawn.

Case study

A complainant requested an internal review of the decision to take no further action on two complaints on the basis that they were raising new concerns that had not been considered as part of a coronial investigation. The delegate originally had decided to take no further action because the Coroner had found the death at the centre of the complaint was not healthcare related.

On review, it was decided to overturn the original decision to take no further action as the new concerns raised by the complainant appeared to justify the need to obtain clinical advice to address the issues.

In addition to conducting reviews of decision, internal review staff have contributed to the office's culture of continuous improvement by providing regular feedback to staff where opportunities for improvement are identified.

This year, the review process greatly contributed to strengthening decision making across the office. This has been achieved through the implementation of a quality improvement feedback process that provides constructive feedback for improvements to both processes and decision making. This feedback has resulted in improvements in the quality, content and communication of decisions being made. For example, significant improvements have been made to the wording used in letters to complainants and practitioners to explain provisions of the legislation.

If the person seeking a review is dissatisfied with the internal review decision, they may apply to the Office of the Queensland Ombudsman for an external review. In 2015–16, the office dealt with 10 matters referred from Office of the Queensland Ombudsman and finalised 6 of these. Suggested improvement measures were made and adopted in 3 of the matters.

health sector
regulation in queensland

The health sector regulatory landscape in Queensland is complex and consists of a number of government agencies and regulatory organisations. Each entity has a role to play and, as illustrated, information sharing and cooperation between entities is essential to protect the health and safety of the public and ensure quality health services and system efficiencies across the entire health sector. The *Health Ombudsman Act 2013* facilitates this by providing clear legislative provisions for sharing information with other key regulatory entities.

Individual practitioners and health service organisations work on the frontline providing health services to the people of Queensland. Generally, health service complaints are about these frontline providers. First and foremost, health practitioners are supported and oversighted by their employers and corporate and clinical governance areas within the public and private health systems. Complaints about a practitioner or health organisation are often made to or addressed at this level.

Complaints may progress beyond employers and governance areas when:

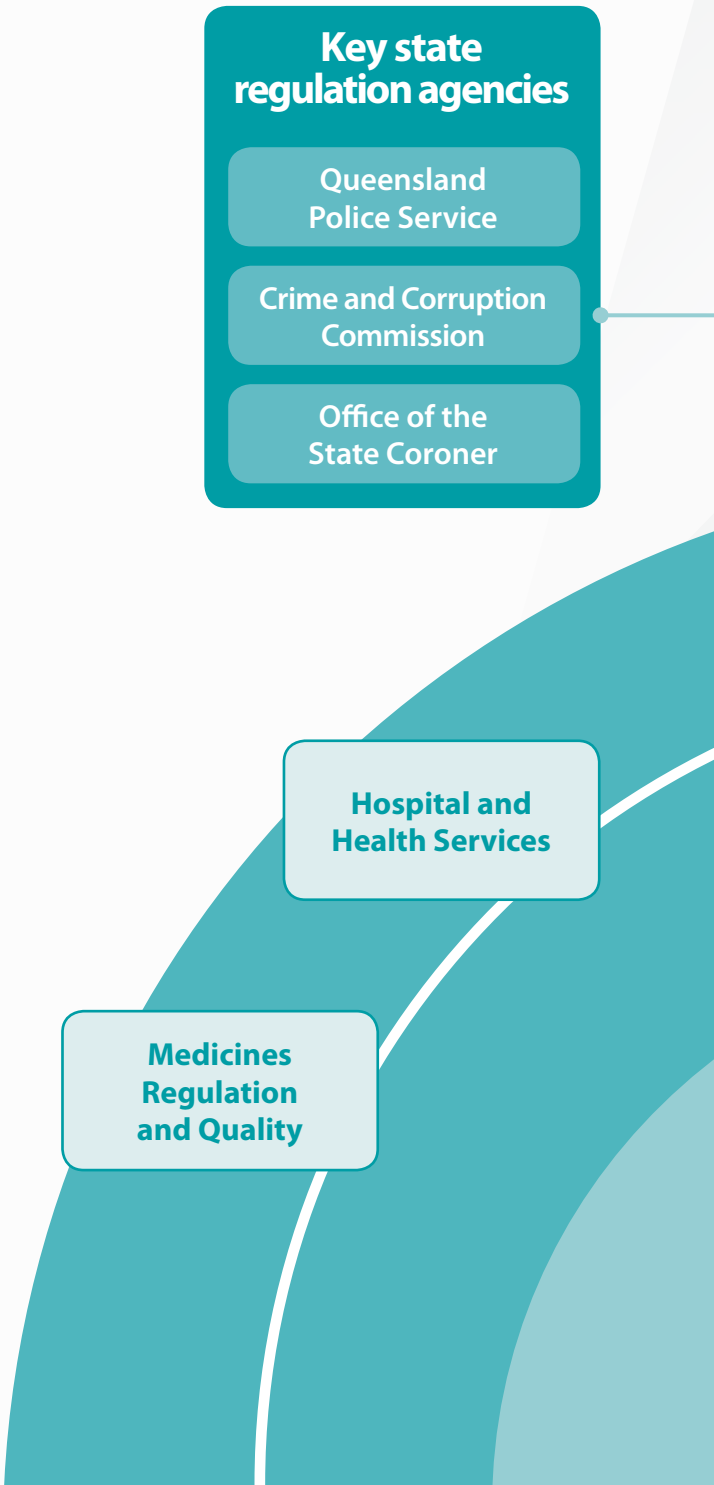
- they are more serious
- they're not able to be resolved at that level
- the employer or governance area needs to refer to or work with regulators to address an issue
- complainants are not comfortable raising their complaints directly with the health service provider.

Broadly speaking, there are three groups of agencies with overarching responsibility for health regulation in Queensland.

1. Queensland's health sector co-regulatory partners—Office of the Health Ombudsman and Australian Health Practitioner Regulation Agency.
2. Other state regulatory agencies—such as Queensland Police Service, Crime and Corruption Commission and Office of the State Coroner.
3. National regulatory agencies—such as Medicare, Therapeutic Goods Administration and the Aged Care Complaints Scheme.

Multiple agencies can be involved in managing and responding to individual complaints or systemic issues. Agencies share information across jurisdictions to effectively manage issues and protect the health and safety of the public, while not interfering with each other's statutory responsibilities or duplicating effort. Agencies also work together, including with employers and governance areas, to identify areas for improvement and contribute to better quality health services in Queensland.

The below diagram is a high level representation of the sector.
A full list of stakeholders can be found in Appendix 2.



Queensland's co-regulatory health complaints agencies

- Office of the Health Ombudsman
- AHPRA and the national boards in Queensland

Key national health regulation agencies

- Medicare
- Therapeutic Goods Administration
- Aged Care Complaints Scheme

Key employer and operational governance agencies

- Department of Health
- Patient Safety Unit
- Private Health Regulation Unit

Frontline health providers

co-regulatory partnership with the **Australian Health Practitioner Regulation Agency**

In Queensland, the Office of the Health Ombudsman and AHPRA work as co-regulatory partners in managing health service complaints about registered health practitioners.

Complaints are received first by the office for initial screening and triage and the office then decides whether to accept a complaint for further action—such as assessment, investigation, or referral to another agency such as AHPRA—or close a complaint with no further action being taken. This approach ensures consistency in decision making and information collection and clarity for health consumers and providers on where to go and how to make a complaint or notification. As an independent statutory agency, the office also provides a significant degree of accountability and impartiality to the health complaints management system in Queensland.

Since its establishment in July 2014, the office and AHPRA's Queensland office have worked closely in establishing an effective co-regulatory system in Queensland. Both agencies have acknowledged the importance of collaboration and transparency and the critical role this plays in instilling confidence in the way health service complaints are managed in Queensland. The two agencies play a vital role in protecting the health and safety of the public.

Work continued in 2015–16 to embed consistent methodologies and eliminate duplication. This work has seen the office and AHPRA more effectively communicating and engaging with each other to fulfil complementary functions.

For example, in instances where a practitioner poses a serious risk to the health and safety of the public, the Health Ombudsman is able to immediately suspend or impose conditions to protect Queenslanders before impartially investigating the matter and taking it to QCAT for determination—with the office working with AHPRA to ensure registration conditions are reflected on the public register. Conversely, the national boards are able to conduct health and performance assessments and form professional standards panels, which are processes the office has no power to conduct, but are critical for managing certain concerns about registered health practitioners and for managing the risks to public health and safety these concerns may pose.

As partners, the office and AHPRA have also added value to each other's operational practices. For example, the office provided input into the development of a national restrictions library which is now available on the AHPRA website. The library was developed to provide a repository of common restrictions placed on the registrations of practitioners to manage the risks their health, conduct or performance may present.

The office and AHPRA will continue to work together to protect the health and safety of the public and effectively manage the health, conduct and performance of registered health practitioners in Queensland.

Referrals

The Health Ombudsman refers issues relating to the health, conduct and performance of registered practitioners to AHPRA and the national boards when they are best dealt with using the options available to AHPRA and the relevant board.

In 2015–16, the office referred 3121 matters relating to 1993 health practitioners to AHPRA. A significant increase from the 1387 matters relating to 948 practitioners referred in 2014–15.

Process improvements have allowed referrals to be made earlier in the office's complaint management process. When a matter is referred to AHPRA, all relevant information about the complaint is provided to enable ongoing management. These improvements have led to more timely resolution for complainants and health practitioners, more timely risk assessments and more cost effective complaint management for Queensland's co-regulatory system.

A further key improvement this year which allowed for the faster referral of matters was the development in March 2016 of a secure, online referrals portal between the office and AHPRA.

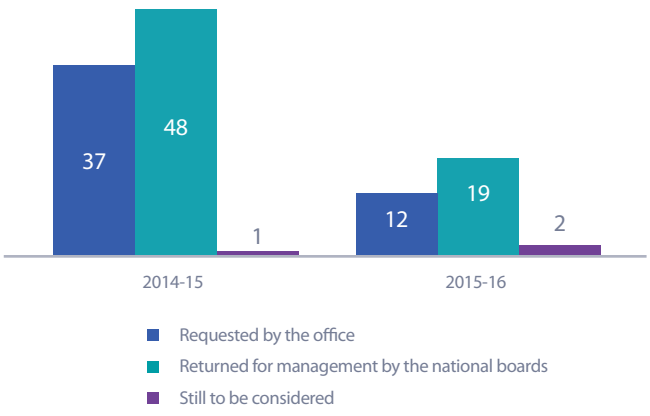
Notifications

Under the co-regulatory arrangements, AHPRA must notify the Health Ombudsman of all serious matters. Serious matters include a health practitioner behaving in a way that constitutes professional misconduct, or when other grounds may exist for the suspension or cancellation of the practitioner's registration.

In 2015–16, AHPRA notified the office of 33 matters identified as serious. Of these, the Health Ombudsman requested 12 to be referred to the office for management, determined that 19 should continue to be dealt with by AHPRA and the national boards and 2 were still to be considered as at 30 June 2016. The majority of the 19 matters that were to continue being managed by AHPRA related to impaired practitioners, who are most appropriately dealt with by AHPRA.

As expected, the number of notifications the Health Ombudsman received from AHPRA declined this year. This is the result of matters coming directly to the office due to increased awareness in the community of the office and its function.

Notifications from AHPRA to the office



stakeholder **engagement**

Community engagement

Engaging with health consumer organisations was a high priority for the office in 2015–16, in particular, organisations representing people with a disability.

People with a disability often have more complex health needs, a higher mortality rate and face more barriers to accessing appropriate health services than the general population. In parallel to the release of the Office of the Public Advocate's *Upholding the right to life and health: A review of the deaths in care of people with disability in Queensland* report, the office commenced a review of its processes to ensure they accommodated people with a disability, their guardians and the Public Guardian.

In 2015–16, the office also engaged with representative groups such as Carers Queensland and the Queensland Aged and Disability Advocacy service, to ensure their members were aware of the work the office does and how to make a complaint.

Health service provider engagement

The office may occasionally identify a specific need for focused stakeholder engagement as a result of trends or patterns in complaints. In 2015–16, one such pattern was the misuse of mandatory notifications to report alleged professional misconduct by disgruntled colleagues. In these instances the office alerted the relevant facilities of the human resource matters requiring attention and provided educational resources. The office took the opportunity to provide further support and presentations on its role and has subsequently observed improvements in the nature and content of notifications received.

The office also routinely engages with other health service organisations and employers to help educate employees on the office and its functions.

Health Ombudsman engagement

Throughout the year, the Health Ombudsman continued to engage with the office's key partners and health sector stakeholders. Engagement activities predominantly focussed on education, feedback, performance, risk management, business improvements, idea generation and the enhancement of key relationships.

Stakeholders included AHPRA and the national boards; the Minister for Health and the Health, Communities, Disability Services and Domestic and Family Violence Prevention Parliamentary Committee; health service providers; professional associations; government agencies; other complaints management organisations; educational institutions; consumer associations; unions and others.

Operational collaboration

Effective operational stakeholder engagement is essential for the office to perform its functions. In 2015–16, the office focussed on the growing importance of cooperation and collaboration with other government agencies. Functions such as investigations and taking immediate action often require involvement of multiple agencies to ensure appropriate coordination of investigation activities into serious allegations presenting serious risk.

The Health Ombudsman's role to protect the health and safety of the public often intersects with functions undertaken by other entities, such as the Queensland Police Service and the Office of the State Coroner. When a matter falls within the jurisdiction of more than one entity, it is imperative there is close coordination and cooperation so the office can act quickly and protect the health and safety of the public, while avoiding interference with other entities' statutory responsibilities and eliminating duplication of effort wherever possible.

At times a complaint will also be referred to another organisation if it is the appropriate entity to manage or resolve the matter.

Case study

A doctor received multiple complaints of alleged sexual assault while performing examinations.

As a result of its statutory powers, the office was able to obtain the patient's files and clinical notes that were previously being withheld by the practitioner. This new information provided evidence of professional misconduct and was shared with the Queensland Police Service to progress the criminal aspects of the matter.

client satisfaction surveys

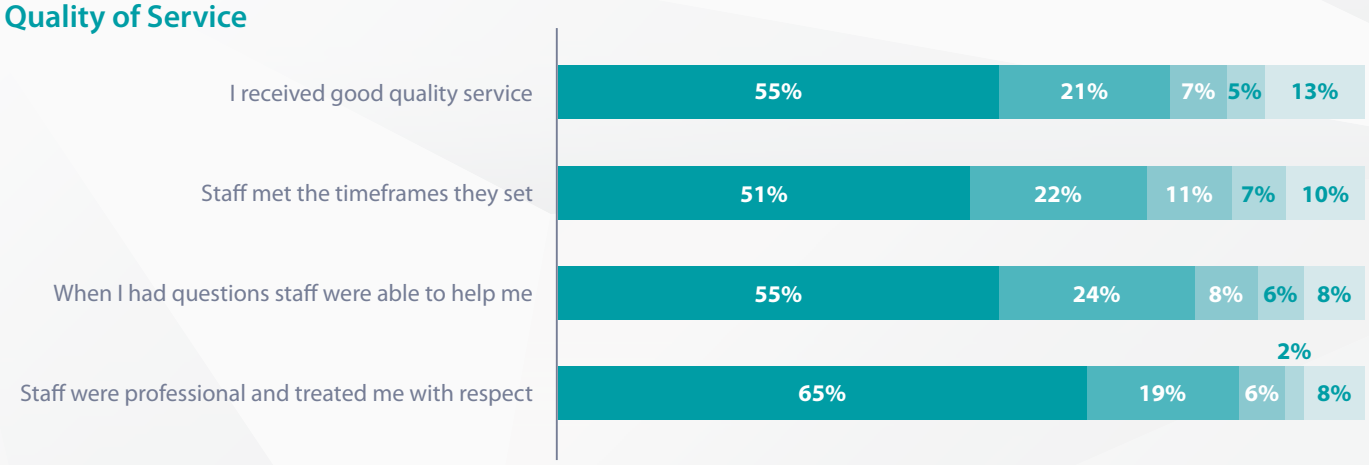
Obtaining feedback and collaborating with stakeholders and the community allows the office to identify where it can make service improvements to ensure services are accessible, transparent and accountable and provide a robust system for effectively and quickly dealing with complaints and other health service matters.

Client feedback is a valuable source of information and can help drive improvements in the office's operations and services. In February 2016, the office implemented an ongoing client satisfaction survey to gather feedback from complainants and health service providers on their experience with the office. The survey is provided to all parties of a complaint upon the completion of the complaint management process.

