

# Annual report

2017–18

September 2018



Office of the  
**HEALTH  
OMBUDSMAN**

*Listen. Respond. Resolve.*

## Office of the Health Ombudsman annual report 2017–18

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20 September 2018

**The Honourable Steven Miles MP**

Minister for Health and Minister for Ambulance Services  
GPO Box 48  
BRISBANE QLD 4001

Dear Minister

I am pleased to present the *Office of the Health Ombudsman annual report 2017–18* 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* for 2017–18.

A checklist outlining the annual reporting requirements can be found at pages 154–155 of this report.

Yours sincerely



Andrew Brown  
Health Ombudsman

# The year in review

## The Health Ombudsman's report

I commenced acting as Health Ombudsman in November 2017. In May 2018 I was formally appointed to the role for a period of three years. As well as ensuring that the important day-to-day work of the office was being delivered, I had two key areas of focus during 2017–18, namely to facilitate **improved operational performance** and **improved relationships with key stakeholders**, particularly OHO's coregulatory partner the Australian Health Practitioner Regulation Agency (AHPRA) and associated boards.

### Operational performance

One of the key reasons given for the creation of the OHO was that the previous system had 'resulted in unjustifiable delays in dealing with serious allegations'. It is fair to say that a universal criticism of the OHO in the past has been its failure to meet timeframes. For this reason, operational performance was a significant focus of the OHO during 2017–18. In some divisions of the office, momentum was already gathering with some changes implemented before I commenced, while in other areas it was necessary to refocus and reprioritise.

I am pleased to report that 2017–18 was our most productive and strongest year yet, as we delivered significantly improved performance against the majority of our legislative timeframes and addressed backlogs in some critical areas.

We achieved this while facing a continued increase in workload, with contacts up 13 per cent, complaints up 12 per cent, and accepted complaints up 7 per cent (from the previous financial year).

Key performance highlights include:

- **89 per cent** of intake decisions made within the seven day statutory timeframe (up from 74 per cent in 2016–17 and 48 per cent in 2015–16)
- **72 per cent** of assessment decisions made within their statutory timeframe (up from 61 per cent and 32 per cent in the previous financial years)
- **halving the average age of open assessment matters** compared with the previous financial year (average assessment age being 18 days as at 30 June 2018). Importantly, all but one aged assessment (older than 60 days) was finalised by 30 June 2018, setting the assessment team up for even stronger performance in 2018–19
- completing a greater number of investigations than in any previous year, **reducing open investigations by 61 per cent**, with only 153 investigations remaining open at the end of the financial year, down from 394 open as at 30 June 2017—arguably the most substantial achievement of 2017–18
- further **completing a substantial number of aged investigations**—reducing these to just 48 investigations open more than one year (down from 196) and 14 investigations open more than two years (down from 53)—setting the Investigations division up to further improve on timeframes in 2018–19.

The upsurge in performance meant that in 2017–18 the OHO's Director of Proceedings received from investigations 175 matters to consider for prosecution through the Queensland Civil and Administrative Tribunal (QCAT) (compared with only 56 matters referred in 2016–17 and 24 in 2015–16). While the Director of Proceedings (and the Legal Services division) has also demonstrated a significant improvement in productivity in 2017–18—having filed 52 matters in QCAT (up from 12 and 5 in the previous financial years)—the challenge now is dealing with the large number of cases sitting with the Director of Proceedings and in QCAT. This is a key focus going forward.

2017–18 was about improving performance and addressing backlogs. I would like to thank the staff of the OHO for their hard work, commitment, dedication and support during the year. Without this, these results would not have been possible. I would also like to acknowledge the members of the OHO's executive management team—a number of whom joined that group during the financial year—who during 2017–18, demonstrated a commitment to a shared vision and purpose, worked collaboratively, and supported each other and each other's divisions.

Most importantly, what this improved productivity and performance means is an improvement in the service we deliver. We are now more responsive to consumers and better positioned to assist them in a more timely way. We are better placed to respond to and manage risk associated with complaints and notifications and thus have improved on our ability to protect the public. And we are able to deal more quickly with matters, reducing the time practitioners wait to hear the outcome of the complaints against them.

## Stakeholder relationships

I have also focused on improving the OHO's relationship with our coregulatory partner AHPRA and associated boards. I am wholeheartedly committed to ensuring the coregulatory scheme in Queensland works effectively and efficiently. A common criticism levelled by stakeholders in the past was the perceived inefficiency of the coregulatory environment. I believe that both the OHO and AHPRA have worked very hard during 2017–18 to counter this and act in a more coordinated way.

I truly believe that the system will only work if there is a strong and cooperative relationship between coregulators. During 2017–18 significant gains have been made in this relationship and I would like to acknowledge the contribution that AHPRA has made to this. I believe that 2017–18 saw a demonstrated commitment by both agencies to work at a strategic level to achieve the best outcomes for the system as a whole.

The recommendations made in 2016 by the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee (the parliamentary committee) play a very important part in improving the coregulatory system. For this reason, I fully support what was recommended. I can report that significant work commenced in 2017–18 (under the coordination of Queensland Health) towards progressing the necessary legislative change to:

- provide for the joint consideration by the OHO and AHPRA of complaints/notifications
- deal more effectively with practitioner matters that are currently split between the OHO and AHPRA.

Although there are still some logistical challenges to work through—including ensuring the agencies can meet their statutory timeframes in the face of increased administrative processes—I am supportive of amendments that essentially give AHPRA and the boards more input into the management of registered practitioners.

Significant progress has also been made in relation to the parliamentary committee's recommendation concerning information sharing. Information is now flowing more effectively between agencies and work to deliver on a nationally consistent set of data is well advanced.

## The future

I am very excited to lead the OHO into 2018–19 as I think the office is well positioned to build on its successes in 2017–18. Some of my priorities for 2018–19 include:

- finalising the legislative amendments necessary to further address the parliamentary committee's recommendations, as noted above, and commencing a joint consideration trial early in the year
- improving internal governance frameworks, systems and processes, particularly in the area of corporate services, and implementing a quality assurance framework across key divisions
- embarking on a process to review and deliver a new strategic plan
- repositioning the organisation as an employer of choice, drawing on employee feedback
- a greater focus on identifying and conducting investigations into systemic issues
- making ourselves more accessible and responsive to the needs of Aboriginal and Torres Strait Islander peoples
- empowering communities by providing additional resources to assist consumers in progressing low risk health complaints directly with their health provider, prior to contacting the OHO
- continuing to build good working relationships with stakeholders.

Once again, I wish to acknowledge the work of the OHO staff, which will no doubt carry us into a strong 2018–19.



**Andrew Brown**  
Health Ombudsman

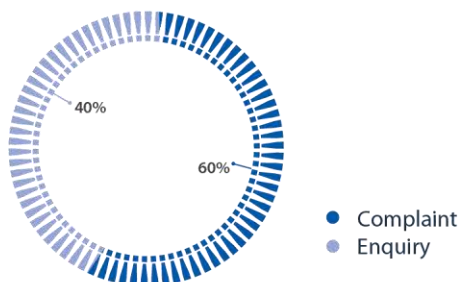
## Profile of healthcare complaints

The number of individuals contacting the OHO continues to grow year-on-year, with 2017–18 seeing a record number of complaints and enquiries. The snapshot below highlights the types of complaints and notifications received, the most common issues raised, and the types of health practitioners identified.

### ! 11,569 contacts received in 2017–18

13% increase from last year

#### Contact types



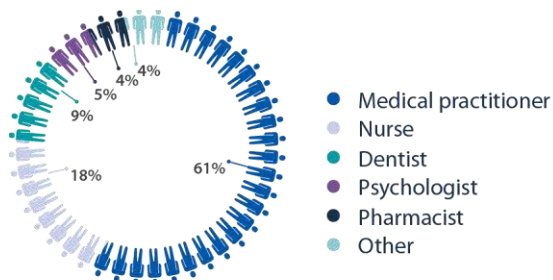
#### Complaint types



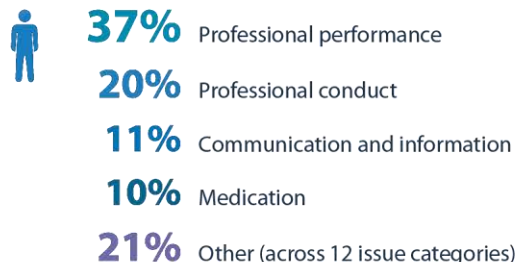
### 49% of complaints identified an individual practitioner\*



#### Top five registered practitioners identified

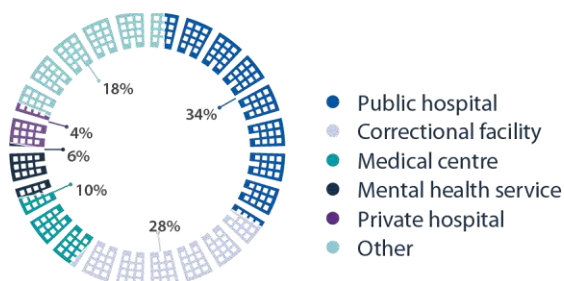


#### Issues raised

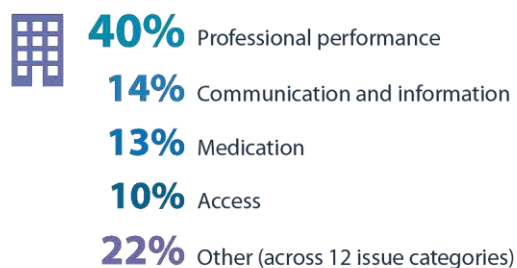


### 54% of complaints identified a health service organisation\*

#### Top five health service organisations identified



#### Issues raised



\* Some complaints identified both an individual practitioner and health service organisation.



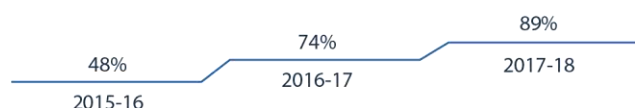
## Performance highlights

Below is a summary of our performance highlights for 2017–18 across our key functions. These are detailed in full in [Our performance](#) (pages 18–55).

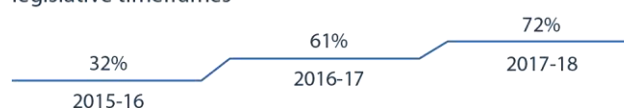


### Improvements to timeliness

**Increase** in complaint intake decisions made in seven days



**Increase** in assessments completed within legislative timeframes



### Addressing backlogs

**Reduction** in assessments remaining open as at end of year



**Reduction** in average age of open assessments



**Reduction** in investigations remaining open as at end of year



**Reduction** in number of investigations open more than 12 months

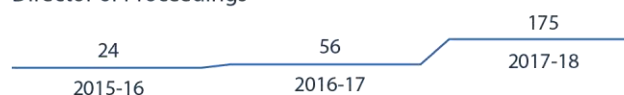


### Increased productivity

**Increase** in number of completed investigations



**Increase** in number of matters referred to the Director of Proceedings



**Increase** in number of matters filed in the Queensland Civil and Administrative Tribunal



## About us

### Vision

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

The Office of the Health Ombudsman (OHO) is Queensland's **health service complaints management agency** and a key component of the **health regulation system** in the state. We are an independent statutory body and the one place all Queenslanders can go if they have a complaint about:

- a health service provided to them or another person
- a health service provider
- any aspect of a health service provided in Queensland.

Our purpose is to **protect the health and safety of the public; promote professional, safe and competent practice and high standards of service delivery; and maintain confidence in the health service complaints and regulation system** in Queensland. We achieve this by delivering a timely, impartial and independent health complaint management and oversight service focused on assessing, investigating, resolving and/or prosecuting health service complaints, notifications and systemic health matters.

In this way, the OHO contributes to the Queensland Government's commitment to keep Queenslanders healthy, keep communities safe, and be a responsive government by:

- strengthening Queensland's health system and protecting the health and safety of the public by assessing, investigating, resolving and/or prosecuting healthcare complaints and identifying systemic healthcare issues and making improvement recommendations
- providing responsive and integrated government services by working within set timeframes and engaging with other agencies to ensure the health service complaint and regulation system in Queensland deals with complaints holistically and effectively
- supporting disadvantaged Queenslanders by making our services accessible and reaching out to those groups that may not know where to go if they have a health service complaint.



## Our values

Our guiding principle as determined under legislation is that **the health and safety of the public are paramount**.<sup>1</sup> This principle—together with the Queensland Government's public sector values—underlie the OHO's governing values,<sup>2</sup> which 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.

## Jurisdiction

The office was established on 1 July 2014 under the *Health Ombudsman Act 2013* (the Act), and replaced the Health Quality and Complaints Commission. Under the Act and the *Health Practitioner Regulation National Law (Queensland)* (the National Law), the OHO has broad powers to deal with complaints and other matters relating to the health, conduct or performance of **both registered and unregistered health practitioners** and the services provided by **health service organisations**.

In our handling of complaints about registered practitioners in Queensland, the OHO shares regulatory powers with AHPRA and the 15 health practitioner national boards under the National Law. The OHO applies the *National Code of Conduct for Health Care Workers (Queensland)* when managing complaints about unregistered practitioners in Queensland.

The office is led by the Health Ombudsman, which is a statutory position with responsibility for acting independently, impartially and in the public interest. In 2017–18 Mr Leon Atkinson-MacEwen finished his term as Health Ombudsman and was succeeded by Mr Andrew Brown.<sup>3</sup>

Under the Act, the Health Ombudsman has power to do all things necessary or convenient to performing key functions, which include:

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<sup>1</sup> Section 4 of the *Health Ombudsman Act 2013*.

<sup>2</sup> As laid out in the OHO's strategic plan 2017–21 (see [appendix 3](#) on pages 83–85).

<sup>3</sup> In January 2018 the Minister for Health announced Ms Rachel Hunter as the succeeding Health Ombudsman. Ms Hunter never formally commenced in the role, having later accepted a position elsewhere, and Mr Brown was subsequently appointed.

- receive and investigate complaints and notifications about health services and health service providers, including registered and unregistered health practitioners
- take relevant action in relation to those complaints and, in certain instances, take immediate action where necessary to protect the health and safety of the public or where it is in the public interest
- investigate and report on systemic issues in order to identify and recommend opportunities for improvement
- monitor the health, conduct and performance functions of AHPRA and the national health practitioner boards
- provide information about minimising and resolving health service complaints
- report publicly on the performance of our functions.

The Health Ombudsman is an independent, impartial decision-maker. Under the Act and the National Law, certain decisions by the Health Ombudsman and other related matters are reviewable by QCAT, in the tribunal's jurisdiction to resolve and determine disputes, reviews and referrals.<sup>4</sup>

The Health Ombudsman is also required to report on specific matters to the parliamentary committee as well as the Minister for Health, who may direct the Health Ombudsman to investigate certain matters.

## Working with AHPRA

AHPRA is a national agency with offices in each state and territory, and 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 OHO and AHPRA work as **coregulatory partners** to oversee and regulate registered health practitioners in relation to matters concerning their health, conduct and performance. The OHO is the first port of call for health service complaints, including notifications about registered practitioners. We **receive, triage and manage these complaints and notifications and, where appropriate, refer matters to AHPRA and the national boards**, unless it appears the practitioner has behaved in a way that constitutes professional misconduct, or another ground exists to cancel or suspend registration.<sup>5</sup>

The 15 health practitioner national boards are an important part of the coregulatory framework, and have additional powers under the National Law. 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.

See [page 57](#) for more detail on matters referred between the OHO and AHPRA and other key developments in this partnership over the reporting period.

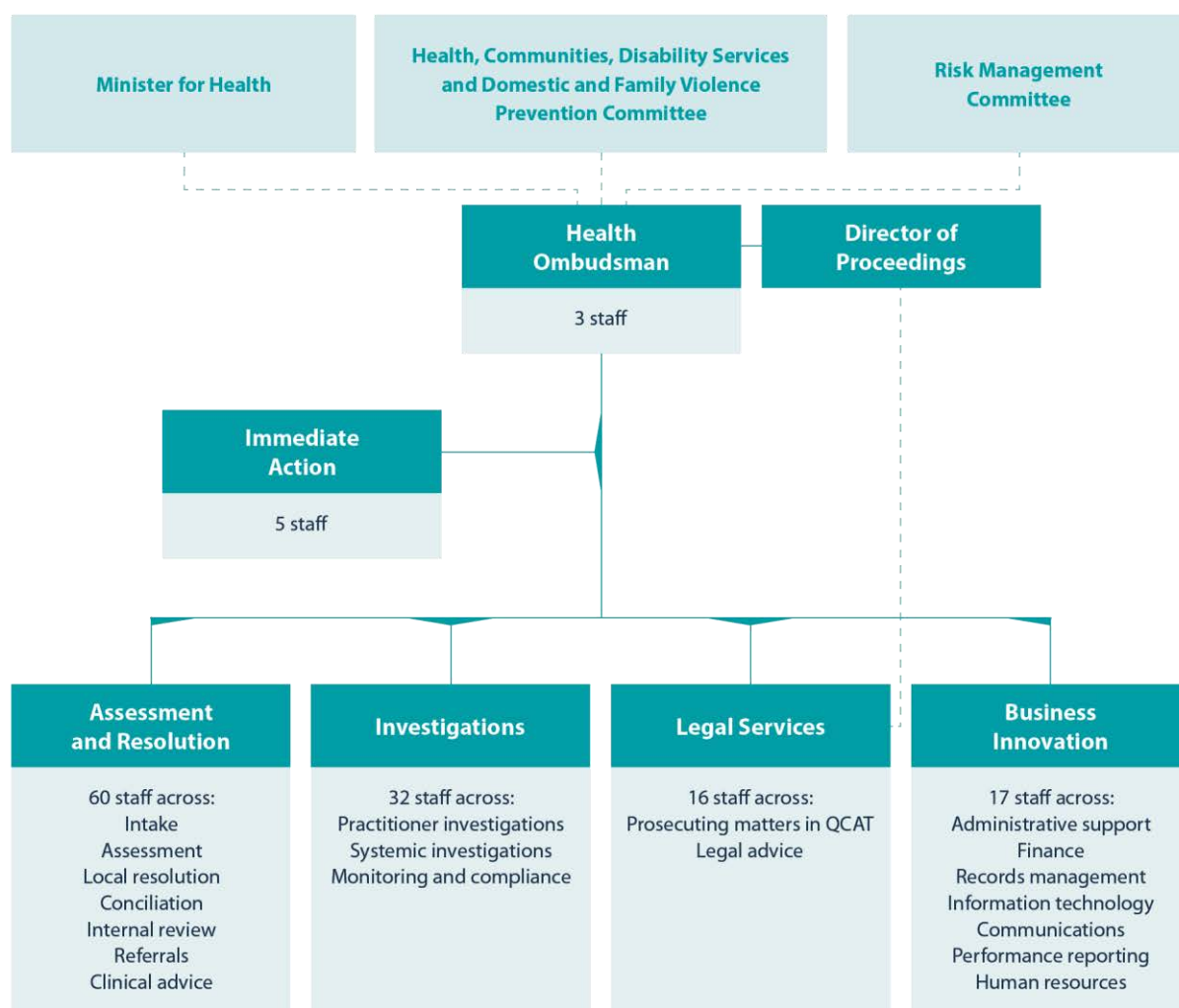
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<sup>4</sup> Section 94 of the Act.

<sup>5</sup> Under section 91 of the Act.

## Organisational structure

Figure 1 Organisational structure of the Office of the Health Ombudsman as at 30 June 2018



# Health service complaints

## Types of complaints

Anyone can make a **complaint or notification** to the OHO about a health service provided in Queensland.

### Complaints

Complaints can be made *by* a health consumer, or *on behalf of* a health consumer, about any aspect of a health service. Complaints may be about:

- Individual **registered** health practitioners      Any person registered under one of the 15 national boards<sup>6</sup>, namely Aboriginal and Torres Strait Islander health practitioners, Chinese medicine practitioners, chiropractors, dentists, doctors, medical radiation practitioners, midwives, nurses, occupational therapists, optometrists, osteopaths, paramedics, pharmacists, physiotherapists, podiatrists, psychologists, and students in these fields<sup>7</sup>.
- Individual **unregistered** health practitioners      Any person outside of the registered professions above that delivers a service that does or claims to maintain, improve, restore or manage people's health and wellbeing, or a support service for these services.
- Health service **organisations**      A facility, other than an individual, that delivers health services whether in a public or private capacity.

