2016
2017
annual report

Office of the
HEALTH
OMBUDSMAN

Listen. Respond. Resolve.

Office of the Health Ombudsman Annual Report 2016–17
ISSN: 2206-0634 (Electronic)
ISSN: 2206-0986 (Printed)

Licence

CC BY licence summary statement

Attribution

Content from this annual report should be attributed as: Office of the Health Ombudsman annual report 2016–17.

Accessibility

The Queensland Government is committed to providing accessible services to Queenslanders from all culturally and linguistically diverse backgrounds. If you have difficulty in understanding this annual report, you can contact us on 133 OHO (133 646) and we will arrange an interpreter to effectively communicate the report to you.

Electronic versions of this document are available at:

www.oho.qld.gov.au/about-us/our-performance/annual-reports

To request a paper copy of this report, or for more information:

Address: Level 12, 400 George St. Brisbane QLD 4000
Mail: PO Box 13281 George St. Brisbane QLD 4003
Phone: 133 OHO (133 646)
Email: info@oho.qld.gov.au
Website: www.oho.qld.gov.au

Images

Where images are included in this annual report, you may only use this image (in its entirety and unaltered) as an integrated part of this entire annual report or as an unaltered integrated part of an extract taken from this annual report.

Disclaimer

The materials presented in this document are provided by the Queensland Government for information purposes only. Users should note that the electronic version of the annual report is not recognised as the official or authorised version. The official copy of the annual report, as tabled in the Legislative Assembly of Queensland, can be accessed from the Queensland Parliament's tabled papers website database:

www.parliament.qld.gov.au/work-of-assembly/tabled-papers

table of **contents**

Office of the HEALTH OMBUDSMAN
Listen. Respond. Resolve.

400 George Street, Brisbane
PO Box 13281 George Street,
Brisbane QLD 4003
www.oho.qld.gov.au
133 OHO (133 646)

15 September 2017

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

Dear Minister

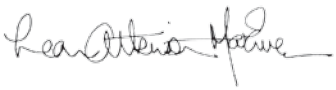
I am pleased to present the *Office of the Health Ombudsman Annual Report 2016–17* and financial statements for the Office of the Health Ombudsman.

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 153** and **154** 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. We are an independent statutory body and the one place all Queenslanders should go if they have a complaint about a health service provided to them or someone in their care, a health service provider or any aspect of a health service provided in Queensland.

The office has broad powers to ensure the integrity and quality of healthcare services provided throughout Queensland. Complaints can be made about the nature and quality of services provided by individual registered and unregistered practitioners and health service organisations.

The office also 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.

As well as receiving health service complaints, the office thoroughly reviews all information collected for systemic issues that have the potential to threaten the health and safety of Queenslanders.

The ***Health Ombudsman Act 2013*** came into effect on 1 July 2014 and replaced the ***Health Quality and Complaints Commission Act 2006***. The office also has powers under the ***Health Practitioner Regulation National Law (Queensland)***. Queensland has co-regulatory functions and powers under the National Law with AHPRA and the national boards.

In addition, the office applies the ***National Code of Conduct for Health Care Workers (Queensland)*** in fulfilling its duties.

The Health Ombudsman is a statutory position with responsibility for acting independently, impartially and in the public interest. The 2016–17 financial year was the office's third year under the leadership of Mr Leon Atkinson-MacEwen.

The office's vision is to be the cornerstone of a transparent, accountable and fair system for effectively and quickly dealing with complaints and other healthcare matters in Queensland.

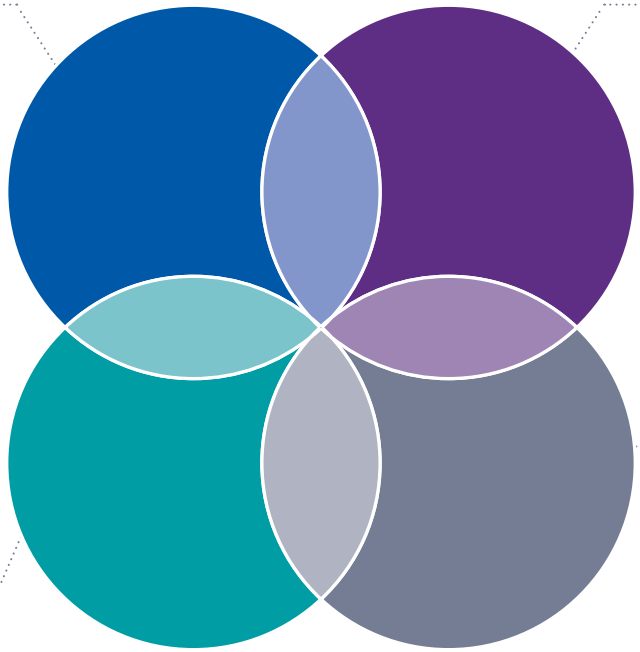
The office is guided by its purpose to protect the health and safety of the public and instil confidence in the Queensland health system by investigating, resolving or prosecuting complaints about healthcare..

promote

Professional, safe and competent practice by health practitioners.

promote

High standards of service delivery by health service organisations.



protect

The health and safety of the public.

maintain

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

health sector
regulation in queensland

Regulation of the health sector in Queensland is complex and consists of a number of government agencies and regulatory organisations. Collaboration and information sharing between these entities ensures quality health services for consumers and protects the health and safety of the public.

Individual practitioners and health service organisations provide face-to-face health services to the people of Queensland. Generally, health service complaints are about these frontline providers. Within the public and private health systems, health practitioners are supported and overseen by their employers in the areas of clinical practise and corporate governance. Complaints about a practitioner or a health service organisation are often made to employers or governance bodies and are addressed at this level.

Complaints may progress beyond employers and governance entities when:

- they are more serious
- they are 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
- complainants are not satisfied with the outcome of a complaints process initiated directly with the health service provider.

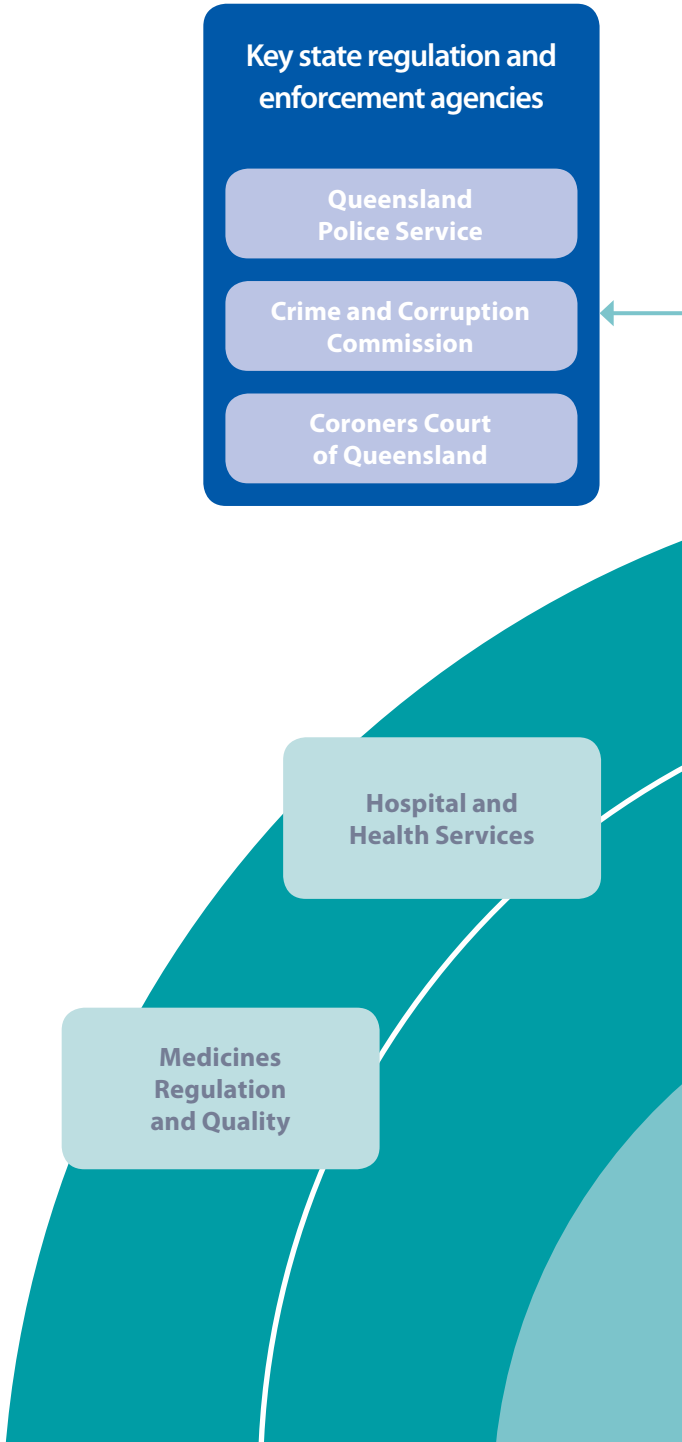
Broadly speaking, there are four groups of agencies with overarching responsibility for health regulation in Queensland:

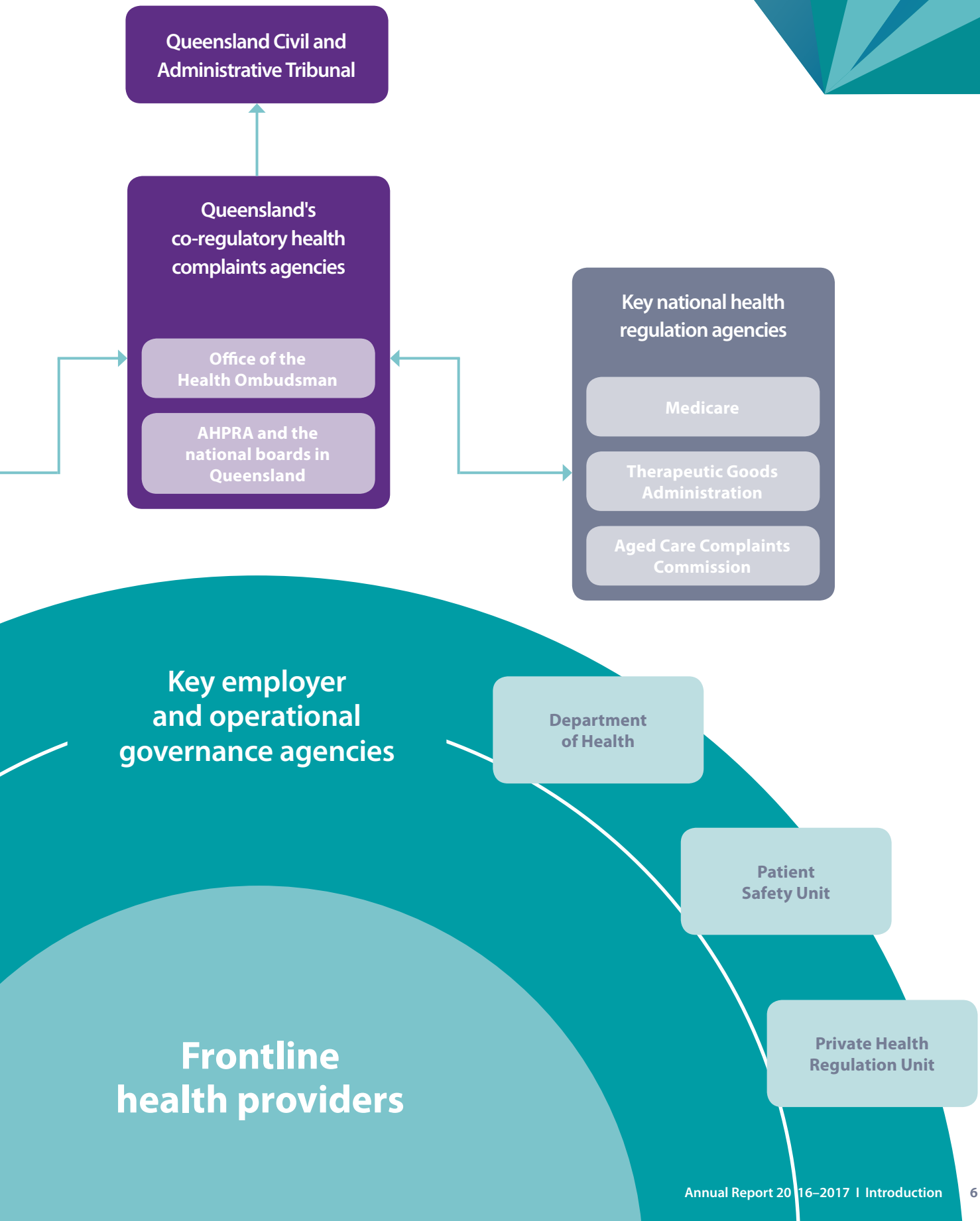
- The Queensland Civil and Administrative Tribunal (QCAT)—the Health Ombudsman takes disciplinary matters against registered and unregistered health practitioners to QCAT for determination. Registered and unregistered practitioners who have had an order for immediate action imposed on them by the Health Ombudsman may apply to QCAT for a review of this order within 28 days of the order being imposed.
- Queensland's health sector co-regulatory partners—Office of the Health Ombudsman and AHPRA and the national boards.
- Other Queensland regulatory and enforcement agencies—Queensland Police Service, Crime and Corruption Commission and Coroners Court of Queensland.
- National regulatory agencies—Medicare, Therapeutic Goods Administration and Aged Care Complaints Commission.

Multiple agencies can be involved in managing and responding to an individual complaint or systemic issue. Agencies consult with each other and share information, within the scope of their governing legislation, to manage health service complaints and protect the health and safety of the public. Boundaries between statutory responsibilities are maintained and duplication of effort is avoided. These agencies also work together to identify areas for improvement and contribute to better quality health services in Queensland.

At the end of its third year, the office is pleased to report positive progress in the cohesive, collaborative and productive relationships that have been built with regulatory colleagues and wider stakeholders.

This diagram is a high level representation of the regulatory framework in Queensland. For a full list of stakeholders please turn to **Appendix 2**.




Queensland Civil and Administrative Tribunal
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 Commission
Key employer and operational governance agencies
Department of Health
Patient Safety Unit
Private Health Regulation Unit
Frontline health providers

the year in review
health ombudsman

As this will be my final annual report as Health Ombudsman, I would like to reflect not only on the year just past but also on the performance of the Office of the Health Ombudsman since its inception.

The office was born out of concerns with the transparency, timeliness and thoroughness of the previous health complaints management system in Queensland. In particular, there was evidence that registered practitioners were not receiving the levels of impartial oversight that would ensure Queenslanders received safe and appropriate healthcare. The regulatory paradigm that now exists in Queensland provides greatly improved rigour and impartiality in the assessment of the health, conduct and performance of registered and unregistered practitioners to ensure complaints are thoroughly and properly dealt with. The flexibility inherent in the ***Health Ombudsman Act 2013*** makes it possible to determine a range of pathways to deal with matters so that complainants' concerns (where valid) are addressed appropriately and systemic change effected where necessary.

There has been significant year-on-year increases in complaints made to the office since 1 July 2014. The number and nature of these complaints far exceed the level of work envisaged in 2013 when planning for the new agency began. The number and complexity of complaints, coupled with the significant under-estimation of the resources required, meant that in our initial years, we struggled at times to meet legislated timeframes. The statistics for 2016–17, however—particularly for the period January to June 2017—demonstrate that the office has made significant progress towards consistently meeting its key performance indicators. This is to the credit of the staff of the office who have never wavered from not only giving their best to the organisation but also looking for ways to do things better and more efficiently with no loss of quality.

The office has, at times over the past three years, been criticised for the time it takes to complete investigations into registered and unregistered practitioners. Just over half of the investigations conducted into individual practitioners take more than 12 months to complete, and a not-insignificant proportion of these matters relate to charges of criminal conduct, of varying kinds, that are working their way through the criminal justice system. These criticisms have also focused on the range of matters the office examines including those that have been dealt with or dismissed by national boards. The thoroughness with which the office does its job and the number of allegations previously dismissed which can and have *in fact* been substantiated is an indication that the reasons that led to the establishment of the office on 1 July 2014 were justified and that some practitioners (and their representatives) would prefer much less scrutiny of their conduct and performance than they now receive.

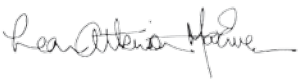
This was particularly evident in many of the submissions made to the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee inquiry in 2016 into the performance of the office, where a number of stakeholders argued for a return to the previous failed system of regulation without any evidence other than anecdote.

This is not to say that the office is perfect. Much more can be done to improve the efficiency with which we conduct our business and I am confident that staff are committed to ensuring that this work of continuous improvement does not falter in the years ahead. In my submission to the Parliamentary Committee Inquiry I flagged a number of potential amendments to the ***Health Ombudsman Act 2013*** that, if enacted, would assist in:

- correcting deficiencies that have resulted in either inefficient work-arounds or processes being unable to reach their natural conclusion
- providing clarity around timeframes and legislative requirements
- removing uncertainty or barriers to the effective sharing of information to ensure that the health and safety of the public are protected.

Despite these barriers to efficiency, the office has achieved an enormous amount in its first three years. The identification of systemic issues has seen the creation of a statewide taskforce to improve the delivery of maternity services in Queensland and significant improvements in the way in which scheduled medicines are regulated in this state. In less obvious ways, the office has worked with individual health services to improve the delivery of a range of services and has provided resolution and closure to thousands of individual complainants and their families.

I am very proud of the work of the staff of the office. They have dealt with the ever-rising workload with good humour and dedication, while never compromising their focus on ensuring that Queenslanders receive health services that are safe and delivered in a reasonable manner. I believe that Queenslanders are now much better served than they ever have been, not only because the new paradigm is superior to the old but also because of the quality of the staff of the office. I shall miss my frequent walks around the office chatting to staff, but I can leave knowing that it is they, not I, who are the reason for the office's success. So fare thee well awhile.



Leon Atkinson-MacEwen
Health Ombudsman

types of
health service complaints

Health consumer complaints

By 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.

Complaints can be made about:

- individual registered health practitioners—e.g. doctors, nurses, dentists, physiotherapists, chiropractors, occupational therapists, optometrists, osteopaths
- individual unregistered health practitioners—e.g. nutritionists, massage therapists, naturopaths, homeopaths, integrated health practitioners, dieticians, social workers, 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 also be made 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

The Office of the Health Ombudsman is responsible for receiving complaints about health services provided by registered and unregistered practitioners. This includes receiving notifications from health practitioners, employers and educators relating to the health conduct or performance of registered and unregistered health practitioners and students.

Mandatory notifications

Practitioners, employers and education providers are required by law to notify the Health Ombudsman if they believe another practitioner has behaved in a way that constitutes notifiable conduct. 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

Anyone can make a voluntary notification about a health practitioner including:

- 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.

Relevant event notifications (self-notifications)

Relevant event notifications are to be made to AHPRA. While these notifications are not managed by the office, health practitioners should be aware they must self-notify within seven days to their relevant board if certain relevant events occur, including issues relating to criminal charges and convictions, rights to practise, insurance, billing privileges and other matters which are outlined in section 130 of the National Law.

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
- Coroners Court of Queensland
- Medicines Compliance and Human Tissue Unit.

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

The overview of Queensland health service complaints presented on **pages 9** and **10** is a useful reference to understand the context of these trends.

Who is contacting us

80% health consumer complaints

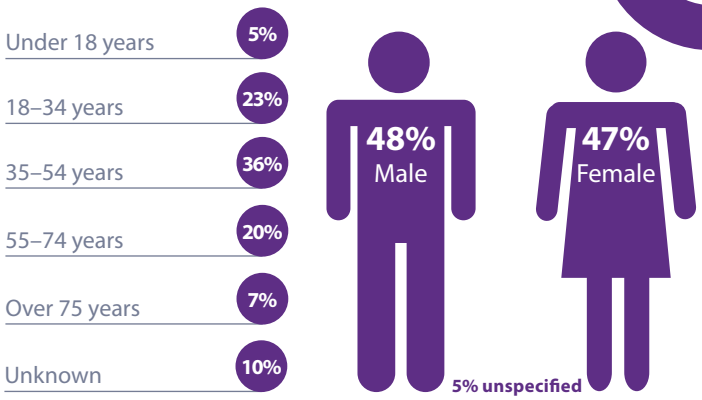
6% mandatory notifications

12% voluntary notifications

1% self-notifications

1% referred from external organisations

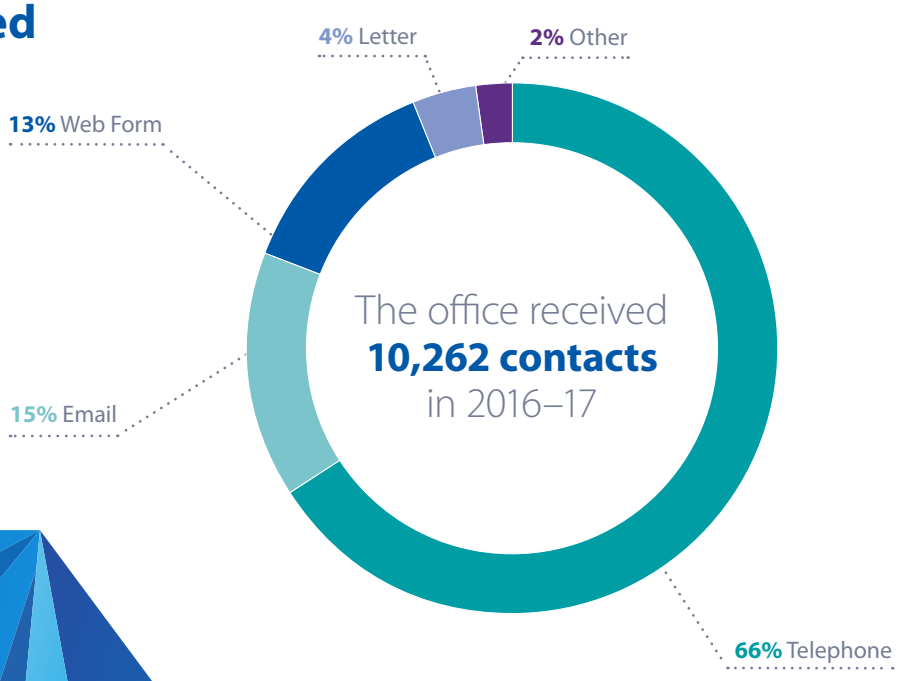
Health consumer complaints were received from:



62% of complainants were from South East Queensland:

- Brisbane
- Darling Downs
- Gold Coast
- Sunshine Coast
- West Moreton

How we were contacted

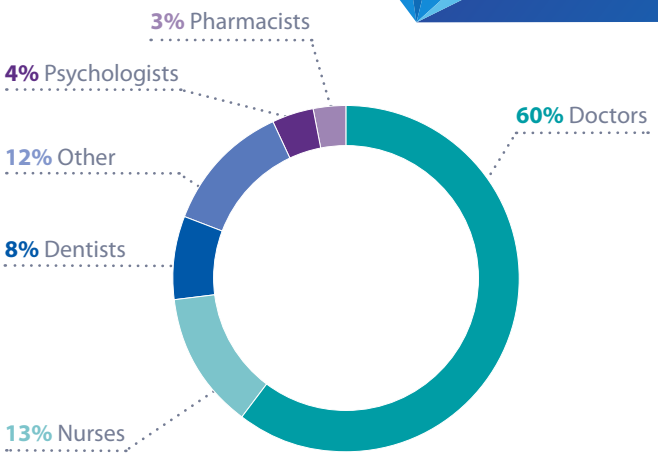


What are complaints about*

*Individual practitioners**

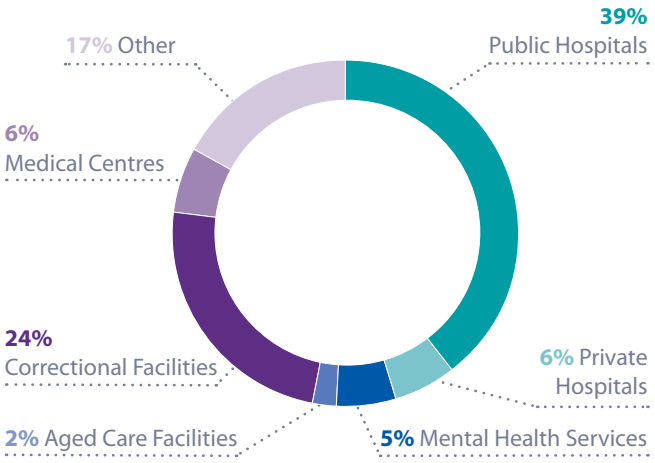
54% of issues raised in complaints were about individual practitioners.

94% of identified practitioners were registered, and **6%** were unregistered.

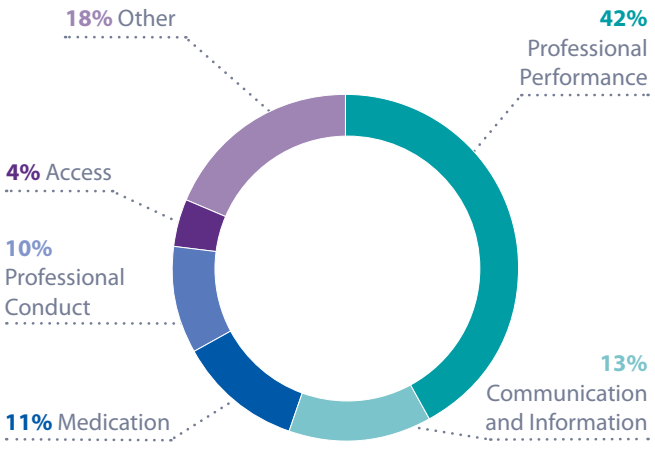


*Health service organisations**

46% of issues raised in complaints were about a health service organisation.



Main issues raised in complaints



* This data excludes 267 issues raised by complainants where the associated provider was unable to be identified.

performance **summary**

Spotlight on 2016–17

Received **10,262** contacts

9% more than last year

Accepted **4119** health service complaints

14% more than last year

74% of decisions on how to proceed made within 7 days

Completed **2078** assessments

10% more than last year

61% within legislated timeframes

Completed **1150** local resolutions

7% less than last year

96% within legislated timeframes

Reached agreement in **73%** of matters that started conciliation

Issued **51** immediate registration actions

Completed **209** investigations

Issued **26** interim prohibition orders

13 **matters referred** *to QCAT*

2060 **non-serious matters referred** *to AHPRA*

10 **serious investigations requested** *from AHPRA*

key achievements

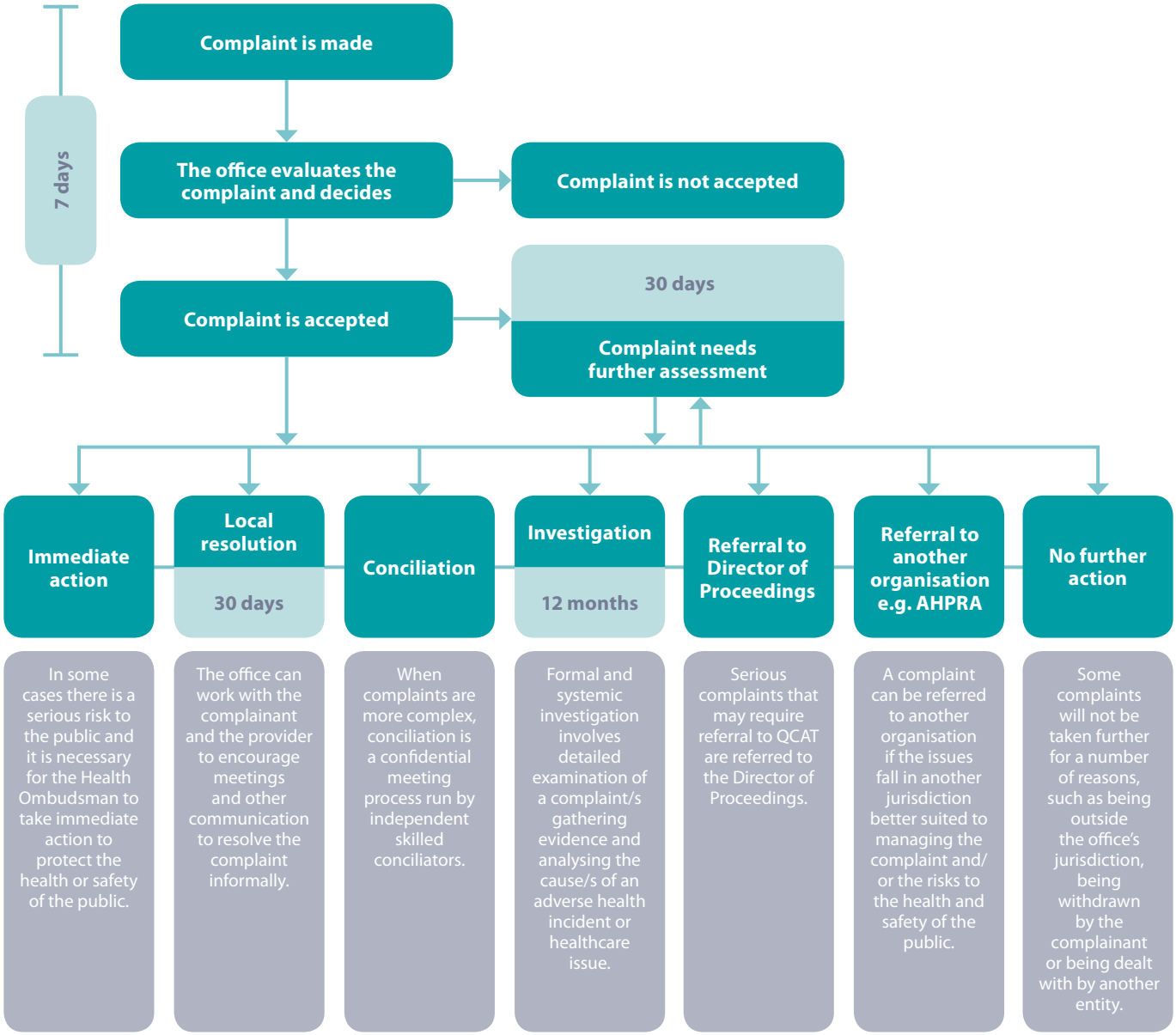
Below is a snapshot of the key achievements the office has delivered in 2016–17. These achievements are measured against objectives outlined in the office's strategic plan, of which further detail can be viewed on **page 75**.