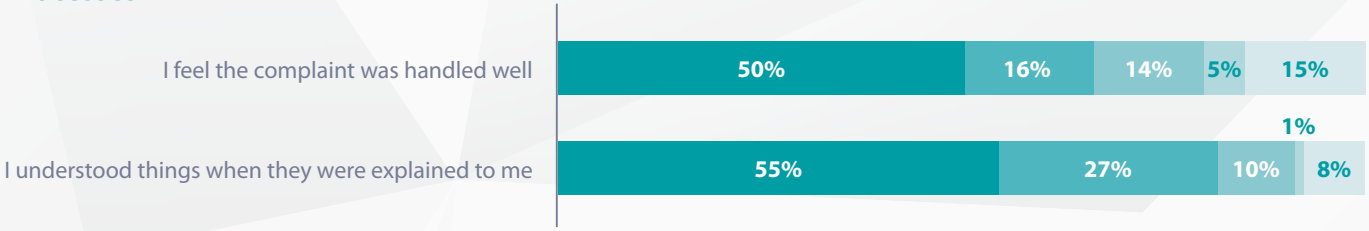
Since February 2016, 133 survey responses were received, of which:

- 50 per cent were from the complainant who received the health service
- 29 per cent were from the health service provider who responded to the complaint
- 12 per cent were from a person who complained on behalf of someone else
- 9 per cent were from other sources.

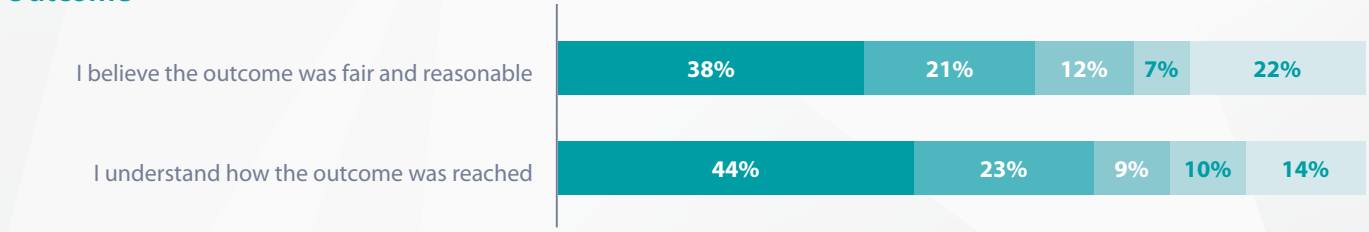
Quality of Service



Processes



Outcome



Strongly Agree Agree Neither Disagree Strongly Disagree

Key highlights

The office was pleased to see almost 75 per cent of respondents across all quality of service questions reflected positively on their experience and were complimentary in their feedback.

Areas for improvement

A number of respondents provided useful feedback on how the office could further improve aspects of its service.

Setting clear expectations upfront

When a desired outcome doesn't eventuate, it's natural for either party to be disappointed that their expectations were not met. Stakeholders recommended the office place more emphasis on explaining the role of the office in the process and what could be reasonably expected as an outcome. This has been included in training for staff who manage the receipt of new complaints.

Decision making and communication

It's important that the office's decision making is clear and the outcomes of complaints are communicated effectively to all parties involved. Feedback identified there were instances where this could be improved. To ensure our decisions are clearly communicated all staff with administrative decision-making responsibility undertake administrative decision-making training delivered by an external training provider.

Significant work has also been undertaken to improve all of the office's written communications and to ensure clear and easy-to-understand language is used.

Timeframes for providing information

A number of health service providers raised concerns about the challenges they faced in providing records and responses to complaints within the required timeframes. The *Health Ombudsman Act 2013* only allows for 14 calendar days, including weekends and public holidays. The office acknowledges this may be challenging at times and has made efforts to work with stakeholders to ensure the process of providing information is as efficient as possible. This includes providing a secure web portal to allow immediate delivery of electronic information to the office.

strategic **challenges**

Strategic planning has identified a number of challenges to the achievement of office's strategic objectives.

Communicating the purpose and outcomes of the office's work to protect public health and safety

So many matters have passed through the complaint management system in the last year, and more are nearing the final stages—such as referral to QCAT. A clear challenge in the coming year will be the effective communication of a large volume of new knowledge about and understanding of the health system to the office's stakeholders— including the public.

Communicating the outcomes of the office's work is an important action and area of focus in the coming year, as it:

- helps instil confidence in the healthcare system
- increases the public's awareness of their healthcare rights and contributes to improving the standards of healthcare expected by the public
- demonstrates the role of the office in protecting the health and safety of the public
- promotes excellence in service delivery for committed practitioners and health service organisations.

Appropriate resourcing

The office's end of year statistics have shown a significant increase in the number of complaints received this year, and this trend looks set to continue. Given the office's very large jurisdiction and the ever-expanding health sector, ongoing growth is inevitable, both in the number of complaints and in the variety of health services complained about.

Complaint data and workloads are actively monitored to ensure an appropriate level of resourcing to provide ongoing high quality and timely service delivery. The lack of applicable, historical data, however, makes it hard to forecast the workload for the office in 2016–17 and beyond. This presents challenges in identifying, in the longer term, the necessary level of resourcing for each function delivered by the office required to provide high quality outcomes within statutory timeframes.

Timeframes

An important part of managing an effective and successful complaints management system is the ability to meet statutory timeframes. In practice, conducting thorough, quality complaints management within tight statutory timeframes requires the right number of staff with the appropriate tools and support.

The introduction of working groups focused on ensuring consistency, significant IT system development, stakeholder feedback surveys, a focus on fostering a positive internal culture, refined communication platforms and structured caseload management have all generated some improvements to the office's timeliness.

Continuing to build the co-regulatory relationship with AHPRA has also resulted in more efficient referral of matters, ultimately producing positive outcomes for stakeholders in terms of consistency and timeliness.

It's important to note that in parallel to these timeliness process improvements, quality decision-making must also be a continued focus of the office in supporting thorough, impartial and reasonable outcomes for parties involved in complaints. This can mean that, at times, in order to make a well-informed, robust, quality decision there can be delays in getting all the necessary information required. While delays are undesirable, thorough processes ultimately benefit all parties involved and the integrity of the complaints management system.

Community and health service provider engagement

Balancing the office's management of high volumes of complaints with its need to actively engage with stakeholders has been a challenge in the past year.

The office recognises the important contribution stakeholder engagement makes in achieving excellence in client service delivery, transparency, and in demonstrating the office's value in making the Queensland health system safer for the communities it serves. It is this collaboration with, and feedback from, healthcare consumers, health service providers and the broader community that identifies where the office can improve the effectiveness and efficiency of its activities.

The office has refined its stakeholder engagement strategy to ensure engagement has a clear purpose and maximum benefits for all involved. Continuing to identify and support staff to champion the office's community engagement activities will further help build and nurture these productive stakeholder relationships.

Data integration and intelligence gathering

The office now has two years of data at its disposal. This data can now be interrogated and integrated with external data sources to identify emerging public health and safety risks and inform the scope of systemic investigations. This will also alleviate duplication of multi-agency regulatory responses and support an effective holistic state and national co-regulatory response.

operational **challenges**

A number of issues will challenge the day-to-day operations of the office in the next year.

Refining the office's work practices

The office's electronic case management system—Resolve—is a critical tool for the office in its capture and ongoing management of complaints. Through further development of Resolve, the office has already made significant progress in its goals to simplify its business processes, improve the client experience and reduce its operating costs.

A crucial factor of this success is the direct involvement of the office's end-users of the system—its complaints management staff—in identifying areas for improvement. An ongoing challenge the office has faced is setting aside dedicated time for these staff members to work on the system improvements in conjunction with progressing their day-to-day work.

Balancing these competing priorities has been, and will continue to be, a challenge as it inevitably impacts some of the office's operational complaint targets.

Legislative threshold for investigations

Where a matter is serious, the Health Ombudsman has no choice but to investigate the matter and, assuming the allegations are substantiated, the Health Ombudsman must refer the matter to the Director of Proceedings for a decision about whether to refer the matter to QCAT. It is worth noting that significant resources are required to thoroughly investigate and prepare quality cases for hearing in QCAT.

In reflecting on the two years' worth of data that the office has captured, and the objectives of the legislation, the office has identified a number of matters which only just met the threshold of professional misconduct for a registered practitioner. These matters raise the question of whether public funds could be better diverted to more serious matters requiring adjudication by QCAT.

The inability of the Health Ombudsman to deal with lower-range serious matters is in contrast to other regulatory bodies, including those that regulate occupations and professions. It is also in contrast to the national boards, which currently have the power to deal with non-serious matters directly under the National Law.

A change in approach to matters which just meet the serious threshold would allow the Health Ombudsman and QCAT to concentrate efforts on protecting the public in more serious matters, in shorter timeframes, and at less cost.

Similarly, the Health Ombudsman lacks a range of powers to deal with unregistered health practitioners. Currently, only matters that give rise to serious risk to people can be referred to QCAT. This means most breaches of the National Code of Conduct for Health Care Workers cannot be dealt with.

Establishing an effective disciplinary litigation practice

The office aims to present the entirety of the evidence at the start of proceedings in QCAT, so that the issues in dispute can be identified early and agreement reached more quickly. The office has used this approach from the start, and has seen positive results.

Not only does work upfront save time and legal costs, it also achieves efficiencies for all parties involved, including QCAT, with the potential for parties to identify and narrow the issues in dispute prior to listing the matter for compulsory conference. If successful, these negotiations allow QCAT to deal with matters in a timelier manner.

Staff development to manage high workloads

Continued attention to staff development and retention strategies is an ongoing focus for the office. This assists in retaining skilled and experienced staff in what is a high-volume, dynamic and complex health regulation environment.

Training and development was a significant factor in the first year of the office's operations, as it should be for any new organisation. The recruitment of additional staff to meet growing workloads has required, and will continue to require, an on-going focus on training and development.

priorities for the **year ahead**

Refining business processes and system capability

The office is committed to continuing to refine business processes to maintain public confidence in the management of health complaints. As part of the office's commitment to continuous improvement and excellence in service delivery, it has launched a project to enhance business process efficiencies even further.

The first stage of the project involves ensuring there is clarity of purpose across the organisation about business outcomes. This re-engagement on clarity of purpose is expected to increase staff commitment and fulfilment, promote organisational, divisional and team goals and identities, and further improve the focus on service delivery for stakeholders.

Some additional benefits of the project include:

- further development of the electronic case management system to integrate and support efficient business processes, including tracking the progress of matters referred to QCAT
- the creation of comprehensive complaint management procedure manuals across the organisation.

Access to timely and comprehensive information about the notification history of registered practitioners from AHPRA

One of the keys to the success of the co-regulatory system is the ability to share data between the office and AHPRA and obtain information about registered practitioners as quickly and efficiently as possible.

The office continues to experience challenges in being able to receive and log complaints, obtain all necessary information, and progress to a decision within seven calendar days. The lack of ready access to registered practitioner data from AHPRA continues to be a significant challenge in managing complaints about registered practitioners.

While there has been some improvements over the past year, the office's inability to access data in a timely way has an impact on its ability to progress assessments, local resolutions and investigations, in a timely manner.

The priority this year is to work with AHPRA to assist them in identifying IT system enhancements that will ensure the office has access to all the available real-time data on registered practitioners providing a service in Queensland.

Looking after our staff

The nature of health service complaints is such that the office is trusted with very sensitive and confidential personal information. This information can at times be graphic and may relate to traumatic experiences for complainants. This can impact on the psychological wellbeing of staff involved in analysing the information.

Psychologists have identified that vicarious trauma can occur in those repeatedly exposed to material of this kind. To minimise the risks of vicarious trauma in our staff, the office has commenced discussions with academics and practitioners to develop a model to guide recruitment, induction, training, business processes and crisis response.

The expected benefits of this work include an overall improvement in staff wellbeing, staff satisfaction and retention, and consistent high quality service delivery.

Even better stakeholder engagement

Further development of the office's structured stakeholder engagement strategy will support improved interactions with key stakeholders and more timely information exchange.

Improvements to the office's investigation model

The office will continue to improve the planning and conduct of investigations to ensure statutory timeframe requirements are met and, at the same time, the quality and thoroughness of the office's investigations are maintained. This will include an even greater emphasis on effective risk mitigation in the interests of public health and safety.

In addition, data will be analysed and shared, wherever possible, with other agencies to identify emerging public health and safety risks and the need for systemic investigations.

Embedding the learnings from internal reviews

The office's commitment to providing a robust internal review process is important in maintaining confidence in the transparency of the complaints management system. As a result, the consolidation of the internal review process is a priority for the coming year. This will include further work on the Internal Review of Decisions Policy to ensure that internal and external stakeholders clearly understand which decisions will be open for internal review and the reasons why.

Consolidation of this function will also involve refining business processes, including feedback loops to ensure that the outcomes of review processes inform business process improvements. In addition, internal review business processes will be integrated into the electronic case management system and a review conducted of standard correspondence and ancillary processes to support consistent high-quality decision making.

the health ombudsman

Mr Leon Atkinson-MacEwen is Health Ombudsman of Queensland, a statutory position, appointed under the *Health Ombudsman Act 2013*. The Health Ombudsman must act independently, impartially and in the public interest.

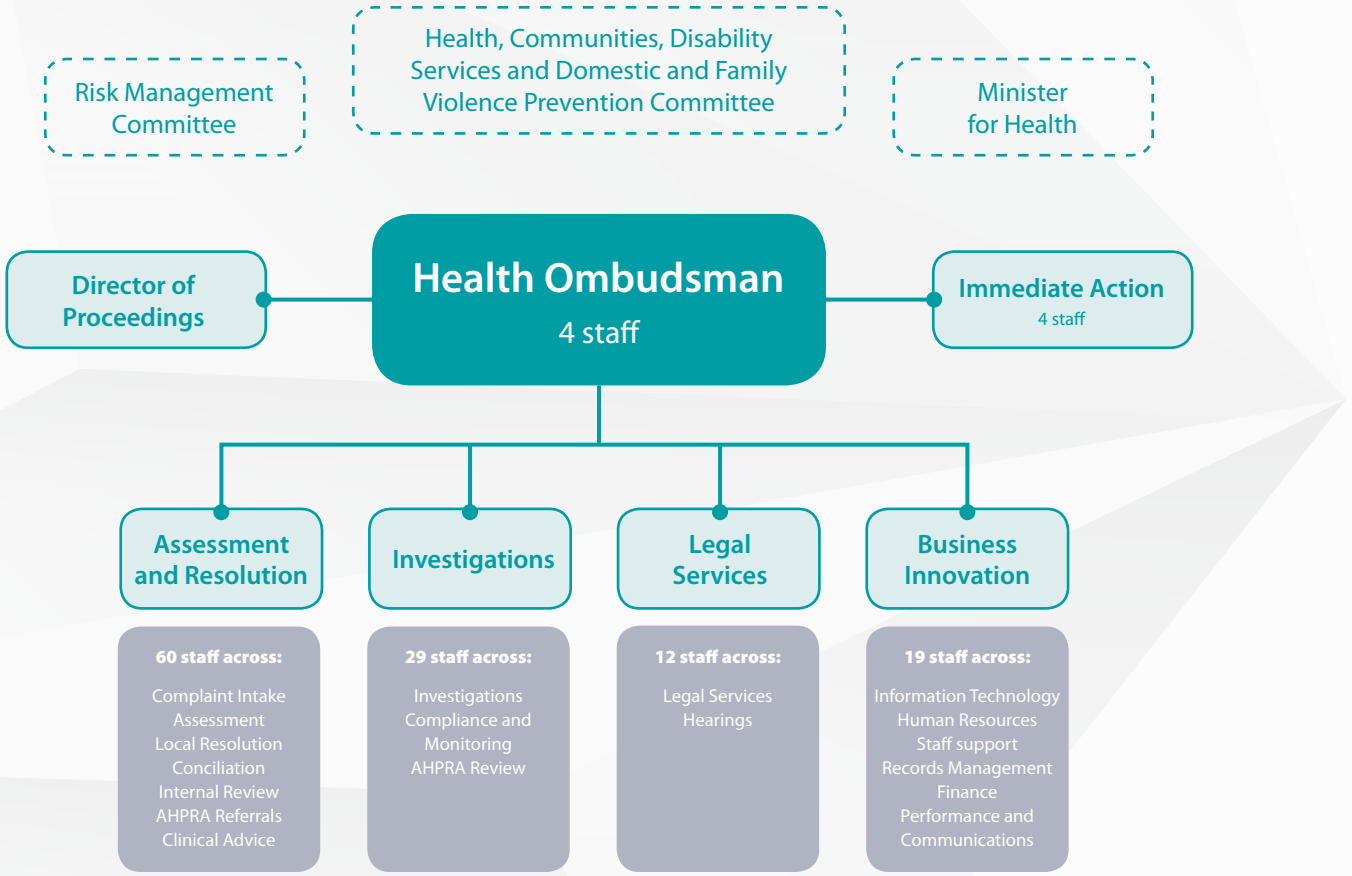
The Health Ombudsman's functions and responsibilities are to:

- receive health service complaints and decide on the relevant action to deal with them
- identify and deal with health service issues by taking relevant action, such as undertaking investigations inquiries
- identify and report on systemic issues in the way health services are provided, including their quality
- monitor the performance of AHPRA and the national health practitioner boards in their functions relating to the health, conduct and performance of registered health practitioners in Queensland
- provide information about delivering health services in ways that minimise health service complaints, and about how to resolve health service complaints
- report to the Minister for Health and the parliamentary committee about the administration of the health service complaints management system, the performance of the Health Ombudsman's functions, and the performance of AHPRA and the national boards
- report publicly on the performance of the health complaints management system in Queensland.