### Notifications

#### Mandatory notifications

Under the National Law, **health service providers, employers and education providers** are required to advise us if they believe another practitioner has behaved in a way that constitutes *notifiable conduct*. These complaints are referred to as mandatory notifications and may be about a health practitioner's **health, conduct and/or performance**. 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.

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<sup>6</sup> In 2017–18 the Paramedicine Board of Australia was established however, as at 30 June 2018, registration of paramedics in Australia had not yet commenced. Paramedics are therefore considered unregistered practitioners for the purposes of this report.

<sup>7</sup> This includes students enrolled in a program of study or clinical training for a registered health profession.

### *Voluntary notifications*

**Anyone** can make a voluntary notification to the OHO about a health practitioner for matters relating to their health, conduct or performance, such as:

- 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.

### *Referrals from other organisations*

We may also receive notifications and complaints in the form of referrals from other organisations where their dealings raise concerns with the provision of healthcare by a practitioner or provider. Matters may be referred from agencies such as the Queensland Police Service, the Coroners Court of Queensland, and the Medicines Compliance and Human Tissue Unit of Queensland Health.

### *Self-notifications*

Under the National Law, registered health practitioners must advise their relevant national board of specific matters relating to their own health, conduct and performance. Practitioners have seven days to self-notify of relevant events—events related to criminal charges and convictions, rights to practise, insurance, billing privileges and others as outlined in the legislation. The National Law also requires students in these fields to make certain self-notifications.

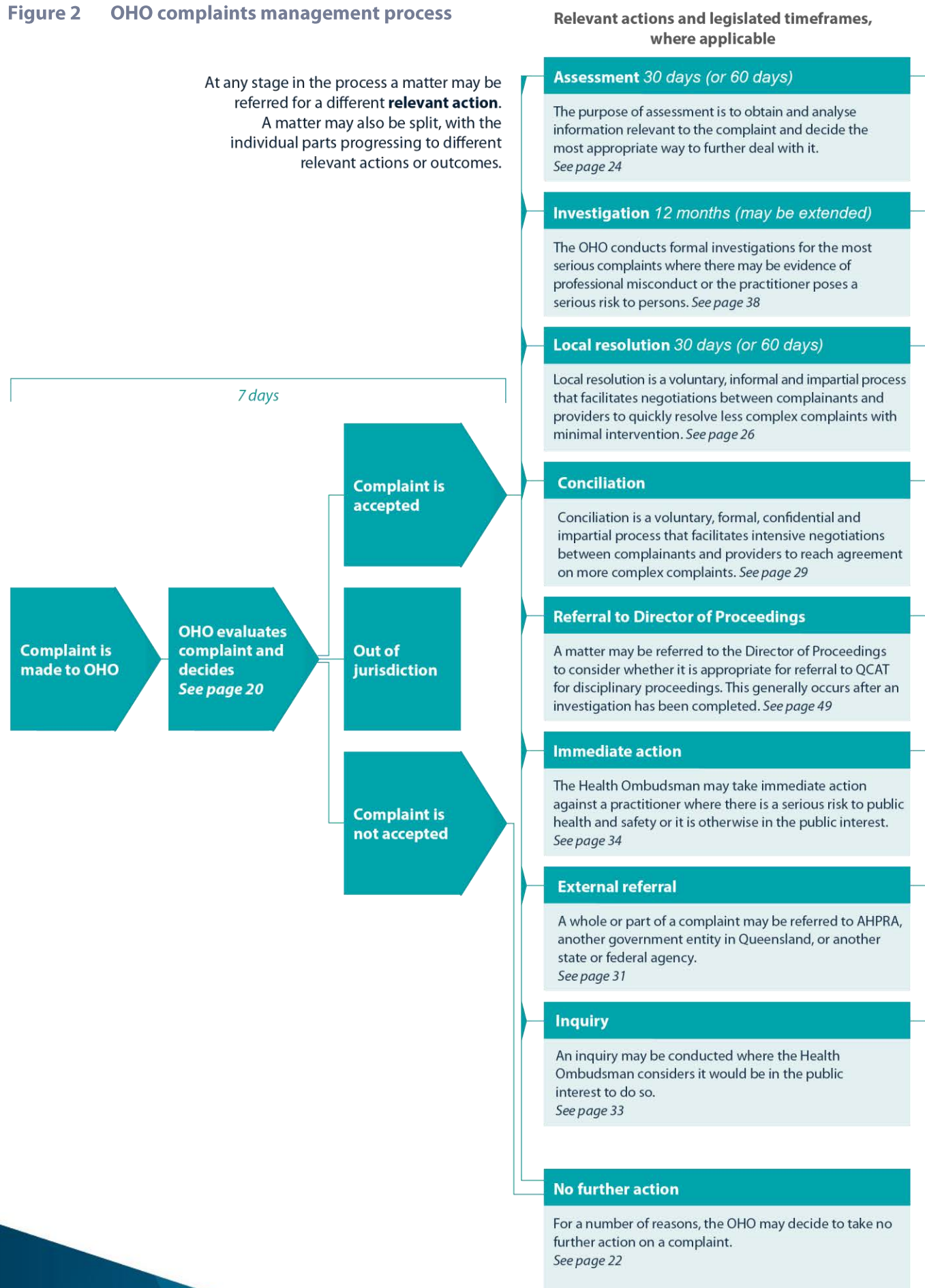
## **The complaints process**

We are guided by our legislative imperative to manage complaints effectively, protect public health and safety, and maintain confidence in the health regulation and complaints system. The complaints process is therefore dynamic, allowing flexibility for complaints to move between different stages of the process as necessary. Many complaints do not necessarily follow a linear workflow; **figure 2 gives a general overview** of the interaction between the stages of the complaints process.

We receive, classify and process complaints under a number of potential actions and outcomes as defined by the Act, which are referred to as *relevant actions*. A complaint or parts of a complaint may progress simultaneously to different relevant actions, and may move between relevant actions throughout the process.

Each stage of the process is explained in further detail in the following pages.

**Figure 2 OHO complaints management process**







## Our performance

The OHO has legislated powers under the Act to receive and accept complaints; collect information and evidence to inform actions and decisions; take action against health practitioners and service providers; refer matters to other relevant agencies; bring disciplinary proceedings before QCAT; and facilitate resolution in different ways.

The following pages detail our 2017–18 performance across these key functions, enabling us to contribute to the Queensland Government's commitment to keep Queenslanders healthy, keep communities safe, and be a responsive government.

### Service delivery statements

The service standards featured below are reported in the Service Delivery Statements as part of the Queensland Government budget process each year. The table sets out the end of year position for all measures published in the OHO's service delivery statement 2017–18 (part of the [2017–18 Service Delivery Statement for Queensland Health](#)).

**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 of AHPRA and national health practitioner boards.

**Table 1     The Office of the Health Ombudsman service standards**

Service standards	Notes	2017–18 target/estimate	2017–18 actual
<i>Effectiveness measures</i> Percentage of complaints received and accepted within 7 days	1	80%	89%
Percentage of complaints assessed within timeframes	2	80%	72%
Percentage of complaints finalised within timeframes	3	100%	97%
Percentage of investigations finalised within 12 months	4	80%	46%



Service standards	Notes	2017–18 target/estimate	2017–18 actual
Percentage of clients satisfied with the complaint management process	5	80%	70%
Percentage of disciplinary matters in which Queensland Civil and Administrative Tribunal (QCAT) decides there is a case to answer	6	90%	100%
Percentage of immediate action decisions upheld by QCAT at review hearings	7, 8	90%	50%
<i>Efficiency measures</i>	9		

Notes:

1. This is a measure of timeliness of services provided. The seven day timeframe for decisions made on complaints received is mandated in the Act. The high volume of contacts has impacted on the office's ability to process matters within the seven calendar day timeframe. However, improvements to business practices have seen a significant improvement in performance against this measure during 2017–18 compared with the previous two years. The OHO will continue to review and improve business systems and processes.
2. This is a measure of timeliness of services provided. The 30 and 60 day timeframes for assessment decisions is mandated in the Act. The office's ability to meet these timeframes has been affected by the continuing complexity of matters, and delays in receiving information from parties and in sourcing the independent clinical advice required to appropriately and effectively assess matters. However, changes to business practices have seen a gradual improvement in performance against this measure during 2017–18 compared with the previous two years. The OHO will continue to review and strive to improve business systems and processes.
3. This measure is related to local resolution services provided within the 30 and 60 day timeframes mandated under the Act. Local resolution timeframes have been consistently high and continue to improve.
4. This measure reports the percentage of investigations that are effectively managed and finalised within the required 12 month timeframe. Improvements to systems and processes have resulted in the number of investigations closed in 2017–18 increasing by 85 per cent when compared with the previous year. A focus on the finalisation of aged investigations (investigations open more than 12 months) has resulted in a lower level of achievement for 2017–18 against this measure than targeted. However, the significant reduction in the proportion of aged matters achieved in 2017–18 will allow the OHO to enhance its performance against this measure in 2018–19.
5. This is a measure of effectiveness that shows the quality of services provided to clients. This service standard reports the level of client satisfaction with the OHO's complaints 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. The reported client satisfaction rate shows an improvement when compared with 2016–17.
6. This service standard is 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 considered. Matters are referred to the Director of Proceedings following an investigation; the Director of Proceedings must then decide whether to refer the matter to QCAT for it to hear and decide the matter. A 'case to answer' means that QCAT has upheld all or part of the case against the practitioner. Between 1 July 2017 and 30 June 2018, QCAT handed down four decisions on matters referred by the Director of Proceedings on behalf of the Health Ombudsman; in all four matters QCAT upheld all or part of the case against the practitioner.
7. This service standard acts as a measure of the effectiveness of OHO investigations and prosecutions. When the Health Ombudsman takes immediate action, a practitioner can apply to QCAT to review the decision. QCAT will decide whether the immediate action is upheld, amended or overturned. Between 1 July 2017 and 30 June 2018, QCAT handed down two decisions on immediate action review requests, one of which was upheld and one of which was overturned, resulting in a 50 per cent success outcome.
8. This result varies from the 0 per cent estimated result as published in the 2018–19 Service Delivery Statement, which only took into account the one overturned immediate action matter at the time, when there was in fact one upheld matter as well.
9. An efficiency measure is being investigated and will be included in a future Service Delivery Statement.

For details of our service delivery standards related to staffing levels, see [Our people](#) on page 71.

## Complaints intake and acceptance

### Intake and acceptance

Members of the public and health service providers can contact the OHO through a number of different methods; every one of these *contacts* is identified as either a *complaint* or *enquiry*. Where a matter is identified as a complaint (including notifications and referrals received from other agencies), it is then subject to a triage process and risk assessment, during which we have seven days to decide whether to accept the matter and what to do next.<sup>8</sup>

#### *Improved timeframes notwithstanding increase in contacts*

In 2017–18 we **received 11,569 total contacts, an increase of 13 per cent** on the 10,262 contacts received last year. Of the contacts received, 60 per cent (6936) were complaints and 40 per cent (4631) were enquiries.<sup>9</sup>

The 6936 complaints received this year represent a 12 per cent increase on the 6201 complaints received in 2016–17. Of these 6936 complaints, 87 per cent were complaints by health service consumers and 12 per cent were notifications.

Figure 3 Number of contacts received

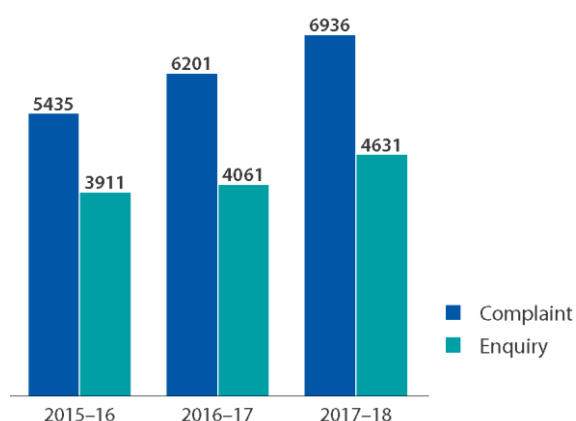
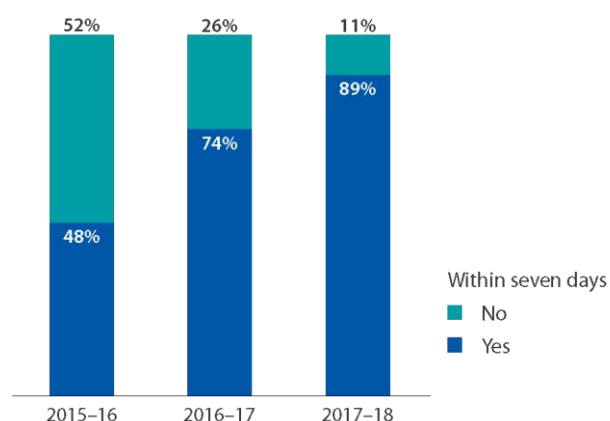


Figure 4 Percentage of decisions made within seven days



A key performance highlight for 2017–18 was our strong improvement in intake decisions made within the seven day legislative timeframe. This year **89 per cent of intake decisions were made within seven days**, compared with 74 per cent in 2016–17 and 48 per cent in 2015–16. This was achieved despite the aforementioned increase in total contacts and corresponding 13 per cent rise in complaint intake decisions in 2017–18 (6579 decisions up from 5841 in 2016–17).<sup>10</sup>

<sup>8</sup> This timeframe is mandated under section 35 of the Act.

<sup>9</sup> Two contacts were yet to be classified as at 30 June 2018.

<sup>10</sup> The 6936 complaints received by the office resulted in 6579 intake decisions on matters within the jurisdiction of the office. A further 313 complaints were determined to be out of jurisdiction.

Figure 5 Percentage of complaints accepted vs not accepted

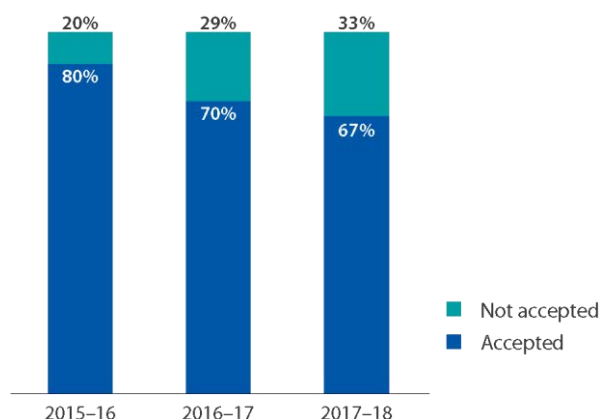
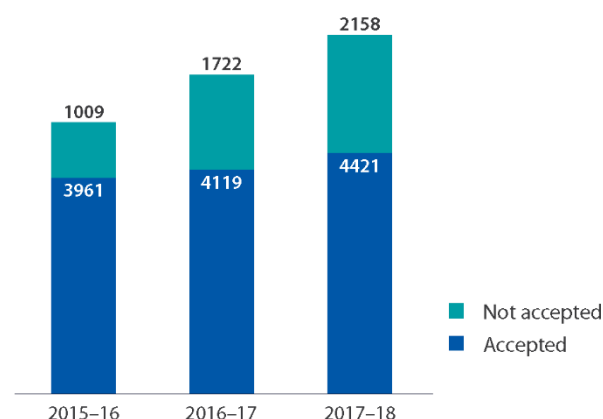


Figure 6 Number of complaints accepted vs not accepted



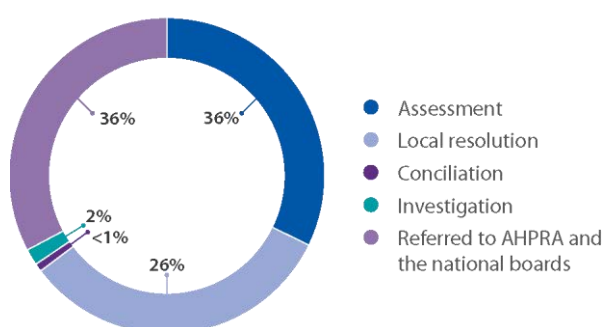
To facilitate this achievement, in 2017-18 we made a number of process improvements and introduced several tools to increase efficiency and consistency in decision-making, including:

- a designated service and phone line for the handling and triaging of complaints from prisoners
- refining our internal consultation process for the identification and escalation of serious matters, including development of a risk assessment and escalation decision-making framework
- reallocation of staff resources to manage the increasing volume of contacts.

These improvements have also enabled us to better assess the level of risk presented to the health and safety of the public in the early stages of the complaints management process.

In terms of outcomes of accepted decisions, the results were relatively consistent with the previous year's with the majority of accepted decisions referred to AHPRA and the national boards (36 per cent), progressed for further assessment (36 per cent), or directed to local resolution (26 per cent).

Figure 7 Outcomes of accepted complaints in 2017-18



Our process improvements in recent years have assisted in earlier identification of matters suitable for referral to AHPRA and the national boards, with fewer of these matters progressing to the later stages of complaint handling, such as assessment. In 2017–18 and 2016–17 more than three-quarters of all matters referred to AHPRA were referred at intake (76 per cent and 77 per cent respectively), up from 55 per cent of matters referred to AHPRA at intake in 2015–16. This has seen correspondingly fewer assessments resulting in a referral to AHPRA (18 per cent in 2017–18 and 19 per cent in 2016–17, down from 41 per cent in 2015–16). More detail on all matters referred to AHPRA in 2017–18 can be found on [pages 57–59](#).

The trend of continually increasing contacts and complaints is predicted to continue into the future as the Queensland population grows alongside greater general awareness of the OHO. In 2018–19 our focus will be on creative strategies to manage this increase in contacts without necessitating a corresponding increase in resources.

To this end, we are developing a number of education and information sharing initiatives to address common contacts through our public channels—such as our website—to assist parties in resolving matters prior to escalation of a complaint to the OHO (see [Our future](#) on pages 74–75).

### No further action

At any time, the Health Ombudsman may decide it is appropriate to take no further action on a health service complaint.<sup>11</sup> This decision may be reached following or during any stage of the complaints process. Under the Act, a decision to take no further action may include situations where the complaint:

- has been withdrawn (and it is appropriate to take no further action)
- is being adequately dealt with by another appropriate entity
- has been resolved or otherwise appropriately finalised by the Health Ombudsman or another appropriate entity
- is frivolous, vexatious or not made in good faith
- is misconceived or lacking in substance
- cannot be resolved despite reasonable efforts by the Health Ombudsman or another appropriate entity.

A decision to take ‘no further action’ does not necessarily reflect the legitimacy or otherwise of the complaint. Similarly, it is not reflective of the amount of work and resources invested in reaching that decision.

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<sup>11</sup> Section 44 of the Act.

## OHO in action

### Deciding to take no further action

A complaint was lodged regarding the health services provided by a pharmacist. The complainant alleged they had attended a physiotherapy appointment for treatment of chronic pain resulting from an injury several years prior, and subsequently presented to a nearby pharmacy, where the pharmacist refused to dispense prescription pain medication in a form suitable to the complainant.

After further discussion with the complainant, we determined that the complainant did not in fact have a prescription for the sought medication, which would have enabled the pharmacist to dispense the medication. Upon consideration of the facts, the Health Ombudsman decided to take no further action on the matter, on the basis that there was a misunderstanding of fact. The reasons for this decision were communicated to the parties.

## Relevant actions

As shown in the [complaints process flowchart](#) (see figure 2 on page 16), once a complaint is accepted, the Health Ombudsman has the power under the Act to take a number of different relevant actions, these being:

- assessment
- facilitating local resolution
- taking immediate action
- investigating the subject matter
- referring the complaint to AHPRA or another government entity in Queensland, or another state or federal agency
- referring the complaint to the Director of Proceedings
- conciliating the complaint
- carrying out an inquiry into the subject matter.

As stated above, at any point in time, the Health Ombudsman may also decide to take no further action (see [page 22](#)).