Objectives	Key achievements
Our overarching objective is to protect the health and safety of the public.	▪ The office provides a robust, effective and efficient process for receiving, responding to and resolving health service complaints with a focus on continual service improvement to protect public health and safety and bring about systemic change. The office received 6201 health service complaints in 2016–17. Please refer to **page 13** for how these complaints have been treated. ▪ The Health Ombudsman has taken immediate action to protect the health and safety of the public by issuing 51 immediate registration actions and 26 interim prohibition orders. ▪ Thirteen matters have been referred by the Director of Proceedings to QCAT for prosecution in 2016–17.
Promote professional, safe, competent practice and high standards of service delivery from health practitioners and health service organisations.	▪ The office maintains a collaborative relationship with AHPRA and the national boards 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 247 investigations and completed 13 investigations into systemic issues within the health system in Queensland to 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 by delivering a robust and accountable complaints management process.	▪ Increased awareness of the office and confidence in its processes is reflected in the increased number of contacts, enquiries and complaints. ▪ The office received and actioned 10,262 contacts and managed a 14 per cent increase in complaints in a thorough and impartial way. ▪ The office resolved 83 per cent of matters referred for local resolution and successfully closed 73 per cent of matters in which parties agreed to participate in conciliation. ▪ A robust mechanism for accessing advice from expert clinicians ensures, where necessary, matters are reviewed by suitably qualified and experienced health practitioners. ▪ Comprehensive reporting is available on the office website, including: – 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. ▪ The Health Ombudsman gave six formal presentations to stakeholders to explain his role and that of the office and participated in many more meetings, teleconferences and discussions with a wide range of organisations regarding his responsibilities.
Create strong business operations and a culture of continuous improvement.	▪ The development of infrastructure including best-practice technology, case management and record keeping mechanisms has underpinned the office's operations and supported productivity in the workplace. ▪ Extensive process mapping and refinement has enabled the office to improve its efficiency, improve its ability to meet legislative requirements and deliver on its objectives.
Foster an environment where our people are valued, resilient and empowered to actively contribute to improving service delivery.	▪ 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 is committed to creating an environment where staff are engaged and valued through professional development opportunities.

the office's **management of complaints**

Managing complaints is a dynamic process. While this diagram shows the relationships between various stages, in reality the process is rarely straightforward. For example, complaints can be split or combined. They can be redirected for further assessment or they may be 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 focused and yet flexible processes, balanced with our overarching focus to ensure the health and safety of the public.

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 at the point of intake or at any stage during the process, that the complaint requires no further action by the office or should be referred to another organisation, such as AHPRA and the national boards. Each of these stages is explained in further detail in the following pages.



complaint **contacts**

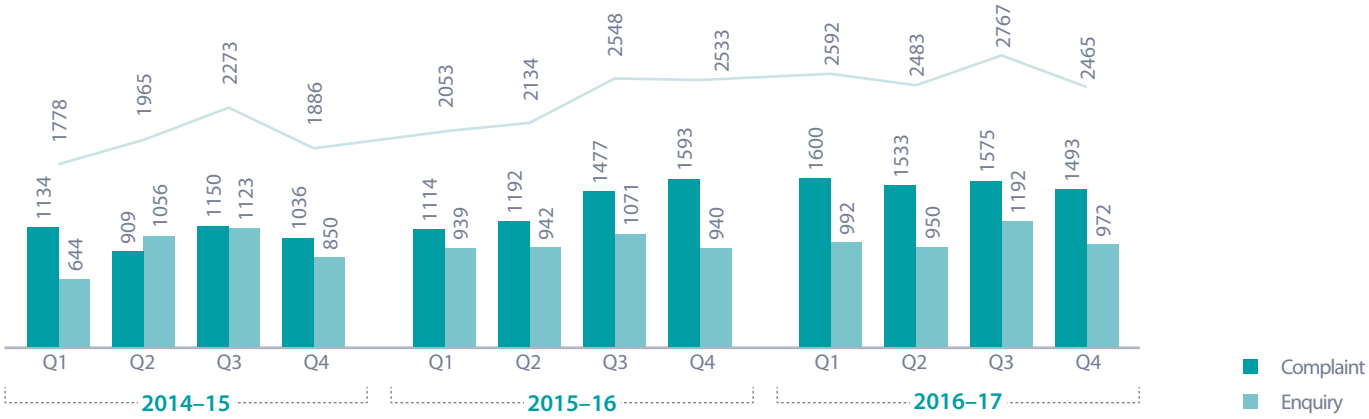
Intake and acceptance

There was a rise in the number of contacts in 2016–17 of 10 per cent compared with the previous year. Of the 10,262 contacts received by the office, 6201 were complaints and 4061 were enquiries. This is a 14 per cent increase in the number of complaints compared to 2015–16 (5435).

The number of decisions on how to deal with a complaint increased by 18 per cent to 5841 compared to 4970 in 2015–16. Of these, the number of complaints accepted increased by four per cent to 4119 from 3961 in 2015–16.

It is expected that the number of complaints received by the office will maintain similar momentum in 2017–18. Growing awareness of the office and its function, consolidation of its role and position within the co-regulatory framework and increased confidence in its processes to resolve health service complaints will continue to drive the number of contacts received by the office.

Type of contact by quarter

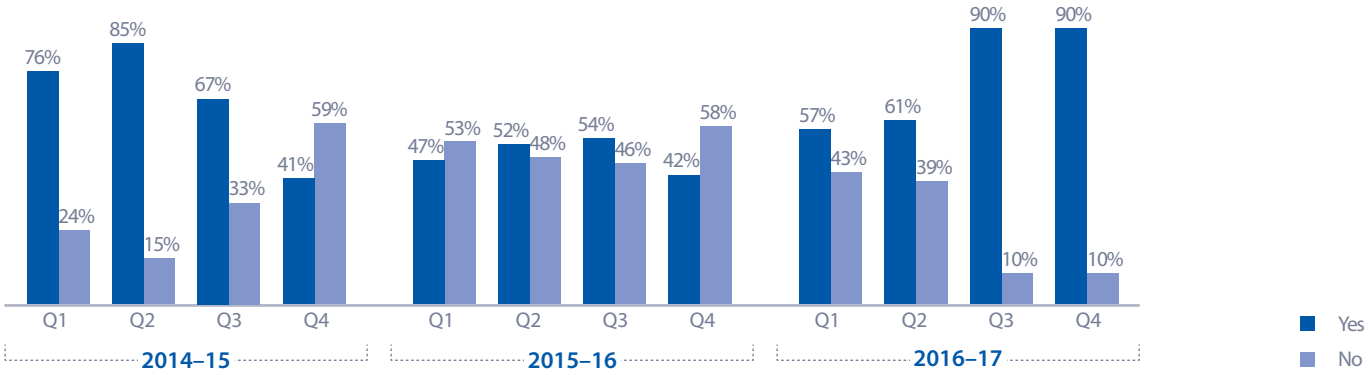


Seven day decisions

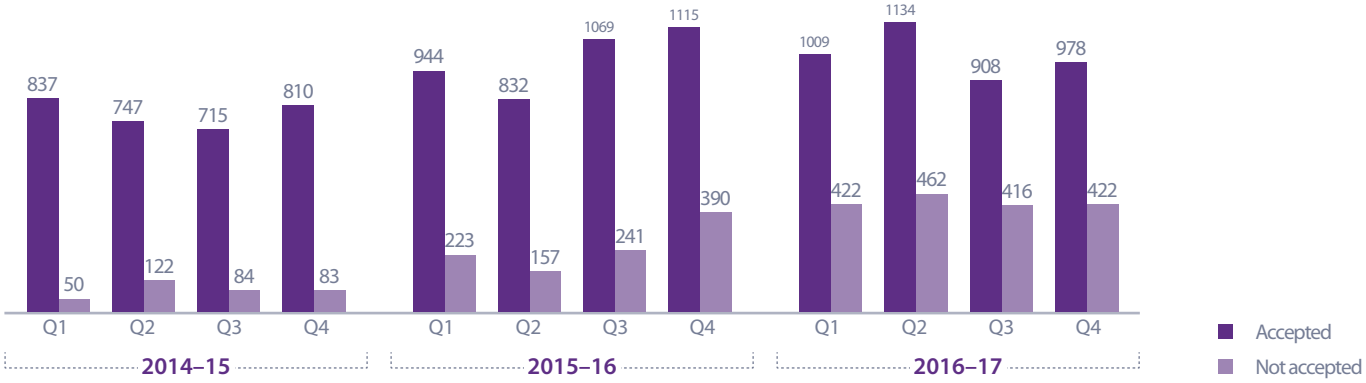
Once a complaint has been made, the office has seven days to decide whether or not to accept it as a health service complaint. In 2016–17, 74 per cent of complaint decisions were made within the legislative timeframe of seven days compared with 48 per cent in 2015–16. This figure rose to more than 90 per cent in Q3 and Q4 of 2016–17.

This near doubling of the number of complaint decisions made within seven days is a result of significant structural and process oriented changes that have been introduced across the early stages of the complaints management process. This major achievement has positive flow-on consequences for subsequent stages of the complaints management process.

Percentage of decisions made within seven days



Number accepted vs not accepted complaints



Accepted complaints

In 2016–17 the office accepted 4119 complaints (70 per cent). An additional 1722 complaints (29 per cent) required no further action. The decision to take no further action can occur as a result of a complaint being withdrawn, lacking substance, having been adequately dealt with by another organisation, being frivolous or vexatious, or not being made in good faith. The majority of no further action decisions were taken due to complainants not responding to our request for further information.

In 2016–17, 37 per cent of accepted complaints required further assessment and 28 per cent were referred directly for action within the office—local resolution, conciliation, investigation or, in potentially serious matters, for immediate action. In addition, 35 per cent of complaints were referred directly to AHPRA or another regulatory entity without needing to undergo further assessment. Of the referrals to AHPRA, 96 per cent took place at the intake and assessment stages of complaints management.

A single complaint may be split into multiple actions, with aspects of the complaint split between different divisions within the office, or with other regulatory bodies such as AHPRA and the national boards.

Continuous improvement

Work will continue in 2017–18, on mapping workflows for further refinement of procedures and processes in intake and assessment. Development will continue on the office's electronic case management system, procedure manuals for all aspects of complaints intake will be completed and the necessary level of resourcing will be determined to enable the office to meet the seven day statutory timeframe for complaints decisions.

Additional key areas have been identified as areas for ongoing focus. These are:

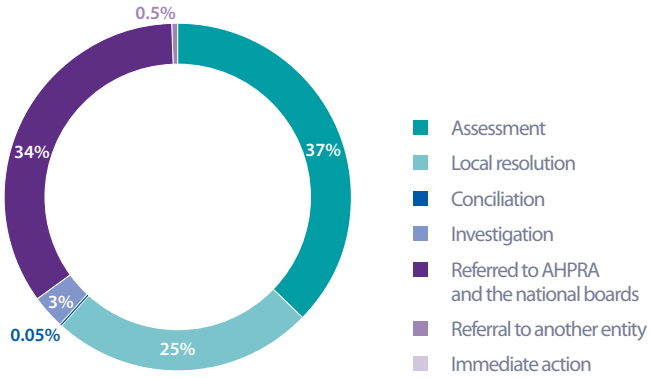
- recruiting staff with particular skill sets and experience, particularly in relation to risk assessment and health regulation
- continuous improvements in team capability as a result of organisational and individual learning, accrued experience and structured training programs
- improved team cohesion and focus through the development and ongoing modelling of team-based values and purpose, aligned with the organisational purpose
- expanded performance reporting giving greater transparency as to whether a complaint is progressing appropriately
- expanded performance reporting to identify obstacles to progressing a complaint so they may be addressed quickly
- an increase in direct referral to AHPRA to avoid duplication
- early use of clinical advice when necessary to assess the risk to public health and safety
- proactive and maturing relationships with external stakeholders.

In addition, a dedicated prisoner phone line is proposed for 2017–18, to ensure better access to the office for prisoners wanting to make health service complaints.

Actions that pose the greatest threat to public health and safety will be prioritised in a formal high-risk escalation process. Serious or potentially serious complaints will be progressed to immediate action or investigation within 24 hours, unless further assessment is required to obtain sufficient detail in order to progress these matters. Early engagement with complainants and health service providers, and early use of clinical advice will be key parts of this process.

The office will also continue to work with AHPRA to obtain timely and comprehensive information about registered practitioners.

Outcomes of complaint acceptance 2016–17



Case study

A patient had been receiving long-term treatment from a health service provider. She claimed the treating practitioners were not listening to her, that she was in continuous pain and was seeking further treatment from the health service provider for her health problems.

The matter was referred to an external entity which investigated the complainant's concerns and facilitated the current healthcare service provider's participation in managing the complaint and addressing the complainant's concerns. The facility undertook to:

- provide a contact person that the complainant could talk to about her care and who would keep her updated on its progress
- provide the complainant with a plain language explanation about the treatment she had received and why further treatment was required
- address pain relief and discuss further pain relief options
- use a multidisciplinary treatment team in her ongoing treatment, which included an occupational therapist, a social worker and an Indigenous liaison officer to address the complainant's requests to feel more at ease in the hospital setting as her treatment was long-term
- apologise to the complainant and implement measures to ensure future interactions and explanations are clear and consistent.

assessment

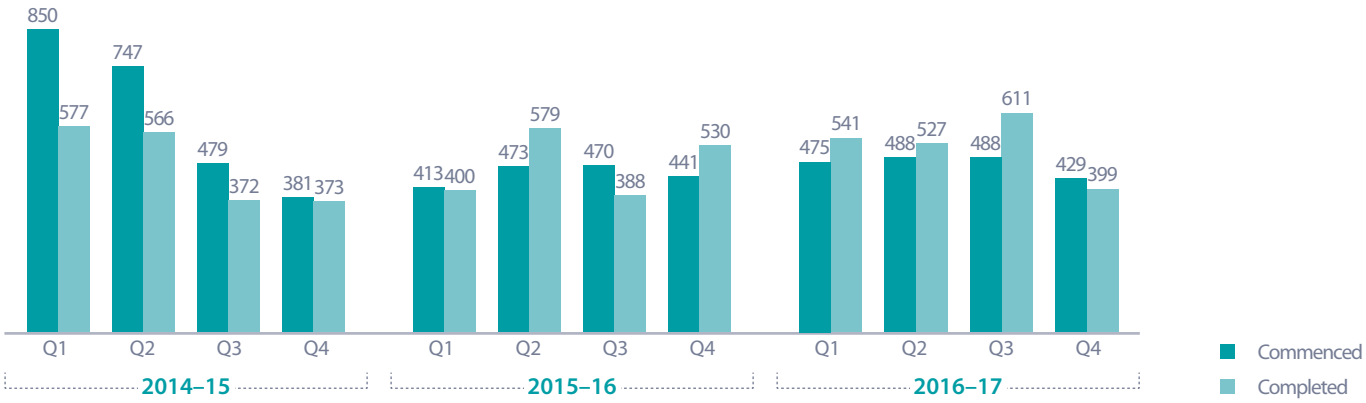
Complaints are referred for assessment if they require further information and analysis to determine the full scope of the complaint and the most appropriate way to deal with the matter. In 2016–17, the office's assessment team commenced 1880 assessments and completed 2078. At 30 June 2017, 236 complaints remain open for assessment.

As a result of further assessment a complaint may be referred within the office to local resolution, conciliation, investigation, or in potentially serious matters, for immediate action.

Complaints may also be assessed as being more appropriately dealt with by an external regulatory agency such as AHPRA, the national boards or a government entity.

As in the intake stage, complaints may be split into multiple actions with aspects of the complaint split between different divisions within the office, or with other regulatory bodies such as AHPRA and the national boards.

Assessments commenced and completed



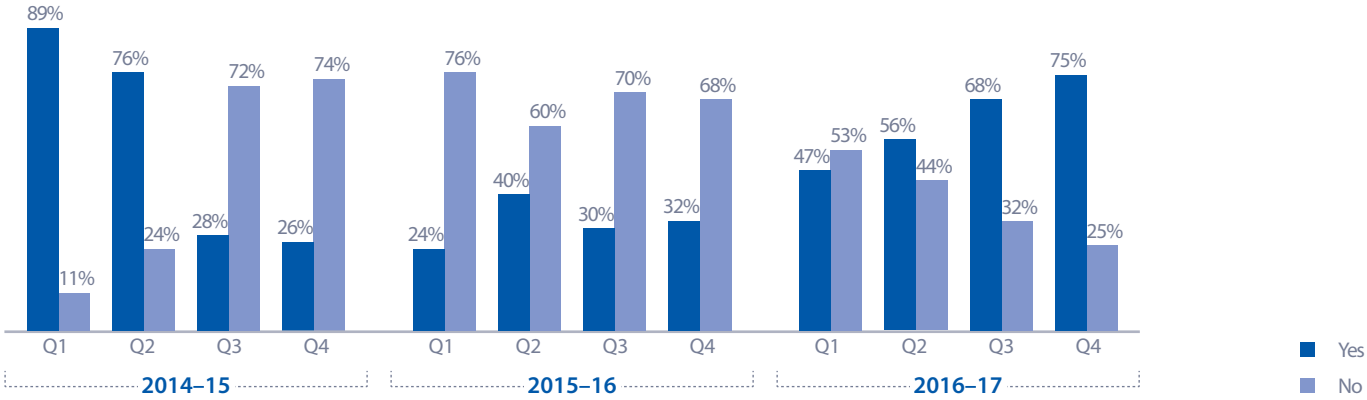
Assessment timeframes

Assessment timeframes are legislated under the Act and provide for assessments to be completed within 30 days, or within 60 days subject to an approved extension. In 2016–17, 61 per cent of assessments were completed within legislated timeframes compared with 32 per cent in 2015–16.

Our performance against these timeframes has consistently improved due to:

- identifying process refinements and improvements
- increased internal reporting to improve case load management
- training and development
- establishing triage teams dedicated to assessing complex matters.

Assessments completed within legislative timeframes



Case review framework

The development and implementation of a case review framework has improved the consistency and efficiency of assessment decisions. It has also enabled early identification of areas of potential risk that may require escalation to immediate action or systemic investigation.

In 2017–18, work will continue on mapping workflows, refining processes to facilitate faster assessments of complaints, and further developing procedure manuals to promote certainty and consistency in the assessment of complaints.

Collaboration with external stakeholders

The progression in relationships with external agencies since the inception of the office has resulted in increased trust and sharing of information, development of collaborative guidelines and the refinement of co-regulatory processes. This has enabled more appropriate decision making at the early stages of the complaints resolution process and made a significant contribution to increased efficiencies and the timeliness of acceptance, triage and assessment decisions.

Case study

A complainant contracted a rare and complex infection after three surgeries to repair injuries from a power tool accident. The ensuing complications required a further six surgeries over four-and-a-half months. After 12 months, the complainant was concerned he had not regained full movement in his hand.

He revisited the health service provider where it was found a tendon tear remained unrepaired. Due to waiting times, the complainant ultimately underwent surgery by a private practitioner and the tendon was repaired resulting in a full recovery.

The office sought the advice of a suitably qualified orthopaedic surgeon in relation to the complications and the large number of surgeries. The specialist clinician identified the initial treatment fell below reasonable standards expected in the circumstances and expressed concern at the number of surgeries performed.

As a result of the independent clinical advice the office was able to identify the practitioners responsible for the surgeries and refer them to AHPRA and the Medical Board of Australia for further assessment of their professional performance. The office took further action and referred the matter to conciliation in an effort to further resolve the complaint.

Case study

A complainant presented to hospital emergency with back pain and was discharged the following day. A few days later the complainant presented to emergency at a second hospital with back pain and other symptoms which had since developed. While there, the complainant experienced difficulty urinating as well as a tingling sensation in her feet. She was discharged from that hospital the following day.

The complainant then went to a third hospital where she was diagnosed with staph infection causing an abscess to compress against her spinal cord. She underwent multiple surgeries to treat the condition but suffered neurological damage resulting in paraplegia.

As part of the assessment process, the office obtained independent clinical advice to assess the adequacy of treatment and the timeliness of the diagnosis.

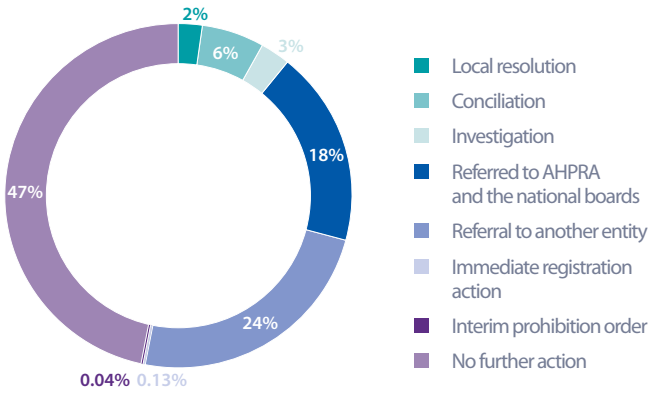
The clinical advisor was not critical of the first hospital, noting the difficulty in diagnosing staph infection and some complicating factors in the complainant's presentation. The clinician was critical of several aspects of the care and treatment provided by the second hospital. In the course of the clinician's assessment, additional issues were identified in relation to two individual practitioners.

As a result of the complexity of the issues raised, the outcome for the complainant and the criticisms contained in the independent clinical advice, the office took a number of actions.

Complaint issues relating to the second hospital were referred for investigation and individual practitioners from the first and second hospital were referred to AHPRA. The matter was referred for conciliation.

The complainant expressed her desire to prevent others from going through similar experiences. The various outcomes of the assessment are important steps in achieving this aim.

Outcomes of assessment decisions 2016–17



Outcomes of assessment

A single assessment may identify multiple matters requiring action. In 2016–17 the office completed 2078 assessments resulting in 2297 individual actions being taken. Of these, the most frequently reported outcomes were:

- matters closed requiring no further action—up from 903 in 2015–16 to 1072 in 2016–17
- matters referred to a state or commonwealth entity (other than AHPRA)—up from 121 in 2015–16 to 548 in 2016–17
- matters referred to AHPRA and the national boards—down from 811 in 2015–16 to 419 in 2016–17.

The remaining 258 (11 per cent) per cent were referred to local resolution, conciliation, investigation or immediate action. The increased number of complaints requiring no further action and the increase in referrals to external government entities means that only valid complaints progress to the subsequent stages of the complaints management process.

Referral to AHPRA

Complaints may contain issues or elements that are more appropriately dealt with by AHPRA. As part of the co-regulatory framework and the National Law, AHPRA and the national boards have options to respond to particular issues in ways that are not available to the office under the ***Health Ombudsman Act 2013***. For example, where a practitioner whose state of health or degree of impairment impacts their ability to deliver care safely, the national boards may direct health assessments and undertake monitoring programs to protect the public.

When the office refers a matter, AHPRA is provided with all relevant information through an online portal to enable the efficient and ongoing management of the matter. Eighteen per cent of referrals to AHPRA took place as a result of the assessment process.

No further action

The office may take no further action when:

- the assessment process supplies information to the complainant that provides an explanation or reasoning that addresses the complaint issues
- 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 meet requests for information.

Case study

A complainant attended a cosmetic clinic for dermal filler injections in her lips. The registered nurse who performed the procedure was instructed by a doctor via video conference. The complainant returned to the clinic a number of times. The consulting doctor, again via video conference, prescribed antibiotics and on a subsequent visit her lips were treated to melt the filler. Still experiencing pain and swelling after three weeks, the complainant saw a plastic surgeon who drained her lips and performed corrective surgery.

The complainant expressed concerns that the doctor advising the nurse may not have been in Australia and may not have been registered. The doctor's name on the dispensed antibiotics did not match the name of the advising doctor.

The complainant sought the reimbursement of the cost of her initial treatment, the cost of her private hospital admission and treatment, and her lost income from taking time off work.

AHPRA advised the doctor was not registered at the time of advising the nurse performing the filler injections. Given its seriousness, the office retained the matter with subsequent investigations revealing the cosmetic clinic was located in Victoria and that the doctor in question had provided video conference consultations on hundreds of procedures.

The following actions were taken in the management of the complaint:

- The nurse was referred to AHPRA.
- The complainant's concerns with the clinic and her subsequent costs were referred for conciliation.
- Concerns that the doctor may not be registered were referred to the Health Complaints Commission in Victoria.
- Relevant information was shared with AHPRA, Medicare, the Department of Health Medicines Compliance and Human Tissue unit and the New South Wales Health Complaints Commission.
- The office commenced an own-motion investigation into systemic concerns about the registration of medical practitioners who provide advice in cosmetic procedures.

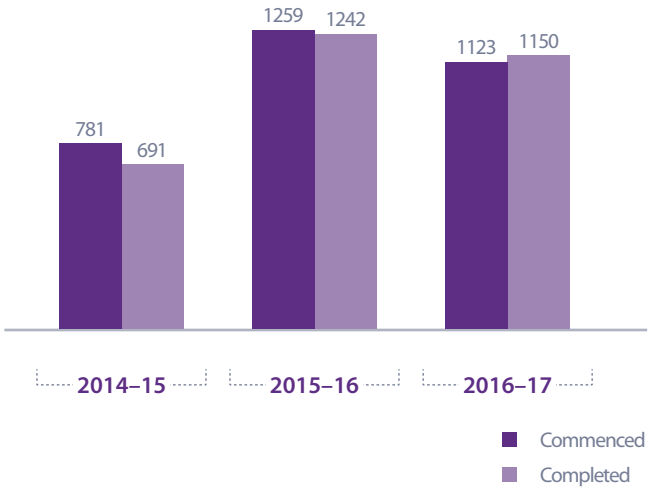
local resolution

Local resolution is a process which facilitates the exchange of information between the complainant and the health service provider with a view to resolving the matter to the satisfaction of both parties within 30 days. Parties to a local resolution agree to participate in the process voluntarily and may opt out at any time.

Local resolution is suited to simpler health service complaints and for health service consumers that require ongoing healthcare from their provider. It can be critical to rebuilding trust and confidence. 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.

In 2016–17, 1123 local resolutions were started—11 per cent less than last year (1259)—while 1150 local resolutions were completed—a decrease of 7 per cent from last year (1242).

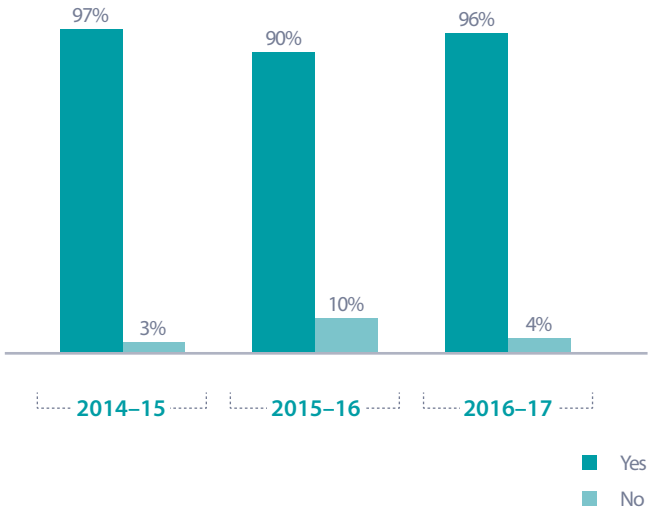
Local resolutions commenced and completed



Local resolution timeframes

Of the complaints referred to local resolution 96 per cent of resolutions (1102) were completed within legislative timeframes—that is within 30 days, or within 60 days when granted an extension.

Local resolutions completed within legislative timeframes

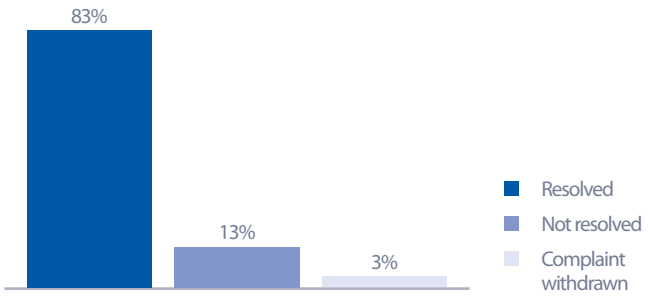


Local resolution outcomes

In 2016–17, 83 per cent of completed local resolutions were resolved, compared with 86 per cent in 2015–16. Local resolution is a voluntary process and the outcomes that can be achieved are varied and are tailored to the circumstances of each complaint.

Of the 13 per cent of local resolutions which were not resolved, 5 per cent of these matters were referred on for further action—that is, assessment, conciliation, investigation, referral to AHPRA or to another appropriate external agency—while 95 per cent required no further action as the complaint was withdrawn, a party did not agree to participate in the process or the matters were resolved without the involvement of the office.

Local resolution outcomes 2016–17



"I found the local resolution officer very helpful, understanding and sensitive. I would like to thank her very much for her service. I am so glad that I got in touch with the Office of The Health Ombudsman and received help in relieving my concerns."

— Complainant

Case study

A prisoner complained about a prison health service which stopped providing his pain medication abruptly and without consultation. Additionally the complainant—who had been suspected of diverting medication at the time—complained that no alternate medication had been provided to him.

Information was gathered via local resolution, including a response from the prison health service, a copy of the diversion policy and the prisoner's medical records. Following a review of these documents, it was identified that the prison health service had acted in breach of its diversion policy.

This finding resulted in the complainant being reissued with his medication, a letter of acknowledgement from the prison health service and a commitment from the prison health service that the policy would be correctly applied in the future.

Case study

A mother complained after being refused information on her son who was being treated as an outpatient at a rural hospital. The complainant felt that she should be have been provided with assistance to treat her son at home and that scheduled hospital transportation services failing to arrive on some occasions was the reason she had not attended outpatient appointments.

Following discussions and negotiation, the office encouraged both parties to meet to discuss the matter and exchange information.

The matter was resolved with a community health worker assigned to assist the complainant with meal preparation, as well as transport assistance so that scheduled appointments could be attended.

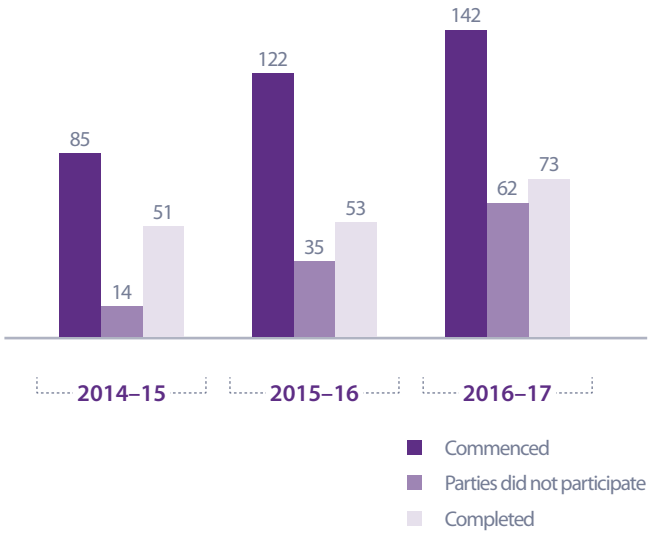
conciliation

For matters that go to conciliation, the office acts as an impartial and independent third party to facilitate discussion. The purpose of conciliation is to engage complainants and providers of health services in a privileged and confidential process, and assist the parties in reaching mutual agreement in clinically complex and sensitive complaints

An independent and impartial conciliator works with parties to gather information, identify issues and interests, clarify misunderstandings and provide explanations. In order for the conciliation process to operate effectively, conciliators ensure that the parties engage in the process in good faith, comply with conciliation arrangements and remain focused on reaching agreement.

In 2016–17, 73 conciliations were completed and an additional 62 conciliations were closed as the parties declined the opportunity to participate in the process. The number of conciliations started also increased, up from 122 in 2015–16 to 142 in 2016–17—a 16 per cent increase. As at 30 July 2017, 12 of these open matters were on hold pending finalisation of other processes.