Director of Proceedings

The Director of Proceedings is a statutory role that refers matters to QCAT on behalf of the Health Ombudsman, and maintains independence from the Health Ombudsman in this regard.

Further details on the functions of the Director of Proceedings can be reviewed on page 52 of this report.



Staff numbers highlighted above relate to actual headcount rather than full-time equivalent positions.

the executive **management team**

Leon Atkinson-MacEwen

Health Ombudsman

Leon has strong senior management experience in both the Australian public service and Tasmanian state service. He was most recently the Tasmanian Ombudsman, Health Complaints Commissioner, and Energy Ombudsman. He brings extensive experience and insight from the health service complaints environment and in public administration.

Dan Matthias

Executive Director, Legal Services and Director of Proceedings

Dan is admitted as a Barrister-at-Law and has 20 years of experience as a public lawyer with expertise in statutory interpretation, regulation, administrative, constitutional and criminal law. He has managed litigation in different jurisdictions, from tribunals to the High Court. His previous roles include working for Crown Law as counsel in criminal defence and prosecution and experience in regulating diverse industries including corporations, child-care and fisheries.

The Legal Services division provides legal services to the office and prosecutes matters that the Director of Proceedings refers to QCAT.

Lisa Pritchard

Executive Director, Assessment and Resolution

Lisa has more than 25 years of experience in regulation and complaints management in the UK and Australia. Her expertise includes policy and legislation development, and leading operational service delivery of registration, accreditation and complaints management and investigation programs.

Her previous roles include leading the professional standards program at the Office of the Medical Board of Queensland, and the Queensland Health Ethical Standards Unit.

The Assessment and Resolution division is the entry point for enquiries and complaints. It assesses complaints by reviewing all accompanying information provided to the office for each respective complaint and in certain circumstances will seek to resolve and conciliate complaints.

Robbie Wilson

Executive Director, Investigations

Robbie has more than 25 years of experience in a range of government regulatory, investigative, and leadership roles within the Queensland and New South Wales governments. He has previously worked with a number of health complaint regulatory agencies in senior leadership roles.

The Investigations division is responsible for the formal investigation of matters of significant importance to public health or safety, or that warrant disciplinary action against a health service provider in Queensland. The division also monitors and reports on the health, conduct and performance functions of AHPRA and the national boards, as well as monitoring compliance with recommendations made as a result of investigations.

Kylie Guthrie

Director, Business Innovation

Kylie has almost 30 years of experience in the public sector, primarily in the areas of public sector governance and provision of corporate support functions including human resources, information and communication technology, financial management, facilities, and records management.

Her previous roles include managing business support functions in Queensland government agencies including the Department of Health, the Department of Justice and Attorney-General, and the Anti-Discrimination Commission Queensland.

The Business Innovation division provides innovative and flexible corporate support services, advice, business solutions, and performance monitoring and reporting functions to the office. The division has an active role in implementing the strategic direction for the office, providing the systems and support to enable continuous improvement in how the office delivers its objectives.

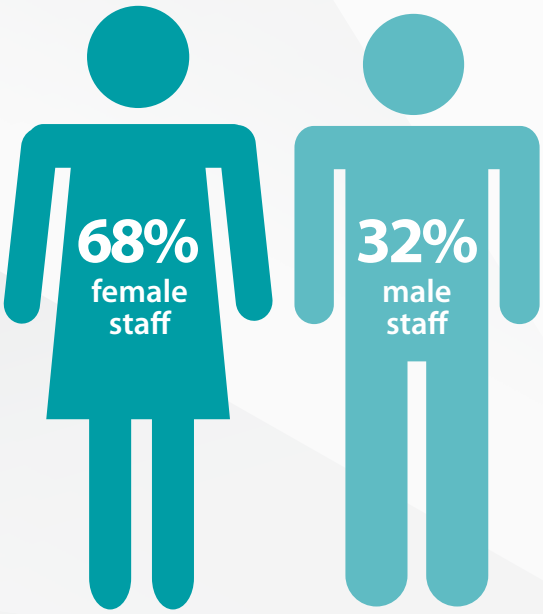
our **people**

The office is relatively small in size and as such relies heavily on the skills of its 125.56 full time equivalent employees. Additional recruitment occurred in 2015–16 to adequately resource the high-traffic areas of the business and ensure complaints are dealt with in a timely and thorough way—increasing from 94 full time equivalent employees in 2015.

Employment type

The large majority of the workforce are permanent full-time employees.

82%
permanent employment

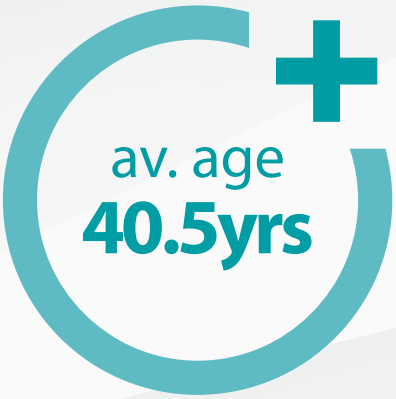


Gender distribution

59% of managerial positions are held by female staff—managerial positions are classified as AO7, or equivalent, and above.

Age distribution

The office does have a slightly younger age profile—the average age of an employee in the Queensland Public Service is 44 years.



25–29yrs old	16%	50–54yrs old	9%
30–34yrs old	23%	55–59yrs old	5%
35–39yrs old	13%	60–64yrs old	6%
40–44yrs old	15%	65 and over	1%
45–49yrs old	12%		

The office benefits from cultural diversity in its workforce and this year extended its engagement through the support of an Indigenous business administration traineeship.

No redundancy, early retirement or retrenchment packages were paid in 2015–16. Where employees have resigned, exit interviews were completed to capture valuable feedback from outgoing staff members.

All staff are located at 400 George Street, Brisbane, Queensland.

Induction

The office is committed to ensuring that its induction processes assist new staff to become productive and integrated members of the organisation in as short a time as practicable. Effective induction is also a key factor in retaining staff.

On commencement, staff receive an immediate orientation and safety briefing. They also participate in a face-to-face orientation workshop soon after they commence with the office. In addition, all new employees are enrolled to complete mandatory e-learning courses within their first three months of employment.

Staff care and development

The office is committed to creating an environment where staff are engaged, valued contributors, with opportunities to grow professionally. During 2015–16, the office delivered a range of learning and development activities to staff including training in:

- anti-discrimination
- the Code of Conduct for the Queensland Public Service
- effective workplace communication
- fire safety and occupational health and safety
- first response evacuation
- good decision making
- managing priorities
- managing stress
- leadership development for senior leaders
- local induction
- performance development program for team leaders
- management of mental health
- right to information and information privacy
- using the National Relay Service
- workplace bullying
- ethical decision making.

An employee assistance program is available to all staff, providing a short-term professional, confidential and free counselling service. The program is easily accessible, voluntary and can provide support on a range of personal and work-related issues.

Staff can also access a range of flexible working arrangements in line with whole-of-government workplace policy. The majority of staff are able to work flexible hours and a number work part-time or receive study assistance.

Performance and development

The office's performance development program provides a platform for meaningful conversations between managers and their staff about responsibilities, performance and expected behaviours and how these align to the office's strategic plans, goals and objectives.

Performance expectations are set with new staff within one month of commencement. A formal performance review is held between managers and their staff to discuss progress towards agreed performance standards twice a year. A key element in the success of the program is regular and ongoing feedback between staff and their manager throughout the year.

Industrial and employee relations

The office is part of the Queensland Health enterprise bargaining arrangement.

Staff satisfaction

The *2016 Working for Queensland employee opinion survey* was completed in May 2016 with 95 per cent of eligible staff participating. 76 per cent of employees reported they were satisfied with their job.

An action plan was developed to maintain and make improvements to staff morale and engagement in the office following the 2015 employee opinion survey. This plan will be reviewed and updated with the outcomes of the 2016 survey, focusing on a number of key areas where improvements could be made.

accountability and **transparency**

Record keeping systems

The office is committed to implementing an effective and accessible record keeping system in compliance with the *Public Records Act 2002* and associated information standards.

Since installing HP Records Manager—a new electronic document records management system in May 2015—the office has continued to migrate legacy records and train existing and new staff in the standards, roles and responsibilities to create and maintain accurate public records.

The office's case management system, Resolve, is critical to the running of the business. Ongoing training for staff ensures the effective use of this system.

The office has significantly adapted Resolve to meet its needs, including the redesign of workflows, integration with HP Records Manager and online complaint details into the system. Following these upgrades, efforts to transition physical documents to a digital source have been made. Plans for full digitalisation will commence once process improvements are completed to ensure accuracy and ease through the transition.

The office has also commenced discussions with Queensland State Archives to update its retention and disposal schedule adopted from HQCC so that it is specific to the office.

Records are held on-site in restricted access areas and with an external storage provider. There have been no security breaches to these areas.

Risk management committee

As a regulator, the office is conscious of its responsibility to the community and the need to manage risks appropriately. As such, the office has comprehensive risk management plans in place as determined by its Risk Management Committee.

The primary role of the committee is to provide the Health Ombudsman with independent assurance and assistance in risk, control and compliance frameworks. The committee also satisfies external accountability responsibilities as required and identified as arising from the *Health Ombudsman Act 2013* and *Health Practitioner Regulation National Law (Queensland)*, and obligations under the *Statutory Bodies Financial Arrangements Act 1982*.

The committee has six core responsibilities:

- To assess and contribute to risk management planning processes relevant to the office, taking into account any inherent or arising risks and exposures, its performance management framework, and the financial and operational environment in which it operates.
- To assess and enhance the office's corporate governance, including its systems of internal control, and report on any identified risks.
- To review and evaluate the strategic plan.
- To oversee and appraise the office's financial reporting processes.
- To appraise the office's systems for risk management.
- To review the annual financial statements and management representations for recommendation and endorsement by the Health Ombudsman.

The committee meets quarterly to review, oversee and report to the Health Ombudsman.

The committee conducted its annual self-assessment and is committed to an external peer review at least once every three years, with due regard for Queensland Treasury's *Audit Committee Guidelines: Improving Accountability and Performance*.

Committee members for 2015–16 were Mr Eric Muir (Chair), Mr Dan Matthias, Ms Lisa Pritchard and Mr Robbie Wilson.

Mr Muir commenced as the Chair of the Risk Management Committee on 29 June 2015, and holds the position of external member of the committee. He served as the Auditor-General of the Solomon Islands for three years, and was Assistant Auditor-General with the Queensland Audit Office from 1994 to 2006. The remuneration of Mr Eric Muir is $220 per hour plus GST.

Open data

The following information for the 2015-16 financial year is available through the Queensland Government Open Data website www.qld.gov.au/data:

- consultancies
- Queensland Language Services Policy.

The office had no expenses for overseas travel in 2015-16.

Summary of non-financial measures

Outcomes	
9351	contacts received
49%	of decisions made within 7 days
26%	of assessments completed in 30 days
90%	of local resolutions completed in 30 days
86%	of local resolutions where a resolution is reached
75%	of conciliations where agreement is reached
249	investigations commenced
53%	of investigations completed within 12 months
11	immediate registration actions
24	interim prohibition orders
18	practitioners referred to the Director of Proceedings
1993	practitioners referred to AHPRA
12	serious matter notifications referred and requested from AHPRA
159	root cause analysis reports received

Reporting	
3	investigation reports published
4	monitoring and quality improvement reports published
155	matters listed on the investigations register

People	
76%	staff satisfaction
125.56[1]	full time equivalent employees
24%	permanent separation rate[2]
0	redundancy, early retirement or retrenchment

[1] As at end of last full pay fortnight before 30 June

[2] No. of staff who resigned in 12 months/number of staff employed as at end of last full pay fortnight before 30 June

Performance against strategic objectives

The office's performance is measured against the strategic objectives outlined in its 2015-19 strategic plan.

Objective

Protect the health and safety of the public.

Measure	Result
Percentage of assessment matters completed within statutory assessment timeframe.	32%
Percentage of investigations completed in less than 12 months.	53%

Objective

Promote professional, safe, competent practice and high standards of service delivery from health practitioners and health service organisations.

Measure	Result
Proportion of recommendations arising from investigations or reports adopted to implement healthcare service improvements.	100%
Proportion of recommendations arising from investigations or reports adopted to implement complaint management process improvements.	No relevant recommendations
Evidence of the office identifying and reporting on systemic safety and quality issues.	Ongoing
Feedback from key stakeholder and groups on the performance of the office.	Ongoing
Feedback on the quality and utility of investigative reports outlining systemic issues and recommendations.	Ongoing
Proportion of immediate registration actions upheld by QCAT.	100%*

* Only one matter was determined by QCAT during 2015–16.

Objective

Maintain public confidence in the management of complaints and other matters relating to the provision of health services.

Measure	Result
Percentage of complaints accepted, assessed and/or resolved by the office within legislative timeframes:	
▪ accepted within seven days	49%
▪ assessed within legislated timeframes	32%
▪ locally resolved within legislated timeframes.	90%
Percentage of matters subject to resolution or conciliation where an agreement is achieved:	
▪ local resolution	86%
▪ conciliation.	75%
Regular public reporting through:	
▪ monthly and quarterly performance reports	Completed
▪ annual report	Completed
▪ the office website	Completed
▪ investigative reports	Partially completed
▪ prosecution outcomes.	Completed
Feedback on the level of consumer confidence in the management of complaints.	Completed
Percentage of adverse findings by the Queensland Ombudsman in relation to complaints about our performance.	50%
Feedback from healthcare consumers on the performance of the office.	Ongoing

Objective

Deliver robust and accountable business operations and foster a culture of transparency, accountability and continual improvement.

Measure	Result
Efficient and effective business support services leading to measurable productivity gains.	Completed
Corporate reporting is streamlined across the business with an emphasis on progress against outputs and outcomes rather than activities.	Completed
Compliance with governance and policy standards.	Ongoing
Contemporary, fit-for-purpose and continuous training provided to employees that addresses technical and professional learning needs.	Ongoing
Implementation of a management and leadership capability development program.	Completed
Increased employee skills, knowledge and experience.	Ongoing
Employees are engaged and empowered to formally and informally suggest process improvements.	Ongoing
Establish tools and baseline measures to monitor staff satisfaction and organisational culture.	Completed
Established performance agreements linked to corporate objectives with a high percentage of staff rated 'meets expectations or better'.	Completed

commitment to the **system of government**

Minister for Health

Effective statutory oversight of the health complaints management system is provided by the Minister for Health and the Health, Communities, Disability Services and Domestic and Family Violence Prevention parliamentary committee.

The Minister for Health oversees the administration of the health service complaints management system and the performance of the Health Ombudsman. He also oversees the performance of AHPRA and the national boards in relation to the health, conduct and performance of practitioners providing health services in Queensland. The Minister also keeps the Queensland Parliament and the community informed of these matters.

The Minister for Health, the Honourable Mr Cameron Dick MP has been the Minister for Health since 16 February 2015.

The Minister for Health meets with the Health Ombudsman each quarter.

Parliamentary Committee

As of 18 February 2016, the previous Health and Ambulance Services committee and the previous Communities, Disability Services and Domestic and Family Violence Prevention committee amalgamated to form the Health, Communities, Disability Services and Domestic and Family Violence Prevention committee.

This is the Queensland parliamentary portfolio committee with oversight of the office. In its functions relevant to the office, the parliamentary committee:

- monitors and reviews the operation of the health service complaints management system
- identifies and reports on ways it might be improved
- monitors and reviews the performance of the Health Ombudsman
- monitors and reviews the performance of AHPRA and the national boards in relation to the health, conduct and performance of practitioners providing health services in Queensland
- examines reports of the Health Ombudsman, AHPRA and the national boards
- advises the Minister for Health in relation to the appointment of the Health Ombudsman
- reports to the Legislative Assembly.

The committee meets with the Health Ombudsman each quarter. Recordings and transcripts from these meetings are available on the Queensland Parliament website www.parliament.qld.gov.au/work-of-committees, as well as the office's website **www.oho.qld.gov.au.**

Directions by the Minister to the Office

There were no directions by the Minister for Health to the Health Ombudsman in 2015–16.