In addition to the service standards set out in our Service Delivery Statements (see [page 18](#)), the different stages of the complaints process and relevant actions have distinct performance measures and timeframes, some of which are mandated by the Act. These are expounded below along with detailed analysis of our performance in 2017–18.

## Assessment

Complaints may be referred for assessment if further information and analysis is required to establish the full scope of the matter, conduct a detailed risk assessment, and determine what actions need to be taken to manage the complaint. If we decide to assess a complaint, that process must be carried out and completed within 30 days, or 60 days with an approved extension.<sup>12</sup>

### *2017–18 sees reduction in number of open assessments and age of matters*

In 2017–18 we completed 1989 assessments, of which 72 per cent were completed within legislative timeframes, compared with 61 per cent in 2016–17 and 32 per cent in 2015–16.

We also succeeded in **reducing the number of open aged assessments**—that is, assessments open more than 60 days—resulting in a reduced overall age of open assessments. As at 30 June 2018, 114 assessments were open with an average age of 18 days, compared with the 219 assessments that were open as at 30 June 2017 with an average age of 38 days. Furthermore, of the 114 assessments open as at 30 June, only one assessment was open longer than 60 days.

Figure 8 Number of assessments

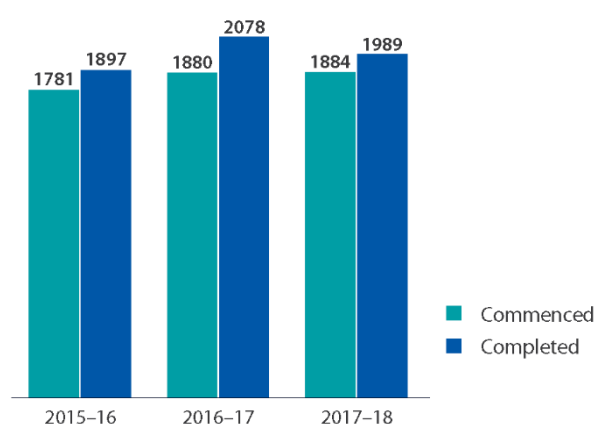
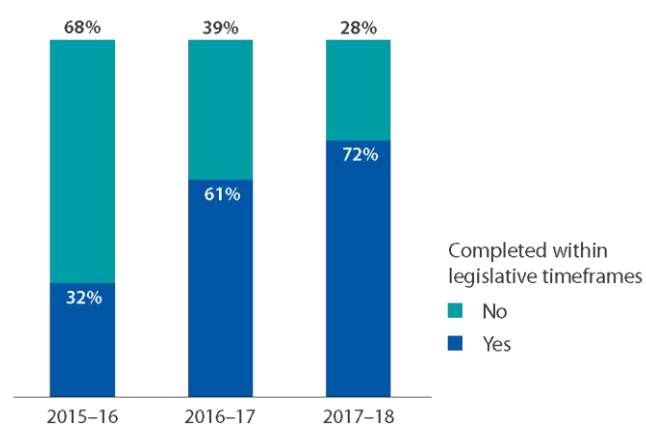


Figure 9 Percentage of assessments completed within legislative timeframes



This improved performance is largely due to process improvements, including the implementation of a risk and complexity framework that better enables us to prioritise, allocate and review serious matters. In 2017–18 we also focused on completing aged assessments, as demonstrated by the strong reduction in the overall age of matters. Despite increased productivity, this focus on clearing older assessments has correspondingly impacted on timeframes with only 72 per cent of assessments completed within legislative timeframes. This is, however, an improvement on the 61 per cent of assessments completed within legislative timeframes in 2016–17. Furthermore, significantly reducing the proportion of aged assessments this year will allow us to enhance our performance against this measure in 2018–19.

<sup>12</sup> Section 49(2) of the Act provides grounds for the Health Ombudsman to extend the assessment period for an additional 30 days in certain circumstances.

## OHO in action

### Assessing a complaint

A complaint was lodged by a health consumer in relation to alleged conduct that occurred several years ago, and involved inappropriate examination by a general practitioner. The complainant did not provide the practitioner's name, when the alleged events occurred, or details of the issues and alleged conduct.

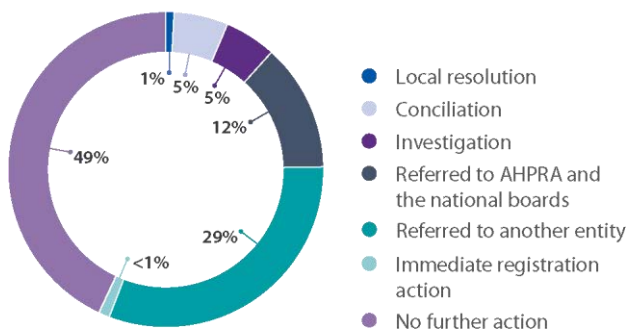
The matter was identified as a complaint and accepted within seven days, and was progressed to assessment to allow the OHO to gather information to establish the facts. This included having a sensitive conversation with the complainant and support person to understand the specifics of the incident/s, dates, history, and other information the complainant could recall.

The assessment process facilitated the gathering of third party information, such as medical records for the consultation, whether a chaperone was present, practitioner history, and other relevant documentation to inform the decision. Upon consideration of all the information gathered, a decision was made that the matter was appropriate for referral to AHPRA, as it did not amount to professional misconduct and no other grounds existed for cancelling or suspending the practitioner's registration.

### Assessment outcomes

In 2017–18, after assessment, matters were referred for local resolution (1 per cent), conciliation (5 per cent), investigation (5 per cent), referral to AHPRA and the national boards (12 per cent), referral to another entity (29 per cent), or immediate registration action (less than 1 per cent), with no further action taken for the remaining matters (49 per cent). This range of outcomes demonstrates how the assessment process enables us to gather sufficient evidence to determine the appropriate course of action.

Figure 10 Outcomes of assessment in 2017–18



These outcomes are relatively consistent with those for 2016–17, with the exception of matters referred to AHPRA. This year 12 per cent (255) of matters were referred to AHPRA and the national boards, down from 18



per cent (419) in 2016–17 and 38 per cent (811) in 2015–16. As noted previously, in recent years we have worked to improve the early identification of matters for referral to AHPRA and the national boards at the intake stage, to ensure efficiency in the core regulatory management of complaints. Consequently fewer complaints requiring referral to AHPRA or other agencies are reaching the assessment stage.

## OHO in action

### Potential outcomes of assessment

We received several complaints about the provision of healthcare by a private health service facility. During the assessment process, we obtained information from individual patients in each complaint, as well as their medical records and prescribing history.

These disparate complaints were received over a period of time and were unrelated. However, through the detailed analysis undertaken in assessment, we identified similarities in the issues raised, namely, general prescribing concerns; failing to counsel appropriately for prescribed medication; failure to coordinate treatment with the consumers' general practitioners and other allied health services; unreasonable billing practices; and potential Medicare fraud.

Consequently, the matter was referred for investigation of potential systemic issues (see [page 44](#)), and was simultaneously referred to an external agency—specifically the Department of Human Services—in relation to the potential Medicare fraud.

## Local resolution

Local resolution is a voluntary, informal and impartial process for resolving matters between complainants and health service providers as quickly as possible and with minimal intervention by the Health Ombudsman. Local resolution can be effective in dealing with complaints where there is an obvious practical outcome that can be achieved—or when, by negotiating impartially between the health service consumer and the provider, we can help support continuity of care and rebuild people's trust and confidence in the healthcare system. As such, matters identified for local resolution typically concern less complex clinical issues, breakdowns in basic systems or processes, or matters that result from a misunderstanding or failed communication between parties.

In facilitating a resolution, the Health Ombudsman may:

- analyse information provided with the complaint
- consider submissions from complainants and health service providers
- analyse information obtained by way of a formal notice
- facilitate meetings and other communications between parties
- facilitate agreement on a course of action between parties.



In accordance with the Act, once the Health Ombudsman makes the decision to attempt local resolution, the complaint must be resolved within the next 30 days, or 60 days subject to an extension.<sup>13</sup>

## Spotlight

### Feedback from parties to local resolution

"I wanted to sincerely thank you for the kind and professional manner in which you dealt with my case. I had so many reservations about making a complaint about inappropriate behaviour but I'm honestly so glad I did. Thank you for studiously keeping me up to date and answering all my questions."

"I am very happy and impressed with the speed and professionalism with which my complaints were investigated and handled. Thank you."

"Our sincere thanks for your professional help resolving our problem."

### 'Perfect quarter' for local resolution

In 2017–18 we completed 1264 local resolutions—with 97 per cent (1226) of matters finalised within legislative timeframes—notwithstanding a 16 per cent increase in matters referred for local resolution. Furthermore, in the final quarter for the year **we achieved the OHO's first 'perfect quarter', with 100 per cent (259) of local resolutions finalised within legislative timeframes.**

Figure 11 Number of local resolutions

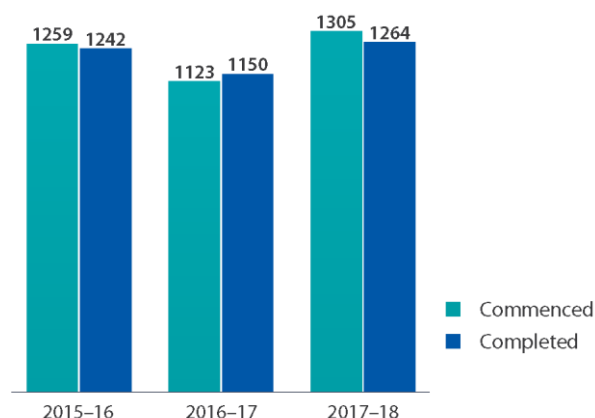
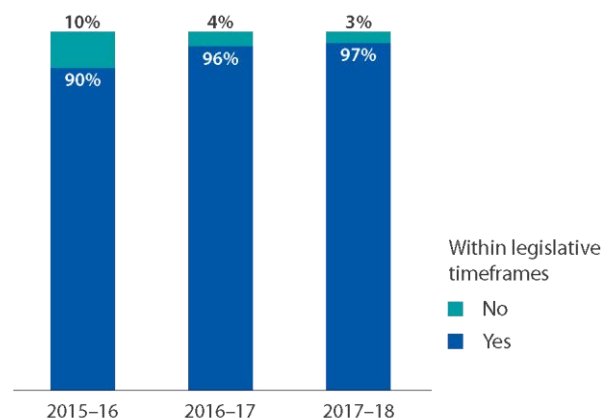


Figure 12 Percentage of local resolutions completed within legislative timeframes

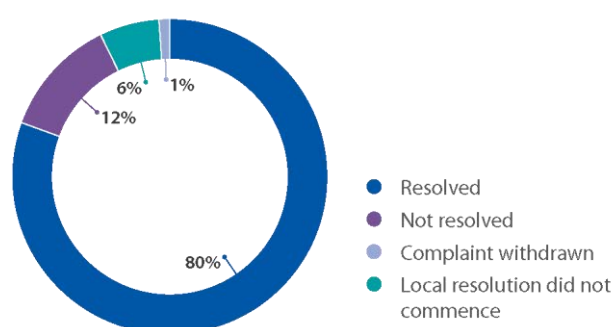


<sup>13</sup> Under section 55 of the Act, the Health Ombudsman may extend the timeframe by an additional 30 days under certain circumstances.

As local resolution is a voluntary process, the outcomes that can be achieved are varied and are tailored to the circumstances of each complaint. Potential outcomes include an apology, policy or process improvements, and refunds for out-of-pocket expenses or corrective costs. Often the health consumer may require ongoing healthcare, making the local resolution process an important step in rebuilding trust and confidence in the relationship. This may be achieved by sharing information regarding the care received, improving the understanding of clinical treatment or administration procedures, and developing communication protocols for the future. This year we also developed a fact sheet to assist parties in better understanding these potential outcomes and what the local resolution process can achieve.

In 2017–18, 80 per cent of matters were finalised as being resolved.

Figure 13 Outcomes of local resolution in 2017–18



## OHO in action

### Facilitating local resolution

We received a number of individual complaints in relation to a practitioner who was forced to suddenly cease practising after falling seriously ill. The practitioner's patients were transferred to other practitioners to ensure continuation of treatment. However, some of those patients had purchased treatments in advance—prior to the practitioner ceasing practice—but had not been refunded for treatments still owed to them.

We contacted the practitioner and alerted them to the problem. The practitioner expressed surprise and embarrassment as all payments received for prepaid treatments were meant to have been either refunded or transferred to the patients' new practitioners and subsequently honoured. We provided the practitioner with details of those who had complained to us, so those matters could be resolved. As well as arranging for those refund payments to be made immediately, the practitioner identified and contacted other former patients who had suffered the same fate—albeit unknowingly—and proactively resolved those matters before they developed into complaints to the OHO.

## OHO in action

### Facilitating local resolution

A hospital patient consented to surgery after being assured by the hospital's staff that his private health insurance would cover all associated costs. Weeks later, having had the surgery, the patient received a bill in the mail from the hospital requiring payment in full. The complainant told us that, when he contacted his private health insurer about it, he was alarmed to learn that—contrary to what the hospital's staff had told him at the time he consented to the surgery—the procedure was not covered by his health insurance policy, meaning he was potentially liable and would need to pay out of his own pocket.

Upon receiving the complaint, we contacted the parties—including the patient, the hospital and the patient's private health insurer—to establish what happened, request supporting documents, and determine the likelihood of the complaint being resolved. This process resulted in the hospital locating evidence, which supported the complainant's claims (i.e. that the hospital's staff told him his private health insurance policy would cover the costs). The hospital said providing that advice was a mistake and accepted that it was likely a key factor in the complainant's decision to consent to the procedure. Consequently, the matter was quickly resolved with the hospital agreeing to waive all costs and review its internal policies and staff communications to ensure similar mistakes do not occur in future.

## Conciliation

Conciliation is a voluntary process for resolving complex complaints that require detailed explanations or confidential complaint resolution. The process is facilitated by skilled conciliators, who use their independence and specialist dispute resolution and negotiations skills—within a confidential and privileged environment—to assist complainants, consumers and providers to be heard, identify issues for discussion and negotiate outcomes between the parties.

Unlike local resolution—which is used in resolving complaints where an immediate practical solution may exist—matters addressed in conciliation tend to be more complex, requiring greater intervention on our part to help parties reach agreement. To facilitate the voluntary engagement of parties with the process, information disclosed during a conciliation process—including details relating to any agreements or negotiations—is confidential and privileged, meaning it cannot be discussed outside the process or admitted as evidence in a proceeding before a court, tribunal or disciplinary body.

For these reasons, conciliation can be effective in resolving complaints that:

- involve sensitive information or complex clinical issues
- require detailed explanations, including opportunities for parties to hear each other, ask each other questions, and provide responses
- require confidential dispute resolution.

### Open conciliations nearly halved at year end

In 2017–18 we started 103 conciliation matters and closed 128. We also completed 69 conciliation processes during the year, including 9 which were open 12 months or more. While there are no legislated timeframes that apply to conciliation, we aim to facilitate the process as quickly and efficiently as possible. To that end, we had **36 open conciliations as at 30 June 2018, compared with 61 open conciliations as at 30 June 2017.**

Figure 14 Number of conciliations

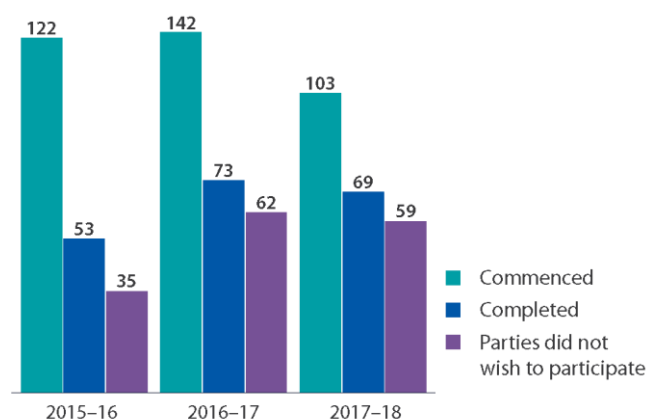
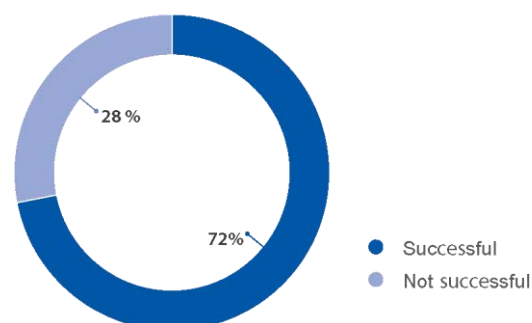


Figure 15 Outcomes of conciliation in 2017–18



## OHO in action

### Facilitating conciliation

A complaint was made by the family of a patient who died unexpectedly due to complications during surgery. The conciliator analysed the information and assisted and encouraged the parties to identify matters for discussion, share information, and agree on an agenda for a conciliation meeting.

The conciliation meeting provided a safe, confidential and privileged environment for the health practitioners to explain what happened and for the family to ask questions and share their feelings with the other parties involved. The family said the conciliation process gave them a sense of closure as well as the comfort that comes with knowing that their efforts might assist other families in similar circumstances. Equally, the practitioners found comfort in:

- expressing their sympathies to the family
- explaining the lengths they went to in their attempts to save the patient
- explaining what procedural improvements had been made as a result of the incident.

## OHO in action

### Facilitating conciliation

A complaint was made about a hospital by a patient who experienced a significantly negative birthing experience and, despite many attempts, requests for assistance were ignored. Within the confidential, safe and supportive environment of the conciliation conference utilising the specialised dispute resolution skills of the conciliator, the parties:

- explored, discussed and acknowledged the concerns and the appropriate clinical pathway used for the treatment
- apologised for any communication shortcomings
- highlighted learnings that had been taken from the experience
- discussed working together on a training package for staff.

### External referral

The Health Ombudsman has powers under the Act to refer matters to AHPRA, another government entity in Queensland, or another state or federal agency as the more appropriate entity to manage the complaint.<sup>14</sup> As we are the single entry point for health service complaints in Queensland, the role we play in coordinating referrals and in following up to ensure complaints are managed appropriately is critical to the efficient operation of the complaints handling system.

The Health Ombudsman may refer a complaint about a registered health practitioner **to AHPRA and the national boards**, unless it appears the practitioner has behaved in a way that constitutes professional misconduct, or another ground exists to cancel or suspend the practitioner's registration.<sup>15</sup> In Queensland the OHO and AHPRA operate as coregulatory partners to manage health service complaints. In 2017–18 we referred 2145 matters to AHPRA (see [page 58](#) for more detail).

A complaint about any practitioner may also be referred **to another relevant government (state or Commonwealth) agency**.<sup>16</sup> In practice, the range of government entities that we refer matters to is extremely diverse and relies on consulting these stakeholders to ensure streamlined processes and information sharing. In 2017–18 we referred 618 matters to another appropriate government entity.

As noted previously, if multiple practitioners and/or complaint issues are identified within the one complaint, the complaint may be split for different relevant actions, including external referral. For example, a single complaint may result in part of a matter relating to a registered health practitioner being referred to AHPRA, with the OHO retaining and managing other parts of the matter, such as those relating to possible professional misconduct or unregistered practitioners.

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<sup>14</sup> Section 38 and Part 9 of the Act.

<sup>15</sup> Section 91 of the Act.

<sup>16</sup> Sections 92 and 93 of the Act.

## OHO in action

### Referring a matter to AHPRA

A health service provider—acting in the capacity of an employer of health service practitioners—made a mandatory notification after taking action to terminate the employment of a registered nurse for reasons relating to medication management, recordkeeping of scheduled medicines, and performance in recognising and responding to clinical deterioration.

Upon accepting the matter we conducted a risk assessment to determine if it was necessary to take immediate action against the practitioner to protect public health and safety. From that assessment we determined the practitioner presented a low risk to public health and safety which did not necessitate immediate action. As the issues related to the practitioner's performance and would not have amounted to professional misconduct, it was appropriate to refer the matter to AHPRA. Altogether, the entire process—from receiving the complaint to referral—took place within four days.