Conciliations commenced and completed

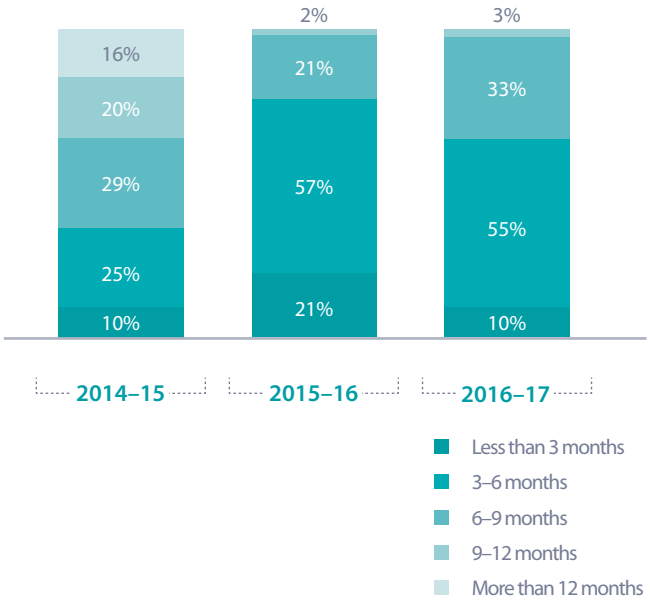


Conciliation timeframes

The sustained increase in the number of complaints moving to conciliation has put pressure on desired timeframes. While there are no legislated timeframes for conciliation, the office aims to resolve conciliated matters within six months.

Despite the increase in the number of conciliations completed in 2016–17, 64 per cent of matters that completed the conciliation process were finalised within six months.

Completed conciliation timeframe



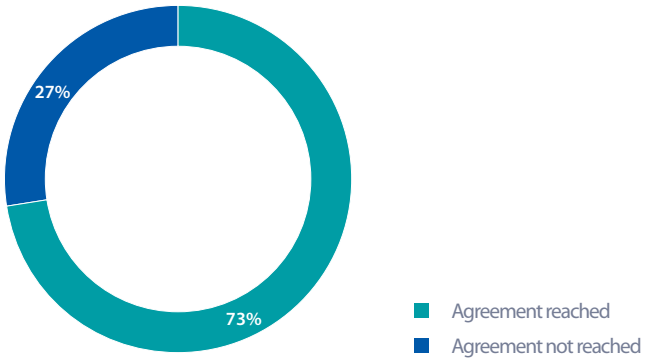
Conciliation outcomes

In 2016–17, 73 per cent of matters in which a full conciliation was undertaken were successful. Outcomes included:

- an acknowledgement, apology or detailed explanation
- reimbursement for out-of-pocket expenses
- meet the costs of the complainant's future treatment
- ex-gratia payments.

For the 27 per cent of conciliations where agreement was not reached, all were closed requiring no further action.

Completed conciliation outcomes 2016–17



Matters where parties declined conciliation

Of the 135 conciliations closed in 2016–17, 62 were due to parties declining to participate in the process. While conciliators work with complainants and health service providers to improve understanding and the benefits of conciliation, parties cited a number of reasons for not participating, including:

- wishing to proceed with a personal injuries claim through the court system
- the type of compensation being sought not being available through conciliation—e.g. damages for pain and suffering or economic loss
- one or both of parties not seeing a benefit to participating in conciliation
- one or both of the parties not trusting the process and its outcomes
- a perception that the other party would not participate in good faith
- the complaint being resolved prior to conciliation.

Managing the increase

The conciliation unit continues to focus on improving processes to ensure conciliations are conducted within reasonable timeframes. The team has compensated for its small size by identifying a pool of temporary conciliators within the office who can fill short-term vacancies.

"The OHO officer was very helpful in the lead up to the meeting and also during the meeting. The officer was very kind and considerate of the complainant and her partner and was also very fair in providing us advice and in listening to our explanations and in navigating the conciliation process path to a satisfactory resolution."

— Complainant

conciliation

Case study

A patient presented to a hospital with a serious eye injury and was triaged on arrival. After spending considerable time in the waiting room awaiting treatment, he lost sight in the eye.

Unfortunately, the triage category that was assigned to him did not reflect the seriousness of his injury or that he required urgent treatment. It is understood these factors could have contributed to the loss of sight in his eye.

Both parties agreed to participate in the conciliation process. The conciliator reviewed all the information and assisted both parties to identify clinical and process/policy issues that may require explanation and clarification at a conciliation conference.

Because the parties were in different geographic locations, the conciliator suggested a telephone conciliation conference. The parties discussed the issues in detail resulting in the hospital acknowledging and apologising for the error in the triaging that had occurred.

The hospital outlined several potential improvements to the triaging of patients in the emergency department to prevent a recurrence in the future. In order for the complainant to be part of this journey and provide real-time feedback for the potential improvement strategies, the complainant was invited to participate in a community reference group for on-going feedback about hospital services and protocols.

Case study

A patient died at his home after being discharged from hospital following brain surgery. The family of the deceased made a complaint to the office and expressed their dismay at the hospital's decision to discharge him.

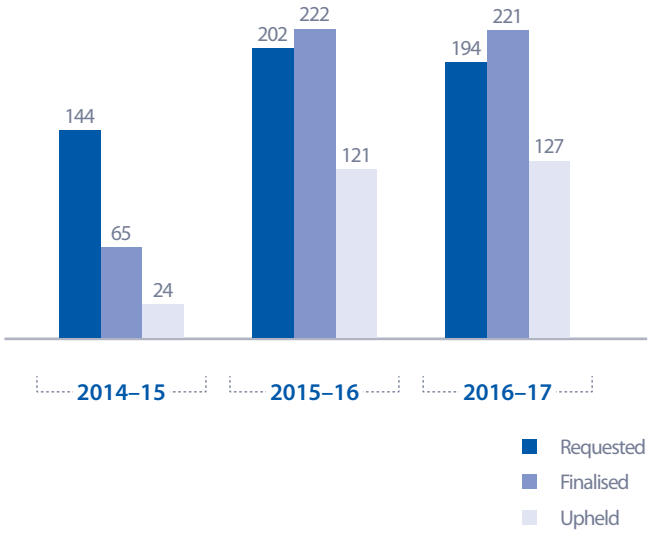
Both parties agreed to participate in conciliation during which the patient's family was able to seek an explanation from the hospital as to why he was discharged.

At the conciliation conference there was an in-depth exploration of the sequence of events which clarified the family's negative perception of the premature discharge. The conciliation conference enabled the family to ask questions about the assessments conducted prior to discharge and for the hospital to provide a detailed account which indicated that the patient's recovery made his discharge appropriate. The open discussion between the parties identified potential areas for change to policies and procedures to be explored. The family were also able to better understand and acknowledge the clinical pathways leading to a decision to discharge a patient.

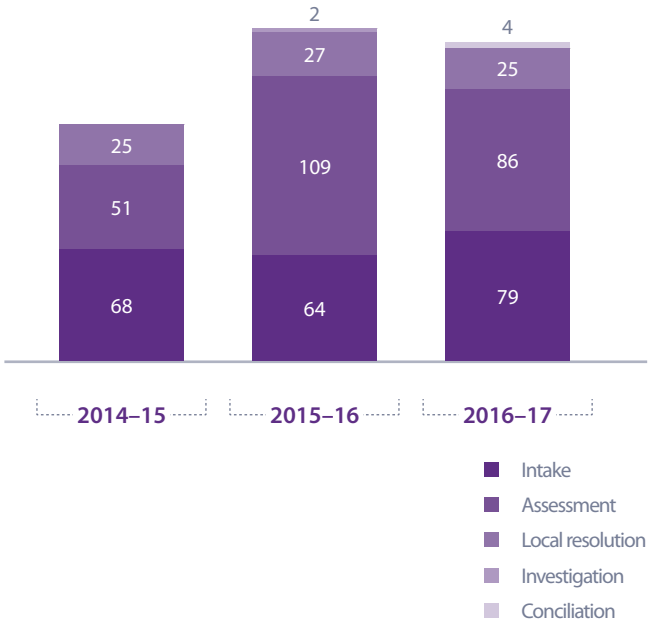
internal **review**

Complainants and health service providers can seek an internal review of our decisions on administrative grounds. In 2016–17, the office received 198 and finalised 221 review requests. Reviews were conducted for 177 (80 per cent) of the 221 finalised review requests. Of the review requests received by the office, 44 per cent related to assessment, 41 per cent to intake, 13 per cent to local resolution and 2 per cent to conciliation.

Reviews requested, finalised and upheld



Original decision area for internal review request



Internal review timeframes

While there is no legislated timeframe for internal review, the office has established a best-practice timeframe of 40 business days.

Internal review outcomes

Following review, the original decision was upheld for 127 decisions (72 per cent) of matters.

For the 38 requests (17 per cent) 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.

Internal reviews have identified broad themes and opportunities for process improvement, including a need:

- for clarity in communication with complainants and the need to use easily understood language
- to explain clearly any legislative basis for deciding complaint outcomes
- to explain clearly if a complaint falls outside the jurisdiction of the office
- to seek clarification or further analysis of clinical advice.

The lessons learned through the internal review process make a vital contribution to the continual improvement in the quality of service delivery by the office and the rigour placed around its administrative processes.

Office of the Queensland Ombudsman

If an applicant for review remains dissatisfied following an internal review, they may request that the matter be reviewed by the Queensland Ombudsman.

internal **review**

Case study

A decision was made to refer a complaint to an external agency for further action. In a review request, the complainant raised concerns the office had failed to provide three-monthly progress reports despite providing advice to that effect in the original decision letter. The subsequent review confirmed the complainant's concerns . While this issue did not affect the validity of the decision, the provision of incorrect advice had impacted negatively on client service.

It was explained to the complainant that while we previously provided three-monthly progress reports, process changes meant that was no longer the case. An apology was offered to the complainant for the incorrect information provided.

These facts were communicated internally to staff and processes were refined to ensure similar mistakes are not repeated.

Case study

The office accepted a complaint concerning the alleged failure of a health service provider to supply reasonable health services. The matter completed the local resolution process and was finalised.

The complainant did not agree that all the complaint issues had been resolved and sought a review. On review, it was decided the original decision had been appropriate. The complainant then sought a review by the Queensland Ombudsman. The Office of the Queensland Ombudsman reviewed all the information and recommended that further consideration of some aspects of the complaint relating to record keeping in medical records may be warranted.

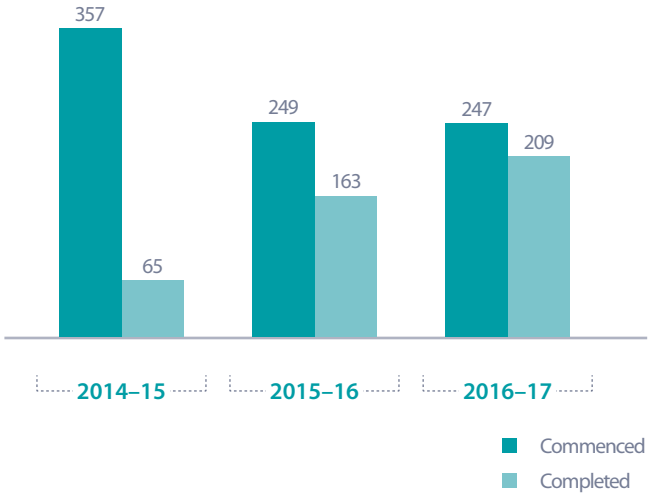
After accepting the Queensland Ombudsman's recommendation the office took corrective action by referring the matter to the health service provider to address the record keeping issues identified within the health service.

investigation

Formal investigations are conducted into more serious matters and involve detailed planning, identification and sourcing of evidence. Investigations focus on matters that may amount to professional misconduct on the part of health service providers. By their nature investigations are complex, involving multiple agencies and jurisdictions.

In 2016–17 the office commenced 247 investigations and completed 209. This is an increase in the number of completed investigations of 28 per cent (163 completed in 2015–16).

Investigations commenced and completed



Investigation timeframes

While an increasing number of investigations have been finalised and closed, an ongoing challenge remains to complete investigations in a timely manner.

Generally, investigations are to be completed within 12 months, although this may be extended due to the size, nature or complexity of a matter. As an investigation can have serious consequences for a health service provider and the wider community, it is important, that in line with the office's overarching goal of protecting the health and safety of the public, investigations are carried out in a thorough, transparent and efficient manner, and are consistent with procedural fairness.

Open investigations

As at 30 June 2017, 394 investigations remain open, of which 196 (50 per cent) have been open for more than 12 months. The metrics for reporting the number of investigations were expanded in 2016–17 to reflect greater accuracy, and the number of open investigations now includes the number of paused investigations.

Of the 394 open investigations, 289 (73 per cent) related to health service complaints, 71 (18 per cent) related to matters brought to the attention of the Health Ombudsman other than through a health service complaint or notification and 34 (9 per cent) related to systemic issues.

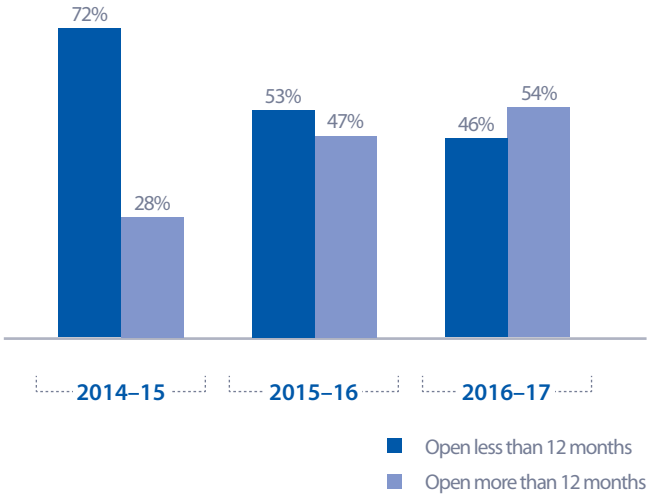
All investigations that have been open for more than 12 months are published on the investigations register, available on the office's website.

Completed investigations

In 2016–17 there was a significant increase in the number of matters closed. Of the 209 investigations completed in 2016–17, 46 per cent were finalised within 12 months, while 54 per cent were open for more than 12 months.

In 2016–17, there was a large increase in the proportion of matters being referred to the Director of Proceedings and a reduction in the number referred externally to AHPRA.

Completed investigation timeframes



AHPRA transitional matters

As part of the establishment of the new co-regulatory arrangement in Queensland, 124 investigations started by AHPRA were transferred to the office in 2014–15. These transferred matters created challenges during the office's first two years and have had a major impact on the office's investigations timeframes. At the end of 2016–17, only 14 transitional matters remained open, relating to five practitioners.

Barriers to timeliness

In 2016–17, strategic initiatives were introduced to address barriers to meeting investigation timelines. An increased number of permanent positions and the introduction of administrative assistants within the division has led to greater stability and process efficiencies. Process and system developments, standardisation, guidelines for prioritisation and increased professional development and training will result in smoother workflows which will transition to more investigations being completed within desired timeframes.

Reporting requirements

An invisible but significant impact on the office's ability to complete investigations within desired timeframes is the amount of documentation and reporting required as part of the investigation management process. In 2016–17, 209 investigations were completed—some of which were extremely complex, impacting on associated reporting requirements. The office is also required under the Act to provide regular documented updates on the progress of an investigation to practitioners, employers and complainants, and to seek quarterly extension approvals for all investigations more than 12 months old.

While these requirements are appropriate, the Act provides few opportunities to streamline or find efficiencies in these processes to ensure they occur with a minimum of impact on staff resources. With 209 investigations completed in 2016–17, and 394 still open and ongoing, there has been a significant impact on staff to fulfil these administrative obligations while also thoroughly investigating serious and complex matters.

Legislative requirement to investigate

The ***Health Ombudsman Act 2013*** requires that an investigation must be started when a matter reaches the threshold of a potential 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 cancellation.

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 must be started.

Paused matters

Of the investigations that remain open at the end of 2016–17, 54 matters were paused. Pausing a matter allows other agencies to complete their investigations. 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 or the Coroners Court of Queensland.

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

Access to information

Information required from external stakeholders has a significant effect on investigation timeframes and the office currently relies on a voluntary arrangement with the Queensland Health Police Liaison Unit. To address this problem, this year the office has put in place a formal arrangement with the Department of Justice and Attorney-General to obtain information concerning potential criminal matters. The office has commenced discussions with the Department of Justice and Attorney-General to access the Queensland Wide Inter-linked Court system and the Health Ombudsman has sought legislative change to allow the office access to the Queensland Police Records and Information Management Exchange.

Multi-disciplinary nature of investigations

Investigations are multi-disciplinary actions that require collaboration across the office.

An investigation may require immediate action and the involvement of legal services and may also require consideration of monitoring and compliance, particularly when immediate action has been taken by the Health Ombudsman.

The office regularly collaborates with a range of external stakeholders including government agencies that provide valuable expertise, knowledge and resources so investigations can be executed in a thorough and transparent manner. Clinical advice may also be used in relation to matters of practitioner practice and as part of onsite gathering of evidence.

In 2016–17, 35 requests were made for clinical advice in the course of investigations and 12 search warrants were issued.

The office is continuing to develop and improve information sharing and collaboration with other agencies to make the best use of all agencies' resources and powers in the protection of the health and safety of the public.

Spotlight on inter-divisional cooperation

The office received two separate complaints in March 2016 concerning an unregistered practitioner who claimed to be a doctor and who told a patient—who subsequently died—that he could cure their cancer using alternative therapies.

The seriousness and complexity of the matter required extensive interaction and cooperation across the whole organisation to ensure a thorough examination of the facts and timely and appropriate action against the practitioner.

The complaints were immediately referred directly from intake for further investigation and consideration of whether immediate action was necessary to protect the health and safety of the public.

The Investigations and Immediate Action teams worked closely together to gather the necessary evidence from complainants and other witnesses. The Health Ombudsman advised the practitioner he was considering taking immediate action against him and invited the practitioner to make a submission.

After considering the gathered evidence and the practitioner's submissions, the Health Ombudsman issued an interim prohibition order against the practitioner prohibiting him from providing any health services in a clinical or non-clinical capacity—paid or otherwise.

After this occurred, the practitioner was monitored to ensure compliance with the Health Ombudsman's order. Evidence gathered by the Monitoring and Compliance team suggested the practitioner was continuing to treat patients in breach of the prohibition order.

Investigations into the suspected breach commenced, with an external agent engaged to carry out a covert operation posing as a patient. In addition, a search warrant was executed on the practitioner's clinic to obtain further evidence.

The unregistered practitioner made an application to QCAT for a review of the Health Ombudsman's decision to issue the interim prohibition order. In response to the request for review, the Legal Services division worked closely with the Investigations, Immediate Action and Monitoring and Compliance teams to gather the necessary evidence and to present to QCAT at a review hearing.

QCAT found the evidence presented by the Health Ombudsman showed the practitioner had advised the patient that he could cure cancer, diverting him from potentially life-saving conventional medical treatment. QCAT also found that the practitioner had practiced during the period of the interim prohibition order. QCAT was satisfied that the practitioner posed a serious risk to the health and safety of the public and confirmed the Health Ombudsman's interim prohibition order.

The Health Ombudsman filed a complaint and summons in the Magistrates Court for the practitioner's breaches of the interim prohibition order. The Health Ombudsman referred the matter to the Queensland Police Service and AHPRA.

The investigation into the practitioner's conduct is expected to be finalised and referred to the Director of Proceedings for consideration of possible referral to QCAT.

Outcomes of investigations

Of the 209 investigations completed in 2016–17, 80 matters (38 per cent) were recommended for referral to the Director of Proceedings, 72 matters (34 per cent) resulted in no further action being taken and 47 matters (22 per cent) were referred to AHPRA.

Once investigated, a matter may turn out to be less serious than first thought, and further investigation or prosecution is not needed. The matter may relate to the health and performance of a practitioner and be more appropriately managed by AHPRA or a government agency.

Referral to AHPRA or other government agencies

In the course of an investigation, a matter may be identified as being suitable for referral to AHPRA or to another government agency. For example, the conduct of the practitioner may be found to be unprofessional, but not amount to professional misconduct, or the practitioner may have a health impairment which impacts their professional performance. These matters are more appropriately managed by AHPRA and the national boards.

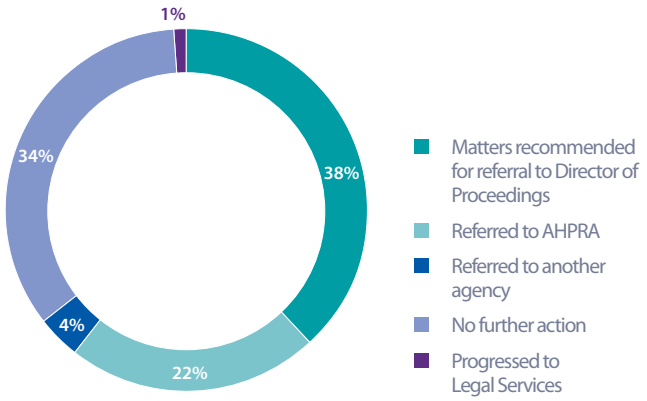
Referral to the Director of Proceedings

The significant increase in the number of briefs of evidence referred to the Director of Proceedings with recommendations for referral to QCAT reflects the growth in the number of serious complaints requiring comprehensive investigation. These cases are complex and there are often multiple allegations for a single practitioner.

Immediate action

If a practitioner poses a serious enough risk to the health and safety of the public, the Health Ombudsman may prevent the practitioner from practising by taking immediate action against them. This can occur while the investigation takes place, and remains in place during any time for which an investigation is open. Immediate action can take place in response to the findings of an investigation.

Outcomes of completed investigations 2016–17



Monitoring of investigation recommendations

At the completion of an investigation, the Health Ombudsman may make recommendations to reduce the likelihood of a similar adverse event occurring again and improve the safety and quality of health services provided to Queenslanders. The office monitors and reports on the implementation of these recommendations.

Recommendations generally relate to changes in organisational practice or may be specific initiatives to address identified failings, such as further education in relation to a particular area of practice.

This year the office commenced four monitoring cases as a result of completion of an investigation undertaken by the office, and closed two. The four new cases contained 30 recommendations to improve the quality of health service delivery. As at 30 June 2017, four of these recommendations were fully implemented, seven were partially implemented and 19 were yet to be implemented.

In 2016–17, the office also commenced nine monitoring cases based on the outcomes of activities undertaken by other agencies, such as reviews or investigations undertaken by a hospital and health service. These cases contained 38 recommendations. As at 30 June 2017, 14 recommendations were fully implemented, seven were partially implemented and 17 were still to be implemented.

The office also closed six monitoring cases based on the outcomes of activities undertaken by other agencies this year. The office has made a strategic decision to scale down the monitoring of recommendations made by external agencies. Resources will be focused on monitoring the implementation of recommendations for improvements, resulting from investigations undertaken by the office.

Under his jurisdiction, the Health Ombudsman did not commence any inquiries into any matters under part 12 of the ***Health Ombudsman Act 2013*** in 2016–17 and did not assist with any inquiry initiated by another government agency.

Site visit to assess implementation of recommendations

In 2016–17, the office made its first onsite monitoring inspection to assess progress on implementation of recommendations made by the Health Ombudsman. This action illustrates the office's focus on quality improvement in monitoring the implementation of recommendations arising from investigations.

As a result of an investigation following the death of a patient in a regional hospital, the Health Ombudsman made four recommendations to improve the safety and quality of care provided by the hospital. The office received and reviewed three progress reports provided by the hospital but the Health Ombudsman was not satisfied that adequate action had been taken in response to all of the recommendations.

In consultation with the hospital, staff from the office undertook a site visit to obtain additional information and assess the changes to processes that had been effected. As a result, the office was able to revise the assigned status for all recommendations to *fully implemented* and to note the commitment of the hospital to the ongoing implementation of quality systemic improvements. The onsite visit also enhanced the relationship between the office and the hospital, contributing to a more efficient and effective relationship.

investigation

Case study

The office received a complaint about a dentist in relation to appropriate infection control, sterilisation and hygiene standards.

The complainant raised concerns that the room used for sterilising equipment was also being inappropriately used for other purposes including where staff ate their lunch, undertook lab work and processed x-rays.

After interviews with a number of former staff members were conducted, it was identified that the infection control measures in place at the practice may have been inadequate. It was also established that the owner of the practice was attending nursing homes to treat elderly patients and may have been reusing equipment during these consultations. Concerns were raised that the patients tended to be older and may have been taken advantage of due to their age and condition.

On the basis of the initial investigation, a search warrant was granted in order to search and seize evidence relating to the allegations. The warrant was executed by investigators from the office in conjunction with two environmental health officers from the Department of Health and two independent clinical advisors who provided specialist advice in relation to sterilisation and infection control.

This was the first time that the office had taken clinical advisors on site during a search warrant. They were engaged to provide timely advice during the execution of the warrant and to advise the Health Ombudsman and the Department of Health about the seriousness of the matter. The department's environmental health officers collected samples and medical equipment for testing. During the course of the warrant, a number of staff including the dentist participated in voluntary interviews with the independent clinical advisors and investigators from the office.

The Health Ombudsman took immediate action and suspended the dentist. The Department of Health issued a public health order and closed the practice until certain rectifications were made. The dentist remains under investigation for infection control issues, but the suspension has been lifted and replaced with conditions. The matter has been filed with QCAT.

referral to the **director of proceedings**

Under the ***Health Ombudsman Act 2013***, serious complaints must be retained by the Health Ombudsman and investigated. Depending on the outcome of an investigation, a matter may require referral to QCAT, in which case it is referred to the Director of Proceedings. The decision to refer a matter to the Director of Proceedings is made by the Health Ombudsman.

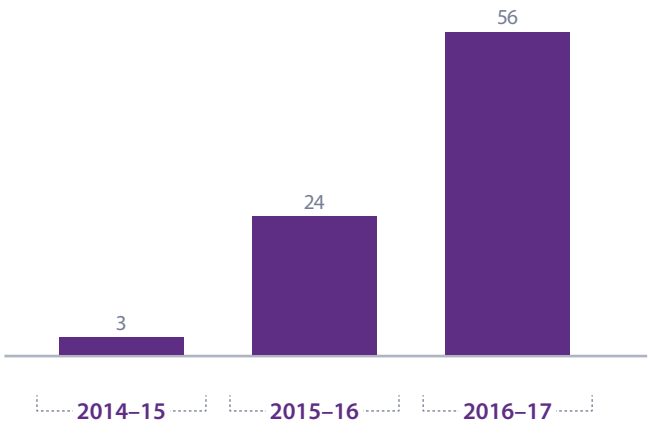
Matters referred to the Director of Proceedings

In 2016–17, the Health Ombudsman referred 56 matters relating to 51 practitioners to the Director of Proceedings. This compares with 24 matters relating to 18 practitioners in 2015–16.

Of these:

- 24 matters involved medical practitioners
- 20 matters involved nurses
- 3 matters involved pharmacists
- 2 matters involved psychologists
- 2 matters involved dentists
- 1 matter involved a massage therapist
- 1 matter involved an unregistered chiropractor
- 1 matter involved a student nurse
- 1 matter involved a chiropractor
- 1 matter involved a podiatrist.

Matters referred to the Director of Proceedings



The sharp increase in the number of referrals in 2016–17 reflects the increased number of serious matters that progressed through the complaints management system to the end-stage areas of case management. The significant volumes seen in earlier stages of the complaint management process in previous years have now made their way through to litigation. It is expected this increase will continue in 2017–18, before settling to a more predictable case load.

The growth in immediate actions issued by the Health Ombudsman has corresponded with an increase in breaches by practitioners and applications for review of these decisions by QCAT.

Decisions by the Director of Proceedings

During the 2016–17 financial year, the Director of Proceedings made 18 decisions. These related to:

- boundary violations
- criminal conduct—including possession of illicit drugs, possession of child exploitation material, maintaining a relationship with a child, sexual assault, rape, and weapons charges
- prescribing and/or dispensing of drugs—including schedule 4 and 8 drugs
- self-administration of drugs
- poor clinical performance
- fraud.

The Director of Proceedings referred five matters back to the Health Ombudsman. Four of these matters were referred with a recommendation to undertake further investigation, and one of these matters was referred with a recommendation to take no further action. Of these:

- 2 matters involved registered nurses
- 2 matters involved medical practitioners
- 1 matter involved a dentist.

Decision timeframes

Of the decisions made by the Director of Proceedings:

- 5 (27 per cent) decisions were made in more than six months
- 4 (22 per cent) decisions were made in four to six months
- 8 (50 per cent) decisions were made in less than four months.

Referral to the Queensland Civil and Administrative Tribunal

When deciding whether to refer a matter to QCAT, the paramount guiding principal under the ***Health Ombudsman Act 2013*** is the protection of the health and safety of the public. 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. Factors which inform the seriousness of the matter include:

- the nature and extent of the conduct
- whether there were any breaches of relevant codes, standards and guidelines
- whether the practitioner has shown remorse or insight.

In relation to the likelihood of proving relevant matters, the ***Health Ombudsman Act 2013*** reflects the principle under the common law that serious allegations should not be made about a person lightly. The Act applies to registered and unregistered practitioners and requires a higher standard of proof than the previous regime where a national board had to refer a registered health practitioner to QCAT if there was *reasonable belief* the practitioner had behaved in a way that constituted professional misconduct.

The standard of proof under the Act is the civil threshold of *on the balance of probabilities*. This means that the more serious the allegation and the more serious the outcome for a practitioner, the higher the degree of probability required to be proved in the course of proceedings.

In 2016–17, the Director of Proceedings referred 13 matters to QCAT compared with five in 2015–16. Of these:

- seven matters involved registered nurses
- three matters involved medical practitioners
- two matters involved pharmacists
- one matter involved a dentist.

At the end of 2016–17, there were 53 matters being examined ahead of a final decision by the Director of Proceedings.

Best-practice processes

The office is mindful of the significant adverse impact that disciplinary proceedings may have on a practitioner, as well as on the complainant and third parties. The office exercises its statutory powers in accordance with procedural fairness and is committed to implementing best-practice litigation process. The consideration of referrals, and subsequent proceedings before QCAT, are conducted in accordance with model-litigant principles. This ensures the process is managed in an impartial, fair and independent manner; matters are within jurisdiction; and they are progressed as effectively and efficiently as possible.

On average, it takes six months to prepare a case for QCAT after the investigation has been completed and any prosecution components have been processed. When appropriate, the Director of Proceedings may seek the advice of clinical experts and will engage with stakeholders involved in the litigation process with a view to more efficient and cost effective outcomes.

The office seeks to engage positively with practitioners and health service providers, particularly where the respondent is an unregistered practitioner, or does not have legal representation. This helps the practitioner to completely understand the nature of the charge against them, the possible outcomes and provides an opportunity for them to consider their options.

When a matter is referred to QCAT, the office provides the practitioner with a statement of facts and a brief of evidence to substantiate the grounds for referral. By providing this material to the practitioner at an early stage, the office seeks to streamline the disciplinary process and facilitate meaningful discussions with respondents to reach agreement on as many issues as possible. Early feedback and engagement from practitioners and their legal representatives has yielded positive results.

Evolving focus of Legal Services

In the initial years of the office's operation, the primary role of the Legal Services division was to provide statutory interpretation and in-house advice in relation to individual complaints. In 2016–17, a significant body of statutory interpretation has been established, with the addition of case law and insights into the direction of judicial reasoning.

With an increase in matters now requiring litigation the focus has transitioned to ensuring that systems and processes are in place to facilitate best-practice legal services in the health service complaints management system in Queensland.