Statutory appointments

Health Ombudsman

The Health Ombudsman of Queensland is a statutory position, appointed under the Health Ombudsman Act 2013 by the Governor-in-Council on the recommendation of the Minister for Health. The Minister must advertise for suitably qualified candidates, consult with the parliamentary committee, and be satisfied the person has the skills and knowledge to perform the Health Ombudsman's functions effectively and efficiently.

The Health Ombudsman's term of appointment is four years and the person may be reappointed.

The Health Ombudsman has various powers such as:

- issuing notices requiring provision of information for the purpose of facilitating resolution of a complaint
- taking immediate action to suspend or place conditions on a registered health practitioner's registration where the practitioner poses a serious risk to the public and it is necessary to protect public health or safety
- issuing an interim prohibition order against unregistered health practitioners where the practitioner poses a serious risk to the public and it is necessary to protect public health or safety.

Further functions of the Health Ombudsman are detailed on page 43 of this report.

Director of Proceedings

The Director of Proceedings is a statutory position appointed by the Health Ombudsman, and must be an employee of the office. The appointee must be a lawyer and otherwise appropriately qualified.

Serious complaints that may require review or referral to QCAT are referred to the Director of Proceedings. The functions of the role are to:

- decide whether or not to refer health service complaints and other matters to QCAT on the Health Ombudsman's behalf
- prosecute the complaints and other matters that the Director of Proceedings refers to QCAT.

The Director of Proceedings is not subject to the direction of the Health Ombudsman or anyone else in performing these functions. This ensures that the process of referral of serious matters to QCAT is conducted in an impartial and independent manner.

integrity and **impartiality**

Government objectives for the community

The office supports the Queensland Government's objectives for the community relating to creating jobs and a diverse economy, delivering quality frontline services, and building safe, caring and connected communities. The office does this by:

- ensuring safe, productive and fair workplaces by providing advice and recommendations to health practitioners and their employers on how they can manage complaints and structure their processes to protect the public as well as their colleagues and employees
- strengthening Queensland's public health system and protecting the health and safety of the public by assessing, investigating, resolving or prosecuting complaints about healthcare and identifying systemic healthcare issues and making recommendations on improvements
- providing responsive and integrated government services by working within set timeframes and engaging with other agencies to ensure the health service complaint system in Queensland deals with complaints holistically and effectively
- supporting disadvantaged Queenslanders by making the office's services accessible and reaching out to those groups that may not know where to go if they have a health service complaint.

Code of conduct

The office has adopted the *Code of Conduct for the Queensland Public Service*. All staff complete mandatory code of conduct training annually. This training is also embedded into the employee induction framework as a face-to-face session.

The office's administrative procedures and management practices have proper regard for both its values and the public sector ethics principles of the code of conduct. These are integrity and impartiality, accountability and transparency, promoting the public good, and commitment to the system of government.

Values

The office's values define its behaviours. They guide its actions and influence how it interacts with people and engages with the community. They are:

- The health and safety of the public are paramount.
- We act independently, impartially and in the public interest.
- We treat all people fairly and equitably.
- We recognise that open and honest communication and the sharing of information helps to improve health service delivery.
- We make our services accessible to all Queenslanders.
- We embrace transparency and ensure accountability across the health service complaints system in Queensland.
- We produce timely and high quality work.
- We develop our capability and use innovative processes to improve our service.

The office's values are complemented by the public service values—customer first, ideas into action, unleash potential, be courageous and empower people. These values have been incorporated into the employee induction process and the performance framework by which individual staff and the office as a whole measures its success.

our finances

Office of the Health Ombudsman

for the financial year ended 30 June 2016

table of **contents**

General information

These financial statements cover the Office of the Health Ombudsman. The Office of the Health Ombudsman is Queensland's independent health service complaints management agency, and the single point of entry for all health service complaints. The agency is controlled by the state of Queensland which is the ultimate parent.

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

Level 12, 400 George St
BRISBANE OLD 4000

For information in relation to the agency's financial statements please email **info@oho.qld.gov.au**. Amounts shown in these financial statements may not add to the correct sub-totals or total due to rounding.

financial **snapshot**

Overview

The operating result for the office for the 2015–16 financial year was a deficit of $2.581 million. This was due to the engagement of 24 additional complaint management and investigation officers to manage the increasing workload of the office.

The financial impact of this result is provided in detail in the audited financial statements provided with this report and on the office's website **www.oho.qld.gov.au**.

Funding

There are three sources of funding for the office. They are the government grant, own-source revenue and regulatory funding provided by AHPRA.

The regulatory funding component is a proportion of the registration fees of Queensland-registered health practitioners. In 2015–16, the Minister for Health determined that $4.203 million was to be provided to the office by AHPRA. The amount reflects the cost of the office managing complaints that would otherwise have been conducted by AHPRA and the national boards. It was decided by the Minister for Health after consultation with other Ministers, national boards and AHPRA.

Financial position

The financial position provides an indication of the office's underlying financial health at 30 June 2016. The office's assets at 30 June 2016 were $2.365 million and liabilities were $862,000. This resulted in a total equity of $1.503 million.

Assets

The office's total assets are valued at $2.365 million as at 30 June 2016. Current assets are valued at $1.964 million and are available to meet current liabilities, which are valued at $706,000.

Liabilities

Total liabilities for the office at 30 June 2016 were $862,000 and the largest single liability was $559,000 for accrued employee benefits. Remaining liabilities relate predominantly to payables and deferred lease liability.

Financial performance

The income statement shows the total income for 2015–16 as $14.177 million—a reduction of $568,000 from the 2014–15 financial year—and expenses as $16.758 million, finishing the year with an operating deficit of $2.581 million.

Income

In 2015–16, the office derived the majority of its income from the Queensland Government through a contribution of $9.868 million. Additional regulatory funding of $4.203 million was provided by AHPRA as determined by the Minister for Health.

Expenses

Total operating expenses for 2015–16 were $16.758 million. The largest expense category was for employee expenses ($13.961 million), which accounted for 83 per cent of expenses. The second largest category was supplies and services ($2.662 million), which accounted for 16 per cent of expenses.

Internal audits

In 2015–16, the office was not instructed by the Minister for Health to establish an internal audit function or committee.

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Statement of Comprehensive Income

for the year ended 30 June 2016

	Notes	2016 $'000	2015 $'000
Income			
Revenue			
Grants and other contributions	2	14,072	14,495
Interest		99	239
Other revenue		6	11
Total Income		14,177	14,745
Expenses			
Employee expenses	3	13,961	10,762
Supplies and services	4	2,662	3,117
Depreciation	7	129	114
Other expenses	5	7	10
Total Expenses		16,758	14,003
Operating Result		(2,581)	742
Total Comprehensive Income		(2,581)	742

The accompanying notes form part of these statements.

QAO certified statements

Statement of Financial Position

as at 30 June 2016

	Notes	2016 $'000	2015 $'000
Current Assets			
Cash and cash equivalents		1,569	3,953
Receivables	6	287	235
Prepayments		109	105
Total Current Assets		1,964	4,293
Non Current Assets			
Prepayments		33	64
Plant and equipment	7	368	365
Total Non Current Assets		401	429
Total Assets		2,365	4,722
Current Liabilities			
Payables	8	147	180
Accrued employee benefits	9	559	352
Total Current Liabilities		706	532
Non Current Liabilities			
Deferred Lease Liability		156	106
Total Non Current Liabilities		156	106
Total Liabilities		862	638
Net Assets		1,503	4,084
Equity			
Contributed equity		1,394	1,394
Accumulated surplus		109	2,690
Total Equity		1,503	4,084

The accompanying notes form part of these statements.

QAO certified statements

Statement of Changes in Equity

for the year ended 30 June 2016

	Notes	2016 $'000	2015 $'000
Contributed Equity			
Balance as at 1st July		1,394	-
Transactions with Owners as Owners			
- Net transfers in from other Queensland Government Entities		-	1,394
Balance as at 30 June		1,394	1,394
Accumulated Surplus			
Balance as at 1st July		2,690	1,948
Operating Result		(2,581)	742
Balance as at 30 June		109	2,690

The accompanying notes form part of these statements.

QAO certified statements

Statement of Cash Flows

as at 30 June 2016

	Notes	2016 $'000	2015 $'000
Cash flows from operating activities			
Inflows:			
Grants and other contributions		14,072	14,495
GST collected from customers		5	4
GST input tax credits from ATO		330	552
Interest receipts		99	239
Other		6	11
Outflows:			
Employee expenses		(13,828)	(10,598)
Supplies and services		(2,617)	(5,431)
GST paid to suppliers		(305)	(392)
GST remitted to ATO		(8)	(4)
Other		(7)	(10)
Net cash used in operating activities		(2,253)	(1,134)
Cash flows from investing activities			
Outflows:			
Payments for plant and equipment		(131)	(13)
Net cash used in investing activities		(131)	(13)
Net decrease in cash held		(2,384)	(1,147)
Cash at beginning of financial year		3,953	3,706
Cash transfers from restructure		-	1,394
Cash at end of financial year		1,569	3,953

The accompanying notes form part of these statements.

QAO certified statements

Notes to the Statement of Cash Flows

for the year ended 30 June 2016

	2016 $'000	2015 $'000
Reconciliation of Operating Result to Net Cash used in Operating Activities		
Operating surplus/(deficit)	(2,581)	742
Depreciation expense	129	114
Changes in assets and liabilities:		
(Increase)/decrease in receivables	(51)	22
(Increase)/decrease in prepayments	27	(169)
Increase/(decrease) in payables	(33)	(2,249)
Increase/(decrease) in accrued employee benefits	207	300
Increase/(decrease) in other non-current liabilities	50	106
Net cash used in operating activities	(2,253)	(1,134)

QAO certified statements

Notes to and forming part of the Financial Statements 2015-16

QAO certified statements

Notes to and forming part of the Financial Statements 2015-16

Continued

1. Basis of Financial Preparation

Statement of Compliance

The Office of the Health Ombudsman 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. The Office of the Health Ombudsman has applied those requirements applicable to not-for-profit entities, as the Office of the Health Ombudsman is a not-for-profit agency. In addition, the financial statements comply with Queensland Treasury's Minimum Reporting Requirements for the year ending 30 June 2016, and other authoritative pronouncements.

Except where stated, the historical cost convention is used.

Issuance of Financial Statements

The financial statements are authorised for issue by the Health Ombudsman and the Director, Business Innovation at the date of signing the management certificate.

Currency, Rounding and Comparatives

Amounts included in the financial statements are in Australian dollars and have been rounded to the nearest $1,000 or, where that amount is $500 or less, to zero, unless disclosure of the full amount is specifically required.

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

Cash

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.

Leases

The Office of the Health Ombudsman has an operating lease for office accommodation. Operating lease payments are recognised in the period they are incurred using a straight line basis over the period of the lease. The difference between the expense and the cash payment at a point in time is recorded as a deferred lease liability.

The Office of the Health Ombudsman has no finance leases.

Taxation

The agency 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 agency. GST credits receivable from, and GST payable to the ATO, are recognised (refer to Note 6).

Judgement

The preparation of financial statements necessarily requires the determination and use of certain critical accounting estimates, assumptions, and management judgements that have the 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. No material judgements or estimates were required in the preparation of the current year's financial statements.

Notes to and forming part of the Financial Statements 2015-16

Continued

	2016 $'000	2015 $'000
2. Grants and Other Contributions		
Administered Grants	9,868	9,995
Contributions from Government	4,203	4,500
Total	14,072	14,495

Accounting policy

Grants and contributions that are non-reciprocal in nature are recognised as revenue in the year in which the agency obtains control over them (control is generally obtained at the time of receipt).

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

3. Employee Expenses		
Employee Benefits		
Wages and salaries	10,307	7,898
Employer superannuation contributions	1,360	1,022
Annual leave levy	1,176	925
Long service leave levy	218	179
Employee Related Expenses		
Workers' compensation premium	56	44
Payroll tax	596	447
Other employee related expenses	248	247
Total	13,961	10,762

The number of employees as at 30 June, including both full-time and part-time employees measured on a full-time equivalent basis reflecting Minimum Obligatory Human Resource Information (MOHRI)) is 125 (2015: 98).

Accounting policy

Employee Benefits

Employer superannuation contributions, annual leave levies and long service leave levies are regarded as employee benefits.

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.

QAO certified statements

Notes to and forming part of the Financial Statements 2015-16

Continued

3. Employee Expenses (contd)

Wages, Salaries and Sick leave

Wages and salaries due but unpaid at reporting date are recognised in the Statement of Financial Position at the current salary rates.

As the agency expects such liabilities to be wholly settled within 12 months of reporting date, the liabilities are recognised at undiscounted amounts.

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

Annual Leave and Long Service Leave

Under the Queensland Government's Annual Leave Central Scheme and Long Service Leave Scheme the agency is levied for the cost of employees' annual leave (including leave loading and on-costs) and long service leave (including on-costs). The levies are expensed in the period in which they are payable. Amounts paid to employees for annual leave and long service leave are claimed from the scheme quarterly in arrears.

No provision for annual leave and long service leave is recognised in the agency's financial statements as the liability 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.*

Superannuation

Employer superannuation contributions are paid to QSuper, the superannuation scheme 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 agency's obligation is limited to its contribution to QSuper.

Therefore, no liability is recognised for accruing superannuation benefits in the agency's financial statements, the liability being 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.*

Notes to and forming part of the Financial Statements 2015-16

Continued

		2016 $'000	2015 $'000
4. Supplies and Services			
Corporate service charges		154	171
Consultants and contractors		456	668
Employment agency staff		249	243
Property Lease and rental		1,105	1,177
Repairs and maintenance		25	18
Minor plant and equipment		57	104
Supplies and consumables		200	163
Information technology		248	410
Communications		159	136
Sundry		9	27
Total		2,662	3,117
5. Other Expenses			
Insurance		4	3
External audit fees	*	3	7
Total		7	10

Disclosure relating to Other Expenses

* Total audit fees payable to the Queensland Audit Office relating to the 2015-16 financial statements are quoted to be $10,000. (2015 $9,750). There are no non-audit services included in this amount.

Accounting policy

Insurance

The agency's risks are insured through the Queensland Government Insurance Fund, premiums being paid on a risk assessment basis. In addition, the agency pays premiums to Workcover Queensland in respect of its obligations for employee compensation.

QAO certified statements

Notes to and forming part of the Financial Statements 2015-16

Continued

	2016 $'000	2015 $'000
6. Receivables		
Accounts receivable	2	2
	2	2
GST receivable	68	93
GST payable	3	-
	71	93
Long service leave reimbursements	50	10
Annual leave reimbursements	164	130
Total	287	235

Accounting policy

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.

7. Plant and Equipment		
At cost	615	484
Less: Accumulated depreciation	(248)	(119)
Total	368	365

Plant and Equipment Reconciliation

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

	Plant and Equipment		*WIP*		*Total*	
	2016 $'000	2015 $'000	2016 $'000	2015 $'000	2016 $'000	2015 $'000
Carrying amount at 1 July	365	151	-	315	365	466
Acquisitions	132	13	-	-	132	13
Transfers between asset classes	-	315	-	(315)	-	-
Depreciation for period	(129)	(114)	-	-	(129)	(114)
Carrying amount at 30 June	**368**	**365**	**-**	**-**	**368**	**365**

QAO certified statements

Notes to and forming part of the Financial Statements 2015-16

Continued

7. Plant and Equipment (contd)

Accounting policy

Acquistion of Assets

Actual cost is used for the initial recording of all non-current physical asset acquisitions. Cost is determined as the purchase price plus costs incidental to the acquisition, including all other costs incurred in getting the assets ready for use. However, any training costs are expensed as incurred.

Where assets are received free of charge from another Queensland department (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.

Plant and Equipment

Items of plant and equipment with a cost or other value equal to or in excess of $5,000 are recognised for financial reporting purposes in the year of acquisition. Items with a lesser value are expensed in the year of acquisition.

Depreciation of Plant and Equipment

Plant and equipment is depreciated on a straight-line basis so as to allocate to the agency the net cost of each asset progressively over its estimated useful life.

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

Class	*Rate%*
Plant and Equipment:	
Office Equipment	25%
Audio visual equipment	25%
Leasehold improvement	20%

Impairment of Non-Current Assets

All non-current physical assets are assessed for indicators of impairment on an annual basis. If an indicator of possible impairment exists, the agency determines the asset's recoverable amount. The asset's recoverable amount is determined as the higher of the asset's fair value less costs of disposal and depreciated replacement cost. Any amount by which the asset's carrying amount exceeds the recoverable amount is recorded as an impairment loss.

QAO certified statements

Notes to and forming part of the Financial Statements 2015-16

Continued

	2016 $'000	2015 $'000
8. Payables		
Trade and other creditors	124	116
Accrued expenses	23	64
Total	147	180

Accounting Policy

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.