## OHO in action

### Referring a matter to another government agency

A complainant advised us that she was made to feel humiliated after allegedly overhearing two midwives talking disparagingly about her outside her maternity room. The complainant said she had been having trouble breastfeeding her newborn baby and therefore needed to ask midwives to assist her. She later allegedly overheard the staff talking about her and denigrating her decision not to persist with breastfeeding. The complainant wrote to us seeking an explanation and apology.

As the matter was about an incident at a public hospital and the midwives were not identified in the complaint, we referred the matter to the appropriate Hospital and Health Service (HHS). The director of the hospital's maternity ward raised the matter with the staff who were on duty during the complainant's stay in hospital. The staff responsible were regretful for the anguish they caused the complainant and recognised that their actions were insensitive and unprofessional. As well as addressing the matter individually with those staff, the director instructed them to undergo further training in patient-centred care. Finally, the director phoned the complainant to explain the actions that had been taken as a result of her complaint, and to apologise on behalf of the hospital and the staff involved. This was also reiterated in a letter from the director to the complainant.

The HHS provided the OHO with a report detailing the action taken, and advised us that the complainant had accepted the hospital's apology.

## Inquiry

Under the Act, where it is considered in the public interest to do so, the Health Ombudsman has the power to conduct an inquiry into:

- a matter to which a health service complaint relates
- a systemic issue relating to the provision of a health service
- another matter the Health Ombudsman considers relevant to achieving the objectives of the Act.<sup>17</sup>

The Health Ombudsman may initiate an inquiry in line with the above stipulations, or may be directed by the Minister for Health to conduct an inquiry.

To date, the Health Ombudsman has not conducted an inquiry into any matter.

### Spotlight

#### Changes to the Health Ombudsman Act

A number of changes to the Act came into effect on 1 March 2018, which primarily affect the Health Ombudsman's power to take immediate action, including:

- expanding the power to allow immediate action where the Health Ombudsman reasonably **believes it is in the public interest**—under sections 58(1) and 68(1)
- allowing for **immediate actions to be varied** after issue, either by the Health Ombudsman's own initiative or on application by the practitioner—under sections 58A, 58B, 68A and 68B
- granting power to QCAT to **review a decision of the Health Ombudsman not to vary** an immediate action where applied for by a practitioner—under section 94(1)(a)
- changes to the **required content** of an immediate action order and ensuing **notice issued to the practitioner**—under sections 70(a) and 71.

To take action in the public interest it is necessary to identify an explicit interest held by the whole community or a class of people, and establish that **the proposed action protects that interest**. This may include where it is necessary to act to maintain public confidence in the profession—for example, where the conduct is of a serious and alarming nature but is unrelated to the practitioner's position as a health practitioner—or where there is no necessity to act because the risk has been addressed—for example, by imprisonment of the practitioner.

Immediate action orders can now be varied after issue if there has been a material change to the matter giving rise to the immediate action. In practical terms, variations may be considered where there is sufficient evidence that the immediate action can be varied and will **continue to mitigate the serious risk** posed to the health and safety of the public. Immediate actions can be varied either by the Health Ombudsman's own initiative or on application by the practitioner.

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<sup>17</sup> Part 12 of the Act.



## Immediate action

In the most serious cases, it may be necessary for the Health Ombudsman to take immediate action against a practitioner. Under the Act, the Health Ombudsman can take immediate action against any health practitioner who **poses a serious risk to public health and safety, where it is necessary to act** to protect public health and safety. Under recent changes to the Act, the Health Ombudsman can now take immediate action where it is reasonably believed to be **in the public interest**.

Immediate action is taken by way of *immediate registration action* against a registered health practitioner or *interim prohibition order* issued to an unregistered health practitioner or a registered health practitioner practising in an unregistered capacity. Under the Act, immediate registration actions may, and interim prohibition orders must, be published on the OHO website,<sup>18</sup> to ensure the public and employers are aware of practitioners' restrictions, conditions or suspension.

In 2017–18 the Health Ombudsman took immediate action against 41 practitioners by way of 21 immediate registration actions and 24 interim prohibition orders.

While the number of interim prohibition orders issued this year was consistent with those issued in 2016–17, there were significantly fewer immediate registration actions taken by the Health Ombudsman. One reason for this decrease was the adoption of a more coordinated approach with AHPRA in responding to alleged professional misconduct linked to a potential health impairment. For such matters, we liaise closely with AHPRA to determine whether it is more appropriate for AHPRA to take immediate action (including to impose conditions on registration) to mitigate the risk in relation to the practitioner's impairment first, rather than the Health Ombudsman taking immediate action. In these circumstances it is noted there was no significant variation in the total number of immediate registration actions taken by the OHO and AHPRA collectively.

Figure 16 Number of immediate actions taken by the Health Ombudsman

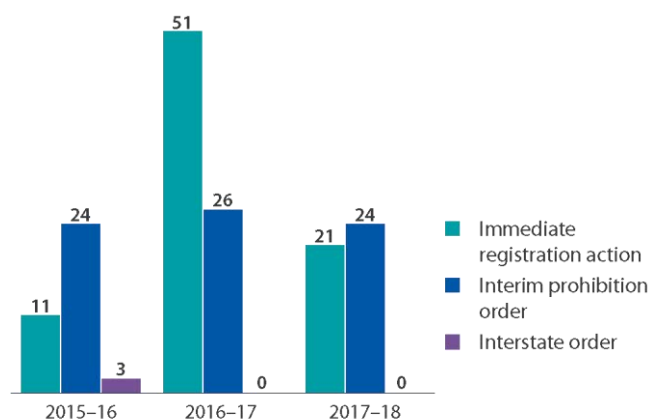
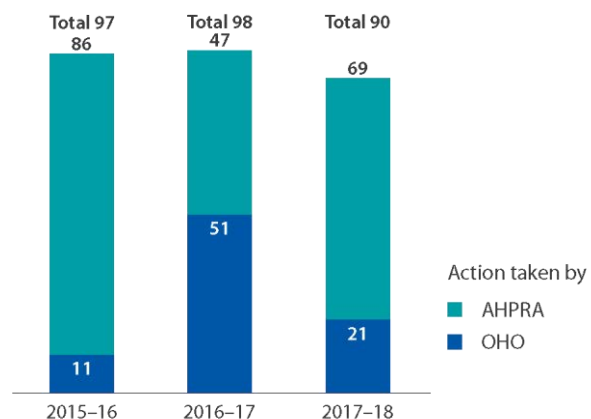


Figure 17 Number of immediate registration actions taken against registered practitioners in Queensland<sup>19</sup>



<sup>18</sup> Section 79 (for interim prohibition orders) and section 273 (for immediate registration action) of the Act.

<sup>19</sup> Data for 2017–18 for immediate actions by AHPRA is taken from publicly available reports for quarters one to three, and from data supplied to the OHO by AHPRA for the fourth quarter. Actions taken by AHPRA includes undertakings accepted.



## OHO in action

### Taking immediate action to protect the health and safety of the public

We received a complaint about a registered health practitioner who was allegedly practising under the influence of drugs, and suffering from a mental health impairment. Rather than take immediate registration action, we first contacted AHPRA who advised the practitioner was the subject of a health assessment and had provided undertakings to AHPRA not to practise.

To protect the public from the risk of harm posed by the practitioner working in an unregistered capacity, the Health Ombudsman issued an interim prohibition order to the practitioner prohibiting the practitioner from providing any health service, but determined it was not necessary to take immediate registration action due to the undertakings provided to AHPRA.

### Show cause notices

Except in the most serious of cases, when immediate action is proposed, the Health Ombudsman must give the practitioner an opportunity to *show cause* as to why the immediate action should not be taken. The responding submission from the practitioner, together with any other evidence provided by the practitioner, will be considered by the Health Ombudsman before any decision to take immediate action is made.

A show cause notice is an important step in providing procedural fairness for the practitioners involved. It also enables the Health Ombudsman to be better informed in relation to the practitioner's health, conduct and/or performance, to assist the Health Ombudsman in determining the context and substance of allegations, and decide whether immediate action is warranted.

In the most serious cases, the Health Ombudsman may take immediate action without issuing a show cause notice to ensure the health and safety of an individual or the public.

In 2017–18, 40 show cause notices were issued to practitioners, up from 35 notices issued in the previous year.

### Immediate action reviews

Practitioners also have the right to seek review of the Health Ombudsman's decision to take immediate action by making an application to QCAT.<sup>20</sup>

In 2017–18 five practitioners filed applications for review of an immediate action and two reviews were finalised. Of those reviews finalised, QCAT:

- set aside one immediate action decision
- upheld one immediate action decision.

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<sup>20</sup> Sections 63 and 74 of the Act.

## OHO in action

### QCAT upholds an immediate action decision

In late 2015 the Health Ombudsman issued an interim prohibition order to an unregistered practitioner, a massage therapist, after the practitioner entered into a personal and sexual relationship with a patient at a rehabilitation retreat. The practitioner filed an application in QCAT to review the Health Ombudsman's decision.

In *A Practitioner v Health Ombudsman* [2017] QCAT 265, the Tribunal upheld the Health Ombudsman's interim prohibition order, finding that the practitioner's actions posed serious risk and that immediate action taken by the Health Ombudsman at the time was necessary to protect public health and safety. The Tribunal also made a non-publication order in relation to the proceedings and, as such, the full judgment of the matter was de-identified prior to publication. QCAT found the non-publication order does not affect the Health Ombudsman's legislative requirement to publish details of the order on the OHO website.

### Monitoring practitioner compliance

Where immediate action is taken against a health practitioner, we monitor the practitioner's compliance with the action to mitigate the risk to public health and safety.

In 2017–18 the OHO commenced 41 new practitioner monitoring cases and closed 48, with 92 cases remaining open as at 30 June 2018. As a single practitioner may be monitored for different issues and orders, the 92 open monitoring cases are across 88 practitioners, down from 91 practitioners under monitoring at the end of 2016–17.

Figure 18 Number of practitioners under monitoring as at 30 June

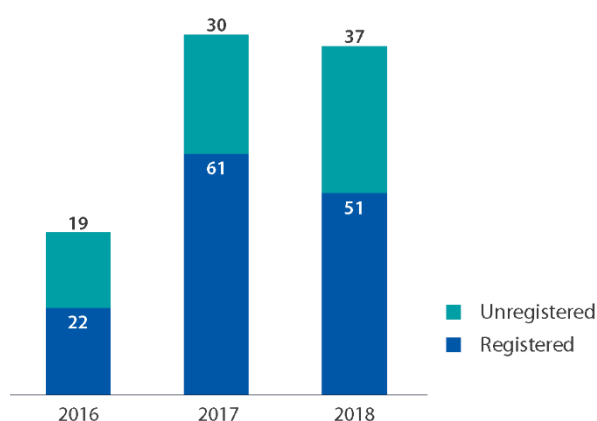
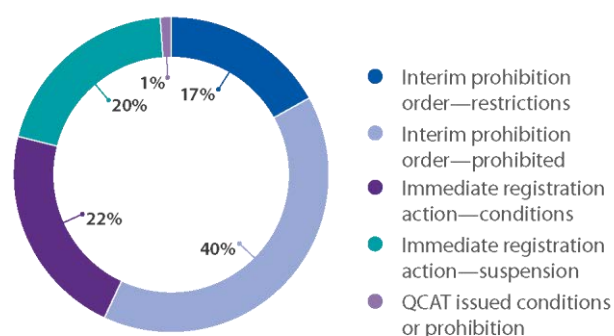


Figure 19 Open monitoring cases by type as at 30 June 2018



In 2017–18 we implemented a number of process improvements and worked closely with key stakeholders to increase efficiencies in monitoring in the coregulatory environment.

Through monitoring, we continually assess practitioners' compliance and level of risk to ensure the protective measures in place are relevant, effective and appropriate. With cases of suspected non-compliance and escalation of risk, early intervention is critical for continued protection of the public.

The recent legislative changes enabling the Health Ombudsman to vary immediate actions have further supported this work; allowing variations means the OHO's protective measures can also be amended to ensure they are proportionate to the risk status and are effectively protecting public health and safety without compromising our resources. To further maximise our resources, we are continuing to work collaboratively with AHPRA for split matters—where the OHO retains part of a matter with the other part managed by AHPRA. For the purposes of monitoring compliance with an immediate action, in these split cases we monitor practitioners' compliance with the immediate action/s taken by the Health Ombudsman, while AHPRA monitors and manages practitioners' impairments.

## **OHO in action**

### **Monitoring practitioners in the coregulatory environment**

Together with AHPRA, we have developed a coordinated approach to monitoring to ensure effective decision-making that mitigates risks to the public health and safety in the least restrictive way. In a recent matter, we received a notification of a practitioner who had been forging prescriptions for schedule 8 medications (drugs of addiction). The practitioner presented the forged prescriptions to obtain and then self-administer the dispensed drugs. The Health Ombudsman previously took immediate action to suspend the practitioner's registration. Diversion of drugs for personal use often suggests a practitioner may have a health impairment, and the Health Ombudsman therefore also referred the matter to AHPRA for consideration of this issue.

AHPRA and the relevant national board carried out the health assessment. Medical evidence thus obtained indicated the practitioner had sought treatment for the drug addiction and that the practitioner's condition had subsequently improved. The evidence suggested the practitioner may be able to return to work, provided treatment was continued and conditions were imposed to manage the practitioner's access to schedule 8 medications. The national board then proposed conditions that would allow the practitioner to practise while affording appropriate protection of the health and safety of the public. Considering these conditions together with the medical evidence, the Health Ombudsman lifted the suspension of the practitioner's registration as AHPRA and the national board simultaneously imposed the proposed conditions.

We have developed a new process with AHPRA to manage similar matters and ensure both agencies can consider changes in a practitioner's risk status and take appropriate action as swiftly as possible.

### *Breaches of immediate action orders*

For registered practitioners, a breach of their immediate registration action order may constitute professional misconduct, whereas for unregistered practitioners a breach of their interim prohibition order is a criminal

offence<sup>21</sup>. When the OHO identifies or suspects a practitioner is not complying with the immediate action taken against them, we will investigate further and may take appropriate action.

Where there is evidence of a breach against the Act, a matter may be referred within the office to the Executive Director, Legal Services for potential prosecution through the courts. In 2017–18 no new matters were referred for summary prosecution. Two matters were filed in the Magistrates Court as a result of practitioners referred in 2016–17 for alleged breaches of an interim prohibition order.

## Investigation

For more serious matters the OHO conducts formal investigations, which fall into one of two categories: **individual health practitioner** investigations and/or **systemic investigations**.

In relation to individual **registered health practitioners**, we undertake investigations to determine whether the practitioner's conduct or performance constitutes professional misconduct, or whether another ground exists to suspend their registration. In relation to individual **unregistered practitioners**, we undertake investigations where it appears that the practitioner poses a serious risk to persons, due to the practitioner's health, conduct and/or performance.

We undertake **systemic investigations** to determine if there are systemic issues impacting on the provision or quality of health services. These investigations may result from a complaint or notification, emergence of a systemic issue, or may be initiated by the Health Ombudsman.<sup>22</sup>

Investigations are to be completed within 12 months, though this may be extended due to the size, nature or complexity of a matter.<sup>23</sup> Under the Act, all investigations open for more than 12 months must be published to a register on our website. We are further required under legislation to advise the parliamentary committee and Minister for Health of any investigations that have been open for more than two years.

While open, an investigation will be either *active* or *paused*—the latter being where the OHO halts an investigation to allow a criminal matter to be progressed through the criminal justice system without interference or duplication of work, for example, an investigation being undertaken by the Queensland Police Service. Despite being unable to progress paused investigations, they are still considered open investigations and are resumed once criminal proceedings have been finalised.

### *Investigation performance significantly improved in 2017–18*

In 2017–18 the OHO **completed a significantly greater number of investigations than in any previous year of operation**. This year we commenced 213 investigations and completed 387, which represents an increase in completed investigations of 85 per cent compared with 2016–17 (209 investigations completed).

As at 30 June 2018 a total of 153 investigations remained open, down from the 394 outstanding investigations open at the end of the previous financial year. We also significantly reduced the number of aged investigations

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<sup>21</sup> Section 78 of the Act.

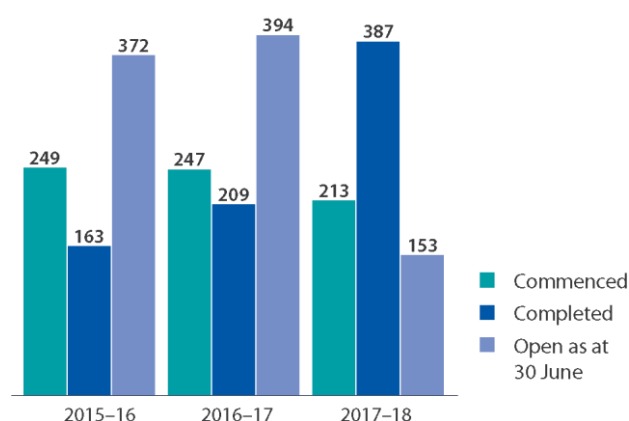
<sup>22</sup> Section 80(c) of the Act.

<sup>23</sup> Section 85 of the Act.

during the year, with only 34 (22 per cent) open investigations being 12 to 24 months old and 14 (9 per cent) more than 24 months old—down from 53 (13 per cent) as at 30 June 2017.

This represents a **reduction in open investigations of 61 per cent** over the reporting period, and a **reduction in investigations older than 12 months of 76 per cent**.

Figure 20 Number of investigations



These achievements followed on from a series of strategic measures aimed at improving our efficiency and timeliness, and reducing the number of open investigations by:

- focusing on earlier identification of matters that are *not* likely to meet the threshold for professional misconduct or necessitate action by the Health Ombudsman
- newly exercising the Health Ombudsman's power to combine similar complaints regarding a single practitioner into one investigation, thereby amalgamating 74 investigations<sup>24</sup>
- establishing a dedicated investigations team to manage cases older than 12 months
- introducing a case review and risk categorisation framework for prioritising high risk and aged matters
- enhancing processes for managing paused matters
- introducing administrative and report-writing support, to allow investigators to focus on reducing backlogs
- developing strategies for improving staff retention
- streamlining processes and information sharing with other appropriate agencies.

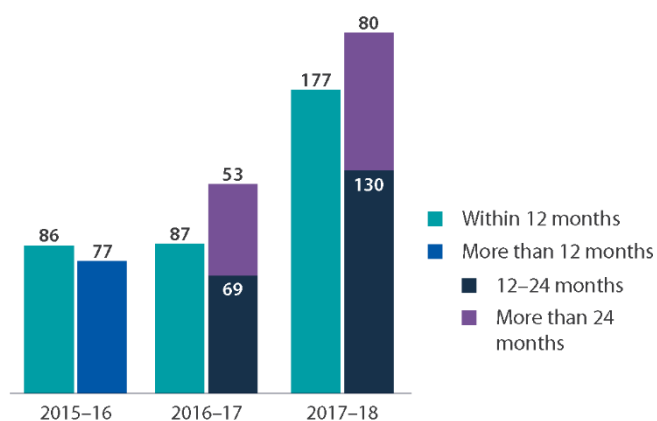
These measures have also effectively resulted in the **reduction of investigation timeframes across the board**, with the number of remaining investigations open more than 12 months reduced from 196 to 48, as noted above. This focus on completing aged investigations to clear the backlog has adversely impacted the

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<sup>24</sup> Under section 40(2) of the Act, the Health Ombudsman may deal with investigations jointly where they involve similar allegations against a health service provider. From October 2017 to 30 June 2018, 74 investigations were amalgamated under section 40(2).