In addition, a continual focus on process improvement across all areas of the business involved in matters reaching the Director of Proceedings has delivered positive improvements in timeliness, quality and rigour.

Case study

A medical practitioner was convicted of the sexual assault of a female patient. The Health Ombudsman took immediate action and prohibited the practitioner from consulting with or medically treating female patients.

The medical practitioner sought review of the order by QCAT. Evidence of other behaviour that fell below the reasonable standards expected of a medical practitioner was presented by the Health Ombudsman and accepted by QCAT.

The medical practitioner believed the condition was too harsh, and proposed the use of practice monitors when consulting with or treating female patients. His reception staff would provide the monitoring.

The Health Ombudsman took the view that to ensure the health and safety of female patients the practice monitors should be registered or enrolled nurses engaged from an agency.

QCAT made an order to this effect with subsequent conditions for monitoring and compliance.

Case study

During QCAT proceedings against a registered nurse for fraud and other related charges, the practitioner provided a falsified medical certificate to QCAT and the Health Ombudsman. As a result of legal officers recognising the certificate as falsified, the Health Ombudsman commenced an own-motion investigation and the matter was referred to the Director of Proceedings.

The Director of Proceedings made a decision to refer a further charge to QCAT, noting that it is likely to be joined with the existing charges in QCAT against the practitioner.

queensland civil **and administrative tribunal**

QCAT is an independent tribunal that resolves disputes and makes and reviews decisions in relation to a range of matters defined by legislation, including regulatory frameworks that govern particular occupations and professions.

Immediate action reviews

A practitioner has a right to seek review of the Health Ombudsman's decision to take immediate action by making application to QCAT within 28 days of receiving a notice of immediate registration action or interim prohibition order.

QCAT handed down five decisions to which the Health Ombudsman was a party in 2016–17. The body of case law will evolve rapidly over the next 12 months as the office continues to refer more matters to QCAT.

In 2016–17, nine applications for a review of an immediate action were filed. Of these:

- three matters involved medical practitioners
- two matters involved unregistered practitioners
- one matter involved a registered nurse
- one matter involved an physiotherapist
- one matter involved a dentist
- one matter involved a Chinese medical practitioner.

In 2016–17, six reviews of an immediate action were finalised, four of these were withdrawn by the applicant, and two proceeded to hearing.

QCAT's decisions:

Colagrande v Health Ombudsman

QCAT confirmed the Health Ombudsman's decision that immediate action was necessary but set aside the Health Ombudsman's decision preventing Colagrande, a medical practitioner, from treating female patients and instead imposed chaperone conditions on his registration.

Zaphir v Health Ombudsman

QCAT confirmed the interim prohibition order issued by the Health Ombudsman preventing Zaphir, an unregistered practitioner and former chiropractor, from providing any health services.

Queensland Civil and Administrative Tribunal outcomes

In 2016–17, QCAT made decisions in five matters.

Health Ombudsman v Lara Joanne Antley

A registered nurse stole blank prescriptions from her employer, forged prescriptions and used them to fraudulently obtain drugs of dependence. She also failed to notify the Nursing and Midwifery Board of Australia about the criminal charges and convictions. QCAT made an order that Antley is reprimanded and disqualified from applying for registration as a registered health practitioner for nine months.

Health Ombudsman v Dorothy MacDonald

A registered nurse stole schedule 4 restricted drugs with the intention of supplying the drugs to her niece. QCAT found MacDonald's conduct was professional misconduct and suspended her registration as a nurse for six months. QCAT also ordered that MacDonald pay the Health Ombudsman's costs of the proceedings.

Health Ombudsman v David John Levick

A medical practitioner assaulted a child patient by slapping the patient's face and also applied for registration renewal without notifying that he had been charged with the assault. QCAT found Levick behaved in a way that constituted professional misconduct and suspended his registration for two months. QCAT also ordered that Levick pay the Health Ombudsman's costs of the proceedings.

Health Ombudsman v John Christopher Riek

A registered nurse stole schedule 8 restricted drugs and, while on duty, self-administered in a hospital bathroom and lost consciousness. QCAT found that Riek's conduct amounted to professional misconduct and he was reprimanded.

Health Ombudsman v Stepheny Eliza Jamieson

A registered nurse/midwife stole three boxes of antibiotic medicines from her place of employment with the intention of supplying them to her son. QCAT found that Jamieson's conduct amounted to professional misconduct and she was reprimanded.

Full details of these QCAT decisions can be found on the office's website **www.oho.qld.gov.au**.

immediate **action**

In the most serious cases it may be necessary for the Health Ombudsman to take immediate action against registered and unregistered practitioners. This action is only taken when the Health Ombudsman holds a reasonable belief that a health practitioner's health, conduct or performance poses a serious risk to the public and believes it is necessary to act to protect the health and safety of the public. Immediate action may also be taken in response to the outcomes of an investigation or may be taken during the course of an investigation.

In matters involving the clinical performance of a practitioner, specialist clinical advice may be sought to assist the Health Ombudsman in making his decision. Immediate registration actions may, and interim prohibition orders must, be published on the office website. This is done as part of the office's commitment to transparency and to ensure the public and employers are aware of restrictions or conditions a practitioner has on their registration or practice.

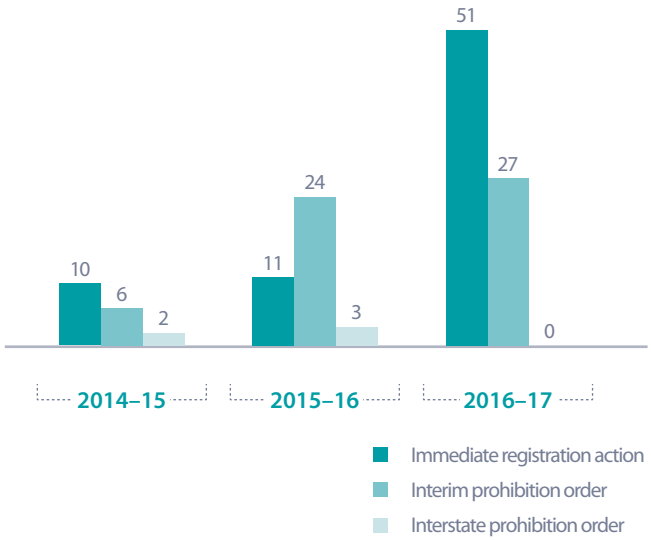
In 2016–17, the Health Ombudsman took 77 immediate actions relating to 64 individual practitioners, an increase from the 38 taken in 2015–16. Immediate action was taken against 44 registered practitioners and 20 unregistered practitioners.

Of these 77 immediate actions:

- 51 immediate registration actions were taken against registered practitioners
- 26 were interim prohibition orders.

No corresponding interstate prohibition orders were issued.

Immediate actions taken



Show cause notices

In addition, the Health Ombudsman served 35 show cause notices to practitioners to alert them to proposed action, inviting them to make submissions within seven days. If the Health Ombudsman proposes to take immediate action he must give the registered or unregistered practitioner a notice stating the purpose of the action and invite the practitioner to respond within seven days as to why the immediate action should not be taken. This is an important step in providing procedural fairness for the practitioners involved.

In most serious cases, the Health Ombudsman is able to take immediate action without requesting a response if he is satisfied it is necessary to do so to ensure the health and safety of an individual or the public. The practitioner is able to respond after the immediate action is taken.

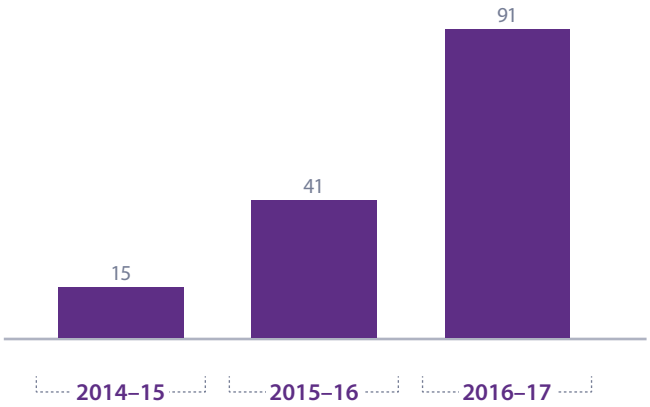
Once immediate action is taken, the matter is referred for investigation. Following investigation the matter may be referred to the Director of Proceedings to decide whether the matter should be referred to QCAT.

Monitoring of practitioner compliance

The office monitors compliance with any conditions or restrictions imposed on registered and unregistered 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 function performed by the office and seeks to mitigate any risk that a practitioner's performance or conduct may have on the health and safety of the public.

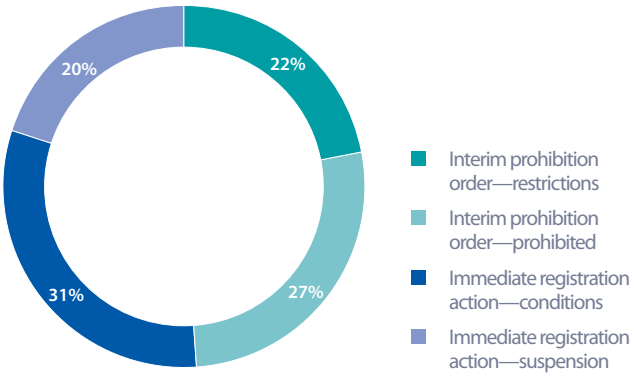
In 2016–17, the office commenced 64 new practitioner monitoring cases and closed 12, resulting in 100 cases open at 30 June 2017. These 100 cases involved 91 practitioners (61 registered and 30 unregistered) representing a 122 per cent increase on the 41 practitioners under monitoring at the end of 2015–16.

Practitioners under monitoring



* One practitioner may be under monitoring in relation to more than one immediate action.

Monitoring cases by immediate action type



An additional area of demand on the office is the length of time for which practitioners require monitoring. At the close of the 2016–17 year, 35 (35 per cent) cases had been subject to monitoring for longer than 12 months, 36 (36 per cent) for between 6 and 12 months and 29 (29 per cent) for less than 6 months.

When monitoring suggests a practitioner is not complying with their conditions, the office will investigate and take appropriate action. For registered practitioners, a breach of a condition may constitute professional misconduct whereas for unregistered practitioners a breach of a restriction is a criminal offence.

A notable example in 2016–17 is the matter of ***Zaphir v Health Ombudsman***, in which an unregistered practitioner sought a review of an interim prohibition order which prohibited him from practising. During the course of this review, the practitioner provided submissions to the office suggesting he may be continuing to practice in breach of the interim prohibition order. Following enquiries by the office, an own-motion investigation was commenced into the practitioner's alleged breach of the interim prohibition order.

Immediate action breaches

During 2016–17, six investigations were commenced into practitioners for breaches of immediate actions—five breaches of immediate prohibition orders, and one breach of an immediate registration action.

In certain situations the breach of an immediate action may constitute a summary offence under the ***Health Ombudsman Act 2013***. Where there is evidence of such a breach, a matter may be referred to the Executive Director, Legal Services to commence prosecution in the courts.

Of the six investigations, two matters were closed and referred to the Executive Director, Legal Services. Two matters remain open and two were closed with no further action.

Immediate actions removed

In addition to monitoring practitioners who may be a continuing risk to the public, the office also responds when the risk is appropriately mitigated or no longer an issue. In 2016–17, 22 registered practitioners had their conditions lifted because the Health Ombudsman was satisfied the immediate registration action was no longer necessary. These were:

- nine immediate registration actions with full suspension
- six immediate registration actions with conditions
- four immediate prohibition orders with full prohibition
- three immediate prohibition orders with conditions.

Case study

The Queensland Police Service notified the office that an unregistered health practitioner had been charged and convicted for stealing and forgery offences in the course of employment.

The Health Ombudsman took relevant action and initiated an own-motion matter investigation to examine the conduct outlined by the police.

The Health Ombudsman took immediate action and issued an interim prohibition order due to the practitioner's pattern of offending behaviour which was opportunistic in nature and demonstrated a willingness to break the law while working in the capacity as a health service provider.

The Health Ombudsman prohibited the practitioner from providing any health service, paid or otherwise, in a clinical or non-clinical capacity, to protect the health and safety of the public.

Case study

The Queensland Police Service notified the office that a registered health practitioner had been charged with serious criminal offences involving threats, assault and wilful damage. The Health Ombudsman took immediate registration action and suspended the practitioner's registration.

The Health Ombudsman found the practitioner's alleged conduct placed the public at serious risk as the behaviour was violent and threatening towards alleged victims. The Health Ombudsman also considered the practitioner was expected to deal with all people with care and respect, and in a professional, responsible and safe manner.

Case study

The office received a self-notification from a medical practitioner regarding an alleged sexual assault of a female patient. In response, the Health Ombudsman took immediate action and imposed conditions on the practitioner's registration, restricting him from treating female patients. The medical practitioner was subsequently found guilty of the sexual assault and received a wholly suspended sentence.

The practitioner applied to QCAT for a review of the Health Ombudsman's decision to impose conditions.

QCAT took a different view to the Health Ombudsman, commenting that the practitioner should be entitled to treat female patients with a chaperone present. QCAT considered that this represented the least onerous action required to protect the health and safety of the public.

The office is now actively monitoring the practitioner and has undertaken a site visit of the practitioner's principal place of practice to ensure his compliance with the chaperone requirements.

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 the health system in Queensland. The office provides recommendations to the health sector to assist in bringing about overarching improvements.

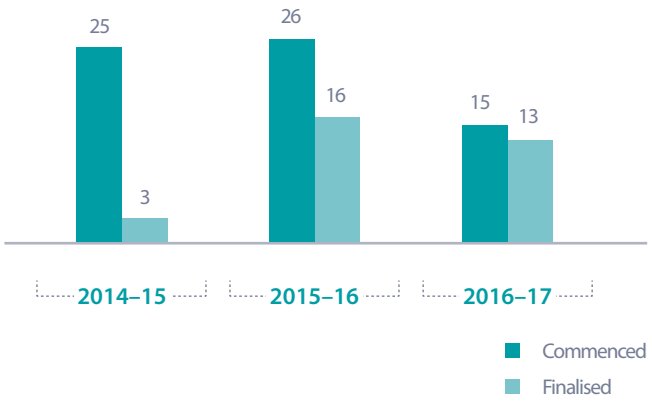
The office commenced 15 systemic investigations in 2016–17 and closed 13. Systemic investigations may be started as an own-motion investigation following the identification of trends indicating widespread deficiencies in healthcare provision, as a result of referral from another agency such as the Coroners Court of Queensland, or following receipt of an individual complaint which raises systemic issues.

The office is responding to the increasing number of matters requiring system-wide investigation by refining processes to increase efficiencies and improve collaboration within the office and with external stakeholders.

In particular, the office has placed emphasis on improving external stakeholder engagement and collaboration. This has contributed to investigations being completed within shorter timeframes and has resulted in better healthcare provision across a range of sectors.

Stakeholders can provide valuable information to assist the office in identifying areas of possible systemic risk as well as providing valuable assistance in the course of investigations. They can also play an important role in identifying what can be done to improve the delivery of healthcare services and in implementing solutions.

Systemic investigations commenced and finalised



Prison healthcare

The office has received an increasing number of individual complaints that consistently highlight similar trends and issues occurring in prison health services within Queensland.

The Health Ombudsman is concerned with the high volume of complaints from correctional facilities across Queensland and the office has commenced a systemic investigation to address the various issues simultaneously. While this may lead to individual complaints taking longer to progress, this approach will achieve a more thorough outcome that supports genuine and positive change for access to, and the quality of, health services within correctional facilities.

Broader statewide themes identified in complaints include:

- overcrowding of correctional facilities which creates significant pressure on health services to provide timely and responsive healthcare
- inconsistencies in policies and procedures in some correctional facilities
- inconsistencies in the provision of health services across a number of correctional facilities.

The office is working with Queensland Health and Queensland Corrective Services to initiate a statewide response to addressing these issues at a systemic level.

Maternity services

The office has commenced systemic investigations into the safety and quality of maternity care provided at various hospitals across Queensland.

A review was conducted into complaints relating to maternity care to identify any recurring themes emerging from these investigations. While acknowledging the extensive work that has already been undertaken at individual facilities regarding improvements to maternity services, the review identified a number of common themes. These themes may be reflective of ongoing statewide areas of system weakness regarding the provision of maternity services which could contribute to adverse outcomes for mothers and babies.

The office has advised the Department of Health and all Hospital and Health Services of the recurring themes apparent in the investigation into maternity services including:

- identification and management of risk
- staffing issues and culture
- recording and management of documentation
- continuation of adverse outcomes despite reviews.

The Minister for Health has requested the convening of a maternity services forum. The first meeting of the forum took place on 15 November 2016 and was attended by 119 key stakeholders representing practitioners, consumers, professional and industrial bodies, and experts in safety, quality and governance. Outcomes from the forum are to be considered by each Hospital and Health Service as to how change can be implemented in relation to their services. The formation of three working groups to focus on particular issues was also requested.

Selected systemic investigation reports are available on the office's website.

Own-motion investigations

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 emerging trends, the consistent appearance of issues in complaints, analysis of complaints content, during the course of an investigation and as evident in media reports. For example:

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

The Health Ombudsman may commence an own-motion investigation into a health facility because the risk identified is broader than a specific individual being investigated. In 2016–17 several own-motion investigations were commenced in relation to matters which raised systemic concerns about health care provision.

Case study

In August 2016, the Health Ombudsman released an investigation report, *Radiology services at the Gold Coast Hospital and Health Service*. The large-scale backlog in reporting of radiological reports was found to be below the standard of clinical acceptance. The backlog was found to be the result of inadequate policies, procedures and guidelines to appropriately manage the diagnostic imaging department.

In July 2014, the Director-General commissioned a health service investigation into the low reporting of radiology results by Gold Coast Hospital and Health Service. In November 2014, following a period of consultation with the Department of Health, the Health Ombudsman commenced an own-motion investigation.

The Health Ombudsman found that the Department of Health investigation had adequately examined the issues and had made suitable recommendations. The Health Ombudsman made an additional nine recommendations for implementation by the Gold Coast Hospital and Health Service and the Department of Health with monitoring provisions to facilitate implementation. The office is monitoring the implementation of all nine recommendations, which involves multiple agencies and progress reports have been received. The office will meet with the stakeholders involved to discuss future progress reporting.

clinical **advice**

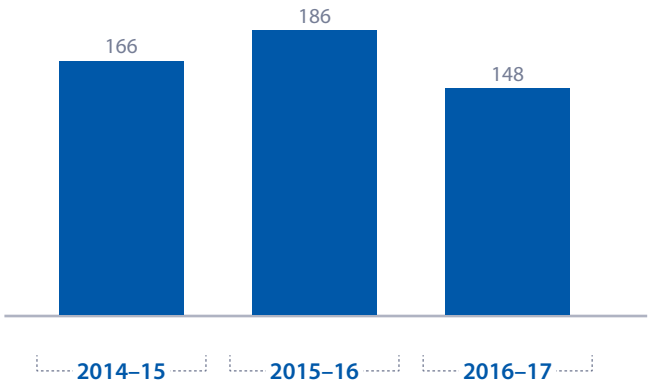
The office seeks clinical advice when an independent, impartial, expert opinion on a clinical matter is required to inform the decision of how best to deal with a complaint.

Independent clinical advice may be used at a number of stages of the complaints management process. The role of clinical advice is to assist in maintaining integrity in the complaints management process and to ensure complaints are managed in a fair, impartial and accountable manner.

In 2016–17, 68 per cent of requests for clinical advice were made in the initial stages of the complaints management process—intake and acceptance, triage, assessment and referral of a complaint. Clinical advice informs the decision about whether to progress the matter, refer it to an external agency such as AHPRA or whether the complaint requires no further action. It may also be sought in complex clinical matters under investigation.

Clinical advice is provided by expert clinicians with appropriate qualifications and clinical experience. It is important advisors are impartial to avoid any potential conflict of interest. The names of clinical advisors, the areas of practise discipline for which advice is sought, the questions asked and the content of the advice are not redacted, and are provided to complainants.

Clinical advice requests



In 2016–17, the Health Ombudsman requested 142 clinical advice reports (186 in 2015–16) in relation to 70 matters. Clinical advice was provided at the following stages of complaints management:

- assessment—96 (68 per cent)
- investigations—35 (25 per cent)
- legal services—6 (4 per cent)
- immediate action—4 (3 per cent)
- local resolution—1 (1 per cent).

Requesting clinical advice

The decision to select a clinical advisor is determined by the particular circumstances of each complaint. Individual selection is based on the facts of the complaint and the clinician's skills, knowledge and experience in the relevant health specialty.

When deciding whether or not to obtain clinical advice, delegates use a formal decision-making framework which considers:

- the potential and actual risk to the health and safety of the public
- whether a matter is serious or potentially serious including conduct that may amount to professional misconduct
- relevant profession or regulatory body's codes and guidelines
- evidence-based research, journal articles and other best practice evidence
- clinical pathways
- the Queensland Health clinical practice guidelines
- analysis of evidence provided by parties, including medical records, submissions, policies and governance frameworks
- detailed analysis of medical records against the issues alleged in the complaint
- whether a matter is suitable for conciliation.

On occasion, delays may be experienced in identifying an appropriately experienced and qualified clinician. For example in areas of sub-specialty where there may be a limited number of appropriately experienced and qualified Queensland-based clinicians available, interstate advisors may be sourced.

Complaints relating to individual practitioners

Complaints about individual practitioners may relate to the performance of the practitioner, their health and capacity to provide health services or their conduct in relation to standards of treatment and professional boundaries. The nature of the complaint has important implications when determining whether clinical advice is required.

Complaints relating to health service providers

Serious complaints relating to health services provided by hospitals and other health facilities or organisations are retained and managed by the office. Clinical advice may be sought in order to provide an independent view of the process used, treatment received and any systemic issues identified in the complaint.

Case study

A chiropractor provided acupuncture to a 61-year-old patient, with unexpected and adverse outcomes. The chiropractor performed acupuncture on the trapezius region of the complainant who developed chest pain shortly afterwards.

The patient presented to the emergency department of a hospital and x-rays revealed a bilateral pneumothorax one large and the other small. The complainant was admitted overnight and released the next day with a discharge plan, including a six-week review.

The matter was accepted and referred to assessment to obtain further information. The pneumothorax were considered to have been caused by overzealous use of dry needling on an area of high risk. Immediate action was taken, with restrictions placed on the practitioner's registration preventing the practise of acupuncture or dry needling. An investigation was commenced to obtain further evidence.

Specialist clinical advice was sought on the process of dry needling, including whether informed consent was obtained. The clinical advice substantiated that although the practitioner's performance resulted in an unexpected outcome or complication, it did not meet the threshold of professional misconduct.

Case study

A complaint was made in relation to cardiac valve replacement surgery provided at a public hospital which may have contributed to the death of a patient. An autopsy revealed that a piece of surgical material was found to have obstructed the patient's artery, causing cardiac arrest and subsequent complications. Clinical advice obtained from a forensic pathologist suggested that the debris was most likely from a graft at the base of the artery, implanted at the time of the valve replacement surgery.

The matter progressed to assessment so further information could be obtained to assist with identifying whether the care provided by the hospital, including the unexpected outcome, was below the reasonable standard of care that would be expected in the circumstances of the case.

Specialist clinical advice was sought from a cardiothoracic surgeon who, after considering possible reasons for the material to be where it was, could not identify that the care and treatment of the consumer was below the reasonable standard of care.

The matter was referred to conciliation for further management of the complainant's concerns with the aim of allowing the complainant to gain a better understanding of the patient's initial surgery and the events leading to his passing.

monitoring and **quality assurance**

Quality improvement in risk-based compliance monitoring

As part of the office's focus on quality improvement, a number of initiatives were progressed in 2016–17.

Risk-based monitoring

The office has adopted a risk-based monitoring framework that provides a more comprehensive and proactive approach to assessing and managing compliance risks. This approach allows the office to direct resources to the areas that, on balance, pose the greatest risk to the health and safety of the public. Using this framework, 61 cases have been assessed as moderate or high risk and 55 involve conditions or restrictions that require intensive monitoring such as compliance with chaperone conditions.

Conditions and restrictions library

A conditions and restrictions library was developed to improve the consistency of the wording and requirements for immediate action conditions and interim prohibition restrictions imposed by the Health Ombudsman. For registered practitioners, this library relied on the work already undertaken by AHPRA and the national boards and serves to improve the alignment of conditions in the co-regulatory jurisdiction. For unregistered practitioners, the office is seeking to be a leader in developing a standardised approach to managing restrictions and requirements.

Reportable events

Under the ***Hospital and Health Boards Act 2011*** and the ***Ambulance Service Act 1991*** a Hospital and Health Service must provide a copy of a root cause analysis of a reportable event to the office. Reportable events are serious clinical events that result in death or serious or permanent harm to a patient that was not reasonably expected as the outcome of the health service.

After completing a review in May 2017, the office will no longer routinely undertake the systemic analysis of individual root cause analysis reports, but will continue to use them to inform the assessment and conciliation of health service complaints, to assist existing investigations and to identify emerging trends.

The Department of Health has an oversight role and has well-established systems and processes for reportable event notification, reporting, monitoring and management across public and private health facilities respectively.

Case study

In December 2016, the Health Ombudsman released the ***Undoing the knots constraining medicine regulation in Queensland*** report after an 18-month investigation into the prescribing, dispensing and regulation of schedule 8 medicines in Queensland.

The own-motion investigation was driven by a trend identified through independent complaints that suggested the system for monitoring the prescribing and dispensing of schedule 8 medicines in Queensland was placing the public at serious risk.

The investigation considered the broader aspects of the appropriateness and effectiveness of the Queensland regulatory system for scheduled medicine, which is complex and involves multiple agencies. The investigation report identified a number of weaknesses in the system, including that the complexity and number of agencies involved left scope for unauthorised prescribing and dispensing of schedule 8 medicines, resulting in misuse.

The Health Ombudsman made 16 recommendations to streamline the system to better protect the health and safety of both the public and health practitioners. Recommendations included a committee to oversee the roles and responsibilities of all participating agencies, formal arrangements between agencies to facilitate the sharing of information, a real-time electronic prescription monitoring system, legislative amendments to facilitate more stringent enforcement, and a move towards a new framework for the regulation of medicines in Queensland.

The report has prompted significant engagement with agencies involved in implementing the recommendations. The office is working collaboratively with stakeholders to secure a safe and appropriate regulatory regime for scheduled medications in Queensland.

The report is available on the office's website www.oho.qld.gov.au.

co-regulatory partnership with **australian health practitioner regulation agency**

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

AHPRA is a national agency with offices in each state and territory which works with the national boards to implement the **National Registration and Accreditation Scheme**, in accordance with the National Law. AHPRA manages the registration and accreditation of all registered health practitioners in Australia.

In Queensland, the office and AHPRA work together to oversee and regulate registered health practitioners in relation to matters concerning their health, conduct and performance. The office is the first port of call for all health service complaints in Queensland and must retain all serious matters relating to registered health practitioners. Less serious matters may be referred by the Health Ombudsman to AHPRA and the national boards to manage, as they have powers in addition to the Health Ombudsman, particularly in relation to health impairment matters that may impact on a practitioner's performance. These additional powers include the ability to counsel practitioners, establish education programs and require practitioner supervision.

The national health practitioner boards

The national boards are an important part of the co-regulatory framework. They are able to conduct health and performance assessments and monitor and enforce professional standards. These processes are critical for managing concerns about registered health practitioners and for managing risks to the health and safety of the public.

The office collaborates with the national boards to promote consistency in decision making across the states and territories, and within the boards themselves, so that the health services regulatory framework remains as consistent and equitable as possible.

Monitoring AHPRA and the national boards

One of the functions of the Health Ombudsman is monitoring the performance of AHPRA and the 14 national boards in their management of matters relating to the health, conduct and performance of registered health practitioners in Queensland.

As part of fulfilling this function, the Health Ombudsman analyses data provided by AHPRA and publishes 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 Queensland public about the performance of AHPRA and the national boards.

Routine performance reporting

In 2016–17, the office published three reports based on the routine performance data submitted by AHPRA. This regular and ongoing reporting allows the Health Ombudsman to monitor emerging trends and any variation in the data over time. In Q4 2015–16, the Health Ombudsman identified AHPRA and the national boards had demonstrated genuine progress towards improving the quality and transparency of their performance data and had generally improved in the performance of their functions.

Targeted assurance activities

In 2016–17, the office also completed a targeted assurance activity designed to determine whether the processes employed by AHPRA and the national boards for monitoring registered health practitioners with a health impairment adequately protected the health and safety of Queenslanders.

The activity provided assurance that AHPRA is committed to identifying, developing and implementing improvements at a national and state level in order to provide a best practice approach to monitoring and compliance.

Work has also progressed on a second targeted assurance activity examining AHPRA's open assessments at the *pending board decision* stage, which is the stage where matters have progressed to a board for consideration and the final decision of the board is yet to be confirmed. The activity will review management processes and timeliness of matters in assessment that are pending board decision. This will provide a complete and accurate view of the process in order to identify opportunities for improvement in this area and, if necessary, make recommendations for process improvements.

Consultation with AHPRA and the national boards

The office consults with AHPRA on matters being considered for referral. AHPRA are provided with all necessary information to inform a decision on whether referral is appropriate.

For certain complex matters, or where a pattern of conduct may be present, the office holds case conferences with AHPRA, either in person or electronically, to determine the best action to take. By encouraging robust conversations during this process, productive and consistent decisions between the co-regulatory agencies are achieved.

In addition, the office regularly shares information with AHPRA outside the formal consultation process to support effective complaints management.

Referral to AHPRA

The office is the single point of entry for health service complaints in Queensland and where matters are first received. Less serious matters related to the health, conduct and performance of registered practitioners are referred to AHPRA and the national boards at various points in the complaints management process when matters are best dealt with by AHPRA and the relevant national board. The office provides all relevant information when a matter is referred to allow for efficient and effective ongoing management.

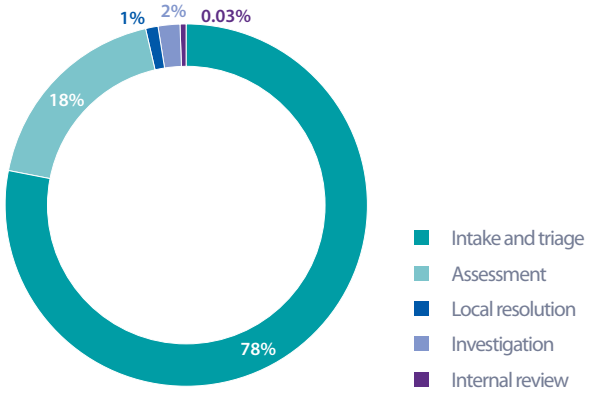
Larger and more complex complaints can be split between the office and AHPRA. For example, a health impairment matter might be referred to AHPRA, as it is best-placed to manage such issues, while the corresponding performance or conduct matter is retained by the office.

Ninety six per cent of referrals made to AHPRA are made at the intake and assessment stage of the complaints management process. As required by the Health Ombudsman Act, the office consults with AHPRA on all matters considered appropriate for referral. In 2016–17 the office consulted on 2080 matters, which resulted in 2060 referrals being made. Seventy-nine per cent of matters commenced consultation within fourteen days of acceptance by the office.