9. Accrued Employee Benefits		
Salary and wage related	166	63
Annual leave levy payable	299	230
Long service leave levy payable	72	51
Superannuation	22	8
Total	559	352

10. Commitments for Expenditure

Non-cancellable Operating Leases

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

	2016 $'000	2015 $'000
Not later than one year	1,046	1,063
Later than one year and not later than five years	2,518	3,780
Total	**3,564**	**4,843**

Operating leases are entered into as a means of acquiring access to office accommodation and storage facilities. Lease payments contain fixed rate increases of 4.5 per cent.

11. Contingencies

There are no legal or any other contingencies that are known to the Agency at 30 June 2016.

12. Financial Instruments

(a) *Categorisation of Financial Instruments*

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

Category	Note	2016 $'000	2015 $'000
Financial Assets			
Cash and cash equivalents		1,569	3,953
Receivables	6	287	235
Total		**1,856**	**4,188**
Financial Liabilities			
Payables	8	147	180
Total		**147**	**180**

Accounting Policy

Recognition

Financial assets and financial liabilities are recognised in the Statement of Financial Position when the agency 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 agency does not enter into transactions for speculative purposes, nor for hedging.

(b) *Financial Risk Management*

The agency's activities expose it to a variety of financial risks - credit risk, liquidity risk and market risk.

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

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

The agency measures risk exposure using a variety of methods as follows -

Risk Exposure	Measurement method
Credit Risk	Ageing analysis
Liquidity Risk	Sensitivity analysis
Market Risk	Interest rate sensitivity analysis

QAO certified statements

Notes to and forming part of the Financial Statements 2015-16

Continued

12. Financial Instruments (contd)

(c) Credit Risk Exposure

Credit risk exposure refers to the situation where the agency 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.

The carrying amount of receivables represents the maximum exposure to credit risk (refer to Note 12(a)).

No financial assets were past due in 2016 and 2015.

(d) Liquidity Risk

Liquidity risk refers to the situation where the agency may encounter difficulty in meeting obligations associated with financial liabilities that are settled by delivering cash or another financial asset.

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

The agency manages liquidity risk through the use of management reports. This strategy aims to reduce the exposure to liquidity risk by ensuring the agency 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.

All financial liabilities were due within one year in 2016 and 2015.

(e) Market Risk

The agency is exposed to interest rate risk through its cash deposits in interest bearing accounts. The agency is not sensitive to movements in interest rates.

13. Events Occurring after Balance Date

There were no significant events occurring after balance date.

Notes to and forming part of the Financial Statements 2015-16

Continued

14. Budget vs Actual Comparison

Statement of Comprehensive Income

	Variance Notes	Orginal Budget 2016 $'000	Actual 2016 $'000	Variance $'000	Variance % of Budget
Income					
Revenue					
Grants and other contributions	1	14,368	14,072	(297)	(2)
Interest	2	245	99	(146)	(59)
Other revenue		5	6	1	20
Total Income		**14,618**	**14,177**	(441)	(3)
Expenses					
Employee expenses	3	10,531	13,961	(3,430)	(33)
Supplies and services	4	3,930	2,662	1,268	32
Depreciation		120	129	(9)	(7)
Other expenses		37	7	30	82
Total Expenses		**14,618**	**16,758**	**(2,140)**	**(15)**
Operating Result		-	**(2,581)**	(2,581)	100
Total Comprehensive Income		**-**	**(2,581)**	(2,581)	100

Explanations of Major Variances

1. Variance due to reduction in AHPRA funding determined by the Minster for Health - $4.5m budgeted and $4.203m approved

2. Decrease in interest received due to not receiving AHPRA contribution until June 2016.

3. Increase in employee expenses due to employment of additional temporary staff required in the Investigations Division (15 employees) and complaint management officers (9 employees).

4. Delays to system development projects has seen a reduction in information technology expenses ($162k) and contractor and consultants costs ($212k). The remaining variance is largely attributable to an over-estimation in supplies and services expenditure of approximately $800k.

QAO certified statements

14. Budget vs Actual Comparison (contd)

Statement of Financial Position

	Variance Notes	Original Budget 2016 $'000	Actual 2016 $'000	Variance $'000	Variance % of Budget
Current Assets					
Cash and cash equivalents	1	5,011	1,569	(3,442)	(69)
Receivables	2	200	287	87	43
Prepayments		108	109	1	1
Total Current Assets		**5,319**	**1,964**	(3,355)	(63)
Non Current Assets					
Prepayments		-	33	33	100
Plant and equipment	3	226	368	142	63
Total Non Current Assets		**226**	**401**	175	77
Total Assets		**5,545**	**2,365**	(3,180)	(57)
Current Liabilities					
Payables	4	2,274	147	2,127	94
Accrued employee benefits	5	398	559	(161)	(40)
Total Current Liabilities		**2,672**	**706**	(1,966)	**(74)**
Non Current Liabilities					
Deferred Lease Liability	6	-	156	(156)	(100)
Total Non Current Liabilities		**-**	**156**	(156)	**(100)**
Total Liabilities		**2,672**	**862**	1,810	**68**
Net Assets		**2,873**	**1,503**	(1,370)	**(48)**
Equity					
Total Equity	7	**2,873**	**1,503**	(1,370)	(48)

QAO certified statements

Notes to and forming part of the Financial Statements 2015-16

Continued

14. Budget vs Actual Comparison (contd)

Explanations of Major Variances

1. The opening cash position was less than budgeted and employee expenses were higher than budgeted. Refer to the cash flow statement variance explanations.

2 Long Service Leave and Annual leave reimbursements increased ($73K) with increasing employee numbers.

3. No budget was allocated for additional property, plant and equipment required to cater for employment of extra staff. Refer to cash flow statement variance explanation note 6.

4. The budget has incorrectly included a payment run transferred in from the Health Quality and Complaints Commission (HQCC) from 2014/15 of $1.9m.

5. Variance is due to overall increase in staffing numbers (31 employees).

6. A budget was not allocated for deferred lease liability.

7. Variance is due to an unbudgeted loss incurred in 2015/16, offset by an unbudgeted $1.4m for net transfers in from HQCC in 2014/15.

14. Budget vs Actual Comparison (contd)

Statement of Cash Flows

	Variance Notes	Original Budget 2016 $'000	Actual 2016 $'000	Variance $'000	Variance % of Budget
Cash flows from operating activities					
Inflows:					
Grants and other contributions	1	14,128	14,072	(57)	(0)
GST collected from customers		120	5	(115)	(96)
GST input tax credits from ATO	2	-	330	330	100
Interest receipts	3	245	99	(146)	(59)
Other		5	6	1	23
Outflows:					
Employee expenses	4	(10,531)	(13,828)	(3,297)	(31)
Supplies and services	5	(3,930)	(2,617)	1,313	33
GST paid to suppliers	2	-	(305)	(305)	(100)
GST remitted to ATO		-	(8)	(8)	(100)
Other		(37)	(7)	30	82
Net cash used in operating activities		**-**	**(2,253)**	**(2,253)**	100
Cash flows from investing activities					
Outflows:					
Payments for plant and equipment	6	-	(131)	(131)	(100)
Net cash used in investing activities			**(131)**	**(131)**	(100)
Net decrease in cash held		-	(2,384)	(2,384)	100
Cash at beginning of financial year		5,011	3,953	(1,058)	(21)
Cash and cash equivalents at end of financial year		**5,011**	**1,569**	**(3,442)**	(69)

QAO certified statements

Notes to and forming part of the Financial Statements 2015-16

Continued

14. Budget vs Actual Comparison (contd)

Explanations of Major Variances

1. Variance due to reduction in AHPRA funding determined by the Minister for Health - $4.5m budgeted and $4.203m approved.

2. Variance is due to no budget being allocated, in error.

3. Decrease in interest received due to not receiving AHPRA contribution until June 2016.

4. Increase in employee expenses due to employment of additional temporary staff required in the Investigations Division (15 employees) and complaint management officers (9 employees).

5. Delays to system development projects has seen a reduction in information technology expenses ($162k) and contractor and consultant costs ($212). The remaining variance is largely attributable to an over-estimation in supplies and services expenditure of approximately ($800k).

6. No budget allocated for additional property, plant and equipment. Additions primarily due to leasehold improvements ($103k) to accommodate additional staff.

Notes to and forming part of the Financial Statements 2015-16

Continued

15. Key Management Personnel Disclosures

Details of Key Management Personnel

The following details for key management personnel include those positions that had authority and responsibility for planning, directing and controlling the activities of the agency during 2015-16 and 2014-15. Further information on these positions can be found in the body of the Annual Report under the section relating to Executive Management.

Health Ombudsman

The Health Ombudsman oversees the administration and performance of the Office of the Health Ombudsman's functions, including the receipt, assessment, resolution and investigation of health service complaints.

Incumbent	Contract Classification and Appointment Authority	Date of Initial Appointment	Date of Resignation or Cessation
Current	Appointed under S245 of the Health Ombudsman Act 2013 by Governor in Council	28-Jan-2014	-

Executive Director, Assessment & Resolution

The Executive Director, Assessment & Resolution manages the triage and assessment unit and the resolution and conciliation unit.

Incumbent	Contract Classification and Appointment Authority	Date of Initial Appointment	Date of Resignation or Cessation
Current	SES 2.3; Public Service Act 2008	19-May-2014	-

Executive Director, Investigations

The Executive Director, Investigation manages the investigations unit and the audit and compliance unit.

Incumbent	Contract Classification and Appointment Authority	Date of Initial Appointment	Date of Resignation or Cessation
Current	SES 2.4; Public Service Act 2008	26-May-2014	-

Executive Director, Legal Services

The Executive Director, Legal Services manages the provision of support and advice with regard to internal legal matters and ensures adherence to the legislative procedures outlined in the Health Ombudsman Act 2013.

Incumbent	Contract Classification and Appointment Authority	Date of Initial Appointment	Date of Resignation or Cessation
Current	SES 2.5; Public Service Act 2008	4-May-2015	-
Former	SES 2.5; Public Service Act 2008	10-Jun-2014	30-May-2015

Director, Business Innovation

The Director, Business Innovation manages the corporate support services of the office.

Incumbent	Contract Classification and Appointment Authority	Date of Initial Appointment	Date of Resignation or Cessation
Current	SO1; Public Service Act 2008	10-Jun-2014	-

QAO certified statements

Notes to and forming part of the Financial Statements 2015-16

Continued

15. Key Management Personnel Disclosures (contd)

Remuneration Policies

The remuneration and other terms of employment for the key executive management personnel are specified in employment contracts. Remuneration policy for the agency's key management personnel (except for the Health Ombudsman) is set by the Queensland Public Service Commission as provided for under the Public Service Act 2008. The remuneration of the Health Ombudsman is set by the Governor in Council.

For the 2015-16 year, remuneration packages of key management personnel (excluding the Health Ombudsman) increased by 2.5 % in accordance with government policy.

The following disclosures focus on the expenses incurred by the agency during the respective reporting periods, that is attributable to key management positions. Therefore, the amounts disclosed reflects expenses recognised in the Statement of Comprehensive Income.

Remuneration expenses for key management personnel comprises the following components:-

Short term employee expenses which include:

- salaries, allowances and leave entitlements paid and provided for the entire year or for that part of the year during which the employee occupied the specified position. All amounts disclosed equal the amount expenses in the Statement of Comprehensive Income.

Long term employee expenses include amounts expensed in respect of long service leave entitlements earned.

Post-employment expenses include amounts expensed in respect of employer superannuation obligations.

Termination benefits 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.

Performance Payments

No performance payments were made to the key management personnel of the agency.

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15. Key Management Personnel and Remuneration (contd)

1 July 2015 – 30 June 2016

Position	Short Term Employee Expenses	Long Term Employee Expenses	Post-Employment Expenses	Termination Benefits	Total Expenses
	Monetary Expenses				
	$'000	$'000	$'000	$'000	$'000
Health Ombudsman	347	7	41	-	395
Executive Director, Assessment & Resolution	175	4	19	-	198
Executive Director, Investigations	187	4	20	-	211
Executive Director, Legal Services	167	3	16	-	186
Director, Business Innovation	133	3	17	-	153
Total Remuneration	**1,009**	**21**	**113**	**-**	**1,143**

1 July 2014 – 30 June 2015

Position	Short Term Employee Expenses	Long Term Employee Expenses	Post-Employment Expenses	Termination Benefits	Total Expenses
	Monetary Expenses				
	$'000	$'000	$'000	$'000	$'000
Health Ombudsman	367	8	41	-	416
Executive Director, Assessment & Resolution	180	4	20	-	204
Executive Director, Investigations	186	4	18	-	208
Executive Director, Legal Services (Former)	191	3	19	77	290
Executive Director, Legal Services (acting)	24	1	2	-	27
Director, Business Innovation	129	3	15	-	147
Total Remuneration	**1,077**	**23**	**115**	**77**	**1,292**

QAO certified statements

Notes to and forming part of the Financial Statements 2015-16

Continued

16. First Year Application of New Accounting Standards or Change in Policy

Changes in Accounting Policy

The agency did not voluntarily change any of its accounting policies during 2015-16.

Accounting Standards Early Adopted for 2015-16

One Australian Accounting Standard have been early adopted for the 2015-16 year as required by Queensland Treasury. These are:

AASB 2015-2 Amendments to Australian Accounting Standards – Disclosure Initiative: Amendments to AASB 101 [AASB 7, AASB 101, AASB 134 & AASB 1049]

The amendments arising from this standard seek to improve financial reporting by providing flexibility as to the ordering of notes, the identification and location of significant accounting policies and the presentation of sub-totals, and provides clarity on aggregating line items. It also emphasises only including material disclosures in the notes. The agency has applied this flexibility in preparing the 2015-16 financial statements, including co-locating significant accounting policies with the related breakdowns of financial statement figures in the notes.

Accounting Standards Applied for the First Time in 2015-16

No new Australian Accounting Standards effective for the first time in 2015-16 had any material impact on this financial report.

17. Future Impact of Accounting Standards Not Yet Effective

At the date of authorisation of the financial report, the expected impacts of new or amended Australian Accounting Standards issued but with future commencement dates are set out below:

AASB 124 - Related Party Disclosures

From reporting periods beginning on or after 1 July 2016, the agency will need to comply with the requirements of AASB 124 Related Party Disclosures. That accounting standard requires a range of disclosures about the remuneration of key management personnel and transactions with related parties/entities. The agency already discloses information about the remuneration expenses for key management personnel (refer to Note 15) in compliance with requirements from Queensland Treasury. Therefore, the most significant implications of AASB 124 for the agency's financial statements will be the disclosures to be made about transactions with related parties, including transactions with key management personnel or close members of their families.

AASB 15 - Revenue from Contracts with Customers

This Standard will become effective from reporting periods beginning on or after 1 January 2018 and contains much more detailed requirements for the accounting for certain types of revenue from customers. Depending on the specific contractual terms, the new requirements may potentially result in a change to the timing of revenue from sales of the agency's goods and services, such that some revenue may need to be deferred to a later reporting period to the extent that the department has received cash but has not met its associated obligations (such amounts would be reported as a liability (unearned revenue) in the meantime). The agency is yet to complete its analysis of current arrangements for sale of its goods and services, but at this stage does not expect a significant impact on its present accounting practices.

AASB 16 Leases

This Standard will become effective for reporting periods beginning on or after 1 January 2019. When applied, the standard supersedes AASB 117 Leases, AASB Interpretation 4 Determining whether an Arrangement contains a Lease, AASB Interpretation 115 Operating Leases – Incentives and AASB Interpretation 127 Evaluating the Substance of Transactions Involving the Legal Form of a Lease.

17. Future Impact of Accounting Standards Not Yet Effective (contd)

Impact for Lessees

Unlike AASB 117 Leases, AASB 16 introduces a single lease accounting model for lessees. Lessees will be required to recognise a right-of-use asset (representing rights to use the underlying leased asset) and a liability representing the obligation to make lease payments) for all leases with a term of more than 12 months, unless the underlying assets are of low value.

In effect, the majority of operating leases (as defined by the current AASB 117) will be reported on the statement of financial position under AASB 16. There will be a significant increase in assets and liabilities for agencies that lease assets. The impact on the reported assets and liabilities would be largely in proportion to the scale of the agency's leasing activities.

The right-of-use asset will be initially recognised at cost, consisting of the initial amount of the associated lease liability, plus any lease payments made to the lessor at or before the commencement date, less any lease incentive received, the initial estimate of restoration costs and any initial direct costs incurred by the lessee. The right-of-use asset will give rise to a depreciation expense.

The lease liability will be initially recognised at an amount equal to the present value of the lease payments during the lease term that are not yet paid. Current operating lease rental payments will no longer be expensed in the Statement of Comprehensive Income. They will be apportioned between a reduction in the recognised lease liability and the implicit finance charge (the effective rate of interest) in the lease. The finance cost will also be recognised as an expense.