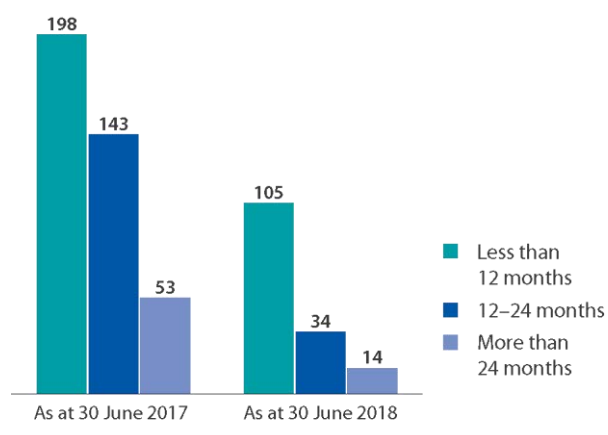
proportion of investigations finalised within 12 months; for 2017–18 only 46 per cent of completed investigations fell within the 12 month timeframe.<sup>25</sup> This is, however, an improvement on the 41 per cent of investigations completed within 12 months in 2016–17. Furthermore, significantly reducing the proportion of aged investigations this year will allow us to enhance our performance against this measure in 2018–19.

Figure 21 Number of investigations completed within timeframes<sup>26</sup>



Of the 387 investigations completed in 2017–18, 46 per cent (177) were finalised within 12 months, 34 per cent (130) were finalised in 12 to 24 months, with the remaining 21 per cent (80) finalised after more than two years. Consequently, **the age of the 153 investigations open at 30 June 2018 was younger than that for 2016–17**, with 69 per cent (105) open for less than 12 months, 22 per cent (34) open for 12 to 24 months and only 9 per cent (14) open for longer than 24 months. As noted above, this is a 75 per cent reduction on the 196 matters open more than 12 months as at 30 June 2017.

Figure 22 Timeframes for open investigations<sup>27</sup>



<sup>25</sup> This is against the 80 per cent target for investigations completed within 12 months, as per the 2017–18 Service Delivery Statements (see [page 18](#)).

<sup>26</sup> Due to changes to reporting methodology, data is not available to show a further breakdown of timeframes for 2015–16.

<sup>27</sup> Due to changes to reporting methodology, data is not available for timeframes of open investigations as at 30 June 2016.



Having significantly reduced the aged investigation backlog as noted above, in 2018–19 we anticipate much stronger performance in relation to the timeliness of investigations. Having finalised a record number of investigations this financial year, we will continue to focus on completing investigations within 12 months, other than paused investigations and systemic investigations (see [page 44](#)); these types of investigations—and other matters where circumstances are beyond our control—will continue to impact our ability to complete all investigations within 12 months.

Of the 153 investigations open as at 30 June 2018, 34 matters (22 per cent) were paused (including 5 of the 14 matters open more than two years), pending the outcome of another agency's processes, such as the Queensland Police Service or the Coroners Court of Queensland.

As at 30 June 2018 there were 17 systemic investigations remaining open. See [systemic investigations](#) (page 44) for more information about these matters.

### *Shifting profile of investigation outcomes*

At the conclusion of an investigation, a matter will be recommended for referral to the Director of Proceedings for potential prosecution in QCAT where the Health Ombudsman concludes there appears to be sufficient evidence to substantiate either professional misconduct or another ground for prohibiting practice or suspending registration. Conversely, an investigation may identify that a matter was less serious than first thought, and may be more appropriately managed by AHPRA or another government agency. Where an investigation has not established sufficient evidence for any of these avenues, no further action is likely to be taken in relation to the matter.

In 2017–18, the 387 completed investigations resulted in:<sup>28</sup>

- 203 matters recommended for referral to the Director of Proceedings (see [page 49](#))<sup>29</sup>
- 67 matters referred to AHPRA (see [page 31](#))
- 26 matters referred to another external agency (see [page 31](#))
- 2 matters referred for conciliation (see [page 29](#))
- 115 matters on which the office took no further action (see [page 22](#)).

Through our improved internal collaboration, stakeholder liaison, and enhanced decision-making frameworks, the OHO has gained a better understanding of the likely outcome of matters. This has resulted in a shifting profile of investigation outcomes. In particular, **a greater number of matters are being recommended for referral to the Director of Proceedings than in previous years**. Matters appropriate for referral to AHPRA or no further action are being identified earlier in the complaints process, with fewer of these matters requiring investigation.

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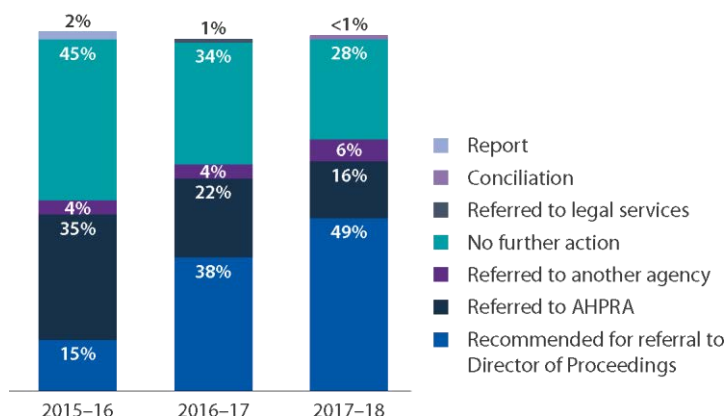
<sup>28</sup> A single investigation may result in multiple outcomes.

<sup>29</sup> Once a matter is actually referred by the Health Ombudsman to the Director of Proceedings, investigations into a single practitioner will be considered as a single matter.



In 2017–18 fewer investigations resulted in no further action (28 per cent) or referral to AHPRA (16 per cent). Conversely, this year a greater number of investigations (49 per cent) were recommended for referral to the Director of Proceedings, an increase of 11 percentage points on these referrals in 2016–17 (see [page 49](#)).

Figure 23 Outcomes of completed investigations



### Practitioner investigations

Practitioner investigations focus on matters where an individual practitioner's health, conduct or performance may amount to professional misconduct or another ground to cancel or suspend registration, or poses a risk to the health and safety of the public.

Of the 387 investigations completed in 2017–18, 369 were investigations into individual health practitioners. Through these investigations, we identified a number of recurring themes. Collectively these investigations form a body of data we can draw on to proactively address repeated issues with health service providers and organisations. For example, this year we investigated a number of allegations of theft of drugs and medications<sup>30</sup> by individual practitioners. The spotlight below discusses some similarities identified in the cases, and how the investigations have enabled our strategic work to further protect the health and safety of the Queensland public.

<sup>30</sup> This classification also includes forging and uttering of prescriptions to obtain drugs.

## Spotlight

### Complaints concerning theft of drugs and medications

The theft of drugs is usually serious enough conduct to result in police involvement and criminal proceedings taken against the accused health practitioner. The OHO also commonly investigates the matter to determine whether to pursue disciplinary proceedings. In 2017–18 we investigated 37 individual practitioners with allegations of theft of drugs and medications.

Of the 37 investigations, 27 involved nurses, with the remaining matters involving registered practitioners in the fields of general practice, anaesthetics, paediatrics, medical practice and pharmacy, and one unregistered dental assistant. The most common place of practice identified was within a Hospital and Health Service, with the alleged conduct in the majority of matters (26) occurring within Queensland's most populous regions of Brisbane and the Gold Coast.

While some of these matters are still under investigation, the drugs were predominantly stolen or fraudulently obtained for the practitioner's personal use. More than half of these investigations included schedule 8 controlled drugs, with the remaining matters largely involving schedule 4 drugs, including some restricted drugs of dependence.

Some of these matters represent a serious risk to public health and safety. In multiple cases, patient details were fraudulently used to access and subsequently steal restricted or controlled drugs. For example, one practitioner working in a public health facility stole medication through an automated electronic dispensing system by entering legitimate patient details; the medication—which cannot be accessed without a patient's information—was neither prescribed nor dispensed to the patient, but taken by the practitioner for personal use.

Diversion of drugs for personal use suggests a practitioner may have a health impairment and may have been practising while impaired, thereby creating a risk to patients. Consequently, for many of these cases the Health Ombudsman will refer part of the matter to AHPRA to simultaneously manage the health impairment/s. Of the 37 investigations, 12 were closed in 2017–18, with 92 per cent (11) of these recommended for referral to the Director of Proceedings for potential referral to QCAT.

Through these investigations, we have seen that many instances of drug theft result from a level of deception intended to bypass a facility's known drug security measures. By analysing these deceptive behaviours and methods, we identified a number of vulnerabilities at key points in facilities' drug control measures. We further discovered that, in these cases, drug control measures and audits frequently failed to identify theft of drugs, with most notifications triggered by scrutiny and vigilance from other staff members after observing anomalous drug movements or offending practitioners' suspicious workplace behaviour. Going forward, understanding these vulnerabilities will enable us to develop education materials and recommended audit procedures to address these concerns, facilitate earlier identification of theft, and potentially reduce the level of drug theft by practitioners.

## Systemic investigations

Under the Act, the Health Ombudsman also has the power to investigate systemic issues<sup>31</sup>, that is, **an issue relating to the operation of a system, process or practice**, rather than to the individual actions of a person or practitioner.

Some examples include:

- a system change that is not operating as expected
- a lack of a policy or procedure
- a lack of a clear structure to support functions or other necessary practices
- a practice, policy or procedure that is not compliant with best practice, guidelines and/or legislative requirements
- an identified area for improvement in a system, policy or procedure, which could have a positive impact on patients and/or other individuals accessing the system or implementing the policy or procedure.

To better manage systemic investigations, in 2017–18 the OHO developed a categorisation system based on population impact. The three categories are:

### Stream 1

These are issues that have the potential to impact individuals at a **single facility** or within a single service line in a local area; these issues **can be resolved directly with the facility**. While important, matters in this stream will have **minimal impact beyond the local community** using the facility's services or engaging with the service line.

### Stream 2

These are issues that have the potential to affect individuals **across facilities within a single region or geographical location** and can be **resolved by engagement with a single key stakeholder** responsible for the relevant facilities. These issues, while serious, have **less potential for widespread impact** outside of the locality in which they occur.

### Stream 3

These are issues that have the potential to impact individuals **across facilities throughout Queensland** and require a **coordinated response by multiple stakeholders** to address identified issues. These matters are likely to be the most complex with the **potential to have the greatest impact** or affect the largest number of people.

The office's scope to investigate systemic matters allows us to take a more strategic, proactive approach to protecting the health and safety of the public. Through systemic investigations, we provide our independent and impartial perspective to identify issues and make recommendations to address these, respond to trends, refine processes, and contribute to preventing a similar adverse event from occurring in future. Where the OHO

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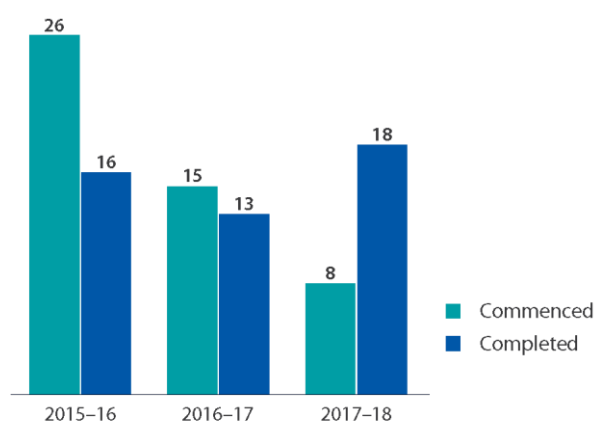
<sup>31</sup> Sections 11(2) and 80 of the Act.

makes recommendations for improvements, we also develop a monitoring plan to oversee implementation of the recommendations (see [page 47](#)).

All of this work requires careful coordination of key stakeholders, engaging each one to define and encapsulate issues; it also relies heavily on our constructive relationships with these stakeholders, as we seek their commitment to implementing and participation in planning effective, contextually appropriate recommendations.

In 2017–18 the OHO commenced 8 systemic investigations and completed 18, with 17 systemic investigations remaining open as at 30 June 2018.

Figure 24 Number of systemic investigations



Through the systemic investigations completed in 2017–18, we explored issues in a number of areas, including maternity services, mental health and prisoner health services.

In 2018–19 the OHO will be addressing a series of new and emerging systemic issues we have identified, while continuing to prioritise the remaining open systemic investigations. We will also continue to develop our relationships with key stakeholders in the health and regulatory sector; this will allow for early identification of systemic issues and potential risks to public health and safety. We intend to utilise these relationships alongside our own complaints data to proactively explore matters for systemic investigation, in line with the Health Ombudsman’s powers.<sup>32</sup>

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<sup>32</sup> Under section 80(c) of the Act, the Health Ombudsman can investigate any matter deemed necessary to upholding the purposes of the Act.

## OHO in action

### Systemic investigation into maternity services

Early in 2018 we finalised an investigation into maternity services at Gold Coast University Hospital (GCUH)—an example of a systemic matter with broader ramifications for Queensland’s health sector. In December 2014 the OHO began the investigation, taking into account a small number of adverse maternity events occurring over time at GCUH. During the investigation it became clear that any identified systemic issues related not to the *quality* of the maternity service provided at GCUH, but to the Gold Coast Hospital and Health Service’s (GCHHS) *response* to these events.

The full report, now published on our website, details the findings that GCHHS had an overly complex safety and quality governance structure; deficiencies in recording and monitoring of the implementation of recommendations; and GCUH lacked sufficient systems to consistently manage obstetric patients presenting to other departments.

This case highlights the importance of stakeholder relationships in addressing systemic concerns in the sector. Our staff worked closely with GCHHS throughout the investigation and in developing recommendations that would appropriately rectify the issues and ensure the outcomes would be in the best interests of the health and safety of the public.

The Health Ombudsman made eight recommendations to address the key issues, targeted at improving GCHHS’s accountability, transparency, and safety and quality governance to prevent adverse outcomes reoccurring insofar as is practicable. GCHHS accepted all of the recommendations and had commenced implementation prior to finalisation of the report.

Ron Calvert, Chief Executive, Gold Coast Hospital and Health Service, commented in correspondence “The confidence of the Gold Coast community in our healthcare services is of paramount importance, and the accuracy of this report has therefore been a focus of our feedback throughout this process. We appreciate the constructive engagement and dialogue that has been afforded during this process to ensure that the system improvements that Gold Coast Health has already identified and started to implement in order to strengthen our service to the community have been recognised. We are committed to learning from clinical incidents and patient experiences, and value the opportunity to engage with the Office of the Health Ombudsman to ensure that where the care we have provided is less than anticipated, we can learn and support impacted patients and clinicians.”

As with all of the OHO’s recommendations, we developed a monitoring plan to oversee implementation. We also recognise that the issues identified in the GCUH maternity service and at GCHHS may be relevant to other health services. We therefore shared the report with other stakeholders, facilities, and Hospital and Health Services in Queensland, encouraging them to utilise the learnings to review and make improvements within their own health service.

## Spotlight

### Prisoner health services

In 2017–18, 15 per cent of all complaints received by the OHO identified a correctional facility in the course of a complaint. With less than 1 per cent of Queenslanders in a correctional facility over the same period, we recognise that healthcare complaints from this consumer group are overrepresented and have sought ways to more efficiently deal with this high volume of complaints.

More than 90 per cent of complaints raised issues around medication, professional performance and access. Identification of these recurring themes prompted the OHO to commence a statewide investigation into prisoner healthcare, underscored by a series of individual case studies of adverse outcomes. Consequently, Queensland Health re-established its formal governance role in relation to prisoner health services, initiating a statewide review of correctional healthcare. The department has established the Offender Health Services Steering Committee Alliance, which first met in January 2018. In lieu of continuing our investigation, the OHO has joined the committee to more effectively contribute to the broader discussion and collectively address the issues identified in healthcare complaints. The progress of the group's work is published on the Queensland Health website at [www.clinicalexcellence.qld.gov.au](http://www.clinicalexcellence.qld.gov.au).

The OHO has also introduced a direct phone line for calls from corrective services to improve access to our services. We intend to remain actively involved in this space and work with Queensland Health and other stakeholders to improve correctional healthcare in Queensland.

### Recommendations to health service providers

Where the Health Ombudsman makes recommendations for improvements in the quality and standard of healthcare delivered to Queenslanders, the OHO oversees the health service organisation's implementation of these recommendations. The OHO may also choose to monitor recommendations made by external agencies, however, as planned in 2016–17, this year we scaled down this component of our monitoring function to focus on the Health Ombudsman's recommendations; the new monitoring cases commenced in 2017–18 were all pursuant to the OHO's own recommendations.

We actively monitor the implementation status of these recommendations to:

- support and assess the timely and appropriate implementation of recommendations
- assure the Health Ombudsman and the public that appropriate activities and improvements have been implemented in response to systemic issues identified during an investigation
- promote the safety and quality of health service delivery through public reporting of shared learnings.

In 2017–18 we commenced 3 monitoring cases, finalised and ceased monitoring 6 cases, and were monitoring 5 cases at the end of the year. A single monitoring case may encompass a number of individual recommendations.



The current recommendations monitoring cases are spread across numerous health service organisations, including Queensland Health—across the Gold Coast, Cairns and Hinterland, Central Queensland and Metro North Hospital and Health Services—and cover issues relating to infectious disease management, maternity services, radiology services, mental health and medications management.

This year we streamlined our monitoring function through numerous process improvements. These changes have enhanced our strategic focus on engaging stakeholders and health service organisations earlier in the process.

We also increased transparency and sought to promote public confidence in Queensland's health system by sharing monitoring activities and implementation progress through published supplementary reports.<sup>33</sup> In 2017–18 the OHO published two supplementary reports.

## OHO in action

### Systemic investigation into medicine regulation in Queensland

Our strategic and regular engagement with stakeholders—both formal and informal—has seen us work closely with Queensland Health to improve medicine regulation in Queensland. In November 2016, the then Health Ombudsman published his report into the appropriateness and effectiveness of the Queensland regulatory system for scheduled medicines as it applies to health services, in particular the prescribing and dispensing of schedule 8 medicines. The OHO commenced the investigation after receiving a number of complaints displaying common trends relating to prescribing and dispensing of scheduled medicines.

The then Health Ombudsman made 16 specific recommendations proposing suggested solutions and risk mitigation strategies. These recommendations primarily focused on areas of legislative complexity, roles and responsibilities, policies and procedures, communication and collaboration, and real time prescription monitoring.

The recommendations have also prompted a number of initiatives to facilitate interagency communication and collaboration. Since the finalisation of the investigation, we have actively participated in these initiatives and have engaged with Queensland Health to oversee the implementation of the 16 recommendations.

The regular progress updates and reports provided by Queensland Health have demonstrated to the OHO a strong commitment to the timely and effective implementation of all recommendations. In 2017–18 we commenced work on a supplementary report to document the progress since the initial investigation. The original report, [\*Undoing the knots constraining medicine regulation in Queensland\*](#), is available in full on the OHO website.

<sup>33</sup> Under section 86 of the Act, in an investigation report the Health Ombudsman may include recommendations for action. Where those recommendations are for action by a particular health service provider, under section 89 of the Act, the Health Ombudsman may ask the health service provider to provide a report about the implementation of the recommendations, and the Health Ombudsman may then prepare a supplementary report, having regard to advice received from the health service provider.

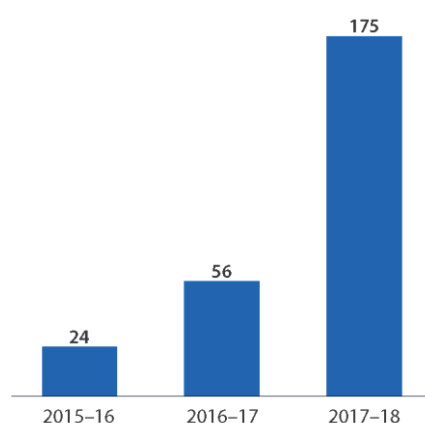


## Referral to the Director of Proceedings

As mentioned above, depending on an investigation outcome, a matter may be referred to the Director of Proceedings for an independent determination on whether the matter is appropriate for referral to QCAT for prosecution. In these instances, the matter is first referred to the Health Ombudsman, who considers the matter and decides whether to refer to the Director of Proceedings.

The increase in completed investigations (see [pages 38–39](#)) saw 175 matters<sup>34</sup> referred by the Health Ombudsman to the Director of Proceedings during 2017–18, which is **more than three times the number of matters referred in the previous year** (56).