Since its inception in July 2014, the office and AHPRA have worked closely in establishing an effective co-regulatory system in Queensland. The office has provided input into the development of a national library of practitioner restrictions which is available on the AHPRA website.

Work continued in 2016–17 to embed consistent methodologies and process improvements. In 2017 the office developed an online case management referral portal streamlining the referral of appropriate matters to AHPRA in the early stages of the complaints process.

Source of proposed referral to AHPRA



The portal contains a practitioner database which gives the office access to practitioner-related information and facilitates the mutual sharing of information and knowledge.

These initiatives avoid duplication, facilitate more cost-effective complaints management and resolution, lead to more timely resolution for complainants and health practitioners, and provide for more timely risk assessments.

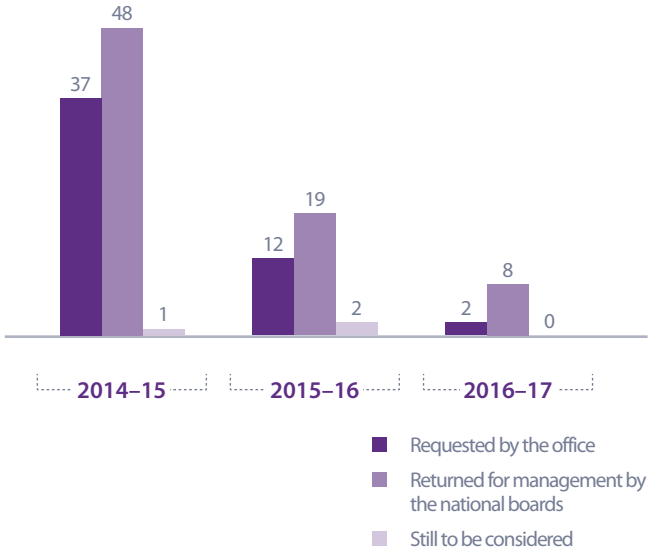
Both agencies acknowledge the importance of collaboration and transparency and the role this plays in instilling confidence in the way health service complaints are managed in Queensland. There is increasing collaboration on split cases, and protocols are being developed to further improve communication and information sharing so that both agencies are fully aware of the progress of a practitioner's case, and the consequences of work done by one agency on the other.

Notification of serious matters

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 2016–17, AHPRA notified the office of 10 matters identified as serious. Of these, the Health Ombudsman requested two be referred to the office for management and determined that eight should continue to be dealt with by AHPRA and the national boards. The majority of matters that were to continue being managed by AHPRA related to practitioners with impairments, who are most appropriately dealt with by AHPRA.

Notifications from AHPRA to the office



stakeholder **engagement**

The office has an ongoing commitment to direct and productive engagement with individual and organisational stakeholders. In addition to regular engagement with AHPRA, Queensland Health, private health service providers, the Queensland Police Service and the Coroners Court of Queensland, representatives of the office in varying capacities engage with stakeholders such as regional Hospital and Health Services, government health agencies and medico-legal firms. For a full list of stakeholders please turn to **Appendix 2** on **page 149**.

Community engagement

Engaging with organisations representing consumers who are over-represented in health services, but under-represented in health service complaints has remained a high priority for the office in 2016–17.

Aboriginal and Torres Strait Islander peoples, people with a disability and the elderly often have more complex healthcare needs, a higher mortality rate and face greater barriers to accessing appropriate health services compared with the rest of the population. Culturally and linguistically diverse communities also face their own challenges in both accessing health services and knowing what to do if they're not satisfied. The office recognises this need and maintains an ongoing review of its systems and processes to ensure they accommodate all Queenslanders.

In 2016–17 the office engaged directly with the Office of the Public Guardian to gain improved understanding of people with a disability. The office also engaged with representative groups including Carers Queensland and the Queensland Aged and Disability Advocacy service, to ensure their members are aware of the work the office does and how to make a complaint.

As the office matures, there is a greater need to engage directly with consumers, practitioners and health service organisations. As part of the office's commitment to increasing grass-roots community engagement and speaking directly with people who may come into contact with the office, either as consumers or health service providers, representatives of the office attended the Pittsworth Health and Wellbeing Expo and NAIDOC Week as part of an evolving community engagement program.

Health service provider engagement

The office engages with a wide range of public, private and community health service providers.

In some cases stakeholder engagement arises as a result of trends or patterns evident in complaints. In 2016–17, the office engaged directly with a number of Hospital and Health Services in the course of systemic investigations into concerns relating to the quality of maternity services for mothers and babies in hospitals across Queensland and the identified difficulty of prisoner access to health services in correctional centres. The office also collaborated closely with the Pharmacy Board of Australia in relation to further education of pharmacists in the requirements of the three-day rule in emergency dispensing of drugs without prescription.

The office also engages with registered and unregistered practitioners and health service providers in the course of monitoring recommendations resulting from internal and external investigations or reviews.

Legal engagement

The office proactively engages with external legal professionals. In 2016–17, the office presented to a number of external stakeholders including the QUT Australian Centre for Health Law Research.

Health Ombudsman engagement

Throughout the year, the Health Ombudsman continued to engage with key partners and members of the wider healthcare sector. Engagement has focussed on education, feedback, performance, risk management, business improvements, idea generation and the enhancement of key relationships.

The Health Ombudsman formally engaged with:

- Chief Health Officer
- Department of Health Medicines Compliance and the Human Tissue Unit
- Coroners Court of Queensland
- Queensland Doctors' Health Program
- Hospital and Health Services throughout Queensland.

The Health Ombudsman also regularly engaged with various health service providers, professional associations, complaints management and government agencies, education institutions, consumer associations and unions.

Operational collaboration

Effective operational stakeholder engagement is also essential for the office to perform its functions. In 2016–17, the office continued its focus on cooperation and collaboration with other government agencies. The Health Ombudsman's overarching purpose is to protect the health and safety of the public and this can intersect with functions undertaken by other entities, such as the Queensland Police Service and the Coroners Court of Queensland. Close coordination and cooperation with external stakeholders enables the office to act quickly, minimise duplication and avoid interfering with other entities' statutory responsibilities. Mutual understanding and efficiencies between participating agencies enhances the credibility of the health service complaints management process and benefits the wider healthcare sector in Queensland.

Responses such as immediate action and investigations often require the involvement of multiple agencies and a matter can fall within the jurisdiction of more than one entity. The office is proactively identifying stakeholders with whom it engages on a regular basis and is preparing memorandums of understanding to facilitate further productive collaboration.

As 60 per cent of investigations relate to criminal matters, a dedicated officer has been appointed to liaise directly with the Queensland Police Service, the Coroners Court of Queensland, the Crime and Corruption Commission, the Office of the Director of Public Prosecutions, Queensland Corrective Services, the Parole Board of Queensland and the Department of Justice and Attorney-General to assist the office in performing its key functions.

Spotlight on stakeholder engagement

Prior to the design and development of the initial complaints intake and referral processes, the office consulted with all state and Australian government agencies involved in the processing or referral of heath service complaints in order to design a best-practice complaints resolution process.

The year-on-year increase in the number of complaints received by the office, and the corresponding increase in the number of required referrals, highlighted the need for revised and even more efficient processes to manage the increased number of referrals to external agencies.

The office identified more efficient pathways and commenced consultation with 16 Hospital and Health Services, and 16 state and Australian government entities to request feedback on the proposed changes. The office received a large number of highly supportive responses from this consultative process. The process also opened up new avenues of communication, particularly with state and Australian government agencies that do not regularly receive complaints referred by the office. Some of these entities used this opportunity to meet with the office with the purpose of establishing pathways for knowledge sharing, increased mutual understanding and establishing points of contact for future referral of complaints.

At the conclusion of this process, information and feedback was incorporated into process adaptions and improvements to manage the early stages of complaints management and referral to external agencies in a more efficient and timely manner.

client **satisfaction**

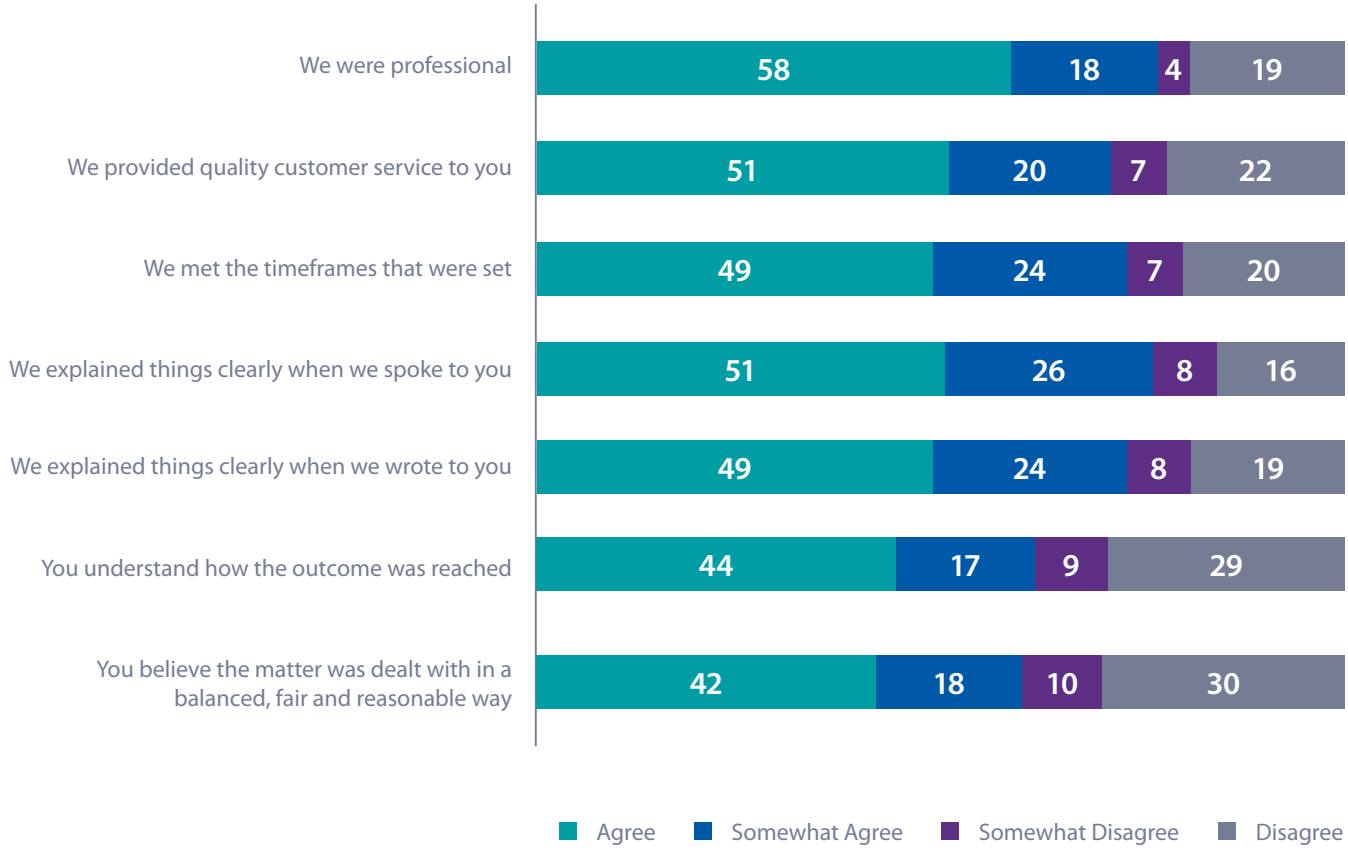
Obtaining feedback and engaging with stakeholders and the community allows the office to identify where it can make service improvements to ensure services are accessible, transparent and accountable and provide a robust system for effectively and quickly dealing with health service complaints.

The office asks clients to complete a client satisfaction survey at the end of the complaint process. Feedback from complainants and health service providers helps inform continual service improvement.

In 2016–17, 223 survey responses were received, of which:

- 77 per cent were from the complainant who received the health service
- 14 per cent were from a person who complained on behalf of another person
- 5 per cent were from practitioners who had a complaint made against them
- 4 per cent were from the health service provider, employer or educator.

Outcomes of client satisfaction survey 2016–17



Key highlights

The office was pleased to see 64 per cent of respondents across all quality of service questions reflected positively on their experience and were complimentary in their feedback.

Totally satisfied with the manner in which my case was handled. No further problems. Thank you.

The person who handled my complaint was thorough, straightforward, compassionate and willing to do as much as possible with my case.

From my first telephone call I was treated with respect and courtesy and felt relief that someone could help me.

Deadset beautiful job you did with my matter. Thank you so very much from the bottom of my heart.

I have only good things to say about the services I received during the processing of my complaint.

Although the outcome is not what I would have liked I sincerely believe the staff were very professional, courteous and respectful.

Areas for improvement

A number of respondents provided useful feedback on how the office could further improve aspects of its service. We value these comments as a pathway to improving overall service quality.

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. To ensure our decisions are clearly communicated to complainants and practitioners, 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 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 and **operational challenges**

The office's overarching purpose and our principal priority is protecting the health and safety of the public. All of our pathways and processes for managing and responding to health service complaints, from the most straightforward to the most complex, are focused on this guiding purpose.

The strategic plan 2016–20 contains five strategic objectives against which the office is benchmarked each year. For further information on evaluation of the performance of the office in relation to these strategic objectives please turn to **page 75**.

Volume of complaints

In meeting our purpose, the key strategic and operational challenge the office continues to face is the increasing number of complaints received each year, and the growth in the size and complexity of serious matters. The office has responded and will continue to respond to this challenge with a focus on continuous innovation and systems-based improvements in processes, efficiencies and outcomes to manage complaints within required timeframes. The achievements in process improvements this year have laid a solid foundation for further progress in 2017–18.

The resolution of complaints is important on an individual basis, however, there are less visible aspects of our work that make a vital contribution to our role and purpose.

A high number of resolved complaints result in better care and protection of the wider community due to significant changes in the practices of registered and unregistered practitioners and aspects of public and private health service provision. Often, just by the office becoming involved in a matter, health service providers proactively seek to identify and address opportunities for improvement in their provision of health services. This is an example of the direct impact the accountability and oversight the office brings to the health system.

Data from an increased number of complaints accepted by the office provides a greater opportunity for identifying trends and insights into emerging areas of weakness and concern within the health system. The office is continuing to develop its data collection and reporting capabilities to allow for further expansion and rigour of health service complaint reporting. With these valuable insights, the office can work collaboratively with healthcare service providers and other stakeholders to refine and adapt services, mitigate risk and enhance service quality for the people of Queensland. Complex matters and systemic investigations are a valuable opportunity to identify, inform and bring about broad system change in the health system to maintain its integrity for all Queenslanders.

Statutory timeframes

Since the inception of the office, the ability to meet statutory timeframes has been increasingly challenged by the growth in the number of complaints.

Despite this challenge, significant milestones have been achieved at all stages of the complaints resolution process and this will remain an area of focus in 2017–18. At the intake stage, 74 per cent of decisions were made within statutory timeframes, increasing to 90 per cent in Q3 and Q4 of 2017. The greatest number of referrals to AHPRA and the national boards take place in the early stages of intake and assessment. In assessment, 61 per cent were completed within statutory timeframes (up from 32 per cent in 2015–16) increasing to 68 percent in Q3 and 75 per cent in Q4 of 2017, while in local resolution 96 per cent of complaints where completed within legislated timeframes.

Complexity of matters

As the office is required to retain all serious matters, a large number of complaints are complex, requiring significant investment of time and human resources. This, in conjunction with the volume, has required ongoing review and improvement of systems and processes to create as many efficiencies as possible while maintaining the quality of decision-making. In addition, targeted staffing strategies have been incorporated across the organisation to identify resourcing needs. With these ongoing strategies in place it is expected that the coming year will see a decline in the backlog of complaints at the more complex stages of the resolution process, and provide clearer insights into what will be the anticipated workload of the office.

Another key challenge is the office's ongoing focus on complex systemic investigations. While these are often time consuming and resource intensive, they are a valuable opportunity to identify, inform and bring about broad change in the health system to maintain its integrity for all Queenslanders. The office will continue to develop this area of its business and work with key stakeholders to ensure that these processes provide clear, meaningful and actionable outcomes.

Quality decisions

The need for timeliness must be balanced with the need for accurate assessment and quality decision making. At times, in order to make well-informed and robust decisions, the office requires further information from the parties involved or external parties, or may have to wait until another agency has finished with the matter before it can be progressed. While these delays are undesirable, they are necessary, with thorough, impartial processes ultimately benefiting all parties involved and the wider health system.

Systems and processes

Across the organisation at the division, unit, team and individual level, a systems-based approach to process improvement and more efficient use of resources has taken place and will continue to evolve.

Initiatives such as the development of formal policy, process and procedure manuals; a legal knowledge database; and ongoing adaptions to the office's case management system to reflect changes and trends evident in complaints accepted by or referred to the office will continue to make significant contributions to operating efficiencies and reaching case management milestones within required timeframes. The success of this approach is reflected in the quantitative increase in the number of complaints accepted, referred, managed and resolved.

Resourcing

The strategic challenge remains to identify, in the longer term, the necessary level of resourcing required for each function delivered by the office to provide high quality outcomes within statutory timeframes. Complaints data and workloads are actively monitored to identify appropriate and responsive levels of resourcing to provide high quality and timely service delivery.

Engagement and information sharing

The office recognises the important contribution made by our stakeholders in achieving excellence in client service delivery, achieving fairness and transparency in the resolution of complaints, and in implementing recommendations to make the health system in Queensland safer for the communities it serves.

The office will continue to actively engage with stakeholders at the operational, health sector and community level. Collaboration in the form of referral, provision of information and information sharing—with AHPRA, the national boards and other members of the co-regulatory framework—reduces duplication within the health service complaints management system and within the office itself. Active engagement with health service consumers, practitioners, hospitals and other health service providers, and the broader community contributes to a more efficient complaints management process and a more robust health service system.

In addition, the office is committed to continuing its education and engagement activities with providers and the community. Meetings, presentations and attendance at various events with health providers is a valuable means of talking about what the office does and answering questions to assist providers in gaining a better understanding of the health complaints system in Queensland. Similarly, engagement with community representative groups and organisations, as well as attendance at various community events, provides direct contact with those in the community who can most benefit from knowing their rights when it comes to receiving health services and what they can do if they or their family members are not satisfied.

The awarding of costs in legal proceedings

The ***Health Ombudsman Act 2013*** is silent as to the issue of costs awarded in disciplinary proceedings. Consequently, the issue of costs must be determined in accordance with the ***Queensland Civil and Administrative Tribunal Act 2009*** which requires that each party bears their own costs of the proceeding when a matter is referred to QCAT unless the 'interests of justice require' an order for costs to be made against one of the parties.

An award of costs against a respondent enables the office to recover some of the costs of disciplinary proceedings, which have the important function of protecting and maintaining the safety of the public. Given the increased number of matters being referred to QCAT, and the increasing number of applications for review of orders for immediate action, the office would like to see future amendment of the Act to clarify the ability to recover those costs.

Communicating purpose and performance

Communicating the role and purpose of the office and reporting performance outcomes continues to be an important area of strategic focus, as this:

- increases the public's awareness of their rights in relation to health services
- increases awareness of the existence of the office and its role as a resolution process
- demonstrates the role of the office in protecting the health and safety of the public.

A related strategic challenge is one of wider community education about the office's role as the single point of contact for complaints relating to health services in Queensland. It is important the community is aware of the office's capacity to regulate and discipline both registered and unregistered practitioners in serious matters, particularly as the number of health consumers choosing alternative therapies increases.

The office is committed to ensuring its services and information about the role it plays are available to people from all corners of Queensland, and are accessible for those community members most at risk or marginalised in the interests of equity in access and accountability.

Regulation of unregistered practitioners

The number of complaints relating to serious matters received by the office in relation to unregistered practitioners poses a challenge to the office in its role of protecting the health and safety of the public.

The controls around who can call themselves a health practitioner when they are not registered, and what services they provide (or claim to provide) are often minimal at best. This not only makes it difficult for consumers to make an informed decision, but also creates difficulties and complexity for the office in how it deals with these matters.

Over the last three years the office has focussed on how it can best protect the public in these instances and will continue to do so. In addition, it is hoped that data and insights from these complaints will inform a more comprehensive regulatory framework to protect the health and safety of consumers in this area over time, supported by the start of a national approach to unregistered practitioner regulation in the form of the National Code of Conduct for Health Care Workers.

Professional development to manage high workloads

Recruiting and retaining skilled and experienced staff in a high-volume, dynamic and complex health regulation environment is a key strategic and operational challenge. Continued attention to staff care, professional development and retention strategies are important areas of ongoing focus for the office. Longer-term and permanent appointments lead to greater team building and cohesion, increased personal and organisational efficiency and better outcomes for the complaints resolution process.

Recruitment of staff to meet growing workloads and the targeted allocation of staff resources to priority areas will be an ongoing requirement, as will a focus on effective induction and orientation and regular professional development training.

priorities for the **year ahead**

Our overarching priority for the year ahead is maintaining our commitment to our legislative purpose of protecting the health and safety of the public. We achieve this through a strategic and operational focus on the quality and integrity of the health service complaints management system. This commitment informs our priorities for the year ahead.

Process innovation and refinement

The achievements in process improvements this year lay a solid foundation for further flexibility and adaption for 2017–18. The office will maintain its momentum of continuous innovation and systems-based process improvements to deliver excellence in service delivery, achieve outcomes within legislative timeframes and maintain public confidence in the healthcare complaints management process.

Cross-functional collaboration and interdisciplinary teams

In our third year of operation, much has been achieved in terms of adopting a multi-disciplinary, cross-functional approach to the complaints management process. This has been an important driver of more efficient management of complaints, better allocation of resources, improvements in legislative timeliness, and a clearer, enhanced experience for complainants and health service providers and seamless interaction with our stakeholders. This has particular benefit in the more complex areas of investigations, immediate action, monitoring and compliance, referral to the Director of Proceedings and referral to QCAT.

A number of concurrent projects are in place to prioritise and focus on internal qualitative goals to facilitate stronger internal cohesion and collaboration at the organisational, team and individual level to further refine shared clarity of purpose across the organisation.

Developing infrastructure

The increase in cross-functional collaboration and interdisciplinary teams is supported by ongoing developments in infrastructure which benefits all units and divisions within the office. Initiatives such as the legal knowledge base, improved internal reporting and ongoing development of the case management system to ensure it adapts and evolves in line with the changing needs of the office are all key priorities in the year ahead.

Looking after our staff

Our staff are our greatest resource. They are the interface between the public, health service providers and the complaints management system. More importantly, they have carriage of the office's purpose and represent its values which both result in the protection of the health and safety of the public, and the instilling of confidence in the complaints management system. At times, analysing distressing complaints information can impact on their psychological wellbeing. To minimise the risks of vicarious trauma and actively care for our staff, the office will continue developing its staff wellness program, including ongoing discussions with academics and practitioners, to develop a model to guide recruitment, induction, training, business processes and crisis response.

The office will also incorporate the outcomes of the ***Working for Queensland*** survey into its human resource management protocols and continue to explore ways of embracing diversity.

The office will proactively recognise staff commitment and acknowledge the importance of individual professional fulfilment. The expected benefits of these initiatives will be to promote an improved sense of staff wellbeing, increase levels of personal and professional satisfaction and encourage staff retention. These measures will provide a positive workplace culture committed to consistently high quality service delivery.

Communicating the role and purpose of the office

Communicating and engaging with key stakeholders involved in the health sector and regulatory environment will continue to be a key priority for the office. A range of initiatives are planned or have commenced to improve information sharing between agencies, which will continue in 2017–18. In addition to improving administrative processes the office is committed to continuing to engage with health service providers and other key stakeholders to identify how it can work with them to further grow the efficiency and effectiveness of the health complaints management system in Queensland.

Raising awareness of the office and its purpose within the broader community is also an ongoing priority. The office will continue reaching out and engaging with various representative bodies to identify the best strategies for reaching various audiences in the Queensland community. Raising awareness of the options and rights people have when they are concerned about health services and educating them on the role of the office remains key, as well as refining targeted messages to best engage with different groups within the community.

A parallel communication priority is to make consumers who attend unregistered health practitioners aware of the fact that many *medications* recommended by unregistered practitioners are not regulated by the Therapeutic Goods Administration.

The office is aware that many complaints in relation to all practitioners go unreported to the office due to the vulnerable state of some complainants and the delicate nature of some practitioner behaviour, particularly in relation to sexual assaults. A key priority is to encourage reporting of these matters to the Queensland Police Service and/or the office as appropriate, by communicating to the wider community the consumer-focused and empathetic nature of the office's complaints process and the ease of notification.

Collaboration and information sharing with AHPRA

The ability to share information and data with AHPRA and the national boards is a key driver of the integrity of the health service complaints management system in a co-regulatory environment. This year has seen some significant achievements in this area and collaboration with AHPRA and the national boards remains an ongoing priority to further improve inter-agency collaboration and contribute to and share nationally consistent data.

The office's development of an online portal with AHPRA for case referral and file sharing in relation to registered practitioners has contributed greatly to mutual efficiencies and improvements in timely outcomes. Early referral of matters to AHPRA for disciplinary action has sped up timeframes in the early stages of the complaints management process and has added to efficiencies in the management of more complex matters.

Work will continue in 2017–18 to further develop data-sharing arrangements and identify opportunities to improve the exchange of information between agencies that provides improvements in efficiency, transparency and consistency.

Informing legislative change

At the end of our third year, a number of areas for legislative amendments to the ***Health Ombudsman Act 2013*** and the office's scope of power have been identified that would make a significant and positive contribution to efficiencies of process and create improved outcomes for the health and safety of the public.

Legislative refinement would increase efficiencies and the number of resolutions in the early stages of the complaints management process and less matters would proceed to the more costly area of investigation, immediate action and referral to the Director of Proceedings.

More precise definition of the scope of power and authority of the Health Ombudsman in relation to other co-regulatory partners would create greater certainty in referral to AHPRA and other organisations, particularly at the intake and assessment stage.

More precise definition of timeframes would also provide greater certainty for a number of functions of the office. Greater flexibility in managing the issues arising from complaints would ensure all relevant parties can be included in the processes of local resolution and conciliation in order to effect appropriate outcomes and resolve a greater number of complaints at the earlier stages of the complaints resolution process.

Legislative amendments to enable more timely access to a broader scope of information held by external bodies would make a significant contribution to efficiencies in process and increase our ability to better meet our overarching purpose. The ability of the office to deal with serious matters is compromised when we are legislatively restricted in access to important and relevant information relating to the conduct of medical practitioners. Access to information from sources such as the Queensland Wide Inter-linked Court and QPRIME, for example, would reduce administrative costs and time, increase flexibility and make better use of human resources when conducting investigations.

Similarly, amendment to section 84 of the ***Health Ombudsman Act 2013***, which relates to three-monthly progress reporting, would reduce the administrative and financial burden and free-up investigators and financial resources for more timely completion of investigations.

The Health Ombudsman also lacks a range of powers to deal with unregistered health practitioners. Currently, only matters that are serious or constitute a serious risk can be managed by the office and referred to QCAT. This means most breaches of the ***National Code of Conduct for Health Care Workers*** are outside the regulatory powers of the office. Data and insights from complaints relating to unregistered practitioners will inform options for legislative change to provide additional and more flexible options to better protect the health and safety of consumers.

In the case of practitioners who have conditions imposed on them, the monitoring of these practitioners to ensure compliance is resource intensive, and diverts the office's resources away from other core functions. Minor legislative amendments to transfer some of this routine responsibility to AHPRA and the national boards would enable more productive use of the office's resources.

Embedding feedback from internal reviews

This year, the internal review process gained momentum and positively influenced stronger 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 processes and decision making. The office will continue to use feedback from internal reviews to make ongoing improvements in the quality, content and communication of decisions being made.

Improving access to the office for all Queenslanders

The office will prioritise its communication to include all areas of Queensland in the interests of equity, access and the integrity of health services in all regions. It is also a priority to communicate and engage with communities that are highly represented in health services, but under-represented in health complaints. This can be due to a number of factors, including access, health literacy or lack of desire to complain. Key community groups include Aboriginal and Torres Strait Islander communities, people with a disability, culturally and linguistically diverse communities and the elderly.

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.

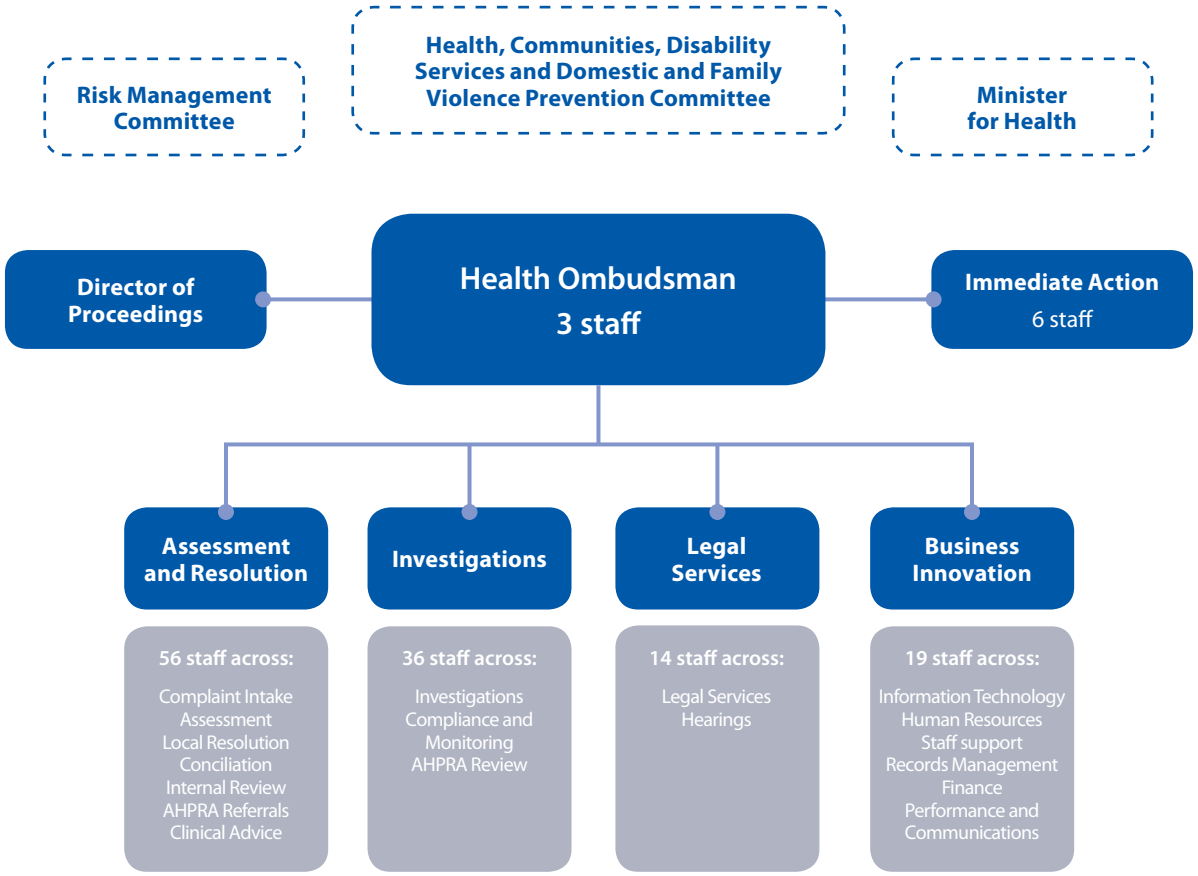
The Health Ombudsman's functions and responsibilities are to:

- 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 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, appointed under the ***Health Ombudsman Act 2013***, 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 39** 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. Prior to his tenure in Queensland as the Health Ombudsman, he served as 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, childcare and animal welfare.