AASB 16 allows a 'cumulative approach' rather than full retrospective application to recognising existing operating leases. If a lessee chooses to apply the 'cumulative approach', it does not need to restate comparative information. Instead, the cumulative effect of applying the standard is recognised as an adjustment to the opening balance of accumulated surplus (or other component of equity, as appropriate) at the date of initial application. The agency will await further guidance from Queensland Treasury on the transitional accounting method to be applied.

The agency has not yet quantified the impact on the Statement of Comprehensive Income or the Statement of Financial Position of applying AASB 16 to its current operating leases, including the extent of additional disclosure required.

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

Management Certificate
for the Office of the Health Ombudsman

These general purpose financial statements have been prepared pursuant to section 62(1) of the *Financial Accountability Act 2009* (the Act), section 43 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 financial statements have been drawn up to present a true and fair view, in accordance with prescribed accounting standards, of the transactions of the Office of the Health Ombudsman for the financial year ended 30 June 2016 and of the financial position of the agency at the end of that year; and

(c) these assertions are based on an appropriate system of internal controls and risk management processes being effective, in all material respects, with respect to financial reporting throughout the reporting period.

Leon Atkinson-MacEwen
Health Ombudsman

Date: 31/8/16

Kylie Guthrie
Director, Business Innovation

Date: 31/8/2016

QAO certified statements

INDEPENDENT AUDITOR'S REPORT

To the Health Ombudsman of the Office of the Health Ombudsman

Report on the Financial Report

I have audited the accompanying financial report of the Office of the Health Ombudsman, which comprises the statement of financial position as at 30 June 2016, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes to the financial statements including significant accounting policies and other explanatory information, and certificates given by the Health Ombudsman and Director, Business Innovation.

The Health Ombudsman's Responsibility for the Financial Report

The Health Ombudsman 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 Health Ombudsman's responsibility also includes such internal control as the Health Ombudsman 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. We conducted the audit 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 Health Ombudsman, 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 Office of the Health Ombudsman for the financial year 1 July 2015 to 30 June 2016 and of the financial position as at the end of that year.

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 J Olive FCPA
(as Delegate of the Auditor-General of Queensland)

Queensland Audit Office
Brisbane

appendices

appendix 1
annual performance report

Figures within this report may differ from respective aggregate monthly totals due to necessary adjustments and alterations being made to historical data subsequent to the publication of monthly or quarterly reports.

Any percentage totals that do not equal 100 are the result of rounding

Office contacts

Number of contacts

Type of contact	Q1		Q2		Q3		Q4		2015–16		2014–15	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Complaint	1114	53.76	1192	55.62	1477	57.85	1593	62.59	5435	58.12	4229	52.75
Enquiry	939	45.32	942	43.96	1071	41.95	940	36.94	3911	41.82	3673	45.82
Yet to be classified	19	0.92	9	0.42	5	0.20	12	0.47	5	0.05	115	1.43
Total	**2072**	**100**	**2143**	**100**	**2553**	**100**	**2545**	**100**	**9351**	**100**	**8017**	**100**

Quarterly figures will not match those reported in the earlier reports due to matters that were yet to be classified at the time, subsequently being classified as a complaint or enquiry.

The number of complaint contacts will not equal the number of decisions made in the table below.

Type of complaints

Type of complaints	Q1		Q2		Q3		Q4		2015–16		2014–15*	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Health consumer	867	77.83	896	75.17	1239	83.89	1289	80.92	4354	80.11	1680	76.85
Mandatory notification	142	12.75	186	15.60	123	8.33	198	12.43	655	12.05	263	12.03
Voluntary notification	50	4.49	47	3.94	60	4.06	66	4.14	226	4.16	105	4.80
Self-notification	30	2.69	21	1.76	32	2.17	17	1.07	101	1.86	31	1.42
Referral	25	2.24	42	3.52	23	1.56	23	1.44	99	1.82	107	4.90
Total	**1114**	**100**	**1192**	**100**	**1477**	**100**	**1593**	**100**	**5435**	**100**	**2186**	**100**

These quarterly figures do not match previous quarterly reports due to matters that were yet to be classified at the time, subsequently being classified as a complaint.

Notifications are made by health service providers, as required in the Health Practitioner Regulation National Law (Queensland). Referrals can be received from both government and non-government agencies.

* Dataset does not capture Q1 and Q2 of 2014–15.

Decisions

Number of decisions made

Assessment timeframes	Q1		Q2		Q3		Q4		2015–16		2014–15	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Accepted	944	80.89	832	84.13	1069	81.60	1115	74.09	3961	79.70	3109	87.68
Not accepted	223	19.11	157	15.87	241	18.40	390	25.91	1009	20.30	339	9.56
Total	**1167**	**100**	**989**	**100**	**1310**	**100**	**1505**	**100**	**4970**	**100**	**3546**	**100**
Decisions pending	41	n/a	90	n/a	103	n/a	158	n/a	0	n/a	98	n/a

Quarterly figures may vary from those reported in earlier reports due to matters deemed 'decisions pending' subsequently being either accepted or not accepted.

Decisions made within seven days of receiving a complaint

Decisions made	Q1		Q2		Q3		Q4		2015–16		2014–15	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Yes	554	47.47	518	52.38	708	54.05	627	41.66	2409	48.47	2309	66.97
No	613	52.53	471	47.62	602	45.95	878	58.34	2561	51.53	1139	33.03
Total	**1167**	**100**	**989**	**100**	**1310**	**100**	**1505**	**100**	**4970**	**100**	**3448**	**100**

Quarterly figures may vary from those reported in earlier reports due to matters deemed 'decisions pending' subsequently being either accepted or not accepted.

Health service complaints profile

Main issues raised in complaints

Issue	Q1		Q2		Q3		Q4		2015–16		2014–15	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Access	15	1.64	9	0.78	11	1.25	16	1.51	51	1.27	91	2.72
Code of conduct for healthcare workers	n/a	n/a	1	0.09	3	0.34	0	0.00	4	0.10	n/a	n/a
Communication /information	112	12.25	138	12.01	138	15.72	171	16.10	560	13.98	466	13.92
Consent	14	1.53	36	3.13	14	1.59	22	2.07	87	2.17	66	1.97
Discharge/ transfer arrangements	37	4.05	25	2.18	31	3.53	40	3.77	131	3.27	47	1.40
Environment/ management of facilities	14	1.53	28	2.44	16	1.82	26	2.45	84	2.10	46	1.37
Fees/cost	8	0.88	14	1.22	5	0.57	10	0.94	37	0.92	79	2.36
Grievance processes	14	1.53	20	1.74	14	1.59	20	1.88	68	1.70	42	1.25
Medical records	44	4.81	33	2.87	33	3.76	33	3.11	144	3.59	102	3.05
Medication	66	7.22	68	5.92	68	7.74	67	6.31	269	6.71	302	9.02
Professional conduct	102	11.16	126	10.97	74	8.43	105	9.89	406	10.13	438	13.08
Professional health	13	1.42	35	3.05	8	0.91	11	1.04	67	1.67	117	3.49
Professional performance	166	50.98	610	53.09	455	51.82	535	50.38	2069	51.65	1350	40.32
Reports/ certificates	6	0.66	6	0.52	8	0.91	5	0.47	25	0.62	29	0.87
Treatment	3	0.33	0	0.00	0	0	1	0.09	4	0.10	173	5.17
Total	**914**	**100**	**1149**	**100**	**878**	**100**	**1062**	**100**	**4006**	**100**	**3348**	**100**

These figures are based on complaints that completed the assessment process during the year. Basing figures on completed assessments produces accurate reporting of the type(s) of issues identified, as all relevant details of a matter have been identified at the time an assessment is completed. Please note, there can be multiple issues identified within a single complaint.

Number and type of complaints by health practitioner

Practitioner type	Access	Code of conduct for healthcare workers	Communication and information	Consent	Discharge/ transfer arrangements	Environment/ management of facility	Fees and costs	Grievance process	Medical records	Medication	Professional conduct	Professional health	Professional performance	Reports/ certificates	Treatment	Total
Alternative care	–	2	1	1	–	–	–	–	–	–	8	1	4	–	–	17
Chinese medicine	–	–	1	–	–	–	–	–	–	–	1	–	–	–	–	2
Chiropractor	–	–	2	2	–	–	–	1	3	–	9	1	12	–	–	30
Dentistry	1	–	6	6	–	4	5	2	10	1	14	1	88	–	–	138
Emergency care	1	–	7	1	6	–	–	–	1	3	4	–	33	–	–	56
General medical	4	–	111	17	13	6	6	3	43	95	99	16	437	8	2	860
Medical radiation	–	–	1	1	1	–	–	–	–	–	2	–	8	4	–	17
Medical specialty	1	1	54	13	5	2	4	1	6	16	25	2	179	3	–	312
Nursing	2	–	25	3	2	2	–	3	5	18	76	27	48	1	–	212
Occupational therapy	–	–	2	–	–	–	–	–	–	–	2	–	3	1	–	8
Optometry	–	–	–	–	–	–	–	–	1	–	2	–	4	–	–	7
Osteopathy	–	–	–	–	–	–	–	–	–	–	–	–	1	–	–	1
Other	–	–	14	1	–	–	2	–	4	10	50	12	32	1	–	126
Pathology	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	0
Pharmacy	–	–	5	–	–	2	1	–	3	27	11	3	1	–	–	53
Physiotherapy	–	–	3	–	–	1	–	–	2	–	7	1	17	–	–	31
Podiatry	–	–	–	–	–	–	1	1	1	–	2	–	2	–	–	7
Psychology	–	1	5	1	–	–	2	2	5	–	19	3	17	–	–	55
Speech pathology	–	–	–	–	–	–	–	–	–	–	2	–	–	–	–	2
Surgical	1	–	48	13	8	–	4	1	10	5	19	–	231	1	–	341
Not yet known	–	–	2	–	–	–	–	–	–	–	–	–	6	–	–	8
Total	**10**	**4**	**287**	**59**	**35**	**17**	**25**	**14**	**94**	**175**	**352**	**67**	**1123**	**19**	**2**	**2283**

These figures are based on complaints that completed the assessment process during the year. Basing figures on completed assessments produces accurate reporting of the type(s) of issues identified, as all relevant details of a matter have been identified at the time an assessment is completed. Please note, there can be multiple issues identified within a single complaint.

Number and type of complaints by health service organisation

Organisation type	Access	Communication & information	Consent	Discharge/ transfer arrangements	Environment/ management of facility	Fees & costs	Grievance process	Medical records	Medication	Professional conduct	Professional health	Professional performance	Reports/ certificates	Treatment	Total!
Aged care facility	–	10	2	–	8	–	4	1	5	1	–	26	1	–	**58**
Allied health service	–	1	–	1	3	2	–	–	–	1	–	–	5	–	**13**
Ambulance service	–	3	–	–	–	–	1	1	2	1	–	9	–	–	**17**
Community health service	1	–	–	–	–	–	2	–	–	–	–	3	–	–	**6**
Correctional facility	4	5	–	–	1	–	1	–	12	3	–	24	–	–	**50**
Dental service	–	2	–	–	2	–	3	–	2	1	–	9	–	–	**19**
Hospital and health service	2	2	2	3	–	–	2	2	1	1	–	15	–	–	**30**
Laboratory service	–	–	–	–	2	–	–	1	–	–	–	1	2	–	**6**
Licensed day hospital	–	1	–	–	–	1	–	–	–	–	–	1	–	–	**3**
Licensed private hospital	3	29	2	11	15	3	6	7	11	3	–	102	1	–	**193**
Medical centre	5	7	–	–	3	2	3	5	–	3	–	9	1	–	**38**
Mental health service	2	13	2	2	3	–	2	3	4	8	–	38	–	1	**78**
Nursing service	–	1	–	–	–	–	–	–	–	–	–	–	–	–	**1**
Other government department	–	–	–	–	1	–	–	–	1	3	–	–	–	–	**5**
Other support service	–	4	–	–	–	–	–	–	9	1	–	1	–	–	**15**
Pharmaceutical service	–	–	–	–	–	–	–	–	–	–	–	1	–	–	**1**
Public health service	–	5	1	5	1	–	–	–	2	4	–	20	–	–	**38**
Public hospital	22	180	18	74	26	2	28	28	44	21	–	660	1	1	**1105**
Residiential care service	1	–	–	–	–	–	–	–	–	–	–	–	3	–	**4**
Specialised health service	1	9	–	–	2	2	2	1	–	2	–	18	–	–	**37**
Not yet known	–	1	1	–	–	–	–	1	1	1	–	1	–	–	**6**
Total	**41**	**273**	**28**	**96**	**67**	**12**	**54**	**50**	**94**	**54**	**0**	**946**	**6**	**2**	**1723**

These figures are based on complaints that completed the assessment process during the year. Basing figures on completed assessments produces accurate reporting of the type(s) of issues identified, as all relevant details of a matter have been identified at the time an assessment is completed. Please note, there can be multiple issues identified within a single complaint.

Assessment

Assessments commenced and completed

Assessments this year	Q1	Q2	Q3	Q4	2015–16	2014–15
Assessments commenced	413	473	470	441	1781	2446
Assessments completed	400	579	388	530	1897	1886

Completed assessment timeframes

Assessment timeframes	Q1		Q2		Q3		Q4		2015–16		2014–15	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Within 30 days	66	16.50	207	35.75	94	24.23	140	26.42	508	26.78	1030	54.61
Within 60 days*	74	18.50	86**	14.85	102	26.29	92	17.36	354	18.66	379	20.09
Greater than 60 days	260	65.00	286	49.40	192	49.48	298	56.23	1035	54.56	477	25.30
Total	**400**	**100**	**579**	**100**	**388**	**100**	**530**	**100**	**1897**	**100**	**1886**	**100**

Of the 354 assessments completed within 60 days, 105 matters were approved for extension.

* Assessments are able to be completed within 60 days when granted an extension of 30 days as a result of legislated requirements being met.

Assessment decisions

Type of relevant action	Q1		Q2		Q3		Q4		2015–16		2014–15	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Local resolution	32	7.64	28	4.70	33	8.21	19	3.49	117	5.44	436	21.38
Conciliation	27	6.44	24	4.03	26	6.47	32	5.88	115	5.34	56	2.75
Investigation	13	3.10	28	4.70	12	2.99	21	3.86	77	3.58	145	7.11
Referred to AHPRA and the national boards	142	33.89	339	56.88	141	35.07	170	31.25	811	37.69	720	35.31
Referral to another entity	19	4.53	23	3.86	21	5.22	48	8.82	121	5.62	52	2.55
Immediate action*	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	15	0.74
Immediate registration action*	3	0.72	0	0.00	4	1.00	3	0.55	7	0.33	n/a	n/a
Interim prohibition order*	1	0.24	0	0.00	0	0.00	0	0.00	1	0.05	n/a	n/a
No further action	182	43.44	154	25.84	165	41.04	251	46.14	903	41.96	615	30.16
Total	**419**	**100**	**596**	**100**	**402**	**100**	**544**	**100**	**2152**	**100**	**2039**	**100**

Total assessment decisions won't equal the total number of assessments (in previous tables), as a single assessment can result in multiple relevant actions.

The figures for the type of relevant action decided in the assessment stage will not correspond with totals for respective relevant actions (e.g. local resolution, conciliation, investigation etc.) due to the time between a decision being made and an action taken crossing over different reporting periods or because of relevant actions commencing directly from intake without having passed through the assessment stage.

* 2014-15 immediate action data does not differentiate between immediate registration actions and interim prohibition orders.

Local resolution

Local resolutions commenced and completed

Local resolutions this year	Q1	Q2	Q3	Q4	2015–16	2014–15
Local resolutions commenced	339	283	365	278	1259	781
Local resolutions completed	303	315	324	305	1242	691

The number of local resolutions started in the reporting period may not match the number of assessment decisions to undertake local resolution due to the time between a decision being made and an action taken crossing over different reporting periods.

Completed local resolution timeframes

Local resolution timeframes	Q1		Q2		Q3		Q4		2015–16		2014–15	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Within 30 days	259	85.48	278	88.25	246	75.92	239	78.36	1019	82.05	623	90.16
Within 60 days*	40	13.20	32	10.16	69	21.30	46	15.08	185	14.90	65	9.41
Greater than 60 days**	4	1.32	5	1.59	9	2.78	20	6.56	38	3.06	3	0.43
Total	**303**	**100**	**315**	**100**	**324**	**100**	**305**	**100**	**1242**	**100**	**691**	**100**

Of the 185 local resolutions completed within 60 days, 96 matters were approved for extension.

* Local resolutions are able to be completed within 60 days when granted an extension of 30 days as a result of legislated requirements being met.

Local resolution outcomes

Local resolution outcomes	Q1		Q2		Q3		Q4		2015–16		2014–15	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Resolved	275	93.86	281	91.83	273	84.26	249	81.64	1074	86.47	608	87.99
Not resolved	18	6.14	25	8.17	51	15.74	56	18.36	168	13.53	83	12.01
Total	**293**	**100**	**306**	**100**	**324**	**100**	**305**	**100**	**1242**	**100**	**691**	**100**

* Complainants can choose to withdraw their complaint at any stage during local resolution.