Figure 25 Number of matters referred to the Director of Proceedings



## The Director of Proceedings

Under the Act, the Director of Proceedings has the power to determine whether a matter is appropriate for referral to QCAT. In making a decision, the Director of Proceedings must consider:

- the paramount guiding principle of the Act
- the seriousness of the matter

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<sup>34</sup> As noted previously on [page 41](#), in 2017–18, 203 investigations were closed with a recommendation for referral to the Director of Proceedings. Once a matter is referred from the Health Ombudsman to the Director of Proceedings, matters regarding a single practitioner will be considered as a single matter, resulting in only 175 matters *actually referred* to the Director of Proceedings in the reporting period. Since October 2017 the Health Ombudsman has also exercised powers to amalgamate multiple investigations into a single practitioner into one investigation (outlined on [page 39](#)). This means that in future reporting periods it is expected there will be closer alignment between the number of investigations closed with a recommendation for referral to the Director of Proceedings and the number of matters *actually referred*.

- the likelihood of proving relevant matters before QCAT<sup>35</sup>
- the orders QCAT might make
- anything else considered relevant.<sup>36</sup>

Factors which inform the seriousness of a matter may include:

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

After making a decision to refer a matter to QCAT, the Director of Proceedings will prosecute the matter on behalf of the Health Ombudsman, with the assistance of our in-house legal team. This includes drafting the referral and presenting the Health Ombudsman's evidence to QCAT for a determination.

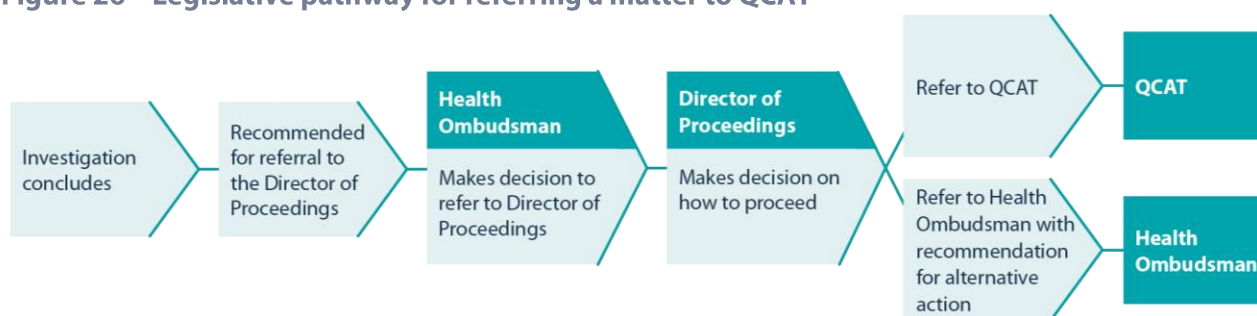
Upon deciding not to refer a matter to QCAT, the Director of Proceedings must refer the matter back to the Health Ombudsman and may recommend alternative action,<sup>37</sup> such as to:

- refer the matter to AHPRA
- undertake further investigation
- take no further action.

The flowchart below demonstrates the pathway a matter takes from the conclusion of an investigation to filing in QCAT or, alternatively, referral back to the Health Ombudsman for an alternative relevant action<sup>38</sup>. The diagram also highlights the distinct and independent decision-making powers held by the Health Ombudsman and the Director of Proceedings respectively, as granted under the Act.

In all matters relating to the OHO's litigation and legal advice, the Health Ombudsman and the Director of Proceedings are supported by our in-house Legal Services division.

**Figure 26 Legislative pathway for referring a matter to QCAT**



<sup>35</sup> In relation to the likelihood of proving a matter before QCAT, the standard of proof required under the Act is the civil threshold *on the balance of probabilities*, applying the 'Briginshaw standard' as established in *Briginshaw v Briginshaw* [1938] 60 CLR 336.

<sup>36</sup> Section 103(3) of the Act.

<sup>37</sup> Section 103 of the Act.

<sup>38</sup> For the Health Ombudsman to deal with the matter under section 105 of the Act.

## Decisions by the Director of Proceedings

In 2017–18 the **Director of Proceedings made 72 decisions, which is a fourfold increase on the number of decisions made in 2016–17 (18)**. Of these, the Director of Proceedings:

- determined 56 matters were appropriate for referral to QCAT<sup>39</sup>
- referred 16 matters back to the Health Ombudsman recommending an alternative relevant action.

The 72 decisions made by the Director of Proceedings this year related to matters such as:

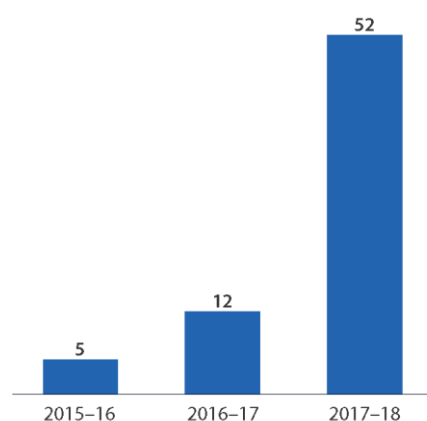
- criminal convictions for conduct related to, and outside of, the practice of the profession
- boundary violations between the practitioner and the consumer/patient
- inappropriate prescribing and/or dispensing of medications
- providing incorrect, inappropriate and/or unapproved treatments
- inappropriate and/or unlawful self-administration of medications.

As at 30 June 2018 there were 156 matters with the Director of Proceedings awaiting a decision. In the coming year, a key challenge for the OHO will be dealing with the large volume of matters currently awaiting a decision, while keeping pace with new matters being referred during the course of the year. For a summary of the key strategies we have developed to address this challenge, refer to [Our future](#) on pages 74–75.

## Matters filed in QCAT

In 2017–18 the Director of Proceedings **referred 52 matters to QCAT, which is more than four times the number of matters referred to QCAT in the previous year (12)**. These 52 matters involved 43 registered and 9 unregistered practitioners.

Figure 27 Number of matters filed in QCAT



<sup>39</sup> Of these, 51 matters were filed in QCAT, including 3 matters filed jointly with another related matter. In 2017–18, 1 additional matter was filed as a result of a referral in 2016–17, bringing the total number of matters filed to 52, as shown in figure 27. As at 30 June 2018, 2 matters determined appropriate for referral to QCAT were awaiting filing.

This year QCAT handed down four decisions on matters filed by the Director of Proceedings on behalf of the Health Ombudsman. These decisions are summarised on our website, with full judgments available to download from the Supreme Court Library Queensland's website at [www.sclqld.org.au/caselaw/QCAT](http://www.sclqld.org.au/caselaw/QCAT).

Matters may also be heard in QCAT where a health practitioner applies to the tribunal to review the Health Ombudsman's decision to take immediate action against them. See [immediate action](#) (page 35) for details of these matters for 2017–18.

## OHO in action

### Disciplinary proceedings in QCAT

In *The Health Ombudsman v Chambers* [2017] QCAT 362, the Director of Proceedings, on behalf of the Health Ombudsman, referred the conduct of a registered nurse to QCAT. The practitioner attended their place of employment intoxicated and scrubbed up for surgery as an anaesthetic nurse. The practitioner became aggressive and abusive when approached by other staff members, who then called the police. The police took the practitioner into custody where they recorded a blood alcohol concentration of 0.260. The practitioner later failed to notify the Nursing and Midwifery Board of Australia of her conviction, as required under section 130 of the National Law.

QCAT found that the practitioner behaved in a way that constitutes professional misconduct and the practitioner was reprimanded and fined \$2000. This decision means that a reprimand will appear on the practitioner's registration details on the national register of health practitioners maintained by AHPRA.

## Support services

Our performance against our legislative functions and overall management of health service complaints is supported by a number of additional internal services, including legal advice, clinical advice and records management. Though there are no performance measures for this work, each unit tracks productivity as part of our legislative requirement of efficient handling of healthcare complaints.

### Legal services

Legal services—encompassing advice, litigation and other relevant work—are primarily delivered by the OHO's in-house lawyers in our Legal Services division, which allows staff to receive consistent and considered advice from lawyers familiar with the OHO's operational and statutory context. Formally, the division services only two clients: the Health Ombudsman and the Director of Proceedings; in practice, however, legal services are requested by the Health Ombudsman through all individual business units within the office.

Legal services can be requested at any stage of the complaints process or through any other operational activities we undertake, such as right to information requests, recordkeeping, and privacy or data requests and breaches. Our lawyers provide advice and services in respect of health regulation, administrative and public law issues—including interpretation of the Act, the National Law, and other relevant legislation—to ensure our

decisions are legally sound. Our in-house legal team divide their work across providing legal services and supporting the Director of Proceedings.

In 2017–18 the Legal Services division received a total of 349 requests for legal advice or support, which is a decrease of 14 per cent on the 407 requests received in the previous year. This drop is reflective of the decrease in support services provided as our legal team focuses on the increasing number of matters referred to the Director of Proceedings (see [page 49](#)).

More legal advice requests are sought during investigations than in any other stage of the complaints process, such as other requests received:

- at the time of assessment, local resolution or immediate action
- directly from the Health Ombudsman
- throughout other litigation or legal proceedings
- through business and information processes, such as right to information requests.

On occasion, legal advice is also sought from external providers such as Crown Law, private law firms, or barristers at the private bar.

## Clinical advice

The OHO 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.<sup>40</sup> This may be to:

- seek guidance on the level of risk to public health and safety presented by performance or conduct issues
- advise on potential mitigation of risk by proposed immediate action
- assist the OHO and the complainant in understanding the issues raised in the complaint
- inform an assessment of or investigation into potential serious professional misconduct.

Unlike legal advice, the OHO doesn't employ experts for clinical advice in-house. We seek clinical advice from both registered and unregistered practitioners as necessary for the matter at hand. In seeking clinical advice, we consider the professional specialty of the health service provider who was responsible for the care when the issue occurred, and seek an advisor who is appropriately qualified and has a similar or *greater* level of expertise and experience. We also select impartial advisors that are free of any conflicts of interest with the matter. Parties to a matter are informed of the names of clinical advisors, the area/s of practice for which the advice is sought, the questions asked, and the content of the advice.

Using expert, independent clinical advice where appropriate and building a network of suitable clinical advisors has helped the OHO enhance its knowledge in relation to complex issues in a constantly evolving health environment.

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<sup>40</sup> Under sections 26 and 29 of the Act, in order to support the performance of the functions of the Act, the Health Ombudsman has the power to seek advice of appropriately qualified persons to advise on clinical matters.

In 2017–18 the Health Ombudsman requested 111 clinical advice reports, down from 142 requested in 2016–17, with an expectation that the number will stabilise in coming years. Of the 111 requests, 61 per cent were made in the initial stages of the complaints management process—intake, triage and assessment. The remaining requests were sought during investigations (33 per cent) or when considering or taking immediate action (5 per cent).

## Recordkeeping and information management

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

Physical records are held onsite in restricted access areas and with two external storage providers. There have been no security breaches to these areas.

In 2017–18 the OHO continued the transition from paper to digital records. Digital corporate records are managed in an electronic document and records management system (HPRM) and complaint records are managed in a case management system (Resolve) which synchronises with HPRM. Both systems are critical to our operation and we ensure effective use through regular staff training.

This year we have been assessing our use of HPRM and have begun work on a software upgrade which will be finalised in 2018–19. We are continually working with developers to ensure the Resolve software services the OHO's needs for privacy and recordkeeping in line with any updated processes and procedures; a number of minor Resolve upgrades have been undertaken throughout 2017–18.

The OHO has a dedicated Information Management Officer to manage Right to Information (RTI) requests.

We are continuing to liaise with Queensland State Archives to finalise an updated retention and disposal schedule specifically for the operations of the OHO. With the appointment of the new Health Ombudsman late in the financial year, this project is now a priority for the coming financial year.





## Monitoring and quality assurance

Regulation of the health sector in Queensland is multifaceted and consists of a number of government agencies and regulatory organisations, which are subject to state and national legislation, standards and other requirements.

The OHO has broad powers to deal with complaints about both registered and unregistered health practitioners and the services provided by health service organisations in Queensland. In our handling of registered practitioners, the OHO shares regulatory powers with AHPRA and the national boards under the National Law.

However, 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 through collaboration, information sharing and established protocols. These agencies also work together to identify areas for improvement and contribute to better quality health services in Queensland.

In ensuring transparency and accountability, each agency within this network is subject to audit, quality assurance and governance frameworks. The OHO is also responsible for maintaining confidence in the health service complaints and regulation system in Queensland and has legislated powers to fulfil this function. Under the Act, one of the Health Ombudsman's functions is to monitor the performance of AHPRA and the national boards.<sup>41</sup> As mentioned previously, the Health Ombudsman also has powers to investigate systemic matters (see [page 44](#)), make recommendations for improvement to health service providers, and monitor the implementation of these recommendations to ensure quality improvements (see [page 47](#)).<sup>42</sup>

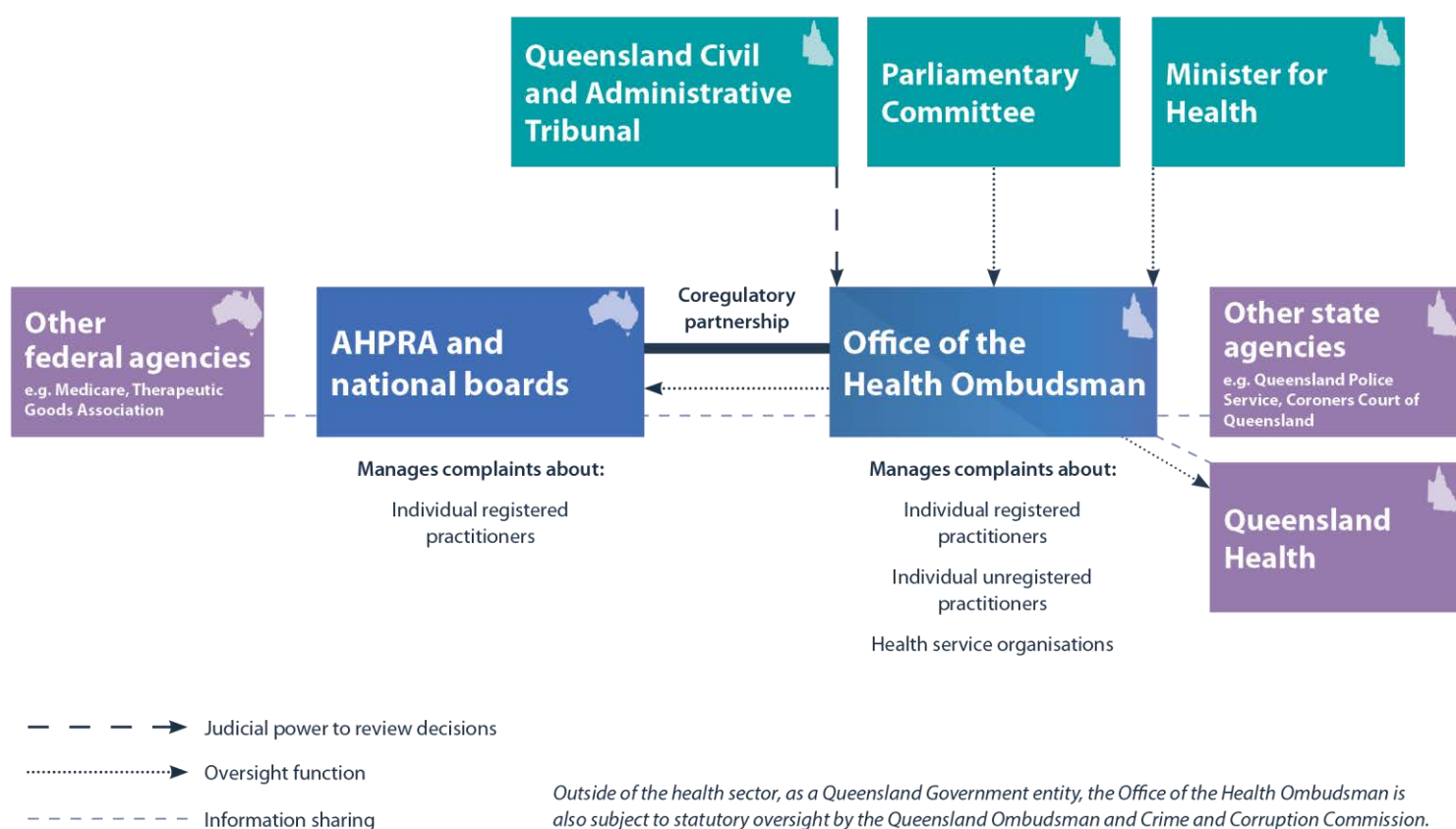
As an organisation, the OHO itself is subject to extensive governance and oversight, with a number of feedback mechanisms and internal and external review processes to ensure accountability, transparency and robustness in decision-making. Each of these elements of the coregulatory system is shown in figure 28 below, along with a detailed look at our coregulatory partnership with AHPRA in practice.

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<sup>41</sup> Section 25 of the Act.

<sup>42</sup> Section 11 and Part 8 of the Act.

**Figure 28 Queensland's health coregulatory system**



## Coregulatory partnership with AHPRA

### Monitoring AHPRA and the national boards

One of the functions of the Health Ombudsman is monitoring the performance of AHPRA and the 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 may analyse data provided by AHPRA, publishes performance reports on our website where appropriate, and reports the findings to the parliamentary committee.

This is an important aspect of the coregulatory 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 assurance to the Queensland public about the performance of AHPRA and the national boards.

## Coregulatory functions

In Queensland the OHO and AHPRA share management of complaints about registered health practitioners. To this end, the Health Ombudsman has the power under the Act to refer certain matters to AHPRA and the national boards,<sup>43</sup> and AHPRA is required to notify the Health Ombudsman of all serious matters received by their office relating to registered practitioners in Queensland.

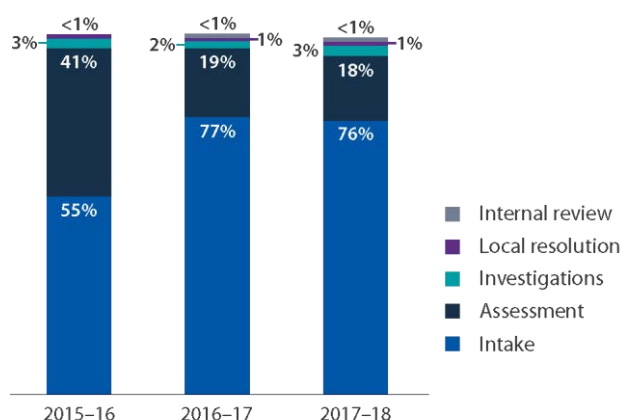
More complex complaints may be split—with the OHO retaining the part of the complaint that relates to potential professional misconduct or serious risk to the public, and referring other matters to AHPRA to manage practitioners' health, conduct and/or performance.

In 2017–18 AHPRA **notified the OHO of 5 serious matters**, as defined under legislation,<sup>44</sup> 3 of which were subsequently referred to the OHO, with the remaining 2 determined appropriate to be retained by the relevant board. The OHO **requested from AHPRA a further 4 matters**, which were then referred.<sup>45</sup>

This year we **referred 2145 matters to AHPRA**, up from 2060 in the previous year.

Matters may be considered for referral at any stage in the complaints management process, and we seek to consult with AHPRA as early as possible on matters being considered for referral. This year more than three-quarters (76 per cent) of matters referred to AHPRA were referred at the initial intake stage of a complaint, with the bulk of the remaining matters referred from assessment (18 per cent), and a small number from investigations (3 per cent), local resolution (1 per cent) and internal review (less than 1 per cent).

Figure 29 Source of referral to AHPRA



<sup>43</sup> The Health Ombudsman can refer a complaint about a registered health practitioner to AHPRA and the national boards, unless it appears the practitioner has behaved in a way that constitutes professional misconduct, or another ground exists to cancel or suspend registration.

<sup>44</sup> Section 193 of the National Law.

<sup>45</sup> Section 193A of the National Law.

We have continued to focus on improving our relationship with AHPRA to improve the efficiency of the coregulatory system overall and ensure it works in a more coordinated manner.