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 United Kingdom 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. The division also manages internal reviews of decisions where a party is concerned the wrong decision has been made.

Scott McLean

Acting Executive Director, Investigations

Scott is a lawyer with 25 years of experience in private, government and regulatory practice focussing on criminal prosecutions, professional regulation and discipline. He commenced his role at the office after 11 years at the Legal Services Commission where he was involved in investigations, disciplinary hearings and compliance auditing relating to the regulation of the legal profession.

The Investigations division is responsible for the formal investigation of matters of significant importance to the health and safety of the public, 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 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 relies heavily on the skills of its 131.58* full time equivalent employees, an increase from 125.56 full time equivalent employees in 2015–16. Additional recruitment occurred in 2016–17 to provide additional temporary resources to manage the increased number of matters requiring investigation and to ensure complaints are progressed in a timely and thorough way.

Employment type

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

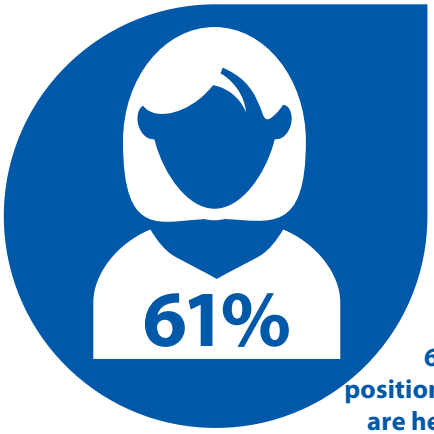
6% part time

94% full time

85% permanent employment

Gender distribution

61% of managerial positions are held by female staff—managerial positions are classified as AO7, or equivalent, and above.



68% female staff

32% male staff

61% of managerial positions at or above A07 are held by female staff

Age distribution

The office aligns with the average age of an employee in the Queensland Public Service which is 41 years.

Years	Female	Male	Total	%
20–24 years	2	0	2	1%
25–29 years	10	4	14	10%
30–34 years	18	10	28	21%
35–39 years	18	8	26	19%
40–44 years	17	5	22	16%
45–49 years	8	6	14	10%
50–54 years	7	4	11	8%
55–59 years	6	4	10	7%
60–64 years	5	2	7	5%
65+ years	0	0	0	0%

* One staff member was paid through OHO but was on secondment to another government agency which has impacted our FTE and headcount by one which will be represented in the PSC MOHRI data. OHO was reimbursed for the cost of 1 FTE.

Induction

The office is committed to ensuring that its induction processes assist new staff to become productive and integrated members of the organisation as quickly as possible. 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 and valued contributors, with opportunities to grow professionally. The office is fortunate to have a culture of dedication and commitment to positively influencing the quality of the health system and caring for and protecting the wider community. This shared purpose underpins a workplace culture of excellence.

The office recognises the high level of emotional labour required to deal with health service complaints and has developed a number of initiatives to support staff.

A staff wellbeing project commenced in August 2016 with the objective of building a resilient workforce in a proactively supportive environment. A ***Risk of Harm*** policy, procedure and management tool has also been developed, along with administrative mechanisms, such as alerts for unsettling or confrontational material contained in complaint files and more tailored position descriptions to support more targeted recruitment.

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.

During 2016–17, the office provided a range of opportunities for learning and development that included training in:

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

Staff forums

Staff forums are held three times a year and provide an opportunity for all employees to engage with the executive management team and openly discuss any issues with team leaders and other colleagues with questions being actively encouraged both in the lead up to and during forums. Staff forums are also a valuable opportunity for different divisions to provide whole-of-organisation updates on particular areas of the complaints management process and to flag any milestones or significant outcomes. The forums facilitate positive internal communication and engagement, collaboration and organisational cohesion in relation to the overarching purpose of the office.

Performance and development

The office's performance development program provides a platform for meaningful conversations between staff and their managers in relation to responsibilities, performance, expected behaviours, supervisory support requirements and development goals, within a framework aligning with the office's strategic plans, goals and objectives.

Performance expectations are set with new staff within one month of commencement. A key element in the success of the program is regular and ongoing feedback between staff and their supervisor throughout the year.

Professional development

The increasing number of contacts received by the office requires the office to work at peak efficiency. To support our staff in doing their jobs well, the office provides regular professional development opportunities to expand individual and collaborative knowledge bases, to promote best practice and nurture career development. Staff are encouraged to attend regular learning opportunities such as briefings by internal and external stakeholders, discipline specialists and professionals, which this year included:

- The Chief Psychiatrist, Department of Health, presented to the office on the ***Mental Health Act 2016.***
- The Office of the Public Guardian presented on decision making and impaired capacity.
- The Queensland Police Service legal unit presented on the types of information that can be requested by the police.
- The Crime and Corruption Commission presented on the gathering of covert evidence.
- The Department of Health presented on the implications for the office of the amended ***Mental Health Act 2016***.

In addition, there are frequent in-house presentations and information sharing sessions by executive directors, directors and team leaders on developments in specialist areas.

Industrial and employee relations

The office is part of the Queensland Health enterprise bargaining arrangement. The new enterprise bargaining agreement ***Queensland Health Sector Certified Agreement (No.9) 2016*** was certified on 7 June 2017.

Staff satisfaction

There was no ***Working for Queensland*** employee opinion survey conducted in 2016–17, with the next survey due to occur in 2017–18. Ongoing internal consultation with staff on workplace satisfaction is consistent with the findings of the 2016 survey in which staff cited job empowerment, their work group or team, management, professional development opportunities and innovation as strong sources of satisfaction in working with the office. There has been an increase in the number of employees intending to remain with the office for the next 12 months.

As a result of the 2016 ***Working for Queensland*** employee opinion survey, action plans were developed to maintain and make improvements to staff morale and engagement in the office. It was found to be more cost effective to develop a framework of action in-house where there is better understanding of key issues and identification of key areas for improvement. The framework will be reviewed and updated in accordance with the outcomes of the 2017 survey.

No redundancy, early retirement or retrenchment packages were paid in 2016–17. 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.

accountability and **transparency**

Recordkeeping systems

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

The office's case management system is critical to the operation of the office and ongoing training for staff ensures the effective use of this system. The office is continuing to develop the system to meet its needs, including the refining and streamlining of workflows and the integration with the electronic recordkeeping system. Plans for full digitalisation have commenced and significant progress has already been made in moving complaint assessment records from hard copy to electronic files.

The office has finalised the migration of legacy records to the electronic recordkeeping system and continues to train existing and new staff in the standards, roles and responsibilities to create and maintain accurate public records.

The office continues to liaise with Queensland State Archives to finalise an updated retention and disposal schedule specifically for the operations of this 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 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 under 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 office gives due regard to Queensland Treasury's ***Audit Committee Guidelines: Improving Accountability and Performance***, and is committed to annual self-assessments and external peer reviews at least once every three years. The risk register was revised during 2016–17 and a reporting process was introduced in late 2016–17 meaning the self-assessment will occur in early 2017–18 to ensure the exercise can meaningfully consider the adequacy of these measures. It will be followed by an external peer review, currently planned for late 2017–18.

Committee members during 2016–17 were:

- Mr Eric Muir (Chair)—*29 June 2015 to 29 June 2017*
- Mr Dan Matthias—*29 June 2015 to present*
- Ms Lisa Pritchard—*7 July 2015 to present*
- Mr Robbie Wilson—*29 June 2015 to 10 January 2017*
- Ms Prue Beasley—*23 November 2016 to present*
- Mr Scott McLean—*10 January 2017 to present*.

Mr Muir's term as Chair of the Risk Management Committee, and external member, ended on 29 June 2017. During his tenure, Mr Muir was remunerated at the rate of $220 per hour (GST exclusive). Mr Muir 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.

Ms Simone Finch has been appointed as an external member and the new Chair for the committee, effective from 1 July 2017. She is currently the Chief Executive Officer for the Darling Downs and West Moreton Primary Health Network. From 2012 to 2014, Ms Finch held roles as Chief Executive, Torres-Strait Northern Peninsula Hospital and Health Service (TNPHHS) and Executive Director Transition, TNPHHS and Cape York HHS amalgamation. Between 2014 and 2016, Ms Finch was General Manager, Service Delivery—Housing and Homelessness Services within the Department of Housing and Public Works, where she also acted in the Deputy Director-General role when required.

Ms Rachael Barabas will also join the committee from 1 July 2017, as an external member and financial expert. She is the Director, Financial Services with the Corporate Administration Agency.

Open data

The following information for 2016–17 is available on the Queensland Government Open Data website **www.qld.gov.au/data**:

- consultancies
- the Queensland Language Services Policy

The office had no expenses for overseas travel in 2016–17.

Summary of non-financial measures

Outcomes	
10262	contacts received
6201	complaints received
74%	of decisions made within 7 days
47%	of assessments completed in 30 days
21%	of assessments completed in 60 days
87%	of local resolutions completed in 30 days
13%	of local resolutions completed in 60 days
83%	of local resolutions where a resolution is reached
73%	of conciliations where agreement is reached
247	investigations commenced
46%	of investigations completed within 12 months
51	immediate registration actions
26	interim prohibition orders
51	practitioners referred to the Director of Proceedings
1847	practitioners referred to AHPRA
126	root cause analysis reports received
Reporting	
3	investigation reports published
4	monitoring and quality improvement reports published
188	matters listed on the investigations register
People	
—	staff satisfaction—the results of the 2017 ***Working for Queensland*** survey were not available at the time of publication
131.58[1]	full-time equivalent employees
7%	permanent separation rate[2]
0	redundancy, early retirement or retrenchment

[1] As at end of last full pay fortnight before 30 June. I [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	61%
Percentage of investigations completed in less than 12 months	46%

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
Percentage of disciplinary matters in which QCAT decided there was a case to answer.	100%
Proportion of immediate registration actions upheld by QCAT	90%

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	74%
▪ assessed within legislated timeframes	61%
▪ locally resolved within legislated timeframes	96%
Percentage of matters subject to resolution or conciliation where an agreement is achieved:	
▪ local resolution	83%
▪ conciliation	73%
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	Ongoing
Percentage of clients satisfied with the complaints management process based on responses to the Client Experience Survey	64%

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
Implementation of a management and leadership capability development program.	Completed
An ongoing focus on systems based process improvements with employees engaged and empowered to formally and informally suggest process improvements.	Ongoing
Establish tools and baseline measures to maintain an organisational culture focused on the role and purpose of the office.	Completed
Maintain established performance agreements linked to corporate objectives with a high percentage of staff rated 'meets expectations or better'.	Completed

Objective

Foster an environment where our people are valued, resilient and empowered to actively contribute to improving service delivery.

Measure	Result
Create an environment where staff are engaged and valued contributors, with opportunities to grow professionally.	Ongoing
Develop a staff wellbeing programme with the objective of building a resilient workforce in a proactively supportive environment.	Ongoing
Develop a ***Risk of Harm*** policy, procedure and management tool with associated administrative mechanisms to foster staff care and promote resilience.	Ongoing
Contemporary, fit-for-purpose and continuous training provided to employees that addresses technical and professional learning needs.	Ongoing
Provide four-monthly staff forums to facilitate engagement with the executive management team and provide internal communication of significant milestones and process developments.	Ongoing
Provide frameworks for professional development and performance appraisal with regular opportunities for meaningful dialogue between managers and team members.	Ongoing

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 keeps the Queensland Parliament and the community informed of these matters.

The Honourable 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

The Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee is the parliamentary portfolio committee that oversees the Office of the Health Ombudsman. The committee is the amalgamation of the previous Health and Ambulance Services Committee and the previous Communities, Disability Services and Domestic and Family Violence Prevention Committee. Amalgamation took place on 18 February 2016.

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**.

Directions by the Minister for Health to the Health Ombudsman

There were no directions by the Minister for Health to the Health Ombudsman in 2016–17.

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 67** 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.

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—customers 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 2017

The official copy of the annual report, as tabled in the Legislative Assembly of Queensland can be accessed from the Queensland Parliament's tabled papers website database: **www.parliament.qld.gov.au/work-of-assembly/tabled-papers**

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 QLD 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 2016–17 financial year was a deficit of $1.023 million. This was due to the engagement of additional investigators and case management officers to manage the increasing number of complaints.

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.

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 October 2016, the office advised the Minister for Health that the cost of managing complaints, that otherwise would have been conducted by AHPRA and the national boards, was $6.02 million. On 10 April 2017, the Minister advised the office that $2.260 million was to be provided to the office by AHPRA and the Department of Health would fund the difference. To ensure continuity of business operations in 2016–17, the Department of Health provided funding of $6.315 million.

Financial position

The financial position provides an indication of the office's underlying financial health at 30 June 2017. The office's assets at 30 June 2017 were $1.589 million and liabilities were $1.109 million. This resulted in a total equity of $480,278.

Assets

The office's total assets are valued at $1.589 million as at 30 June 2017. Current assets are valued at $1.238 million and are available to meet current liabilities, which are valued at $988,927.

Liabilities

Total liabilities for the office at 30 June 2017 were $1.109 million and the largest single liability was $787,185 for accrued employee benefits. Remaining liabilities relate predominantly to payables.

Financial performance

The income statement shows the total income for 2016–17 as $18.560 million—an increase of $4.383 million from the 2015–16 financial year—and expenses as $19.582 million, finishing the year with an operating deficit of $1.023 million.

Income

In 2016–17 the office derived the majority of its income from the Queensland Government through a contribution o0f $9.868 million. Additional funding of $2.260 million was provided by AHPRA and $6.315 million by the Department of Health. Income in the form of interest and other revenue totalled $116,000.

Expenses

Total operating expenses for 2016–17 were $19.582 million. The largest expense category was for employee expenses ($16.395 million), which accounted for 84 per cent of expenses. The second largest category was supplies and services ($3.006 million), which accounted for 15 per cent of expenses.

Internal audits

In 2016–17, the office was not instructed by the Minister for Health to establish an internal audit function or committee.

financial statements

Statement of Comprehensive Income

for the year ended 30 June 2017

	Notes	Actual $'000	Original Budget $'000	Budget Variance* $'000	Actual $'000
Income					
Revenue					
Grants and other contributions	**2**	18,443	14,368	4,075	14,072
Interest		88	245	(157)	99
Other revenue		28	5	23	6
Total Income		18,559	14,618	3,942	14,177
Expenses					
Employee expenses	**3**	16,395	12,381	4,014	13,961
Supplies and services	**4**	3,006	2,079	927	2,662
Depreciation		153	136	17	129
Other expenses	**5**	28	22	6	7
Total Expenses		19,582	14,618	4,964	16,758
Operating Result		(1,023)	-	(1,023)	(2,581)
Total Comprehensive Income		(1,023)	-	(1,023)	(2,581)

* An explanation of major variances is included in Note 15.

The accompanying notes form part of these statements.

QAO certified statements

Statement of Financial Position

for the year ended 30 June 2017

	Notes	Actual $'000	Original Budget $'000	Budget Variance* $'000	Actual $'000
Current Assets					
Cash and cash equivalents	**6**	662	3,877	(3,215)	1,569
Receivables	**7**	388	235	153	287
Prepayments		188	106	82	109
Total Current Assets		1,238	4,218	(2,980)	1,964
Non Current Assets					
Prepayments		23	64	(41)	33
Property, plant and equipment	**8**	328	201	127	368
Total Non Current Assets		351	265	86	401
Total Assets		1,588	4,483	(2,895)	2,365
Current Liabilities					
Payables	**9**	161	180	(19)	147
Accrued employee benefits	**10**	787	352	435	559
Deferred Lease Liability		41	-	41	-
Total Current Liabilities		989	532	457	706
Non Current Liabilities					
Deferred Lease Liability		120	106	14	156
Total Non Current Liabilities		120	106	14	156
Total Liabilities		1,109	638	471	862
Net Assets		480	3,845	(3,365)	1,503
Equity					
Contributed equity		1,394			1,394
Accumulated surplus/deficit		(914)			109
Total Equity		480			1,503

* An explanation of major variances is included in Note 15.

The accompanying notes form part of these statements.

QAO certified statements

Statement of Changes in Equity

for the year ended 30 June 2017

	Notes	2017 $'000	2016 $'000
Contributed Equity			
Balance as at 1st July		1,394	1,394
Balance as at 30 June		1,394	1,394
Accumulated Surplus			
Balance as at 1st July		109	2,690
Operating Result		(1,023)	(2,581)
Balance as at 30 June		(914)	109

The accompanying notes form part of these statements.

QAO certified statements

Statement of Cash Flows

for the year ended 30 June 2017

	Notes	2017 Actual $'000	2017 Original Budget $'000	2017 Budget Variance* $'000	2016 Actual $'000
Inflows:					
Grants and other contributions		18,443	14,248	4,195	14,072
GST collected from customers		7	-	7	5
GST input tax credits from ATO		313	-	313	330
Interest receipts		88	245	(157)	99
Other		17	5	12	6
Outflows:					
Employee expenses		(16,218)	(12,381)	(3,837)	(13,828)
Supplies and services		(3,058)	(2,079)	(979)	(2,617)
GST paid to suppliers		(6)	-	(6)	(305)
GST remitted to ATO		(353)	-	(353)	(8)
Other		(28)	(22)	(6)	(7)
Net cash used in operating activities		(795)	16	(811)	(2,253)
Cash flows from investing activities					
Outflows:					
Payments for plant and equipment		(112)	-	(112)	(131)
Net cash used in investing activities		(112)	-	(112)	(131)
Net decrease in cash held		(906)	16	(922)	(2,384)
Cash at beginning of financial year		1,569	3,861	(2,292)	3,953
Cash at end of financial year	**6**	663	3,877	(3,214)	1,569

The accompanying notes form part of these statements.

	2017 $'000	2016 $'000
Reconciliation of Operating Result to Net Cash from Operating Activities		
Operating surplus/(deficit)	(1,023)	(2,581)
Depreciation expense	153	129
Changes in assets and liabilities:		
(Increase)/decrease in receivables	(102)	(51)
(Increase)/decrease in prepayments	(69)	27
Increase/(decrease) in payables	14	(33)
Increase/(decrease) in accrued employee benefits	228	207
Increase/(decrease) in other current liabilities	41	-
Increase/(decrease) in other non-current liabilities	(36)	50
Net cash used in operating activities	(795)	(2,253)

* An explanation of major variances is included in Note15.

QAO certified statements

Notes to and forming part of the Financial Statements 2016–17

continued

Notes to and forming part of the Financial Statements 2016–17

continued

1. Basis of Financial Statement Preparation

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 QLD 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.

Objectives and Principal Activities of the Office of the Health Ombudsman

The Office of the Health Ombudsman commenced operations on 1 July 2014. The office is Queensland's independent health service complaints management agency, and the single point of entry for all health service complaints.

The Office of the Health Ombudsman is responsible for health complaints functions, including the management of serious matters relating to the health, conduct and performance of registered health practitioners in Queensland. In addition, the Office of the Health Ombudsman has the ability to deal with matters relating to the health, conduct and performance of non-registered health practitioners.

The role of the Office of the Health Ombudsman is to:

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

The Office of the Health Ombudsman performs this role by:

- Receiving and investigating complaints about health services and health service providers, including registered and non-registered health practitioners;
- Deciding what action to take in relation to those complaints and, in certain instances, taking immediate action to protect the safety of the public;
- Monitoring the health, conduct and performance functions of the Australian Health Practitioner Regulation Agency and national health practitioner boards;
- Providing information about minimising and resolving health service complaints; and
- Reporting publicly on the performance of its functions.

Compliance with Prescribed Requirements

The Office of the Health Ombudsman has prepared these financial statements in compliance with section 43 of the Financial and Performance Management Standard 2009. The financial statements comply with Queensland Treasury's Minimum Reporting Requirements for reporting periods beginning on or after 1 July 2016.

The Office of the Health Ombudsman is a not-for-profit entity and these general purpose financial statements are prepared on an accrual basis (except for the Statement of Cash Flow which is prepared on a cash basis) in accordance with Australian Accounting Standards and Interpretations applicable to not-for-profit entities.

New accounting standards applied for the first time in these financial statements are outlined in Note 18.

Presentation

Currency and Rounding

Amounts included in the financial statements are in Australian dollars and 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.

Comparatives

Comparative information reflects the audited 2015-16 financial statements.

Current/Non-Current Classification

Assets and liabilities are classified as either 'current' or 'non-current' in the Statement of Financial Position and associated notes.

Assets are classified as 'current' where their carrying amount is expected to be realised within 12 months after the reporting date. Liabilities are classified as 'current' when they are due to be settled within 12 months after the reporting date, or the agency does not have an unconditional right to defer settlement to beyond 12 months after the reporting date.

All other assets and liabilities are classified as non-current.

Authorisation of Financial Statements for Issue

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

Basis of Measurement

Historical cost convention is used as the measurement basis in this financial report.

Under historical cost, assets are recorded at the amount of cash or cash equivalents paid or the fair value of the consideration given to acquire assets at the time of their acquisition. Liabilities are recorded at the amount of proceeds received in exchange for the obligation or at the amounts of cash or cash equivalents expected to be paid to satisfy the liability in the normal course of business.

	2017 $'000	2016 $'000
2. Grants and Other Contributions		
Grants from Government	18,443	9,868
Contributions from Government	0	4,203
Total	**18,443**	**14,072**

Accounting policy

Grants and contributions are non-reciprocal in nature so do not require any goods or services to be provided in return. Corresponding revenue is recognised in the year in which the agency obtains control over the grant/contribution (control is generally obtained at the time of receipt).

3. Employee Expenses

Employee Benefits		
Wages and salaries	12,106	10,307
Employer superannuation contributions	1,588	1,360
Annual leave levy	1,487	1,176
Long service leave levy	263	218
Employee Related Expenses		
Workers' compensation premium	75	56
Payroll tax	705	596
Other employee related expenses	171	248
Total	**16,395**	**13,961**

	2017 No.	2016 No.
Full-Time Equivalent Employees	132	125

Accounting policy

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.

QAO certified statements

3. Employee Expenses (contd)

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
Post-employment benefits for superannuation are provided through defined contribution (accumulation) plans or the Queensland Government's QSuper defined benefit plan as determined by the employee's conditions of employment.

Defined Contribution Plans - Contributions are made to eligible complying superannuation funds based on the rates specified in the relevant EBA or other conditions of employment. Contributions are expensed when they are paid or become payable following completion of the employee's service each pay period.

Defined Benefit Plan - The liability for defined benefits is held on a whole-of-government basis and reported in those financial statements pursuant to AASB 1049 *Whole of Government and General Government Sector Financial Reporting*. The amount of contributions for defined benefit plan obligations is based upon the rates determined by the Treasurer on the advice of the State Actuary. Contributions are paid by the agency at the specified rate following completion of the employee's service each pay period. The agency's obligations are limited to those contributions paid.

Workers' Compensation Premiums
The agency pays premiums to WorkCover Queensland in respect of its obligations for employee compensation. Workers' compensation insurance is a consequence of employing employees, but is not counted in an employee's total remuneration package. It is not employee benefits and is recognised separately as employee related expenses.

Key management personnel and remuneration disclosures are detailed in Note 16.

	2017 $'000	2016 $'000
4. Supplies and Services		
Property lease and rental	1,314	1,105
Employment agency staff	513	249
Information technology	280	248
Minor plant and equipment	150	57
Supplies and consumables	196	200
Consultants and contractors	203	456
Corporate service charges	170	154
Communications	148	159
Sundry expenses	32	34
Total	**3,006**	**2,662**

Accounting policy

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.

5. Other Expenses		
Insurance	4	4
Queensland Audit Office - external audit fees for the audit of financial statements [(1)]	22	3
Bad debts expense	2	0
Total	**28**	**7**

Audit Fees

(1) Total audit fees quoted by the Queensland Audit Office relating to the 2016-17 financial statements are $10K (2016 $10K). There are no non-audit services included in this amount.

6. Cash and Cash Equivalents		
Imprest accounts	1	1
Cash at bank	661	1,568
Total	**662**	**1,569**

Accounting policy

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.

QAO certified statements

	2017 $'000	2016 $'000
7. Receivables		
Trade debtors	13	2
	13	2
GST receivable	108	68
GST payable	2	3
	110	71
Long service leave reimbursements	12	50
Annual leave reimbursements	253	164
Total	**388**	**287**

Accounting policy

Receivables are mesured at amortised cost which approximates their fair value at reporting date.

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.

Other debtors generally arise from transactions outside the usual operating activities of the office and are recognised at their assessed values. Terms are a maximum of three months, no interest is charged and no security is obtained.

8. Plant and Equipment and Depreciation Expense		
At cost plant and equipment	728	615
Less: Accumulated depreciation plant and equipment	(400)	(248)
Total	**328**	**368**

Plant and Equipment and Depreciation Expense 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.

	Total	
	2017 $'000	2016 $'000
Carrying amount at 1 July	368	365
Acquisitions	113	132
Depreciation for period	(153)	(129)
Carrying amount at 30 June	**328**	**368**

8. Plant and Equipment (contd)

Accounting policy

Cost of Acquisition

Historical cost is used for the initial recording of all property, plant and equipment acquisitions. Historical cost is determined as the value given as consideration and costs incidental to the acquisition (such as architects' fees and engineering design fees), plus all other costs incurred in getting the assets ready for use.

Assets acquired at no cost or for nominal consideration, other than from another Queensland Government entity, are recognised at their fair value at date of acquisition.

Plant and Equipment

Plant and equipment, (excluding major plant and equipment) is measured at historical cost in accordance with the Non-Current Asset Policies. The carrying amounts for such plant and equipment is not materially different from their fair value.

Depreciation Expense

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

Key Judgement: Straight line depreciation is used as that is consistent with the even consumption of service potential of these assets over their useful life to the agency.

Depreciation rates for each class of depreciable asset (including significant identifiable components):

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

Impairment

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. Any amount by which the asset's carrying amount exceeds the recoverable amount is recorded as an impairment loss.

	2017 $'000	2016 $'000
9. Payables		
Trade and other creditors	120	124
Accrued expenses	41	23
Total	161	147

QAO certified statements

9. Payables (contd)

Accounting policy

Trade creditors are recognised upon receipt of the goods or services ordered and are measured at the nominal amount i.e. agreed purchase/contract price, gross of applicable trade and other discounts. Amounts owing are unsecured.

10. Accrued Employee Benefits	2017 $'000	2016 $'000
Salary and wage related	232	166
Annual leave levy payable	434	299
Long service leave levy payable	78	72
Superannuation	40	22
Parental leave payable	3	-
Total	787	559

11. Commitments

Non-cancellable Operating Lease Commitments
Commitments under operating leases at reporting date are exclusive of GST and are payable as follows:

Not later than one year	1,347	1,046
Later than one year and not later than five years	1,748	2,518
Total	3,095	3,564

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.

The Office of the Health Ombudsman have two current lease arrangements as follows:
- Level 12 (expires 30 September 2019)
- Part Level 26 (expires 31 August 2019)

Both office spaces are located at 400 George Street, Brisbane Qld 4000.

12. Contingencies

As at 30 June 2017 there are four matters awaiting (2016:nil) a decision by Queensland Civil and Administrative Tribunal. It is not possible to make a reliable estimate on the costs that may/may not be payable by our office at this point in time.

13. Financial Risk Disclosures

(a) Financial Instrument Categories

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

Financial Assets	Note	2017 $'000	2016 $'000
Cash and cash equivalents	6	662	1,569
Loans and Receivables at amortised cost - comprising:			
Receivables	7	388	287
Total Financial Assets		**1,050**	**1,856**
Financial Liabilities			
Financial liabilities measured at amortised cost - comprising:			
Payables	9	161	147
Total Financial Liabilities at amortised cost		**161**	**147**

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.

No financial assets and financial liabilities have been offset and presented net in the Statement of Financial Position.

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

Risk Exposure

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.

QAO certified statements

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's activities expose it to a variety of financial risks as set out in the following table:

Risk Exposure	Definition	Exposure
Credit Risk	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 agency is exposed to credit risk in respect of its receivables (Note 7).
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 (Note 9).
Market Risk	The risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices. Market risk comprises three types of risk: currency risk, interest rate risk and other price risk. Interest rate risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market interest rates.	The agency does not trade in foreign currency and is not materially exposed to commodity price changes or other market prices.

13. Financial Risk Disclosures (contd)

Risk Exposure	Measurement Method	Risk Management Strategies
Credit risk	Ageing analysis, earnings at risk	The agency manages credit risk through the use of a credit management strategy. This strategy aims to reduce the exposure to credit default by ensuring that the agency invests in secure assets and monitors all funds owed on a timely basis.
Liquidity risk	Sensitivity analysis	The agency manages liquidity risk through the use of a liquidity management strategy. 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.
Market risk	Interest rate sensitivity analysis	The agency does not undertake any hedging in relation to interest risk and manages its risk as per the agency's liquidity risk management strategy articulated in the agency's Financial Management Practice Manual.

14. Events Occurring after Balance Date

There were no significant events occurring after balance date.

15. Budgetary Reporting Disclosures

Explanation of Major Variances - Statement of Comprehensive Income and Statement of Cash Flows

(a) Grants and Other Contributions
The increase is due to additional funding provided by Queensland Health to ensure business continuity for the 2016-17 financial year.

(b) Employee Expenses
The increase is due to the employment of temporary additional investigators and case management officers to manage the increasing number of complaints received during the course of the year.

(c) Supplies and Services
The increase in supplies and services of $927K is due to higher expenses arising from the growth in the agency's activities requiring:

- The lease of additional office space
- The employment of temporary staff to meet the increase in workload and to meet legislative timeframes for addressing complaints
- The renewal of software licences, upgrades and purchaes of new equipment.

Explanation of Major Variances - Statement of Financial Position

(d) Cash and Cash Equivalents
The decrease in cash is due to the use of grant funding to employ and accommodate additional staff to keep up with the growth in complaints.

(e) Receivables
The increase is due to a higher GST receivable and higher than projected increase in staff accessing annual leave entitlements.

(f) Property, Plant and Equipment
The increase is due to fitout improvements related to the additional office space acquired.

(g) Accrued Employee Benefits:
The variance ($435K) is due to:

- An additional week of accrued salaries and on-costs ($281K) for all staff to 30 June 2017
- Increase in annual leave and long service leave levies ($154k) for additional staff carrying forward their leave entitlements at 30 June 2017.

16. Key Management Personnel (KMP) 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 2016-17 and 2015-16. Further information on these positions can be found in the body of the Annual Report under the section relating to Executive Management.

Position	Position Responsibility
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.
Executive Director, Assessment & Resolution	The Executive Director, Assessment & Resolution manages the triage and assessment unit and the resolution and conciliation unit
Executive Director, Investigations	The Executive Director, Investigation manages the investigations unit and the audit and compliance unit.
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.
Director, Business Innovation	The Director, Business Innovation manages the corporate support services of the office.

KMP Remuneration Policies

Remuneration policy for the entities KMP is set by the Queensland Public Service Commission as provided for under the Public Service Act 2008. Individual remuneration and other terms of employment (including motor vehicle entitlements and performance payments if applicable) are specified in employment contracts.