Decisions for matters where resolution wasn't reached

Type of relevant action	Q1		Q2		Q3		Q4		2015–16		2014–15	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Assessment	0	0.00	0	0.00	4	7.84	0	0.00	4	2.38	n/a	n/a
Conciliation	1	3.57	1	3.70	0	0.00	0	0.00	3	1.79	3	3.61
Investigation	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Referred to AHPRA and the national boards	5	17.86	5	18.52	3	5.88	8	14.29	20	11.90	10	12.05
Referral to another entity	0	0.00	0	0.00	0	0.00	1	1.78	1	0.6	0	0.00
Immediate action	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
No further action	12	42.86	12	44.44	44	86.27	47	83.93	128	76.19	70	84.34
Complaint withdrawn*	10	35.71	9	33.33	0	0.00	0	0.00	12	7.14	0	0.00
Total	**28**	**100**	**27**	**100**	**51**	**100**	**56**	**100**	**168**	**100**	**83**	**100**

* Complainants can choose to withdraw their complaint at any stage during local resolution.

Conciliation

Conciliations commenced and closed

Conciliations this year	Q1	Q2	Q3	Q4	2015–16	2014–15
Conciliations commenced	31	28	29	34	122	85
Conciliations closed	16	31	16	25	88	65

The number of conciliations commenced in the reporting period may not match the number of assessment decisions to undertake conciliation due to the time between a decision being made and an action taken crossing over different reporting periods.

Conciliations started includes all matters (including matters where agreement to participate has or has not been reached or the decision is pending) that entered the conciliation workflow during the reporting period following the OHO assessing them as being suitable for conciliation. Similarly, conciliations closed are all matters that were closed during the reporting period, whether due to parties not agreeing to participate or the matter being closed after completing the conciliation process.

Agreement to participate in conciliation

Agreement to participate	Q1	Q2	Q3	Q4	2015–16	2014–15
Party/ies agred to participate	13	16	20	8	57	62
Party/ies did not agree to participate	7	9	6	13	35	14

Completed conciliation timeframes

Conciliations completed	Q1		Q2		Q3		Q4		2015–16		2014–15	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
0–3 months	2	22.22	7	31.82	2	20.00	0	0.00	11	20.75	5	9.80
3–6 months	5	55.56	12	54.55	5	50.00	8	66.67	30	56.60	13	25.49
6–9 months	2	22.22	3	13.64	2	20.00	4	33.33	11	20.75	15	29.41
9–12 months	0	0.00	0	0.00	1	10.00	0	0.00	1	1.89	10	19.61
12+ months*	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	8	15.69
Total	**9**	**100**	**22**	**100**	**10**	**100**	**12**	**100**	**53**	**100**	**51**	**100**

The above data relates to matters where parties agreed to participate in conciliation. After agreeing, the conciliation process was completed within the above timeframes.

Completed conciliation outcomes

Conciliations open	Q1		Q2		Q3		Q4		2015–16		2014–15	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Successful	8	88.89	17	77.27	6	60.00	9	75.00	40	75.47	39	76.47
Not successful	1	11.11	5	22.73	4	40.00	3	25.00	13	24.53	12	23.53
Ended early	0	0.00	0	0.00	0	0.00	0	0.0	0	0.00	0	0.00
Total	**9**	**100**	**22**	**100**	**10**	**100**	**12**	**100**	**53**	**100**	**51**	**100**

The above data relates to matters where parties agreed to participate in conciliation. After agreeing, the conciliation process was completed with parties either reaching or not reaching agreement (or in rare instances, the Health Ombudsman ending it).

Decisions for matters where agreement wasn't reached

Type of relevant action	Q1		Q2		Q3		Q4		2015–16		2014–15	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Local resolution	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Investigation	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Referred to AHPRA and the national boards	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Referral to another entity	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Immediate action	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
No further action	1	100	5	100	4	100	3	100	13	100	12	100
Total	**1**	**100**	**5**	**100**	**4**	**100**	**3**	**100**	**13**	**100**	**12**	**100**

Open conciliation timeframes

Conciliations open	Q1		Q2		Q3		Q4		2015–16		2014–15	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
0–3 months	27	77.14	23	71.88	26	57.78	31	57.41	31	57.41	12	60.00
3–6 months	7	20.00	6	18.75	17	37.78	12	22.22	12	22.22	7	35.00
6–9 months	0	0	1	3.13	0	0.00	9	16.67	9	16.67	0	0.00
9–12 months	0	0	1	3.13	1	2.22	0	0.00	0	0.00	1	5.00
12+ months*	1	2.86	1	3.13	1	2.22	2	3.70	2	3.70	0	0.00
Total	**35**	**100**	**32**	**100**	**45**	**100**	**54**	**100**	**54**	**100**	**20**	**100**

Investigation

Investigations commenced and completed

Investigations this year	Q1	Q2	Q3	Q4	2015–16	2014–15
Investigations commenced	48	57	30	81	249	357
Investigations completed	53	35	16	54	163	65

The number of investigations started in the reporting period will not match the number of assessment decisions to undertake investigation due to the time between a decision being made and an action taken crossing over different reporting periods, or as a result of investigations being started via other processes (e.g. own-motion investigation).

Investigations paused and recommenced

Investigations this year	Q1	Q2	Q3	Q4	2015–16	2014–15
Investigations paused	8	6	16	17	77	41
Investigations recommenced	13	6	9	8	33	n/a

Completed investigation timeframes

Investigation completed within...	Q1		Q2		Q3		Q4		2015–16		2014–15	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
0–3 months	4	7.55	5	14.29	2	7.55	5	9.26	18	11.04	16	24.62
3–6 months	5	9.43	8	22.86	2	9.43	5	9.26	20	12.27	12	18.46
6–9 months	6	11.32	7	20.00	1	11.32	5	9.26	16	9.82	11	19.62
9–12 months	13	24.53	6	17.17	4	24.53	6	11.11	32	19.63	8	12.31
12+ months*	25	47.17	9	25.71	7	47.17	33	61.11	77	47.24	13	27.70
Total	**53**	**100**	**35**	**100**	**16**	**100**	**54**	**100**	**163**	**100**	**65**	**100**

Completed investigation outcomes

Completed investigation outcome	Q1		Q2		Q3		Q4		2015–16		2014–15	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Matters recommended for referral to Director of Proceedings	2	3.70	3	8.57	1	6.25	18	33.33	24	14.72	3	4.62
Report	0	0.00	2	5.71	0	0.00	1	1.85	3	1.84	2	3.08
Referred to AHPRA	14	25.93	19	54.29	7	43.75	15	27.78	57	34.97	27	41.54
Referred to another agency	4	7.41	1	2.86	0	0.00	2	3.70	6	3.68	2	3.08
No further action	34	62.96	10	28.57	8	50.00	18	33.33	73	44.79	30	46.15
Other	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	1	1.54

Open investigation categories

Open investigations	Q1	Q2	Q3	Q4
Health service complaint	222	237	238	250
Systematic issue	0	8	0	4
Another matter*	29	38	37	41

Data does not include 77 paused matters currently with an external agency.

* Matters brought to the Health Ombudsman's attention by means other than through a health service complaint or notification.

Open investigation timeframes

Open investigations	Q1		Q2		Q3		Q4		2015–16		2014–15	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
0–3 months	37	17.74	49	17.31	27	9.82	53	17.97	53	17.97	67	26.69
3–6 months	63	25.10	32	11.30	38	13.82	37	12.54	37	12.54	34	13.55
6–9 months	31	12.35	50	17.67	32	11.64	24	8.14	24	8.14	44	17.53
9–12 months	34	13.55	36	12.72	43	15.64	26	8.81	26	8.81	45	17.93
12+ months*	86	34.26	116	41.00	135	49.09	155	52.54	155	52.54	61	24.30
Total	**251**	**100**	**283**	**100**	**275**	**100**	**295**	**100**	**295**	**100**	**251**	**100**

Data does not include 77 paused matters currently with an external agency.

* All investigations that have been open for more than 12 months are published on our investigations register which is available on our website **www.oho.qld.gov.au**.

Immediate action

Show cause notices

There were 12 show cause notices issued during the year.

Immediate registration actions

The Health Ombudsman took immediate registration action 11 times in 2015–16.

			Issue Type		
Practitioner Type	**Month**	**Action**	**Health**	**Conduct**	**Performance**
Medical practitioner	June	Suspended	✓	✓	
Registered nurse	August	Suspended		✓	
Dentist	August	Conditions		✓	✓
Chinese medicine practitioner	October	Suspended		✓	
Registered nurse	December	Conditions		✓	
Chinese medicine practitioner	December	Conditions		✓	
Registered nurse	February	Suspended		✓	
Registered nurse	February	Conditions		✓	✓
Physiotherapist	February	Conditions		✓	
Medical practitioner	May	Conditions		✓	
Registered nurse	May	Conditions		✓	

Prohibition orders

In 2015–16, the Health Ombudsman issued 24 interim prohibition orders and 3 corresponding interstate orders. Details for current prohibition orders can be found on the OHO website **www.oho.qld.gov.au** on the prohibition order register.

			Issue Type		
Practitioner Type	**Month**	**Action**	**Health**	**Conduct**	**Performance**
Massage therapist	August	Interim prohibition order		✓	
Registered nurse	August	Interim prohibition order		✓	
Massage therapist	September	Corresponding interstate order		✓	
Counsellor	October	Interim prohibition order		✓	
Chinese medicine	November	Interim prohibition order		✓	
Massage therapist	November	Interim prohibition order		✓	
Unregistered practitioner	November	Interim prohibition order		✓	✓
Counsellor	November	Interim prohibition order		✓	
Assistant in nursing	December	Interim prohibition order		✓	
Registered nurse	December	Interim prohibition order		✓	
Massage therapist	December	Interim prohibition order		✓	
Providing services as a paramedic without any qualifications	December	Interim prohibition order		✓	
Counsellor	January	Corresponding interstate order		✓	✓
Assistant in nursing	January	Interim prohibition order		✓	
Massage therapist/dry needling	January	Interim prohibition order			✓
Massage Therapist	January	Interim prohibition order		✓	
Physiotherapist	January	Interim prohibition order		✓	
Paramedic	January	Interim prohibition order		✓	
Audiologist	March	Interim prohibition order		✓	✓
Psychologist/counsellor	April	Interim prohibition order	✓	✓	
Audiologist	April	Interim prohibition order		✓	✓
Massage therapist	May	Interim prohibition order		✓	
Registered nurse	May	Interim prohibition order		✓	
Cosmetic therapist	May	Corresponding interstate order		✓	
Aboriginal health worker	May	Interim prohibition order		✓	
Paramedic	May	Interim prohibition order		✓	
Unregistered nurse	May	Interim prohibition order		✓	

Referrals to Director of Proceedings

In 2015–16, the Health Ombudsman referred 18 practitioners to the Director of Proceedings in relation to 24 separate matters.

Practitioners referred to the Queensland Civil and Administrative Tribunal

The Director of Proceedings referred five practitioners to QCAT in 2015–16, including three nurses, one medical practitioner and one unregistered practitioner.

It is expected decisions about whether to refer the remaining 13 practitioners will be referred by the Director of Proceedings to QCAT in 2016–17.

Matters heard by the Queensland Civil and Administrative Tribunal

Of the five practitioners referred to QCAT by the Director of Proceedings in 2015–16, hearings were held in relation to one practitioner (see ***Office of the Health Ombudsman v Costello*** [2016] QCAT 177).

In the matter of ***OHO v Costello*** QCAT ordered that Costello be prohibited from providing any health service. In handing down that ruling QCAT:

- affirmed the OHO's original decision to issue Costello with an interim prohibition order
- established a precedent for the banning of unregistered practitioners from providing health services in Queensland.

Australian Health Practitioner Regulation Agency

Notifications from AHPRA

In 2015–16, AHPRA notified the Health Ombudsman of 33 serious matters, as prescribed under section 193 of the National Law. These included:

- 12 matters which were referred to the OHO under section 193(2)(a) of the National Law
- 19 matters which remained under the management of the national boards as per section 193(2)(b) of the National Law
- 2 matters were outstanding.

Number of practitioners referred to AHPRA

Practitioner type	Percentage	2014–15
Aboriginal & Torres Strait Islander health	1	0
Chinese medicine	13	3
Chiropractic	21	16
Dental	178	96
Medical	1111	458
Medical radiation	15	8
Nursing and midwifery	443	277
Occupational therapy	13	7
Optometry	9	7
Osteopathy	3	1
Pathology	0	1
Pharmacy	66	29
Physiotherapy	24	11
Podiatry	9	1
Psychology	77	26
Unregistered practitioner	10	7
Total	**1993**	**948**

Number of issues referred to AHPRA by practitioner type

Registered practitioner type	Access	Code of conduct for healthcare workers	Communication & information	Consent	Discharge/ transfer arrangements	Environment/ management of facility	Fees & costs	Grievance process	Medical records	Medication	Professional conduct	Professional health	Professional performance	Reports/ certificates	Treatment	Total!
Aboriginal & Torres Strait Islander health	–	–	–	–	–	–	–	–	–	–	–	–	1	–	–	**1**
Chinese medicine	–	–	1	–	–	–	–	–	–	–	13	–	–	–	–	**14**
Chiropractic	–	–	2	–	–	–	–	–	2	–	14	2	7	–	–	**27**
Dental	–	–	12	10	–	2	10	2	14	2	36	12	194	–	–	**294**
Medical	1	–	202	37	23	12	14	5	68	155	177	94	1070	25	2	**1885**
Medical student	–	–	–	–	–	–	–	–	–	–	1	3	–	–	–	**4**
Medical radiation	–	–	1	–	–	–	–	–	–	–	5	6	5	1	–	**18**
Nursing & midwifery	1	–	23	1	–	2	4	1	8	44	206	185	93	4	–	**572**
Nursing student	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	**0**
Occupational therapy	–	–	2	–	–	–	–	–	1	–	6	5	4	2	–	**20**
Optometry	–	–	–	–	–	–	–	–	–	–	6	–	2	–	–	**8**
Osteopathy	–	–	–	–	–	–	–	–	–	–	1	–	2	–	–	**3**
Pharmacy	–	–	7	–	–	2	2	–	5	37	17	9	3	–	–	**82**
Physiotherapy	–	–	2	–	–	2	–	–	4	–	16	7	14	–	–	**45**
Podiatry	–	–	2	1	–	–	1	1	1	–	11	–	4	–	–	**21**
Psychology	–	1	15	–	–	–	1	–	11	–	39	12	33	7	–	**119**
Unregistered practitioner	–	–	–	–	–	–	–	–	–	–	3	2	3	–	–	**8**
Total	**2**	**1**	**269**	**49**	**23**	**20**	**32**	**9**	**114**	**238**	**551**	**337**	**1435**	**39**	**2**	**3121**

The figures above represent the number of issues referred to AHPRA, not the number of practitioners. The referral of a single practitioner may include multiple issues relating to that practitioner, with each issue requiring its own action.

Demographics

The following demographic data is based on matters that have completed the assessment process. Basing figures on completed assessments produces accurate reporting, as all relevant details of a matter have been identified.

Unless otherwise specified, data is based on healthcare consumers, not the complainant, as the complainant in a matter may not be the consumer of the health service. Matters where the healthcare consumer is an organisation are not included in these figures.

Gender

Gender	Number	Percentage	2014–15
Female	1101	58.04	970
Male	754	39.75	756
Unknown	42	2.21	93
Total	**1897**	**100**	**1819**

Age

Age	Number	Percentage	2014–15
Less than 18	154	8.12	75
18–24 years	100	5.27	66
25–34 years	242	12.76	247
35–44 years	328	17.29	315
45–54 years	295	15.55	286
55–64 years	265	13.97	270
65–74 years	205	10.81	157
More than 75 years	208	10.96	117
Unknown*	100	5.27	286

* Age not recorded or not provided for a particular matter.

Location of healthcare consumers

Location of healthcare consumers	Number	Percentage	2014–15
Brisbane	755	39.80	755
Central West	2	0.11	2
Darling Downs	80	4.22	70
Far North	79	4.16	78
Fitzroy	80	4.22	70
Gold Coast	286	15.08	257
Mackay	45	2.37	51
North West	12	0.63	10
Northern	91	4.80	89
South West	3	0.16	8
Sunshine Coast	149	7.85	132
West Moreton	30	1.58	26
Wide Bay–Burnett	128	6.75	110
Outside Queensland	92	4.85	84
Unknown	65	3.43	77

The above data is based on health consumer location.