The OHO and AHPRA have together developed a number of initiatives to better manage healthcare complaints in Queensland. Some of these initiatives have been rolled out on a trial basis in 2017–18, with others planned for implementation in the coming year. These include:

- establishing a **joint protocol for handling split matters** (that is, matters in which part of the complaint is retained by the OHO and part is referred to AHPRA) to improve communication with the practitioner and complainant/notifier, ensure the OHO and AHPRA are continuously updated with changes, and ensure the best regulatory response to risk
- formulating a **data sharing working group** to identify both parties' information needs and any barriers to information sharing, and agree on an approach for resolving any data issues that prevent the production of nationally consistent data about health service complaints
- formulating a **trial of joint consideration of health service complaints about registered health practitioners** in order to fully consider the potential merits and barriers.

Much of this work has been a direct result of the recommendations from the parliamentary committee's 2016 *Inquiry into the performance of the Health Ombudsman's functions pursuant to section 179 of the Health Ombudsman Act 2013* (see below).

## External accountability

### Governance

The OHO operates with statutory oversight by the **Minister for Health and Minister for Ambulance Services** and the **Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee** (the parliamentary committee).

The Honourable Steven Miles, the current Queensland Minister for Health, oversees the administration of the health service complaints management system and the performance of the Health Ombudsman, as well as the performance of AHPRA and the national boards in relation to Queensland health practitioners. The Minister keeps the Queensland Parliament and the community informed of these matters.

As at 30 June 2018, the members of the parliamentary committee were:

- Mr Aaron Harper MP, Chair
- Mr Mark McArdle MP, Deputy Chair
- Mr Michael Berkman MP
- Mr Martin (Marty) Hunt MP
- Mr Barry O'Rourke MP
- Ms Joan Pease MP.

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.

In 2017–18 we have continued to work with the parliamentary committee to address ongoing concerns about the operation of the OHO, in particular the recommendations arising from the 2016 *Inquiry into the performance of the Health Ombudsman's functions pursuant to section 179 of the Health Ombudsman Act 2013* (the parliamentary inquiry).

### **Risk management committee**

As a regulator, the OHO is conscious of its responsibility to the community to manage risks appropriately. As such, we have risk management plans in place as determined by our 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 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 members for 2017–18 are listed in the table below.

**Table 2 Risk management committee membership 2017–18**

Committee member	Role	Serving dates	Remuneration
Simone Finch	Chair External member	1 July 2017 – 23 March 2018	\$175 per hour (GST exclusive)
Rachael Barabas	Acting Chair External member	1 July 2017 – 30 June 2018 (Acting Chair from 23 April 2018)	Not remunerated
Dan Matthias	Internal member	1 July 2017 – 28 September 2017	Not remunerated
Prue Beasley	Internal member	1 July 2017 – 30 June 2018	Not remunerated
Scott McLean	Internal member	1 July 2017 – 30 June 2018	Not remunerated
Lisa Pritchard	Internal member	1 July 2017 – 30 June 2018	Not remunerated

The committee standardly meets quarterly to review, oversee and report to the Health Ombudsman, however meetings were irregular in 2017–18 as the office was transitioning to a new Health Ombudsman and the committee transitioned to a new acting chair. In 2017–18 an external review of the committee and risk management framework was announced to be undertaken in 2018–19.

### Queensland Ombudsman

In 2017–18 the Queensland Ombudsman received 88 complaints about the OHO and finalised 49 investigations related to complaints about the OHO.<sup>46</sup> Of these, no investigations resulted in formal findings of maladministration. Two investigations were resolved by agreement to partially or substantially rectify an issue.

### Public Sector Ethics Act

The OHO is also governed by the *Public Sector Ethics Act 1994*, which outlines four underlying ethics principles:

- integrity and impartiality
- promoting the public good
- commitment to the system of government
- accountability and transparency.

The OHO is committed to upholding these principles and embedding them through our work. Since the OHO was established in 2014, we have adopted the *Code of Conduct for the Queensland Public Service* for all staff. The OHO works with the Queensland Ombudsman to deliver face-to-face public sector ethics training for new OHO employees; our employees then undertake refresher training online annually. The Code of Conduct and all procedures relating to unethical conduct, breaches of the code, and public interest disclosures are readily accessible through our staff intranet.

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<sup>46</sup> Data supplied to the OHO by the Queensland Ombudsman.

## Internal accountability

### Audit

The OHO does not currently have an internal audit function and has not been directed by the Minister for Health to establish one. We are assessing our current circumstances and may look to establishing an internal audit committee in 2018–19 following a review of the risk management framework of the OHO.

### Client satisfaction survey

The OHO routinely invites parties to provide feedback through a voluntary client satisfaction survey. This feedback from complainants and health service providers helps ensure our services are accessible, transparent and accountable and informs continual service improvement so we can provide a robust system for effectively and quickly dealing with health service complaints.

We seek responses on how satisfied clients were overall with our service, and gauge their level of agreement with a series of statements:

- We were professional and treated you with respect.
- We provided quality customer service to you.
- We met the timeframes that were set.
- We explained things clearly when we spoke with you.
- We explained things clearly when we wrote to you.
- You understand how the outcome was reached.
- You believe the matter was dealt with in a balanced, fair and reasonable way.

In 2017–18 we received 541 survey responses. Seventy per cent of clients were satisfied with our complaints management process, which is an increase on the 67 per cent satisfaction rate in the previous year.

### Spotlight

#### Client feedback received in 2017–18

“I thank you for treating me and my complaint with respect and professionalism. Though not a really serious complaint it was very important to both my husband (on whose behalf I made the complaint) and myself to have the matter resolved to a satisfactory level. We are happy with the outcome.”

“Thank you for the wonderful advice and assistance. Thank everyone for ‘listenability’ or listening expertise and offering help, reassurance and positivity. Excellent all round. I can’t offer any improvements—the service was impeccable.”



## Internal review

Where the Health Ombudsman makes a decision **not to accept a complaint** or to **take no further action**, parties to the matter may request an internal review of our administrative decisions.<sup>47</sup> The internal review process is not mandated in the Act; however, we have developed an OHO policy to guide the process and establish reasonable operational timeframes. Requests for internal review must be made in writing within 28 calendar days of the receipt of the notice of decision.

An internal review request must be supported by information to identify an error in the administrative decision or provide new information that was not available to the OHO at the time of the original decision.

Some examples of grounds that may justify undertaking an internal review are:

- relevant information provided was not considered in the decision made
- the incorrect legislative provision was applied in reaching the decision
- new relevant information is provided that was not available when the decision was made
- the decision failed to address one or more complaint issue/s
- there was a lack of clarity, an error/s or insufficient explanation in the reasons provided for the decision.

For matters subject to internal review, we decide whether the decision reached was fair and reasonable based on an examination of the processes and information used in reaching the decision. If grounds to justify a review are identified, an independent review officer is required to conduct a thorough review of the concerns raised. To that end, internal review is important not only for quality control and identifying process improvements, but also for instilling public confidence in the health service complaints management system.

In 2017–18 the **original decision was upheld in 74 per cent of internal reviews** undertaken.

This year, we received 281 new review requests, and finalised 292 requests for which we conducted reviews for 235 (80 per cent). Of the 235 reviews conducted:

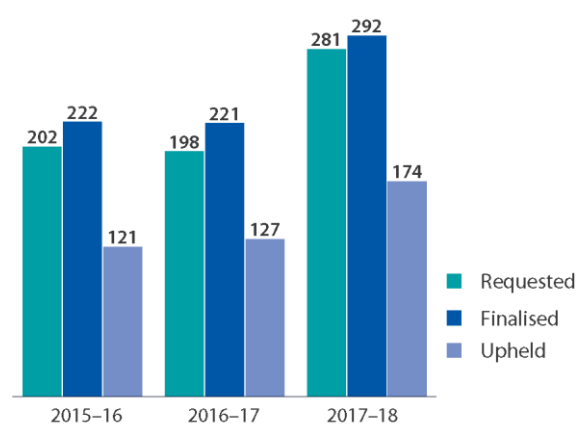
- 174 (74 per cent) original decisions were upheld
- 20 (9 per cent) outcomes not to accept a complaint or take further action remained the same, but a different legislative basis for the decision was applied
- 41 (17 per cent) original decisions were repealed with a new decision to take further relevant action—either for local resolution (18), referral to AHPRA (13), assessment (9) or conciliation (1).

For the 57 (20 per cent) requests which were finalised without conducting a review, either no grounds were identified for review, the request did not relate to a reviewable decision, or the review request was withdrawn.

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<sup>47</sup> While there is no express power in the Act to vary or change decisions made under the Act, section 24AA of the *Acts Interpretation Act 1954* provides a source of power to amend or repeal decisions. The power to amend or repeal a decision can be exercised in the same way and subject to the same conditions as the power to make the decision.

Figure 30 Number of internal reviews



## Spotlight

### Feedback from parties after internal review

"I really appreciate your time and your experience in understanding all my concerns."

"Thank you for forwarding onto me the report of the findings of my complaint to the OHO. I am both satisfied with its findings and grateful for the attention that the OHO has given to my concerns."



# Our finances

## Financial snapshot

### Overview

The operating result for the office for the 2017–18 financial year was a surplus of \$643,665. However, the office incurred a \$287,000 accrued employee expense liability for the 2017–18 financial year that was payable on 2 of July 2018. The operating result also reflects surplus budget from minor building and security works originally intended for completion in 2017–18, and later postponed to 2018–19.

Full details are provided in the audited financial statements in [appendix 5](#) (pages 127–152) and on our website. We advise that note 17 (page 144) relating to the explanation of major variances contains an error identified after independent certification of financial statements. *Employee expenses* should note that the office ended with 131 FTE as at 30 June 2018, not 30 June 2017.

### Funding

The OHO has three sources of funding: 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 November 2017 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 had it not been for the commencement of the OHO—was \$6.739 million. On 29 November 2017 the Minister advised the office that \$6.5 million was to be provided to the office by Queensland Health. To ensure continuity of business operations in 2017–18, Queensland Health also provided funding of \$4.537 million.

### Financial position

The financial position provides an indication of the OHO's underlying financial health as at 30 June 2018. The office's assets as at 30 June 2018 were \$2.270 million and liabilities were \$1.146 million. This resulted in a total equity of \$1.124 million.

#### Assets

The OHO's total assets were valued at \$2.270 million as at 30 June 2018. Current assets were valued at \$2.122 million and were available to meet current liabilities, which were valued at \$1.120 million.

#### Liabilities

Total liabilities for the office as at 30 June 2018 were \$1.146 million, with the largest single liability being \$828,849 for accrued employee benefits. Remaining liabilities related predominantly to payables.

## Financial performance

The income statement (see [appendix 5](#)) shows the total income for 2017–18 as \$21.068 million—an increase of \$2.509 million from the 2016–17 financial year—and expenses as \$20.424 million, finishing the year with an operating surplus of \$643,665.

### Income

In 2017–18 the OHO derived the majority of its income from Queensland Health with funding of \$11.037 million (including \$6.5 million for the AHPRA component), with further grant funding from the Queensland Government totalling \$9.868 million. Income in the form of interest and other revenue totalled \$162,802.

### Expenses

Total operating expenses for 2017–18 were \$20.424 million. The largest expense category was for employee expenses (\$16.396 million), which accounted for 80 per cent of expenses. The second largest category was supplies and services (\$3.817 million), which accounted for 19 per cent of expenses.

Figure 31 Sources of income in 2017–18

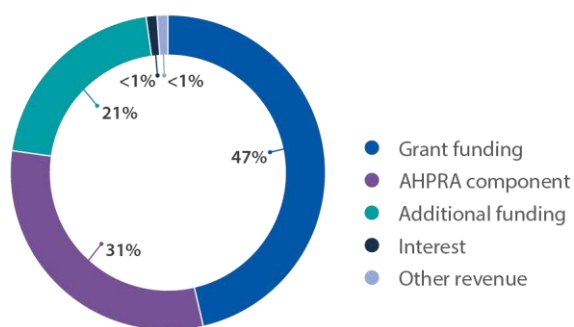
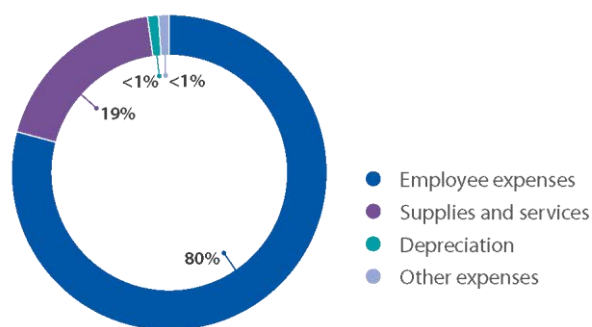


Figure 32 Expenses in 2017–18



For full audited financial statements, refer to [appendix 5](#) (pages 127–152).

# Our people

## Executive management team

Table 3 OHO executive management team membership as at 30 June 2018

Position	Held by <i>as at 30 June 2018</i>
<b>Health Ombudsman</b> <i>Statutory position</i>  The Health Ombudsman is appointed under the Act 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 for no more than four years and the person may be reappointed.  The Health Ombudsman has powers and functions under the Act, which are detailed on <a href="#">pages 11–12</a> .	<b>Andrew Brown</b>  In 2017–18 Mr Leon Atkinson-MacEwen finished in the role of Health Ombudsman on 31 October 2017, and Mr Andrew Brown stepped into the role in an acting capacity on 1 November 2017. Andrew was formally appointed to the role commencing 28 May 2018, for a three year term.  Andrew has more than 25 years' experience in the public sector, primarily in the areas of legal services, regulatory oversight and complaints management. Prior to his appointment, Andrew was the Deputy Ombudsman at the Queensland Ombudsman's Office. He has also worked at Queensland Corrective Services in numerous roles including the Chief Inspector of Prisons, Executive Director of Ministerial and Executive Services, and Director of Legal Services. He brings to the role extensive experience in public administration and designing and implementing effective and efficient regulatory and complaints management processes.
<b>Executive Director, Assessment and Resolution</b>  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 complaint and in certain circumstances will seek to resolve and conciliate complaints.	<b>Lisa Pritchard</b>  Lisa has more than 25 years' 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.

Position	Held by <i>as at 30 June 2018</i>
<p><b>Executive Director, Investigations</b></p> <p>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.</p>	<p><b>Kathleen Florian</b></p> <p>Kath is a barrister with 28 years' experience in the investigation and prosecution of serious and organised crime. Prior to working at the OHO, Kath worked in a number of senior roles at the Australian Crime Commission and, most recently, as Executive Director, Crime, at Queensland's Crime and Corruption Commission.</p>
<p><b>Director, Business Innovation</b></p> <p>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.</p>	<p><b>Kylie Guthrie</b></p> <p>Kylie has 30 years' 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.</p>



Position	Held by <i>as at 30 June 2018</i>
<p><b>Acting Executive Director, Legal Services</b></p> <p>The Legal Services division provides legal services to the office and prosecutes matters that the Director of Proceedings refers to QCAT.</p> <p>Under the current structure of the OHO, the Executive Director, Legal Services, is also appointed as the Director of Proceedings.</p> <hr/> <p><b>Director of Proceedings</b></p> <p><i>Statutory position</i></p> <p>The Director of Proceedings is a statutory role appointed under the Act and must be an employee who is legally and otherwise appropriately qualified.<sup>48</sup></p> <p>The Director of Proceedings is responsible for taking proceedings against health practitioners on behalf of the Health Ombudsman in QCAT. The Health Ombudsman may refer a matter to the Director of Proceedings<sup>49</sup> who then has the power to decide if a matter should be referred to QCAT<sup>50</sup>; the Director of Proceedings maintains independence from the Health Ombudsman in this regard.</p>	<p><b>Scott McLean</b></p> <p>Scott is a lawyer with 25 years' experience in private, government and regulatory practice focusing 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.</p>

<sup>48</sup> Section 12 and Part 16, Division 3 of the Act.

<sup>49</sup> Part 10, Division 2 of the Act.

<sup>50</sup> Section 103 of the Act.

## Staff

### Service Delivery Statements—staffing

**Table 4** The Office of the Health Ombudsman service standards—staffing

Staffing <sup>1</sup>	Notes	2017–18 budget	2017–18 actual
The Office of the Health Ombudsman	2	140	131.1

Notes:

1. Full-time equivalents (FTEs) as at 30 June 2018.
2. This varies from the estimated 137 FTEs as published in the 2018–19 Service Delivery Statement, due to vacant positions not being filled due to review of structures and number of staff taking leave without pay >8 weeks.

### Workforce profile<sup>51</sup>

The year saw relatively high levels of uncertainty for the OHO, with a temporary Health Ombudsman in place for six months before a permanent appointment could be made, as well as a number of changes in executive management roles.

We are a relatively small agency, with **131.1 full-time equivalent (FTE) employees as at 30 June 2018**. This is consistent with the staffing of 131.58 FTEs as at 30 June 2017, showing that our substantial performance improvements have been generated by improved productivity and efficiency, despite the instability experienced throughout the year and without a corresponding increase in human resources.

Our workforce is primarily a permanent workforce with **84 per cent of FTEs employed in permanent roles**, 14 per cent of staff employed on a temporary basis, and the remaining 2 per cent in contracted roles. While only 4 per cent of staff work part-time (compared with 96 per cent full-time), all staff have access to a range of flexible working arrangements in line with the Queensland Government's policies; the majority of staff access flexible working hours, and a number of staff also receive study assistance. The OHO recently invested in a remote working solution which will provide our staff greater flexibility and mobility without compromising information privacy and security.

Women make up 72 per cent (96) of employees, with the majority of managerial positions (at or above AO7 level) held by women (63 per cent). As at 30 June 2018, 11 per cent of OHO employees identify as being from a non-English speaking background, 2 per cent identify as Aboriginal and/or Torres Strait Islander, and 2 per cent identify as having a disability.

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<sup>51</sup> Data supplied to the OHO by the Public Service Commission, as consistent with the Minimum Obligatory Human Resource Information (MOHRI) data.

## Workforce planning

The OHO recognises the importance of building a skilled and capable workforce through strategic planning. New employees undergo a formal induction—including orientation and safety briefing—and are assigned an informal ‘buddy’ to ensure staff become productive, integrated members of the organisation as quickly as possible.

OHO employees are engaged under the current enterprise bargaining agreement *Queensland Health Sector Certified Agreement (No. 9) 2016*. Union members at the OHO meet with HR and the executive management team on a monthly basis as part of the Joint Consultative Committee process to raise and discuss relevant industrial relations matters.

The permanent separation rate for 2017–18 was 4.45 per cent. No redundancy, early retirement or retrenchment packages were paid in 2017–18.

## 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.

Staff undertake mandatory training upon commencing employment with the OHO, and complete required training on an annual basis. During 2017–18 the OHO provided a range of voluntary opportunities for learning and development, including training in:

- managing unreasonable complaint conduct
- interviewing for investigations
- legal advice, requirements and process for investigations
- Resolve (complaints management system)
- project management
- administrative decision-making
- leadership development
- various legal matters (undertaken through local law firms).

The OHO standardly offers a confidential 24-hour employee assistance program for all employees, which provides staff with access to free, short-term, professional counselling for employment or personal matters. We also recognise the high level of emotional labour required to deal with health service complaints and have therefore developed a number of additional initiatives to support staff in this regard. This year we developed a set of ‘risk of harm’ resources to support staff in the instance that a party to a complaint threatens harm to themselves or others. We have also taken steps towards developing procedures around managing unreasonable complaint conduct to further ensure the safety of our staff and members of the public.



## Our future

In 2018–19 we look forward to building on our achievements from this year and establishing Queensland as the benchmark for effective and efficient health service complaints management.

### Engaging with stakeholders

Effective relationships with our key stakeholders are fundamental to the performance of the regulatory system as a whole. Stakeholder engagement will continue to be a key focus for the OHO in the coming year and beyond, shaping the way we interact with stakeholders at all levels across government, industry and the community.

We are committed to ensuring there is a **collaborative relationship with our coregulatory partner AHPRA** (and associated boards) and we will continue to work towards strengthening this relationship. 2018–19 will see a continued focus on seeking to work together at a strategic level to ensure a coordinated response to regulation.