Remuneration expenses for those KMP comprise the following components:

Short term employee expenses, including:

- salaries, allowances and leave entitlements earned and expensed for the entire year, or for that part of the year during which the employee occupied a KMP position;
- performance payments recognised as an expense during the year; and
- non-monetary benefits - consisting of provision of vehicle together with fringe benefits tax applicable to the benefit.

16. Key Management Personnel (KMP) Disclosures (contd)

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 include payments in lieu of notice on termination and other lump sum separation entitlements (excluding annual and long service leave entitlements) payable on termination of employment or acceptance of an offer of termination of employment.

Performance Payments

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

Remuneration Expense

The following disclosures focus on the expenses incurred by the department attributable to non-Ministerial KMP during the respective reporting periods. The amounts disclosed are determined on the same basis as expenses recognised in the Statement of Comprehensive Income.

2016-17

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	369	8	42	0	419
Executive Director, Assessment & Resolution	193	4	20	0	217
Executive Director, Investigations (former)	203	4	19	57	283
Executive Director, Investigations (acting)	89	2	7	0	98
Executive Director, Legal Services	181	4	19	0	204
Director, Business Innovation	150	3	18	0	171
Total Remuneration	**1,185**	**25**	**125**	**57**	**1,392**

2015-16

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	0	395
Executive Director, Assessment & Resolution	175	4	19	0	198
Executive Director, Investigations	187	4	20	0	211
Executive Director, Legal Services	167		16	0	186
Director, Business Innovation	133	3	17	0	153
Total Remuneration	**1,009**	**21**	**113**	**0**	**1,143**

QAO certified statements

17. Related Party Transactions

Transactions with people/entities related to KMP
There were no transactions with people or entities related to our KMP.

Transactions with other Queensland Government-controlled entities
The Office of the Health Ombudsman received funding from Queensland Health. The funding provided is predominately for operational requirements and management of complaints against registered and unregistered practitioners (refer Note 2).

The Office of the Health Ombudsman holds two leases through the Queensland Government Accommodation Office, Department of Housing and Public Works (refer Note 4 and 11).

The Office of the Health Ombudsman has a service level agreement with the Corporate Administration Agency (refer Note 4 - Corporate service charges).

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

Changes in Accounting Policy
The agency did not voluntarily change any of its accounting policies during 2016-17.

Accounting Standards Early Adopted
No Australian Accounting Standards have been early adopted for 2016-17.

Accounting Standards Applied for the First Time
The only Australian Accounting Standard that became effective for the first time in 2016-17, and materially impacted on this financial report, is AASB124 *Related Party Disclosure*. This standard requires note disclosures about key management personnel (KMP) remuneration expenses and other related party transactions, and does not impact on financial statement line items. As Queensland Treasury already required disclosure of KMP remuneration expenses, there was minimal impact for the agency's disclosures compared to 2015-16 (refer to Note 16). Material related party transactions for 2016-17 are disclosed in Note 17. No comparative information is required in respect of 2015-16.

19. Future Impact of Accounting Standards Not Yet Effective

AASB 1058 *Income of Not-for-Profit Entities and AASB 15 Revenue from Contracts with Customers*

These standards will first apply to the agency from its financial statements for 2019-20.

The agency has commenced analysing the new revenue recognition requirements under these standards and is yet to form conclusions about significant impacts. Potential future impacts identifiable at the date of this report are as follows:

- Grants that are not enforceable and/or not sufficiently specific will not qualify for deferral, and continue to be recognised as revenue as soon as they are controlled. The agency receives several grants for which there are no sufficiently specific performance obligations - these grants are expected to continue being recognised as revenue upfront assuming no change to the current grant arrangements.

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

AASB 16 *Leases*

This standard will first apply to the agency from it financial statements for 2019-20. 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*.

Impact for Lessees
Unlike AABS 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 2017 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.

Name: Leon Atkinson-MacEwen
Title: Health Ombudsman

Date: 29 August 2017

Name: Kylie Guthrie
Title: Director, Business Innovation

Date: 29 August 2017

QAO certified statements

This page was intentionally left blank

Independent Auditor's Report

To the Health Ombudsman of the Office of the Health Ombudsman

Report on the audit of the financial report

Opinion

I have audited the accompanying financial report of the Office of the Health Ombudsman.

In my opinion, the financial report:

a) gives a true and fair view of the entity's financial position as at 30 June 2017, and its financial performance and cash flows for the year then ended

b) complies with the *Financial Accountability Act 2009*, the Financial and Performance Management Standard 2009 and Australian Accounting Standards.

The financial report comprises the statement of financial position as at 30 June 2017, 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 summaries of significant accounting policies and other explanatory information, and the management certificate.

Basis for opinion

I conducted my audit in accordance with the *Auditor-General of Queensland Auditing Standards*, which incorporate the Australian Auditing Standards. My responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Report* section of my report.

I am independent of the entity in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) that are relevant to my audit of the financial report in Australia. I have also fulfilled my other ethical responsibilities in accordance with the Code and the *Auditor-General of Queensland Auditing Standards*.

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

Responsibilities of the entity 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 the *Financial Accountability Act 2009*, the Financial and Performance Management Standard 2009 and Australian Accounting Standards, and for such internal control as the Health Ombudsman determines is necessary to enable the preparation of the financial report that is free from material misstatement, whether due to fraud or error.

The Health Ombudsman is also responsible for assessing the entity's ability to continue as a going concern, disclosing, as applicable, matters relating to going concern and using the going concern basis of accounting unless it is intended to abolish the entity or to otherwise cease operations.

Auditor's responsibilities for the audit of the financial report

My objectives are to obtain reasonable assurance about whether the financial report as a whole is free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with the Australian Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of this financial report.

As part of an audit in accordance with the Australian Auditing Standards, I exercise professional judgement and maintain professional scepticism throughout the audit. I also:

- Identify and assess the risks of material misstatement of the financial report, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for expressing an opinion on the effectiveness of the entity's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the entity.
- Conclude on the appropriateness of the entity's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the entity's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial report or, if such disclosures are inadequate, to modify my opinion. I base my conclusions on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the entity to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial report, including the disclosures, and whether the financial report represents the underlying transactions and events in a manner that achieves fair presentation.

Report on other legal and regulatory requirements

I communicate with the Health Ombudsman regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

In accordance with s.40 of the *Auditor-General Act 2009*, for the year ended 30 June 2017:

a) I received all the information and explanations I required.

b) In my opinion, the prescribed requirements in relation to the establishment and keeping of accounts were complied with in all material respects.

D J Olive
as delegate of the Auditor-General

QUEENSLAND
30 AUG 2017
AUDIT OFFICE

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

Intake of complaints

Type of contacts

Type of contact	Q1		Q2		Q3		Q4		2016–17		2015–16	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Complaint	1600	61.73	1533	61.74	1575	56.92	1493	61.69	**6201**	**60.43**	5435	58.12
Enquiry	992	38.27	950	38.26	1192	43.08	927	38.31	**4061**	**39.57**	3911	41.82
Yet to be classified	0	0.00	0	0.00	0	0.00	0	0.00	**0**	**0.00**	5	0.05
Total	2592	100	2483	100	2767	100	2420	100	**10262**	**100**	9351	100

Quarterly totals may not match those reported in earlier reports due to matters 'yet to be classified' having been subsequently 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		2016–17		2015–16	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Health consumer	1276	79.75	1205	78.60	1212	76.95	1272	85.20	**4965**	**80.07**	4354	80.11
Mandatory notification*	152	9.5	111	7.24	49	3.11	40	2.68	**352**	**5.68**	655	12.05
Voluntary notification*	123	7.69	180	11.74	269	17.08	142	9.51	**714**	**11.51**	226	4.16
Self-notification*	29	1.81	19	1.24	22	1.40	14	0.94	**84**	**1.35**	101	1.86
Referral	20	1.25	18	1.17	23	1.46	25	1.67	**86**	**1.39**	99	1.82
Total	1600	100	1533	100	1575	100	1493	100	**6201**	**100**	5435	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 matters raised by health service providers which do not otherwise meet the definition of a health consumer complaint as required under the Health Practitioner Regulation National Law (Queensland).

Complaint decisions

Decisions timeframes—within seven days

Decisions made	Q1		Q2		Q3		Q4		2016–17		2015–16	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Yes	867	57.00	968	60.65	1198	90.48	1261	90.07	**4294**	**73.51**	2409	48.47
No	654	43.00	628	39.35	126	9.52	139	9.93	**1547**	**26.49**	2561	51.53
Total	1521	100	1596	100	1324	100	1400	100	**5841**	**100**	4970	100

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

Accepted vs not accepted

Number of decisions made	Q1		Q2		Q3		Q4		2016–17		2015–16	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Accepted	1099	72.26	1134	71.05	908	68.58	978	69.26	**4119**	**70.37**	3961	79.70
Not accepted	422	27.74	462	28.95	416	31.42	422	29.89	**1722**	**29.42**	1009	20.30
Decisions pending	0	0.00	0	0.00	0	0.00	12	0.85	**12**	**0.21**	n/a	n/a
Total	1521	100	1596	100	1324	100	1412	100	**5853**	**100**	4970	100

Quarterly figures may vary from those reported in earlier reports due to matters deemed 'decisions pending' subsequently being either accepted or not accepted. 'Decision pending' relates to matters where more information is required before a decision on whether to accept or not accept can be made, or because the matter came in just before the end of the reporting period and is still being processed.

Accepted decision outcomes

Number of decisions made	Q1		Q2		Q3		Q4		2016–17		2015–16	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Assessment	403	36.27	396	36.77	413	41.89	332	33.88	**1544**	**37.17**	1733	41.49
Local resolution	320	28.80	229	21.26	207	20.99	275	28.06	**1031**	**24.52**	1121	26.84
Conciliation	1	0.09	1	0.09	0	0.00	0	0.00	**2**	**0.05**	9	0.21
Investigation	36	3.24	48	4.46	28	2.84	23	2.35	**135**	**3.25**	128	3.06
Referred to AHPRA and the national boards	348	31.32	400	37.14	327	33.16	348	35.51	**1423**	**34.26**	1099	26.31
Referral to another entity	3	0.27	3	0.28	11	1.12	2	0.20	**19**	**0.46**	80	1.91
Immediate action	0	0.00	0	0.00	0	0.00	0	0.00	**0**	**0.00**	7	0.17
Total	1111	100	1077	100	986	100	980	100	**4154**	**100**	4177	100

Accepted decisions may result in multiple issues and/or practitioners being identified, each requiring its own action. The data in the above Accepted decision outcomes table includes all identified issues/practitioners requiring action that were identified in the accepted complaints (noted in the previous Accepted vs not accepted table).

Health service complaints profile

Main issues raised in complaints

Reporting parameters for the identification of issues in complaints were updated as of October 2016. Previously, issues contained within the office's reporting related to complaints that completed the office's assessment process during the reporting period. Refinements to systems and processes now allow for the reporting of all issues identified in complaints during the reporting period. This change will result in higher numbers of issues appearing in the following three tables when compared to previous performance reports. This update is an example of the office's commitment to continual improvement as it matures as an agency and the importance it places on transparent, robust data.

Issue	Q1		Q2		Q3		Q4		2016–17		2015–16	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Access	91	4.12	108	4.48	100	4.54	109	4.41	**408**	**4.39**	51	1.27
Code of conduct for healthcare workers	5	0.23	5	0.21	8	0.36	25	1.01	**43**	**0.46**	4	0.10
Communication /information	300	13.57	341	14.14	290	13.16	312	12.64	**1243**	**13.37**	560	13.98
Consent	36	1.63	26	1.08	39	1.77	40	1.62	**141**	**1.52**	87	2.17
Discharge/transfer arrangements	30	1.36	51	2.11	41	1.86	52	2.11	**174**	**1.87**	131	3.27
Environment/ management of facilities	36	1.63	42	1.74	38	1.72	45	1.82	**161**	**1.73**	84	2.10
Fees/cost	58	2.62	80	3.32	72	3.27	81	3.28	**291**	**3.13**	37	0.92
Grievance processes	29	1.31	43	1.78	62	2.81	47	1.90	**181**	**1.95**	68	1.70
Health Ombudsman Act 2013 Offence	0	0.00	0	0.00	0	0.00	1	0.04	**1**	**0.01**	0	0.00
Medical records	72	3.26	66	2.74	47	2.13	77	3.12	**262**	**2.82**	144	3.59
Medication	280	12.67	239	9.91	274	12.43	272	11.02	**1065**	**11.46**	269	6.71
Professional conduct	215	9.73	260	10.78	214	9.71	258	10.45	**947**	**10.19**	406	10.13
Professional health	81	3.67	85	3.52	66	2.99	58	2.35	**290**	**3.12**	67	1.67
Professional performance	943	42.67	1016	42.12	919	41.70	1043	42.24	**3921**	**42.18**	2069	51.65
Reports/certificates	34	1.54	48	1.99	34	1.54	49	1.98	**165**	**1.78**	25	0.62
Research/teaching/ assessment	0	0.00	2	0.08	0	0.00	0	0.00	**2**	**0.02**	0	0.00
Treatment*	0	0.00	0	0.00	0	0.00	0	0.00	**0**	**0.00**	4	0.10
Total	2210	100	2412	100	2204	100	2469	100	**9295****	**100**	4006	100

* Changes to the office's issues taxonomy in 2016–17 resulted in treatment related issues being reclassified as a subcategory of professional performance.

** In 267 of 9295 issues the health service provider was unable to be identified in the course of the complaints management process.

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	Health Ombudsman Act Offence	Medical records	Medication	Professional conduct	Professional health	Professional performance	Reports/ certificates	Research/ Teaching/ Assessment	Total
Alternative care	—	23	2	2	—	—	—	—	—	—	3	11	—	8	—	—	49
Chinese medicine	—	—	—	2	—	2	1	—	—	1	—	18	2	9	—	—	35
Chiropractor	—	1	6	—	—	—	5	—	—	—	—	29	1	16	—	—	58
Dentistry	1	—	32	6	—	4	22	9	—	13	3	38	8	238	—	—	374
Emergency care	—	3	8	—	3	—	1	—	—	3	4	5	5	37	—	—	69
General medical	44	2	308	33	14	9	45	20	1	85	294	192	65	865	57	1	2035
Medical radiation	—	2	1	—	—	—	—	—	—	—	—	4	2	11	1	—	21
Medical specialty	5	—	85	11	11	2	18	2	—	10	29	53	8	200	33	—	467
Nursing	—	2	38	4	—	—	1	1	—	25	59	215	145	136	1	—	627
Occupational therapy	—	—	4	—	—	—	3	—	—	1	—	6	1	8	—	—	23
Optometry	—	—	3	—	—	—	—	1	—	1	2	5	1	8	—	—	21
Osteopathy	—	—	—	1	—	—	1	—	—	1	—	2	—	5	—	—	10
Other	2	8	25	6	—	2	4	1	—	2	7	119	19	28	3	—	226
Pathology service	—	—	1	—	—	—	1	—	—	—	—	1	—	2	—	—	5
Pharmacy	1	—	15	—	—	2	—	1	—	1	69	30	14	5	—	—	138
Physiotherapy	1	—	2	—	—	—	1	1	—	3	—	17	—	19	—	—	44
Podiatry	—	—	2	—	—	—	3	—	—	—	—	4	2	11	—	—	22
Psychology	2	1	33	4	—	6	2	1	—	12	3	53	14	47	21	—	199
Speech pathology	—	—	1	—	—	—	—	—	—	—	—	—	—	3	1	—	5
Surgical	3	—	51	20	7	2	18	4	—	5	7	29	3	270	11	—	430
Total	**59**	**42**	**617**	**89**	**35**	**29**	**126**	**41**	**1**	**163**	**480**	**831**	**290**	**1926**	**128**	**1**	**4858**

These figures are based on issues recorded during the reporting period. A single complaint can contain multiple issues.

Number and type of complaints by health service organisation

Organisation type	Access	Code of conduct for healthcare workers	Communication & information	Consent	Discharge/ transfer arrangements	Environment/ management of facility	Fees & costs	Grievance process	Health Ombudsman Act 2013 offence	Medical records	Medication	Professional conduct	Professional health	Professional performance	Reports/ certificates	Research/ Teaching/ Assessment	Total!
Aged care facility	—	1	10	—	—	5	1	3	—	3	13	3	—	61	—	1	101
Allied health service	—	—	5	—	—	—	10	—	—	1	1	5	—	5	—	—	27
Ambulance service	2	—	6	—	4	—	1	—	—	1	—	2	—	15	—	—	31
Community health service	10	—	13	—	—	6	1	4	—	—	2	2	—	16	—	—	54
Correctional facility	168	—	34	1	1	4	—	5	—	6	352	7	—	418	3	—	999
Dental service	14	—	11	—	—	3	12	5	—	4	—	1	—	49	—	—	99
Hospital and Health Service	4	—	15	—	1	5	2	3	—	—	—	2	—	30	1	—	63
Laboratory service	—	—	4	1	—	2	22	5	—	2	—	—	—	11	1	—	48
Licensed private hospital	6	—	44	1	16	28	24	12	—	4	17	5	—	109	1	—	267
Medical centre	37	—	65	1	—	17	27	13	—	20	13	10	—	40	2	—	245
Mental health service	10	—	50	9	9	5	—	8	—	3	28	9	—	87	5	—	223
Other government department	2	—	1	—	—	—	—	—	—	—	2	—	—	1	—	—	6
Other support service	—	—	2	1	1	1	1	2	—	—	2	2	—	15	—	—	27
Pharmaceutical service	1	—	12	1	—	—	10	4	—	—	43	2	—	3	—	—	76
Private organisation	2	—	12	—	—	2	2	5	—	2	1	5	—	12	—	—	43
Public health service	1	—	16	1	2	6	1	5	—	4	4	5	—	57	—	—	102
Public hospital	74	—	266	33	101	40	14	55	—	42	65	30	—	916	9	—	1645
Residential care service	—	—	3	—	—	1	—	—	—	—	—	1	—	4	—	—	9
Specialised health service	6	—	10	1	—	2	20	6	—	1	5	3	—	24	4	—	82
Administrative service	—	—	—	—	—	1	—	—	—	—	—	—	—	—	—	—	1
Area health services	—	—	—	—	—	—	—	—	—	—	—	1	—	1	—	—	2
Licensed day hospital	—	—	2	—	1	—	1	1	—	1	1	1	—	3	—	—	11
Optical store	—	—	4	—	—	1	2	—	—	—	—	—	—	2	—	—	9
Total	**337**	**1**	**585**	**50**	**136**	**129**	**151**	**136**	**0**	**94**	**549**	**96**	**0**	**1879**	**26**	**1**	**4170**

These figures are based on issues recorded during the reporting period. A single complaint can contain multiple issues.

Assessment

Assessments started and completed

Assessments this year	Q1	Q2	Q3	Q4	2016–17	2015–16
Assessments commenced	475	488	488	429	**1880**	1781
Assessments completed	541	527	611	399	**2078**	1897

Assessments completed

Assessment timeframes are legislated under the Act and provide for assessments to be completed within 30 days, or within 60 days subject to an approved extension. Assessments completed within 60 days, where an extension has not been approved, or in more than 60 days are deemed to have been completed outside of legislative timeframes.

More than twice as many assessments were completed within legislative timeframes in 2016–17 (1262), compared with 2015–16 (613). That period also coincided with a 36.45 per cent reduction in assessments completed outside legislative timeframes.

Of the 1262 assessments completed within legislative timeframes, 980 were completed within 30 days, while 282 were completed within 60 days and approved for extension.

The 661 matters completed outside of 60 days were due to the continuing high volume of matters that require additional assessment, the complexity of many of the matters in assessment, and delays in receiving information from parties or in obtaining the necessary independent clinical advice required to appropriately assess the matters.

Completed within legislative timeframes

Assessment timeframes	Q1		Q2		Q3		Q4		2016–17		2015–16	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Within legislative timeframes*	252	46.58	293	55.60	416	68.08	301	75.44	**1262**	**60.73**	613	32.31
Outside legislative timeframes	289	53.42	234	44.40	195	31.91	98	24.56	**816**	**39.27**	1284	67.69
Total	541	100	527	100	611	100	399	100	**2078**	**100**	1897	100

* Includes matters completed within 30 days or 60 days with an approved extension.

Completed assessment timeframes

Assessment timeframes	Q1		Q2		Q3		Q4		2016–17		2015–16	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Within 30 days	195	30.04	238	45.16	347	56.79	200	50.12	**980**	**47.16**	508	26.78
Within 60 days*	106	19.59	103	19.54	108	17.68	120	30.07	**437**	**21.03**	354	18.66
Greater than 60 days	240	44.36	186	35.29	156	25.53	79	19.79	**661**	**31.81**	1035	54.56
Total	541	100	527	100	611	100	399	100	**2078**	**100**	1897	100

* This category comprises all assessments completed within 60 days—including those approved for extension and those in which no extension was granted.

Completed assessment decisions

Type of relevant action	Q1		Q2		Q3		Q4		2016–17		2015–16	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Local resolution	17	2.76	13	2.23	13	1.94	12	2.81	**55**	**2.39**	117	5.44
Conciliation	42	6.81	38	6.52	21	3.13	35	8.20	**136**	**5.92**	115	5.34
Investigation	9	1.46	21	3.60	16	2.39	17	3.98	**63**	**2.74**	77	3.58
Referred to AHPRA and the national boards	142	23.01	100	17.15	112	16.72	65	15.22	**419**	**18.24**	811	37.69
Referral to another entity	80	12.97	135	23.16	239	35.67	94	22.01	**548**	**23.86**	121	5.62
Immediate registration action*	0	0.00	1	0.17	2	0.30	0	0.00	**3**	**0.13**	7	0.33
Interim prohibition order*	0	0.00	0	0.00	0	0.00	1	0.23	**1**	**0.04**	1	0.05
No further action	327	53.00	275	47.17	267	39.85	203	47.54	**1072**	**46.67**	903	41.96
Total	617	100	583	100	670	100	427	100	**2297**	**100**	2152	100

Total assessment decisions will not equal the total number of assessments (in previous tables) as a single assessment can result in multiple relevant actions.

* Immediate action assessment decision figures may not align with the immediate action figures later in the report due to immediate action decisions being made outside of the assessment process.

Local resolution

Local resolutions started and completed

Local resolutions this year	Q1	Q2	Q3	Q4	2016–17	2015–16
Local resolutions started	349	248	235	291	**1123**	1259
Local resolutions completed	370	268	229	283	**1150**	1242

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.

Local resolutions completed within legislative timeframes

Completed within legislative timeframes

Local resolution timeframes are legislated under the Act and provide for local resolutions to be completed within 30 days, or within 60 days subject to an approved extension. Local resolutions completed within 60 days, where an extension has not been approved, or in more than 60 days are deemed to have been completed outside of legislative timeframes.

Of the 1150 local resolutions finalised in 2016–17, 1102 were completed within 30 days or 60 days with an approved extension, representing a finalisation rate within statutory timeframes of 95.83 per cent—an improvement of 6.06 percentage points when compared to 2015–16.

Of the 149 local resolutions completed within 60 days, 106 matters were approved for extension.

Local resolution timeframes	Q1		Q2		Q3		Q4		2016–17		2015–16	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Within legislative timeframes*	359	97.03	255	95.15	213	93.01	275	97.17	1102	95.83	1115	89.77
Outside legislative timeframes	11	2.97	13	4.85	16	6.99	8	2.83	48	4.17	127	10.23
Total	370	100	268	100	229	100	283	100	1150	100	1242	100

* Includes matters completed within 30 days or 60 days with an approved extension.

Completed local resolution timeframes

Local resolution timeframes	Q1		Q2		Q3		Q4		2016–17		2015–16	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Within 30 days	337	91.08	233	86.94	184	80.35	242	85.51	**996**	**86.61**	1019	82.05
Within 60 days*	32	8.65	34	12.69	44	19.21	39	13.78	**149**	**12.96**	185	14.90
Greater than 60 days	1	0.27	1	0.37	1	0.44	2	0.71	**5**	**0.43**	38	3.06
Total	370	100	268	100	229	100	283	100	**1150**	**100**	1242	100

* This category comprises all local resolutions completed within 60 days—including those approved for extension and those in which no extension was granted.

Outcomes

Local resolution outcomes	Q1		Q2		Q3		Q4		2016–17		2015–16	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Resolved	319	86.22	223	83.21	191	83.41	226	79.86	**959**	**83.39**	1074	86.47
Not resolved	50	13.51	34	12.69	32	13.97	35	12.37	**151**	**13.13**	156	12.56
Complaint withdrawn*	1	0.27	11	4.10	6	2.62	22	7.77	**40**	**3.48**	12	0.97
Total	370	100	268	100	229	100	283	100	**1150**	**100**	1242	100

* Complainants can choose to withdraw their complaint at any stage during local resolution. In 2015–16 withdrawn complaints were reported under Decisions for matters that were not resolved (see table below). In order to provide a more accurate reflection of the local resolution process complaints withdrawn appear as a separate outcome category in this report. For comparison purposes, 2015–16 figures have been adjusted accordingly.

Decisions for matters that were not resolved

Type of relevant action	Q1		Q2		Q3		Q4		2016–17		2015–16	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Assessment	0	0.00	0	0.00	0	0.00	2	5.71	**2**	**1.32**	4	2.56
Conciliation	0	0.00	0	0.00	0	0.00	0	0.00	**0**	**0.00**	3	1.92
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	2	4.00	1	2.94	1	3.13	1	2.86	**5**	**3.31**	20	12.82
Referral to another entity	0	0.00	0	0.00	0	0.00	0	0.00	**0**	**0.00**	1	0.64
Immediate action	0	0.00	0	0.00	0	0.00	0	0.00	**0**	**0.00**	0	0.00
No further action	48	96.00	33	97.06	31	96.88	32	91.43	**144**	**95.36**	128	82.05
Total	50	100	34	100	32	100	35	100	**151**	**100**	156	100

Conciliation

Conciliations started and closed

Conciliations this year	Q1	Q2	Q3	Q4	2016–17	2015–16
Conciliations started	43	41	22	36	**142**	122
Conciliations closed	36	38	28	33	**135**	88

The number of conciliations started in the reporting period may not match the number of decisions to refer for conciliation noted in other areas of the report 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. Closed conciliations differ from completed conciliations below, as completed conciliations only include matters where both parties agreed to participate and the conciliation process was completed.

Agreement to participate in conciliation

Agreement to participate	Q1	Q2	Q3	Q4	2016–17	2015–16
Party/ies agreed to participate	29	25	14	12	**80**	57
Party/ies did not agree to participate	17	17	13	15	**62**	35

Once the decision is made to attempt conciliation, both parties must agree to participate in the process. If either one or both of the parties do not agree, the conciliation process does not commence and the matter is closed.

Completed conciliations

Timeframes

The data below relates to matters where parties agreed to participate in conciliation and the conciliation process was completed within the reporting period. Completed conciliations differ from closed conciliations (in the table above) as they only relate to matters where parties agreed to participate and the conciliation process was completed.

Conciliations completed	Q1		Q2		Q3		Q4		2016–17		2015–16	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
0–3 months	0	0.00	4	19.05	0	0.00	3	16.67	**7**	**9.59**	11	20.7
3–6 months	13	68.42	14	66.67	9	60.00	4	22.22	**40**	**54.79**	30	56.6
6–9 months	5	26.32	2	9.52	6	40.00	11	61.11	**24**	**32.88**	11	20.7
9–12 months	1	5.26	1	4.76	0	0.00	0	0.00	**2**	**2.74**	1	1.89
12+ months	0	0.00	0	0.00	0	0.00	0	0.00	**0**	**0.00**	0	0.00
Total	19	100	21	100	15	100	18	100	**73**	**100**	53	100

In April 2017 refinements to systems and processes resulted in changes to how conciliations are classified into timeframe categories. As such, data detailed below may not match previously reported quarterly data.

Outcomes

Conciliation outcomes	Q1		Q2		Q3		Q4		2016–17		2015–16	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Successful	15	78.95	16	76.19	11	73.33	11	61.11	**53**	**72.60**	40	75.47
Not successful	4	21.05	5	23.81	4	26.67	7	38.89	**20**	**27.40**	13	24.53
Ended by Health Ombudsman	0	0.00	0	0.00	0	0.00	0	0.00	**0**	**0.00**	0	0.00
Total	19	100	21	100	15	100	18	100	**73**	**100**	53	100

The data above relates to matters where parties agreed to participate in conciliation. After agreeing, the conciliation process was completed with the matter either being successful or not successful—or in rare instances, the Health Ombudsman ending it.

Decisions for matters where agreement was not reached

Type of relevant action	Q1		Q2		Q3		Q4		2016–17		2015–16	
	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	4	100.00	5	100.00	4	100.00	7	100.00	**20**	**100.00**	13	100
Total	4	100	5	100	4	100	7	100	**20**	**100**	13	100

This data relates to matters which completed the conciliation process.

Open conciliation timeframes

In April 2017 refinements to systems and processes resulted in changes to how conciliations are classified into timeframe categories. As such, data detailed below may not match previously reported quarterly data.

Conciliations open	Q1		Q2		Q3		Q4		2015–16	
	Number	%	Number	%	Number	%	Number	%	Number	%
0–3 months	37	60.66	35	54.69	20	34.48	31	50.82	**31**	**57.41**
3–6 months	13	21.31	19	29.69	21	36.21	13	21.31	**12**	**22.22**
6–9 months	4	6.56	3	4.69	11	18.97	10	16.39	**9**	**16.67**
9–12 months	5	8.20	2	3.13	0	0.00	3	4.92	**0**	**0.00**
12+ months	2	3.28	5	7.81	6	10.34	4	6.56	**2**	**3.70**
Total	61	100	64	100	58	100	61	100	**54**	**100**

Matters may be placed on hold whilst other processes are being finalised. Those processes may include investigations by the office, referrals to external agencies such as AHPRA and other relevant actions. As at 30 June 2017 there were 12 matters on hold including; 2 matters that were open for less than 3 months, 3 that were open for 3–6 months, 1 that was open for 6–9 months, 2 matters that were open for 9–12 months, and 4 that were open for more than 12 months.

Investigation

During 2016–17, as a part of the office's commitment to continual improvement in transparency of data, changes were made to reporting methodology within the Investigations division. This, combined with a delay in recording some decisions, means that the data reported below may not match that reported in previous performance reports.

Investigations started and closed

Investigations this year	Q1	Q2	Q3	Q4	2016–17	2015–16
Investigations started	56	74	64	53	**247**	249
Investigations closed	54	59	41	55	**209**	163

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).