Location of health service providers

Location of health service providers	Number	Percentage	2014–15
Brisbane	1149	46.65	1078
Central West	2	0.09	3
Darling Downs	108	4.27	76
Far North	145	5.32	122
Fitzroy	106	3.62	83
Gold Coast	359	14.31	326
Mackay	47	1.97	69
North West	14	0.46	17
Northern	131	5.28	111
South West	9	0.32	4
Sunshine Coast	142	6.47	164
West Moreton	17	0.96	20
Wide Bay–Burnett	124	4.91	106
Outside Queensland*	81	3.85	57
Unknown	60	1.51	0

The above data is based on health consumer location.

* Health service provider location is taken from the primary address of the provider recorded in the OHO complaints management system. Complaints can be made about health service providers from other states who have provided health services in Queensland. This could include locums travelling to Queensland from interstate or providers who used to live in Queensland providing services but have since moved interstate (as the OHO can deal with complaints up to two years old).

appendix 2
stakeholders

Governance

- Key Ministerial Roles
  - Premier of Queensland
  - Minister for Health
- All Other Ministers
- Other Members
- Parliamentary committee: The Health, Communities, Disability Services and Domestic and Family Violence Prevention committee

National boards

- Australian Health Practitioner Regulation Agency
- National Boards
  - Aboriginal and Torres Strait Islander Health Practice Board of Australia
  - Chinese Medicine Board of Australia
  - Chiropractic Board of Australia
  - Dental Board of Australia
  - Medical Board of Australia
  - Medical Radiation Practice Board of Australia
  - Nursing and Midwifery Board of Australia
  - Occupational Therapy Board of Australia
  - Optometry Board of Australia
  - Osteopathy Board of Australia
  - Pharmacy Board of Australia
  - Physiotherapy Board of Australia
  - Podiatry Board of Australia
  - Psychology Board of Australia

Complaints management organisations

- Aged Care Complaints Scheme
- Health Complaints Commissions in Other Jurisdictions
  - Health and Community Services Complaints Commission, NT
  - Health and Community Services Complaints Commissioner, SA
  - Health and Disability Services Complaints Office, WA
  - Health Care Complaints Commission, NSW
  - Health Complaints Commissioner, Tasmania
  - Human Rights Commissioner, ACT
  - Health Services Commissioner, Victoria
  - Office of the Health Services Commissioner, Victoria
- The Queensland Ombudsman

Consumer associations

- Aboriginal and Torres Strait Islander
  - Queensland Aboriginal and Islander Health Council
  - Queensland Aboriginal and Torres Strait Islander Legal Services
  - Institute for Urban Indigenous Health
- Culturally and Linguistically Diverse
  - Ethnic Communities Council of Queensland
- Disability
  - Carers Queensland
  - Queensland Disability Advisory Council
- Other Consumer Associations
  - Consumer Health Forum of Australia
  - Council on the Ageing Queensland
  - Health and Community Services Workforce Council
  - Health Consumers of Rural and Remote Australia
  - Health Consumers Queensland
  - Medical Victims Advocate Services
  - Patient Opinion Australia
  - Queensland Aged and Disability Advocacy Inc.
  - Queensland Alliance for Mental Health
  - Queensland Council of Social Services
- The Queensland Public

Health service providers

- Queensland Health (including the Queensland Ambulance Service)
- Hospital and Health Services (and associated boards)
- Private Hospitals/Surgeries
  - Healthscope
  - Mater Health Services
  - Ramsay Health Care
  - Sunnybank Private Hospital
  - Wesley Hospital
- Other Healthcare Providers
  - Anglicare
  - Australian Medical Association Queensland
  - Australian Medicare Local Alliance

- Blue Care
- Catholic Health Australia
- Catholic Healthcare
- General Practice Queensland (CheckUP)
- Private Hospitals Association of Queensland
- Royal Flying Doctor Service
- RSL Care
- Uniting Care Health

- Health Service Practitioners
  - Expert clinicians
  - Registered health practitioners
  - Unregistered health practitioners

Professional associations

- Accreditation Bodies
  - Australian Medical Council
  - Australian Nursing and Midwifery Accreditation Council
  - Postgraduate Medical Education Council of Queensland
- Others
  - Allied Health Professions of Australia
  - Association of Neurophysiological Technologists of Australia
  - Association of Queensland Nurse Leaders (Inc)
  - Audiological Society of Australia Inc.
  - Australasian College for Emergency Medicine
  - Australasian College of Dermatology
  - Australasian Orthopaedic Association Limited
  - Australasian Paediatric Endocrine Group
  - Australasian Podiatric Council
  - Australasian Sleep Technologists Association (ASTA)
  - Australian Acupuncture and Chinese Medicine Association Ltd
  - Australian and New Zealand College of Anaesthetists
  - Australian and New Zealand College of Mental Health Nurses
  - Australian and New Zealand Society of Respiratory Science (ANZSRS)
  - Australian Association of Consultant Physicians
  - Australian Association of Nuclear Medicine Specialists
  - Australian Association of Occupational Therapists (Qld)
  - Australian Association of Social Work (AASW)
  - Australian College of Critical Care Nurses
  - Australian College of Midwives Queensland
  - Australian College of Operative Room Nurses (ACORN)
  - Australian College of Rural and Remote Medicine
  - Australian College Physical Scientists and Engineers in Medicine (ACPSEM)
  - Australian Dental Association (Queensland Branch)
  - Australian Institute of Radiography
  - Australian Medical Association
  - Australian Medical Association (NSW)
  - Australian Medical Association (SA)
  - Australian Medical Association Queensland
  - Australian Music Therapy Association
  - Australian Orthotic Prosthetic Association
  - Australian Osteopathic Association
  - Australian Physiotherapy Association (QLD Branch)
  - Australian Primary Health Care Nurses Association
  - Australian Psychological Society
  - Australian Society of Orthopaedic Surgeons
  - Australian Sonographers Association
  - Chiropractors' Association of Australia (QLD)
  - Clinical Networks Services
  - College of Intensive Care Medicine
  - Dieticians Association of Australia
  - Exercise and Sports Science Australia (ESSA)
  - Federation of Chinese Medicine and Acupuncture Societies of Australia Ltd.
  - Indigenous Allied Health Australia
  - National Aboriginal and Torres Strait Islander Health Worker Association
  - National Enrolled Nurse Association of Australia
  - Occupational Therapy Australia
  - Optometrists Association Australia
  - Optometrists Association Australia (QLD and NT)
  - Orthoptics Australia
  - Pharmaceutical Society of Australia
  - Queensland Law Society
  - Queensland Professionals in Cardiac Science (QPICS)
  - Royal Australasian College of General Practitioners

- Royal Australasian College of Surgeons
- Royal Australian and New Zealand College of Ophthalmologists
- Royal College of Nursing Australia
- Services for Australian Rural and Remote Allied Health
- Society of Hospital Pharmacists Australia (SHPA)
- Speech Pathology Australia

Government departments and agencies

- Queensland
  - Crime and Corruption Commission
  - Aboriginal and Torres Strait Islander Partnerships
  - Department of Communities, Child Safety and Disability Services
  - Department of Education and Training
  - Department of Health (Queensland)
  - Department of Justice and Attorney-General
  - Department of Premier and Cabinet
  - Department of Treasury
  - Office of the Public Guardian
  - Queensland Ambulance Service
  - Anti-Discrimination Commission Queensland
  - Queensland Audit Office
  - Queensland Civil and Administrative Tribunal (QCAT)
  - Queensland Clinical Senate
  - Queensland College of Teachers
  - Queensland Corrective Services
  - Queensland Family and Child Commission
  - Queensland Mental Health Commission
  - Queensland Ombudsman
  - Queensland Police Service
  - Queensland Public Service Commission
  - Office of the State Coroner
- Other Jurisdictions
  - Office of the Information Commissioner (Queensland)
  - Department of Health (Australia)

Unions

- Australian Nursing and Midwifery Federation
- Australian Services Union
- Australian Workers Union
- Queensland Nurses Union
- Queensland Public Sector Union
- Salaried Doctors Queensland
- Together
- Transport Workers Union
- United Voice, Industrial Union of Employees

Insurance companies

- Medical Indemnity Insurance Companies
- Avant Mutual Group Ltd
- Medical Insurance Group Australia

Universities and colleges

- Australian Catholic University
- Bond University
- Central Queensland University
- Griffith University
- James Cook University
- Queensland University of Technology
- Southern Cross University
- University of Queensland
- University of Southern Queensland
- University of the Sunshine Coast
- Colleges of Alternative Health Studies

Others

- Media outlets

appendix 3
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/s	ARRs—section 8	Page 2
Accessibility	▪ Table of contents	ARRs—section 10.1	Page 1
	▪ Glossary	ARRs—section 10.1	Page 113
	▪ Public availability	ARRs—section 10.2	Inside cover
	▪ Interpreter service statement	*Queensland Government Language Services Policy* ARRs—section 10.3	Inside cover
	▪ Copyright notice	*Copyright Act 1968* ARRs—section 10.4	Inside cover
	▪ Information Licensing	*QGEA—Information Licensing* ARRs—section 10.5	Inside cover
General information	▪ Introductory Information	ARRs—section 11.1	Page 3-5
	▪ Agency role and main functions	ARRs—section 11.2	Page 3 and 34
	▪ Operating environment	ARRs—section 11.3	Page 40
Non-financial performance	▪ Government's objectives for the community	ARRs—section 12.1	Page 53
	▪ Other whole-of-government plans / specific initiatives	ARRs—section 12.2	Not applicable
	▪ Agency objectives and performance indicators	ARRs—section 12.3	Page 49
	▪ Agency service areas and service standards	ARRs—section 12.4	Page 86
Financial performance	▪ Summary of financial performance	ARRs—section 13.1	Page 56
Governance – management and structure	▪ Organisational structure	ARRs—section 14.1	Page 43
	▪ Executive management	ARRs—section 14.2	Page 44
	▪ Government bodies (statutory bodies and other entities)	ARRs—section 14.3	Not applicable
	▪ *Public Sector Ethics Act 1994*	*Public Sector Ethics Act 1994* ARRs—section 14.4	Page 53
	▪ Queensland public service values	ARRs—section 14.5	Page 53

Summary of requirement		Basis for requirement	Annual report reference
Governance – risk management and accountability	▪ Risk management	ARRs—section 15.1	Page 47
	▪ Audit committee	ARRs—section 15.2	Not applicable
	▪ Internal audit	ARRs—section 15.3	Page 56
	▪ External scrutiny	ARRs—section 15.4	Not applicable
	▪ Information systems and record keeping	ARRs—section 15.5	Page 47
Governance – human resources	▪ Workforce planning and performance	ARRs—section 16.1	Page 45-46
	▪ Early retirement, redundancy and retrenchment	Directive No.11/12 *Early Retirement, Redundancy and Retrenchment* ARRs – section 16.2	Page 46
Open Data	▪ Consultancies	ARRs—section 17 ARRs—section 34.1	Page 47
	▪ Overseas travel	ARRs—section 17 ARRs—section 34.2	Page 47
	▪ Queensland Language Services Policy	ARRs—section 17 ARRs—section 34.3	Page 47
Financial statements	▪ Certification of financial statements	FAA—section 62 FPMs—section 42, 43 and 50 ARRs—section 18.1	Page 82
	▪ Independent Auditors Report	FAA—section 62 FPMs—section 50 ARRs—section 18.2	Page 83-84

FAA *Financial Accountability Act 2009*

FPMS *Financial and Performance Management Standard 2009*

ARRs *Annual report requirements for Queensland Government agencies*

appendix 4
glossary

Term	Definition
Australian Health Practitioner Regulation Agency	The national organisation responsible for implementing the National Registration and Accreditation Scheme across Australia, in partnership with the national boards.
Assessment	The process of obtaining and analysing information relevant to a complaint and deciding the most appropriate way to further deal with it.
Case management system	The office's case management system, Resolve, is an electronic software program where the office records all details about the complaints it manages.
Complainant	A person who makes a formal complaint.
Complaints management	Management of complaints from their receipt through the various assessment and disciplinary processes to a final outcome.
Conciliation	A confidential meeting process run by skilled negotiators who explore the issues, provide explanations and generate creative options to assist the parties to try and reach agreement.
Director of Proceedings	A statutory position held by a staff member of the Office of the Health Ombudsman. This person is responsible for deciding whether to refer a matter to QCAT on behalf of the Health Ombudsman.
Health care consumer	Any individual who receives a health service.
Health Ombudsman	The person appointed by the government to receive and deal with health service complaints, as well as other matters including investigating systemic issues in the health system.
Health Quality and Complaints Commission	An independent statutory body in Queensland to improve the quality of health services, to monitor the quality of health services, and to manage health complaints. It ceased operations on 30 June 2014, being replaced by the Office of the Health Ombudsman.
Health service organisation	Health service organisations include public, private and not-for-profit healthcare facilities, ambulance services, hospitals, health education services, pharmacies, mental health services, and community health services.
Health service provider	A health service provider can be an individual health practitioner or a health service organisation.
Hospital and Health Services	The name given to the entities operating the public hospitals and public health services available in defined areas in Queensland. Each Hospital and Health Service is managed by its own Board.
Immediate action	When there is a serious risk to persons and it is necessary to protect public health and safety, the Health Ombudsman may take immediate action to suspend, or impose conditions on a registered health practitioner's registration; or to prohibit, or impose conditions on, the practice of other health practitioners.
Internal review	If a party has concerns about a decision made by the office, they can request that an internal review be conducted. If grounds for a review are identified, an independent and objective decision maker will review the decision to ensure that both the process delivered and the decision itself are valid.
Investigation	The process of investigating a matter that is the subject of a health service complaint, or of a systemic issue relating to the provision of a health service. It includes independently gathering high quality evidence and information to help identify and analyse the cause/s of the matter.
Impairment	Physical or mental impairment, disability, condition or disorder (including substance abuse or dependence), that detrimentally affects or is likely to detrimentally affect a registered health practitioner's capacity to safely practise the profession or a student's capacity to undertake clinical training.

Term	Definition
Local resolution	An informal complaint resolution process that focuses on helping parties to try to resolve their complaints in a simple, quick and effective way.
Mandatory notification	A practitioner or student has behaved in a way that constitutes 'notifiable conduct' which places the public at substantial risk of harm.
National Boards	The *Health Practitioner Regulation National Law Act 2009* is applied with modifications as a law of Queensland by the *Health Practitioner Regulation National Law (Queensland)*. This makes Queensland a co-regulatory jurisdiction in relation to the national law.
National Law	The Health Practitioner Regulation National Law Act 2009 is applied with modifications as a law of Queensland by the Health Practitioner Regulation National Law (Queensland). This makes Queensland a co-regulatory jurisdiction in relation to the national law.
Office of the Health Ombudsman	The Health Ombudsman and the staff of the office.
Own-motion	When the Health Ombudsman initiates an investigation in the absence of a complaint due to significant risk to the health and safety of the public.
Parliamentary Committee	Committees assist the Queensland Parliament to operate more effectively. They investigate specific issues and report back to the Parliament. Some committees also have continuing roles to monitor and review public sector organisations or keep areas of the law or activity under review.
Professional conduct	Conduct that is of a standard which might reasonably be expected of the health practitioner by the public or the practitioner's professional peers. Each profession has a set of standards and guidelines which clarify the acceptable standard of professional conduct.
Queensland Civil and Administrative Tribunal	An independent tribunal within the Queensland Department of Justice and Attorney-General. It actively resolves disputes in a fair, just, accessible, quick and inexpensive way.
Queensland Health	The Queensland Department of Health and the Hospital and Health Services.
Registered health practitioner	A person who is registered under the National Law to practise a health profession, other than as a student.
Relevant action	Various specified actions that may be taken to deal with a health service complaint, as defined by the *Health Ombudsman Act 2013*. These are assessment, local resolution, immediate action, investigation, referral to another organisation, referral to the Director of Proceedings, conciliation, and carrying out an inquiry.
Root cause analysis	A method of problem solving used for identifying the root causes of faults or problems.
Schedule 8 drugs	Prescription-only substances which have an important and legitimate therapeutic use but have specific restrictions placed upon their supply and use because of their dependence forming nature and potential for misuse.
Self notification	Like a 'voluntary notification', however the individual practitioner notifies the office about their own conduct—as opposed to a colleague, employer or education provider.
Student	In the context of this report, a student is a person enrolled in a program of study or undertaking clinical training in a health profession.
Unregistered health practitioner	Any person who provides a health service and who is not registered in one of the 14 professions regulated under the National Law, or who is registered but is providing a health service other than in their capacity as a registered health practitioner.
Voluntary notification	A notification made on a voluntary basis. The grounds for a voluntary notification are set out in section 144 of the National Law and summarised on page 5.

appendix 5
abbreviations and acronyms

Term	Definition
AHPRA	Australian Health Practitioner Regulation Agency
National boards	National health practitioner boards
National Law	Health Practitioner Regulation National Law (Queensland)
QCAT	Queensland Civil and Administrative Tribunal

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