Closed investigations

Timeframes

Investigations open	Q1		Q2		Q3		Q4		2016–17		2015–16	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
0–3 months	6	11.11	5	8.47	7	17.07	7	12.73	**25**	**11.96**	18	11.04
3–6 months	11	20.37	2	3.39	1	2.44	14	25.45	**28**	**13.40**	20	12.27
6–9 months	2	3.70	6	10.17	3	7.32	9	16.36	**20**	**9.57**	16	9.82
9–12 months	4	7.41	13	22.03	1	2.44	6	10.91	**24**	**11.48**	32	19.63
12+ months	31	57.41	33	55.93	29	70.73	19	34.55	**112**	**53.59**	77	47.24
Total	54	100	59	100	41	100	55	100	**209**	**100**	163	100

Outcomes

Closed investigation outcomes	Q1		Q2		Q3		Q4		2016–17		2015–16	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Matters recommended for referral to Director of Prosecutions*	4	7.41	28	47.46	25	60.98	23	41.82	**80**	**38.28**	24	14.72
Report	0	0	0	0	0	0	0	0	**0**	**0.00**	3	1.84
Referred to AHPRA	18	33.33	8	13.56	9	21.95	12	21.82	**47**	**22.49**	57	34.97
Referred to another agency	5	9.26	1	1.69	0	0	2	3.64	**8**	**3.83**	6	3.68
No further action	27	50.00	22	37.29	7	17.07	16	29.09	**72**	**34.45**	73	44.79
Referred to legal services**	0	0	0	0	0	0	2	3.64	**2**	**0.96**	0	0.00
Other	0	0	0	0	0	0	0	0	**0**	**0.00**	N/A	N/A

* Matters deemed suitable for referral to the Director of Proceedings are sent to the Health Ombudsman for consideration on whether referral is appropriate.

** These matters are referred to the Executive Director, Legal Services Division within the office for consideration as to whether there is evidence of a breach of the Act that constitutes an offence that should be prosecuted in the courts. These matters differ to those referred to the Director of Proceedings, which require an independent determination of whether the matter should be put before QCAT.

Open investigations

Open investigations consist of two categories—active investigations and paused investigations.

Active investigations are ones that are currently being investigated, while paused investigations are not able to be investigated until such time as another agency—such as the Queensland Police Service or the Office of the State Coroner—concludes their own processes.

Where a matter is referred under section 193A(4) of the Health Practitioner Regulation National Law (Queensland), we calculate timeframes inclusive of any period in which the investigation was open with AHPRA. This provides greater transparency on the complete length of investigations.

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.

Active investigation timeframes

Active investigations	Q1		Q2		Q3		Q4		2016–17		2015–16	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
0–3 months	51	17.77	66	21.93	58	18.07	44	12.94	**53**	**12.94**	53	17.97
3–6 months	48	16.72	47	15.62	60	18.69	41	12.06	**41**	**12.06**	37	12.54
6–9 months	26	9.06	45	14.95	45	14.02	47	13.82	**47**	**13.82**	24	8.14
9–12 months	32	11.15	20	6.64	46	14.33	40	11.77	**40**	**11.77**	26	8.81
12+ months	130	45.30	123	40.86	112	34.89	168	49.41	**168**	**49.41**	115	52.54
Total	287	100	301	100	321	100	340	100	**340**	**100**	295	100

Paused investigation timeframes

Paused investigations	Q1		Q2		Q3		Q4		2016–17		2015–16	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
0–3 months	3	4.22	6	8.33	0	0	4	7.41	4	7.41	n/a	n/a
3–6 months	16	22.53	3	4.17	10	13.33	5	9.26	5	9.26	n/a	n/a
6–9 months	9	12.68	16	22.22	4	5.33	13	24.07	13	24.07	n/a	n/a
9–12 months	22	30.99	9	12.50	17	22.67	4	7.41	4	7.41	n/a	n/a
12+ months	21	29.58	38	52.78	44	58.67	28	51.85	28	51.85	n/a	n/a
Total	71	100	72	100	75	100	54	100	54	100	n/a	n/a

* 2015–16 data is not available for comparison as this data is a new inclusion to this year's report.

Open investigations timeframes

Open investigations	Q1		Q2		Q3		Q4		2016–17		2015–16	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
0–3 months	54	15.08	72	19.30	58	14.65	48	12.18	**48**	**12.18**	n/a	n/a
3–6 months	64	17.88	50	13.41	70	17.68	46	11.67	**46**	**11.67**	n/a	n/a
6–9 months	35	9.78	61	16.35	49	12.37	60	15.23	**60**	**15.23**	n/a	n/a
9–12 months	54	15.08	29	7.78	63	15.91	44	11.17	**44**	**11.17**	n/a	n/a
12+ months	151	42.18	161	43.16	156	39.39	196	49.75	**196**	**49.75**	n/a	n/a
Total	358	100	373	100	396	100	394	100	**394**	**100**	n/a	n/a

* 2015–16 data is not available for comparison as this data is a new inclusion to this year's report.

Open investigations categories

Investigation category	Q1	Q2	Q3	Q4
Health service complaint	267	269	278	289
Systemic issue	36	34	34	34
Another matter	55	70	84	71

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

Monitoring investigation recommendations

We monitor the implementation of recommendations made from certain investigations completed by:

- our office
- other health service providers

OHO recommendations monitoring

At the completion of certain investigations, the Health Ombudsman makes recommendations to health services on what they can do to improve service delivery and/or prevent the issues identified in the investigation from recurring. In these instances, we put in place a monitoring program to track the implementation of recommendations.

Monitoring cases started and closed

Monitoring cases this year	2016–17
Recommendations monitoring cases started	4
Recommendations monitoring cases closed	2

Health service provider recommendations by monitoring

A health service provider may also conduct its own investigation, or engage another entity to conduct an independent investigation, resulting in recommendations for improvement. The Health Ombudsman may decide to monitor the implementation of these recommendations.

Monitoring cases started and closed

Monitoring cases this year	2016–17
Recommendations monitoring cases started	9
Recommendations monitoring cases closed	6

Open recommendations monitoring case timeframes

Timeframes*	2016–17	
	Number	%
Less than 6 months	1	12.50
6–12 months	6	75.00
More than 12 months	1	12.50
Total	8	100

* Open recommendations monitoring cases include those resulting from recommendations by the Health Ombudsman, and those resulting from an investigation conducted by a health service provider. This data is as at 30 June 2017.

Director of Proceedings

The role of the Director of Proceedings is to independently assess the merits of an investigation and determine whether the matter is suitable to be referred to Queensland Civil and Administrative Tribunal (QCAT) for a determination.

Matters referred to the Director of Proceedings by practitioner type

Practitioner type	Q1		Q2		Q3		Q4		2016–17		2015–16	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Massage therapist	0	0.00	0	0.00	0	0.00	1	5.56	**1**	**1.79**	n/a	n/a
Medical practitioner	2	33.33	5	33.33	10	62.50	7	33.33	**24**	**42.86**	n/a	n/a
Psychologist	0	0.00	0	0.00	2	12.50	0	0.00	**2**	**3.57**	n/a	n/a
Nurse	4	66.66	6*	40.00	3	18.75	7	38.89	**20***	**35.71**	n/a	n/a
Chiropractor	0	0.00	0	0.00	1	6.25	0	0.00	**1**	**1.79**	n/a	n/a
Dentist	0	0.00	0	0.00	0	0.00	2	11.11	**2**	**3.57**	n/a	n/a
Pharmacist	0	0.00	2	13.33	0	0.00	1	5.56	**3**	**5.36**	n/a	n/a
Podiatrist	0	0.00	0	0.00	0	0.00	1	5.56	**1**	**1.79**	n/a	n/a
Student nurse	0	0.00	1	6.67	0	0.00	0	0.00	**1**	**1.79**	n/a	n/a
Unregistered chiropractor	0	0.00	1	6.67	0	0.00	0	0.00	**1**	**1.79**	n/a	n/a
Total	6	100	15	100	16	100	19	100	**56**	**100**	24	100

* Data includes one nurse who held dual registration as a midwife. Comparative data for 2015–16 is not available as this data is a new inclusion to this year's report.

Matters determined suitable for referral to the Director of Proceedings at the conclusion of an investigation are sent to the Health Ombudsman for consideration and determination on whether referral to the Director of Proceedings is appropriate. As a result, these figures will differ from closed investigation outcomes figures.

Matters currently with the Director of Proceedings by practitioner type

Practitioner type	Q1		Q2		Q3		Q4	
	Number	%	Number	%	Number	%	Number	%
Medical practitioner	7	43.75	9	37.50	18	50.00	24	45.28
Nurse	5*	31.25	9*	37.50	10	27.78	16*	31.19
Psychologist	2	12.50	2	8.33	4	11.11	4	7.55
Pharmacist	1	6.25	2	8.33	1	2.78	2	3.77
Dentist	1	6.25	0	0.00	0	0.00	2	3.77
Unregistered Chiropractor	0	0.00	1	4.17	1	2.78	1	1.89
Massage therapist	0	0.00	0	0.00	0	0.00	1	1.89
Student nurse	0	0.00	1	4.17	1	2.78	1	1.89
Podiatrist	0	0.00	0	0.00	0	0.00	1	1.89
Chiropractor	0	0.00	0	0.00	1	2.78	1	1.89
Total	16	100	24	100	36	100	53	100

* Data includes one practitioner who holds dual registration as a nurse and a midwife.

Matters referred to the Queensland Civil and Administrative Tribunal

Practitioner type	Q1		Q2		Q3		Q4		2016–17		2015–16	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Nurse	3	100	1*	20.00	2	50.00	1	100	**7**	**53.85**	3	60.00
Medical practitioner	0	0.00	2	40.00	1	25.00	0	0.00	**3**	**23.08**	1	20.00
Pharmacist	0	0.00	1	20.00	1	25.00	0	0.00	**2**	**15.38**	0	0.00
Dentist	0	0.00	1	20.00	0	0.00	0	0.00	**1**	**7.69**	0	0.00
Unregistered practitioner	0	0.00	0	0.00	0	0.00	0	0.00	**0**	**0.00**	1	20.00
Total	3	100	5	100	4	100	1	100	**13**	**100**	5	100

* Data includes one practitioner who holds dual registration as a nurse and a midwife.

Referrals back to Health Ombudsman

The Director of Proceedings referred five matters back to the Health Ombudsman during 2016–17. These matters related to a dentist, two doctors and two nurses. In four matters, the Director of Proceedings recommended further investigation. In the other, the Director of Proceedings recommended no further action.

Offences against the Health Ombudsman Act 2013

The ***Health Ombudsman Act 2013*** specifies a number of breaches of the Act which constitute either a summary or indictable offence.

Where there is evidence of such a breach, a matter may be referred to the Executive Director, Legal Services to commence prosecution within the courts.

One matter was referred for summary prosecution in 2016–17.

Immediate action

The Health Ombudsman can take immediate action against both registered and unregistered health practitioners if the Health Ombudsman reasonably believes the practitioner poses a serious risk to the health and safety of the public.

Show cause notices

There were 35 show cause notices issued during 2016–17. As outlined in the ***Health Ombudsman Act 2013***, upon receipt of a show cause notice, a health service provider is invited to make a submission within a stated period of time. The Health Ombudsman will then consider the submission before deciding whether to take immediate action against the provider.

Immediate registration actions

The Health Ombudsman can take immediate registration action if a registered health practitioner's health, conduct or performance means they pose a serious risk to people and immediate action is necessary to protect the health and safety of the public. The Health Ombudsman can temporarily suspend or impose conditions on the registration of registered health practitioners. The Health Ombudsman took immediate registration action 51 times in 2016–17.

Practitioner type	Number	Action taken	Reason/s for taking action		
			Health	Conduct	Performance
Chiropractor	1	Conditions		✓	✓
Chinese medicine practitioner	1	Conditions		✓	✓
Chinese medicine practitioner	1	Suspension			✓
Dentist	1	Conditions		✓	
Dentist	1	Conditions		✓	✓
Dentist	1	Conditions			✓
Dentist	1	Suspension		✓	✓
Dentist	1	Suspension		✓	
Dentist	1	Suspension			✓
Medical practitioner	6	Conditions		✓	
Medical practitioner	3	Conditions		✓	✓
Medical practitioner	1	Conditions			✓
Medical practitioner	2	Suspension		✓	
Midwife	1	Suspension		✓	
Pharmacist	1	Conditions		✓	✓
Physiotherapy	1	Conditions		✓	
Psychologist	1	Conditions		✓	
Registered nurse	8	Conditions		✓	
Registered nurse	1	Conditions		✓	✓
Registered nurse	2	Conditions			✓
Registered nurse	6	Suspension		✓	
Registered nurse	5	Suspension			✓
Registered nurse	1	Suspension		✓	✓
Student nurse	2	Conditions		✓	
Student nurse	1	Suspension		✓	

Prohibition orders

The Health Ombudsman can prohibit or restrict unregistered health practitioners who are a risk to the health and safety of the public by issuing them with an interim prohibition order. In addition, the Health Ombudsman can also issue corresponding orders to ones made interstate, thereby giving effect to those orders in Queensland.

In 2016–17, the Health Ombudsman issued 26 interim prohibition orders. Details for current prohibition orders can be found on the OHO website (**www.oho.qld.gov.au**) on the prohibition order register.

Practitioner type	Number	Action taken	Reason/s for taking action		
			Health	Conduct	Performance
Audiologist	1	Restrictions			✓
Assistant in nursing	1	Prohibition	✓	✓	
Assistant in nursing	3	Prohibition		✓	
Assistant in natural therapy	1	Restrictions		✓	✓
Chinese medicine practitioner	1	Prohibition			✓
Chiropractor	1	Prohibition		✓	✓
Community health worker	1	Prohibition		✓	
Dental assistant	1	Prohibition		✓	
Enrolled nurse	1	Prohibition		✓	
Massage therapist	1	Prohibition		✓	
Massage therapist	2	Restrictions		✓	
Midwife	1	Restrictions		✓	
Natural therapist	1	Prohibition		✓	✓
Paramedic	1	Prohibition		✓	
Paramedic	2	Restrictions		✓	
Physiotherapist	1	Restrictions		✓	
Registered nurse	1	Prohibition		✓	
Support worker	1	Prohibition		✓	
Student nurse	1	Prohibition		✓	
Student nurse	2	Restrictions		✓	
Unregistered psychologist	1	Prohibition		✓	

Monitoring practitioner compliance

When the Health Ombudsman takes immediate action against a health practitioner, we monitor the practitioner's compliance with the conditions of the order.

For interim prohibition orders, this means monitoring compliance with the restriction(s) on or prohibition of service. For immediate registration actions, this means monitoring compliance with condition(s) on or suspension of a practitioner's registration.

The Health Ombudsman may take immediate action against a single practitioner with both immediate registration action and an interim prohibition order. This can occur, for example, in instances where there is a risk that a registered practitioner may also practice in an unregistered capacity.

Practitioner monitoring cases

Cases	2016–17
Practitioner monitoring cases started	64
Practitioner monitoring cases closed	12

Open monitoring cases

Timeframes

Open cases timeframes	2016–17*	
	Number	%
Less than 6 months	29	29.00
6–12 months	36	36.00
More than 12 months	35	35.00
Total	100	100

* As at the 30th of June 2017

Immediate action types

Open cases by immediate action type	2016–17	
	Number	%
Interim prohibition order—restrictions	22	22.00
Interim prohibition order—prohibited	27	27.00
Immediate registration action—conditions	31	31.00
Immediate registration action—suspension	20	20.00
Total	100	100

* As at 30 June 2017. At the close of the period nine practitioners were under monitoring in relation to both an immediate registration action and an interim prohibition order.

Registered practitioners under monitoring by type

Practitioner type	2016–17	
	Number	%
Aboriginal and Torres Straight Islander health worker	1	1.64
Chinese medicine	2	3.28
Chiropractic	1	1.64
Dental	3	4.92
Medical	11	18.03
Medical radiation	0	0.00
Nursing and midwifery	37	60.66
Occupational therapy	0	0.00
Optometry	0	0.00
Osteopathy	0	0.00
Pharmacy	1	1.64
Physiotherapy	2	3.28
Podiatry	0	0.00
Psychology	3	4.92
Total	61	100

These figures are based on the number of individual registered practitioners being monitored by the OHO as at the end of the reporting period. As a single practitioner may be monitored in relation to more than one immediate action, these figures may not match the total number of open monitoring cases.

Unregistered practitioners under monitoring by type

Practitioner type	2016–17	
	Number	%
Assistant in nursing	3	10.00
Audiologist	2	6.67
Counsellor	2	6.67
Holding out*	4	13.33
Massage therapist	9	30.00
Natural therapist	3	10.00
Paramedic	4	13.33
Social Worker	1	3.33
Support worker	2	6.67
Total	30	100

* Certain titles of registered health professions are protected under the National Law. Anyone who uses a protected title (e.g. medical practitioner), without being registered for that profession, are classified as 'holding out' as a practitioner of that profession.

These figures are based on the number of individual unregistered practitioners being monitored by the OHO as at the end of the reporting period. As a single practitioner may be monitored in relation to more than one immediate action, these figures may not match the total number of open monitoring cases.

Australian Health Practitioner Regulation Agency

Notification from AHPRA

In 2016–17, AHPRA notified the Health Ombudsman of 10 serious matters, as prescribed under section 193 of the National Law. These included:

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

Five further matters were requested from AHPRA and have been referred by agreement under section193A(4) of the National Law.

Consultation on matters

The office consults with AHPRA on matters that are considered appropriate for AHPRA to manage. For matters that we are considering referring to AHPRA under section 91 of the ***Health Ombudsman Act 2013***, we provide AHPRA with all necessary information in order for AHPRA to form a view as to whether referral is or is not appropriate.

For complex cases or where a pattern of conduct may be present, we may hold case conferences with AHPRA, either in person or electronically, which can sometimes delay the consultation process. By encouraging robust conversations during this process productive and consistent decisions between the co-regulatory agencies is achieved.

Consultation matters	Number
Matters consulted on*	2080
Matters referred	2060
Matters retained by the office	43
Decision pending	2

*The number of matters consulted on may not equal the total number of matters referred, retained and pending as a matter may have commenced consultation prior to the start of the reporting period.

Source of proposed referral

Source	2016–17	
	Number	%
Intake and triage	**1607**	**78.30**
Assessment	**397**	**18.13**
Conciliation	**0**	**0.00**
Local resolution	**21**	**1.10**
Investigations	**49**	**2.16**
Internal review	**6**	**0.31**
Total	**2080**	**100**

Age of matters* on commencement of consultation

In order to prevent duplication of work, we aim to ensure that matters are referred to AHPRA as early as possible in the complaint management process.

Due to the type of matters in which investigation or conciliation is deemed appropriate, and the more time intensive nature of these processes, these matters are usually older when consultation commences.

Source	0–7 days	8–14 days	15–30 days	30–60 days	>60 days
Intake and triage	1498	73	18	11	7
Assessment	37	22	71	107	160
Local resolution	0	0	4	9	8
Conciliation	0	0	0	0	0
Investigation	8	3	3	0	35
Internal review	0	0	0	0	6
Total	1543	98	96	127	216

* From the date on which a matter was accepted by the office.

Consultation duration

Consultation duration	2016–17	
	Number	%
0–3 days	1927	93.14
4–7 days	149	6.58
8–11 days	4	0.28
12+ days	0	0.00
Total	2080	100

AHPRA referrals by practitioner type

Practitioner type	2016–17		2015–16		2014–15	
	Number	%	Number	%	Number	%
Aboriginal & Torres Strait Islander health	**1**	**0.05**	1	0.05	0	0.00
Chinese medicine	**16**	**0.78**	13	0.65	3	0.32
Chiropractic	**34**	**1.65**	21	1.05	16	16.69
Dental	**179**	**8.89**	178	8.93	96	10.13
Medical	**1170**	**56.80**	1111	55.75	458	48.31
Medical radiation	**6**	**0.29**	15	0.75	8	0.84
Nursing and midwifery	**459**	**22.28**	443	22.23	277	29.22
Occupational therapy	**15**	**0.73**	13	0.65	7	0.74
Optometry	**8**	**0.39**	9	0.45	7	0.74
Osteopathy	**2**	**0.10**	3	0.15	1	0.11
Pathology	**0**	**0.00**	0	0.00	1	0.11
Pharmacy	**78**	**3.79**	66	3.31	29	3.06
Physiotherapy	**23**	**1.12**	24	1.20	11	1.16
Podiatry	**8**	**0.39**	9	0.45	1	0.11
Psychology	**61**	**2.96**	77	3.86	26	2.74
Unregistered practitioner	**0**	**0.00**	10	0.50	7	0.74
Total	**2060**	**100**	1993	100	948	100

Number of issues referred to AHPRA by practitioner type

Registered practitioner 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	Total!
Aboriginal & Torres Strait Islander health	—	—	—	—	—	—	—	—	—	—	—	3	—	**3**
Chinese medicine	—	—	1	—	1	—	—	1	—	13	2	4	—	**22**
Chiropractic	—	3	—	—	—	—	—	—	—	22	1	15	—	**41**
Dental	—	14	6	—	—	6	4	10	2	19	6	183	—	**250**
Medical	12	219	41	26	5	15	6	58	209	121	59	942	46	**1759**
Medical radiation	—	—	—	—	—	—	—	—	—	3	1	2	—	**6**
Nursing & midwifery	—	28	4	—	—	—	—	26	65	181	142	147	1	**594**
Occupational therapy	—	1	—	—	—	2	—	1	—	6	4	7	—	**21**
Optometry	—	—	—	—	—	—	—	—	1	5	1	2	—	**9**
Osteopathy	—	—	—	—	—	—	—	1	—	—	—	2	—	**3**
Pharmacy	—	8	—	—	—	—	1	1	52	16	14	3	—	**95**
Physiotherapy	—	—	—	—	—	—	—	2	—	11	—	15	—	**28**
Podiatry	—	—	1	—	—	2	—	—	—	—	2	9	—	**14**
Psychology	—	12	—	—	5	—	—	4	—	29	11	14	6	**81**
Unregistered practitioner	—	—	—	—	—	—	—	—	—	—	—	—	—	**0**
Total	**12**	**285**	**53**	**26**	**11**	**25**	**11**	**104**	**329**	**426**	**243**	**1348**	**53**	**2926**

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

Reporting parameters for demographics data were updated as of June 2017. Previously, demographics contained within the office's reporting related to complaints that had completed the assessment process during the reporting period.

Refinements to systems and processes now allow for reporting on the demographics of complainants, consumers and practitioners who have made, or were identified in, a complaint during 2016–17.

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	2016–17	
	Number	%
Female	2522	47.35
Male	2570	48.25
Prefer not to specify	6	0.11
Unknown	228	4.28
Total	5326	100

Age

Age	2016–17	
	Number	%
Less than 18	256	4.81
18–24 years	235	4.41
25–34 years	966	18.14
35–44 years	1022	19.19
45–44 years	879	16.50
55–64 years	658	12.35
65–74 years	429	8.05
More than 75 years	349	6.55
Unknown*	532	9.99

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

Location of healthcare consumers

Location of healthcare consumers	2016–17	
	Number	%
Brisbane	2217	41.63
Central West	5	0.09
Darling Downs	174	3.27
Far North	265	4.98
Fitzroy	160	3.00
Gold Coast	570	10.70
Mackay	93	1.75
North West	29	0.54
Northern	287	5.39
South West	20	0.38
Sunshine Coast	259	4.86
West Moreton	88	1.65
Wide Bay–Burnett	374	7.02
Outside Queensland	216	4.06
Unknown	599	10.68

The above data is based on health consumer location.

Location of health service providers

Location of health service providers	2016–17	
	Number	%
Brisbane	2885	43.82
Central West	9	0.14
Darling Downs	207	3.14
Far North	326	4.95
Fitzroy	170	2.58
Gold Coast	710	10.78
Mackay	160	2.43
North West	31	0.47
Northern	306	4.65
South West	28	0.43
Sunshine Coast	357	5.42
West Moreton	61	0.93
Wide Bay–Burnett	381	5.79
Outside Queensland	107	1.63
Unknown	567	12.85

* 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).

Service area objective

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

Service Area Description

- Receives and investigates complaints about health services and health service providers, including registered and unregistered health practitioners
- Decides what action to take in relation to those complaints and, in certain instances, takes immediate action to protect the safety of the public
- Monitors the health, conduct and performance functions AHPRA and national health practitioner boards.

Office of the Health Ombudsman	Notes	2016–17 Target/Est.	2016–17 Est. Actual	2017–18 Target/Est.
Service standards Effectiveness measures Percentage of complaints received and accepted within 7 days	1	100%	69%	80%
Percentage of complaints assessed within timeframes	2	100%	50%	80%
Percentage of complaints finalised within timeframes	3	100%	96%	100%
Percentage of investigations finalised within 12 months	4	100%	32%	80%
Percentage of clients satisfied with the complaint management process	5	New measure	67%	80%
Percentage of disciplinary matters in which QCAT decides there is a case to answer	6	New measure	100%	90%
Percentage of immediate action decisions upheld by QCAT at review hearings	7	New measure	100%	90%
Efficiency measure				

1. This is a measure of effectiveness that shows the timeliness of services provided. The high volume of contacts impacted on the office's ability to process matters within the seven calendar day timeframe. The Office of the Health Ombudsman (OHO) continues to review and improve on established effective business systems and processes. The 2017–18 Target/Estimate has been revised following consideration of performance to date, the ongoing review of systems and processes, and the continued increase in contacts.

2. This is a measure of effectiveness that indicates the timeliness of services provided. This service standard reports the complexity of matters, and delays in receiving information from parties and in sourcing independent clinical advice required to appropriately and effectively assess the matters has impacted on timeframes. The 2017–18 Target/Estimate has been revised following assessment of the OHO's performance and business needs since its commencement in July 2014.

3. This is a measure of effectiveness, related to the quality of services provided within the required timeframe. Resolution timeframes continue to improve and it is anticipated that the target will be met in 2017–18.

4. This is a measure of effectiveness, related to the quality of services provided within the required timeframe. This service standard reports the percentage of investigations that are effectively managed and finalised within a 12 month period. Approximately 17.87 per cent of investigation matters have been referred to either the Queensland Police Service while criminal proceedings take place; or to the Coroner if the matter relates to reportable deaths, and are listed as "on hold". Completion of these investigations cannot proceed until the QPS and the Coroner have dealt with the matter. A number of investigations that are transferred to the office by Australian Health Practitioner Regulation Agency (AHPRA) have also required re-investigation prior to completion. The 2017–18 Target/Estimate has been revised due to the percentage of matters with which the OHO cannot proceed due to QPS or Coroner involvement, and the number of transferred matters requiring re-investigation.

5. This is a new measure of effectiveness that shows the quality of services provided to clients. This service standard reports the level of client satisfaction for the complaint management service. The client satisfaction survey captures opinion trends in relation to a range of service quality measures, which are used to inform improvement initiatives. Values are compiled and averaged to obtain an overall satisfaction score.

6. This service standard acts as a measure of the effectiveness of OHO investigations and prosecutions in bringing disciplinary proceedings before QCAT. This includes the sufficiency of evidence and that public interest factors are appropriately taken into account. Matters are referred to the Director of Proceedings (DoP) following an investigation or immediate action taken by the Health Ombudsman; the DoP must then decide whether to refer the matter to QCAT for it to exercise its jurisdiction to hear and decide the matter. Only two disciplinary matters have been decided in 2016–17, which is expected to increase in 2017–18.

7. This service standard acts a measure of the effectiveness of OHO investigations and prosecutions. When immediate action is taken, a practitioner can appeal to QCAT to review the decision. QCAT will decide whether the immediate action is upheld, amended or overturned. No immediate action decision appeals were heard by QCAT in 2016–17, which is expected to increase in 2017–18.

8. An efficiency measure is being investigated and will be included in a future *Service Delivery Statement*.

Staffing[1]

Office of the Health Ombudsman	Notes	2016–17 Target/Est.	2016–17 Est. Actual	2017–18 Target/Est.
Office of the Health Ombudsman	2	121	140	140

1. Full-time equivalents (FTEs) as at 30 June.

2. Increase due to engagement of additional in investigators and case officers to manage the increasing number of complaints received.

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
  - Coroners Court of Queensland
- 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' and Midwives' Union
- Salaried Doctors Queensland
- Together
- Transport Workers Union
- United Voice, Industrial Union of Employees

Law firms

- Ashurst Australia Lawyers and Solicitors
- Hall Payne Lawyers Pty. Ltd.
- K & L Gates LLC
- Moray & Agnew Lawyers
- Roberts & Kane Solicitors Pty. Ltd.
- Rogers Barne & Green
- TressCox Lawyers

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 7	Page 3
Accessibility	Table of Contents	ARRs—Section 9.1	Page 2
	Glossary	ARRs—Section 9.1	Page 155–156
	Public Availability	ARRs—Section 9.1	Page 1
	Interpreter Service Statement	***Queensland Government Language Services Policy*** ***ARRs***—Section 9.3	Page 1
	Copyright Notice	***Copyright Act 1968*** ARRs—Section 9.4	Page 1
	Information Licensing	QGEA—Information Licensing ARRs—Section 9.5	Page 1
General Information	Introductory Information	ARRs—Section 10.1	Pages 4–6
	Agency Role and Main Functions	ARRs—Section 10.2	Pages 4–6
	Operating Environment	ARRs—Section 10.3	Pages 61–63
Non-financial Performance	Government's Objectives for the Community	ARRs—Section 11.1	Page 79
	Other Whole-of-Government Plans/Specific Initiatives	ARRs—Section 11.2	N/A
	Agency Objectives and Performance Indicators	ARRs—Section 11.3	Pages 75–77
	Agency Service Areas and Service Standards	ARRs—Section 11.4	Page 147–148
Financial Performance	Summary of Financial Performance	ARRs—Section 12.1	Page 84
Governance—Management and Structure	Organisational Structure	ARRs—Section 13.1	Page 67
	Executive Management	ARRs—Section 13.2	Page 68
	Government Bodies (Statutory Bodies and Other Entities)	ARRs—Section 13.3	N/A
	Public Sector Ethics Act 1994	***Public Sector Ethics Act 1994*** ARRs—Section 13.4	Page 79
	Queensland Public Service Values	ARRs—Section 13.5	Page 79

Summary of Requirement		Basis for Requirement	Annual Report Reference
Governance—Risk Management and Accountability	Risk Management	ARRs—Section 14.1	Page 73
	Audit Committee	ARRs—Section 14.2	N/A
	Internal Audit	ARRs—Section 14.3	Page 84
	External Scrutiny	ARRs—Section 14.4	N/A
	Information Systems and Record Keeping	ARRs—Section 14.5	Page 73
Governance—Human Resources	Workforce Planning and Performance	ARRs—Section 15.1	Pages 69–71
	Early Retirement, Redundancy and Retrenchment	Directive No.11/12 ***Early Retirement, Redundancy and Retrenchment*** Directive No. 16/16 ***Early Retirement, Retrenchment (from 20 May 2016)*** ARRs—Section 15.2	Page 71
Open Data	Statement Advising Publication of Information	ARRs—Section 16	Page 73
	Consultancies	ARRs—Section 33.1	Page 73
	Overseas Travel	ARRs—Section 33.2	Page 73
	Queensland Language Services Policy	ARRs—Section 33.3	Page 73
Financial Statements	Certification of Financial Statements	FAA—Section 62 FPMs—Section 42, 43 & 50 ARRs—Section 17.1	Page 105
	Independent Auditors Report	FAA—Section 62 FPMs—Section 50 ARRs—Section 17.2	Page 107–108

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 national health practitioner boards. Each health profession that is part of the National Registration and Accreditation Scheme is represented by a national board. The boards are responsible for registering practitioners and students for their professions, as well as other functions. They are supported by AHPRA in the framework of a health profession agreement.
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 10**.

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

Office of the
HEALTH
OMBUDSMAN

Listen. Respond. Resolve.

400 George Street, Brisbane
PO Box 13281 George Street
Brisbane QLD 4003

P. 133 OHO (133 646)

www.oho.qld.gov.au