The significant work that we commenced this year on addressing key recommendations from the parliamentary inquiry (see [pages 59–60](#)) will continue in 2018–19, and we look forward to working with AHPRA and the national boards to continue current initiatives. This includes commencing and evaluating the trial in relation to joint consideration of complaints, working with AHPRA and Queensland Health to progress the necessary legislative amendments to enshrine joint consideration into legislation, and to better manage matters that traditionally have been split between the OHO and AHPRA (and the boards).

We will continue to improve on data sharing between the OHO and AHPRA, and build on the work that has already been done in this space. This will require further ICT support to progress solutions to ensure the safe, secure sharing of data between our respective organisations and enable more extensive set of nationally-consistent health service complaints data.

We will continue to seek to improve our working relationship with health service providers, including Hospital and Health Services (HHSs), to promote effective and efficient complaint management responses and address systemic issues that have broader ramifications for Queensland's health sector. We will also continue to work with other agencies, such as the Queensland Police Service, to enable streamlined information sharing to ensure the best possible regulatory response to risk.

### Empowering people

Going forward, the OHO remains committed to ensuring we have the resources, processes and systems to deal with an ever-increasing volume of complaints in a timely manner. We are looking to **develop dedicated tools for health consumers to raise and resolve low risk complaints directly with their health service providers** prior to escalation to the OHO. We will be reviewing our communication materials and channels to support this, as well as providing resources to assist health service providers across the state in developing their own frameworks for best practice complaints management.

We will also be looking at ways we can improve accessibility of our services to disadvantaged groups, starting with a year-long project to better serve the needs of Aboriginal and Torres Strait Islander peoples.

Turning our attention to the needs of our own staff, in 2018–19 we will be focusing on strengthening the OHO's internal corporate governance, reviewing and redeveloping our strategic plan, and enhancing staff health and wellbeing.

## Challenges ahead

In 2018–19 we will also be employing **strategies to address the rapidly growing volume of matters referred to the Director of Proceedings**. We have begun working—and will continue to work—to strengthen our capacity in this regard through strategies such as:

- supplementing in-house legal work by engaging external legal providers where appropriate
- developing transparent and clear frameworks for legal processes, and communicating these with key stakeholders
- enhancing processes for the early identification of matters that are unlikely to proceed to QCAT
- engaging with QCAT to identify opportunities to address this challenge.

These strategies will ensure the OHO has the necessary resources to continue to deal with complaints efficiently and effectively, thereby enabling us to maintain the health regulation system in Queensland and protect the health and safety of the Queensland public.

## Appendices

### Appendix 1—Abbreviations and acronyms

Term	Definition
Act	Health Ombudsman Act 2013
AHPRA	Australian Health Practitioner Regulation Agency
Government	Queensland Government
HHS	Hospital and Health Service
Minister	Minister for Health in Queensland
National boards	The 15 national health practitioner boards, one each for: <ul style="list-style-type: none"><li>▪ Aboriginal and Torres Strait Islander health practice</li><li>▪ Chinese medicine</li><li>▪ chiropractic</li><li>▪ dental</li><li>▪ medical</li><li>▪ medical radiation practice</li><li>▪ nursing and midwifery</li><li>▪ occupational therapy</li><li>▪ optometry</li><li>▪ osteopathy</li><li>▪ paramedicine (board established 19 October 2017)</li><li>▪ pharmacy</li><li>▪ physiotherapy</li><li>▪ podiatry</li><li>▪ psychology.</li></ul>
National Law	Health Practitioner Regulation National Law (Queensland)
OHO	Office of the Health Ombudsman
Parliamentary committee	Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee
QCAT	Queensland Civil and Administrative Tribunal



## Appendix 2—Glossary

Term	Definition
Active investigation	A current OHO investigation that is not paused. See <i>Paused investigation</i> .
Adverse event	An unintended and unwanted incident that occurs during or after clinical care and results in harm to the patient or healthcare consumer. Also referred to as adverse outcome.
Aged matter	A complaint or matter that has exceeded the legislative timeframe (including approved extensions) or, in the case of an investigation, has exceeded 12 months.
Assessment	The process of obtaining and analysing information relevant to a complaint to decide the most appropriate way to further deal with it.
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. Also the OHO's coregulatory partner for healthcare complaints management in Queensland.
Boundary violation	The crossing of a standard professional, clinical boundary, or deviation from standard therapeutic activity, that is potentially harmful to or exploitative of the patient. Boundary violations can be either sexual or nonsexual.
Case management system	The OHO's case management system, Resolve, is an electronic software program where staff record all details about complaints.
Chaperone	In the context of this report, a chaperone is a person who is required to be physically present and directly observe all contact between a registered health practitioner and all patients or certain patient groups.
Clinical advice	An independent, impartial, expert opinion on a clinical matter obtained under legislation to inform a decision on how best to deal with a complaint.
Commonwealth	The Commonwealth of Australia.
Complainant	A person who makes a formal complaint.
Complaint	An expression of dissatisfaction. For the purposes of this report, a complaint refers to a health service complaint, defined by section 31 of the Act as a complaint about the provision of a health service in Queensland.
Conciliation	A voluntary, formal, confidential and impartial process that facilitates intensive negotiations between complainants and providers to reach agreement on more complex complaints.
Contact	An individual engagement with the OHO through any communication method, including post, phone, email or in person,

Term	Definition
	for the purposes of making a complaint (including notifications) or enquiry.
Coregulation	In the context of this report, coregulation refers to the regulatory powers shared by the OHO and AHPRA and the national boards in the management of complaints about registered health practitioners.
Correctional facility	A place of incarceration by government officials. In Queensland the Hospital and Health Services are responsible for delivering health services in correctional facilities in their region.
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.
Disciplinary proceedings	For the purposes of this report, the legal process whereby the Director of Proceedings refers a matter to QCAT for a determination about a health practitioner's health, performance or conduct, and to consider imposing sanctions on the practitioner.
Education provider	In the context of this report, an education provider is a university, other tertiary education institution, specialist medical or other health-profession college that provides a program of study or clinical training for a health professional registered under the National Registration and Accreditation Scheme.
Enquiry	A matter raised with the OHO that does not constitute a health service complaint or notification.
Healthcare 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	A service that is, or purports to be, a service for maintaining, improving, restoring or managing people's health and wellbeing.
Health service complaint	See <i>Complaint</i> .
Health service organisation	A facility, other than an individual, that delivers health services. This includes public, private and not-for-profit healthcare facilities, ambulance services, hospitals, health education services, pharmacies, mental health services, and community health services.

Term	Definition
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	Action taken by the Health Ombudsman to suspend, or impose conditions on, a registered health practitioner's registration, or to prohibit, or place restrictions on, the practice of unregistered health practitioners. Immediate action may only be taken when there is a serious risk to persons and it is necessary to protect public health and safety, or the Health Ombudsman believes it is otherwise in the public interest.
Immediate registration action	Immediate action taken by the Health Ombudsman against a registered health practitioner to suspend or impose conditions upon a practitioner's registration.
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.
Inquiry	A formal inquiry by the Health Ombudsman to collect information on a relevant matter as defined by the Act.
Interim prohibition order	Immediate action taken by the Health Ombudsman against an unregistered health practitioner, or a registered health practitioner working in an unregistered capacity. This may include prohibiting from or placing restrictions on practice.
Internal review	Parties to a matter can request an internal review be conducted of the OHO's administrative decisions. 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. The purpose of an investigation is to determine whether there is evidence of professional misconduct, a practitioner poses serious risk to persons, or whether there is a systemic issue relating to the operation of a system process or practice.
Legislative timeframe	A timeframe mandated by legislation, such as the Act or National Law, in which a specific action or decision must be taken.
Local resolution	A voluntary, informal and impartial process that facilitates negotiations between complainants and providers to quickly

Term	Definition
	resolve less complex complaints with minimal intervention.
Mandatory notification	A notification that a registered health service provider, employer or education provider makes as a requirement under the National Law, when they believe a registered health practitioner or student has behaved in a way that constitutes 'notifiable conduct' which places the public at substantial risk of harm.
National boards	The 15 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 <i>Health Practitioner Regulation National Law Act 2009</i> is applied with modifications as a law of Queensland by the <i>Health Practitioner Regulation National Law (Queensland)</i> . This makes Queensland a coregulatory jurisdiction in relation to the National Law.
National Registration and Accreditation Scheme	The scheme for registered health practitioners, established by the Council of Australian Governments.
No further action	A decision by the Health Ombudsman at any time to take no further action on a matter, in circumstances as defined by the Act.
Office of the Health Ombudsman	The Health Ombudsman and the staff of the office.
Out of jurisdiction	A matter that is not within the Health Ombudsman's jurisdiction to manage under legislation.
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. The OHO operates with statutory oversight by the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee.
Paused investigation	A current OHO investigation that has been halted to allow a criminal matter to be progressed through the criminal justice system without interference or duplication of work.
Prisoner	An individual incarcerated within a correctional facility in Queensland as punishment for a crime.
Professional conduct	Conduct that is of a standard which might reasonably be

Term	Definition
	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.
Professional misconduct	Conduct by a registered health practitioner as defined by the National Law as being substantially below the standard reasonably expected for a practitioner of that profession and level of experience, or is inconsistent with the practitioner being a fit and proper person to hold registration in that profession.
Public health service	A health service delivered by the State of Queensland including services delivered through a Hospital and Health Service.
Public hospital	A hospital operated and managed by the State of Queensland through a Hospital and Health Service.
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. The Tribunal has jurisdiction over the OHO and therefore the judicial power to review certain decisions by the Health Ombudsman.
Queensland Health	Queensland's Government department of health, which includes the Hospital and Health Services.
Referral	A matter that has passed from one individual, agency or entity to another. Referrals occur in a number of different ways, both by the Health Ombudsman and by other entities. Depending on context, this includes matters referred by the Health Ombudsman to AHPRA or another external entity; matters referred to the Health Ombudsman by other entities; and matters referred internally for different relevant actions.
Registered health practitioner	A person registered to practise one of the 15 health professions regulated under the National Law, 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 Act. These are assessment, local resolution, immediate action, investigation, referral to another organisation including AHPRA, referral to the Director of Proceedings, conciliation, and carrying out an inquiry.
Schedule 8 drugs (or medication)	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. Also referred to as 'drugs of addiction'.
Self-notification	A notification that a registered health practitioner makes to the OHO about matters relating to their own health, conduct or performance, usually under requirement by the National Law.

Term	Definition
Show cause notice	A notice issued by the Health Ombudsman to a health practitioner against which immediate action is proposed, to allow the practitioner an opportunity to give reason as to why the proposed immediate action should not be taken.
Split matter	A complaint in which discrete parts are separated for referral to different relevant actions or stages of the complaints management process.
Student	In the context of this report, a student is a person enrolled in a program of study or undertaking clinical training for a health profession.
Summary prosecution	For the purposes of this report, legal proceedings brought in QCAT against a health service provider for a matter defined as a breach against the Act. Such proceedings are distinct from disciplinary proceedings.
Systemic investigation	An investigation to determine if there is an issue relating to the operation of a system, process or practice that is impacting on the provision or quality of health services.
Unregistered health practitioner	Any person who provides a health service and who is not registered in one of the 15 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 to the OHO on a voluntary basis about a health practitioner's health, conduct or performance. The grounds for a voluntary notification are set out in section 144 of the National Law.

## Appendix 3—Strategic plan 2017–21

### Values

- 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.

### Objectives

- Protect the health and safety of the public.
- Promote professional, safe, competent practice and high standards of service delivery from health practitioners and health service organisations.
- Maintain public confidence in the management of complaints and other matters relating to the provision of health services.
- Deliver robust and accountable business operations and foster a culture of transparency, accountability and continual improvement.
- Foster an environment where our people are valued, resilient and empowered to actively contribute to improving service delivery.

### Government objectives

The OHO 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 OHO 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 by 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 our services accessible and reaching out to those groups that may not know where to go if they have a health service complaint.

### **Strategies**

- Administer a health complaints management system founded on the principles of timeliness, impartiality and independence.
- Assess, investigate, resolve and prosecute complaints about healthcare services in a timely manner.
- Take and monitor immediate action against registered and unregistered health service providers in instances where the health and safety of the public are at risk.
- Manage health service complaints ensuring appropriate and timely referral of matters to AHPRA to maximise effectiveness of the coregulatory system in Queensland.
- Analyse complaint and notification data to identify trends and areas of focus for promoting and influencing improvement in health services.
- Investigate systemic issues in order to identify and recommend opportunities for improvement.
- Report publicly on our performance of our functions.
- Report publicly on the performance of AHPRA and the national boards in Queensland in their functions relating to the health, conduct and performance of registered health practitioners.
- Develop and maintain effective stakeholder and consumer relationships to build a collaborative approach to complaint management and improve health service delivery.
- Use technology and standardised processes to improve effectiveness, efficiency and timeliness in service delivery.
- Ensure robust financial and governance practices.
- Deliver customer and business focused corporate services.
- Develop a highly skilled and diverse workforce that meets service delivery needs.

### **Strategic risks**

The Office of the Health Ombudsman (OHO) risk management framework establishes a roadmap for identification and mitigation of risks that could impact on the office's ability to achieve its objectives. Key risks include:

- The effectiveness of the coregulatory jurisdiction in Queensland is dependent on the open communication and efficient cooperation between the OHO, the Australian Health Practitioner Regulation Agency (AHPRA) and a wide range of stakeholders.
- The Health Ombudsman Act 2013 contains unprecedented functions for a health service complaints agency in Australia, meaning many processes and functions are previously untried or untested and are likely to require continual monitoring and adjustment.

### **Performance indicators**

- Percentage of matters finalised within statutory timeframes and internal KPIs.

- Percentage of disciplinary matters in which the Queensland Civil and Administrative Tribunal (QCAT) decided there was a case to answer.
- Percentage of immediate action decisions upheld by QCAT at review hearings.
- Percentage of complaints received, assessed and/or resolved by the OHO within legislative timeframes.
- Feedback from key stakeholder groups on the performance of the OHO.
- Established methods to monitor satisfaction and organisational culture.
- Feedback on the quality and utility of investigative reports outlining system issues and recommendations.
- Percentage of matters subject to local resolution or conciliation where agreement was achieved or partially achieved.
- Client survey  $\geq 80$  per cent satisfaction with the complaints management process.
- Percentage of adverse findings by the Queensland Ombudsman in relation to complaints about our performance.

We publish monthly, quarterly and annual performance reports on our website, in addition to annual reporting on expenditure of funding received from the Australian Health Practitioner Regulation Agency.

## Appendix 4—Annual performance data

### Introduction

This document reports on OHO performance data for the 2017–18 financial year.

It is important to note that annual totals will not equal the sum of the quarterly totals due to necessary adjustments and alterations being made to historical data following the publication of previous reports.

# Intake of complaints

## Type of contacts

Type of contact	Q1		Q2		Q3		Q4		2017–18		2016–17	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Complaint	1697	63.06	1534	60.11	1857	58.09	1848	59.06	<b>6936</b>	<b>59.95</b>	6201	60.43
Enquiry	994	36.94	1018	39.89	1340	41.91	1279	40.88	<b>4631</b>	<b>40.03</b>	4061	39.57
Yet to be classified	0	0.00	0	0.00	0	0.00	2	0.06	<b>2</b>	<b>0.02</b>	0	0.00
<b>Total</b>	<b>2691</b>	<b>100</b>	<b>2552</b>	<b>100</b>	<b>3197</b>	<b>100</b>	<b>3129</b>	<b>100</b>	<b>11569</b>	<b>100</b>	<b>10262</b>	<b>100.00</b>

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		2017–18		2016–17	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Health consumer	1465	86.33	1285	83.77	1633	87.94	1640	88.74	<b>6023</b>	<b>86.84</b>	4965	80.07
Mandatory notification*	41	2.42	63	4.11	32	1.72	57	3.08	<b>193</b>	<b>2.78</b>	352	5.68
Voluntary notification*	167	9.84	155	10.10	166	8.94	110	5.95	<b>598</b>	<b>8.62</b>	714	11.51
Self-notification*	14	0.82	20	1.30	17	0.92	15	0.81	<b>66</b>	<b>0.95</b>	84	1.35
Referral	10	0.59	11	0.72	9	0.48	26	1.41	<b>56</b>	<b>0.81</b>	86	1.39
<b>Total</b>	<b>1697</b>	<b>100</b>	<b>1534</b>	<b>100</b>	<b>1857</b>	<b>100</b>	<b>1848</b>	<b>100</b>	<b>6936</b>	<b>100</b>	<b>6201</b>	<b>100</b>

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 under the *Health Practitioner Regulation National Law (Queensland)*.

## Complaint decisions

### Decisions timeframes – within seven days

Decisions made	Q1		Q2		Q3		Q4		2017–18		2016–17	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Yes	1370	87.54	1322	83.46	1572	93.63	1581	90.29	<b>5845</b>	<b>88.84</b>	4294	73.51
No	195	12.46	262	16.54	107	6.37	170	9.71	<b>734</b>	<b>11.16</b>	1547	26.49
<b>Total</b>	1565	100	1584	100	1679	100	1751	100	<b>6579</b>	<b>100</b>	5841	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		2017–18		2016–17	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Accepted	1155	73.80	1084	68.43	1138	67.78	1044	59.62	<b>4421</b>	<b>67.20</b>	4119	70.37
Not accepted	410	26.20	500	31.57	541	32.22	707	40.38	<b>2158</b>	<b>32.80</b>	1722	29.42
<b>Total</b>	1565	100	1584	100	1679	100	1751	100	<b>6579</b>	<b>100</b>	5841	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		2017–18		2016-17	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Assessment	455	36.84	422	36.54	457	37.52	363	31.98	<b>1697</b>	<b>35.78</b>	1544	37.17
Local resolution	343	27.77	299	25.89	306	25.12	300	26.43	<b>1248</b>	<b>26.31</b>	1031	24.52
Conciliation	0	0.00	0	0.00	0	0.00	2	0.18	<b>2</b>	<b>0.04</b>	2	0.05
Investigation	20	1.62	23	1.99	25	2.05	16	1.41	<b>84</b>	<b>1.77</b>	135	3.25
Referred to AHPRA and the national boards	417	33.77	411	35.58	430	35.30	454	40.00	<b>1712</b>	<b>36.10</b>	1423	34.26
Referral to another entity	0	0.00	0	0.00	0	0.00	0	0.00	<b>0</b>	<b>0.00</b>	19	0.46
Immediate action	0	0.00	0	0.00	0	0.00	0	0.00	<b>0</b>	<b>0.00</b>	0	0.00
<b>Total</b>	<b>1235</b>	<b>100</b>	<b>1155</b>	<b>100</b>	<b>1218</b>	<b>100</b>	<b>1135</b>	<b>100</b>	<b>4743</b>	<b>100</b>	<b>4154</b>	<b>100</b>

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 outcomes resulting from the decisions to accept a matter as noted in the previous *Accepted vs not accepted* table.

# Health service complaints profile

## Main issues raised in complaints

Issue	Q1		Q2		Q3		Q4		2017–18		2016–17	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Access	136	4.98	133	5.66	233	7.89	176	6.23	<b>678</b>	<b>6.24</b>	408	4.39
Code of conduct for healthcare workers	16	0.59	25	1.06	69	2.34	35	1.24	<b>145</b>	<b>1.34</b>	43	0.46
Communication/information	328	12.00	300	12.77	366	12.39	349	12.36	<b>1343</b>	<b>12.37</b>	1243	13.37
Consent	36	1.32	38	1.62	47	1.59	51	1.81	<b>172</b>	<b>1.58</b>	141	1.52
Discharge/transfer arrangements	46	1.68	50	2.13	54	1.83	42	1.49	<b>192</b>	<b>1.77</b>	174	1.87
Environment/management of facilities	72	2.63	47	2.00	65	2.20	61	2.16	<b>245</b>	<b>2.26</b>	161	1.73
Fees/cost	60	2.20	55	2.34	81	2.74	89	3.15	<b>285</b>	<b>2.62</b>	291	3.13
Grievance processes	53	1.94	46	1.96	54	1.83	58	2.05	<b>211</b>	<b>1.94</b>	181	1.95
<i>Health Ombudsman Act 2013 offence</i>	7	0.26	1	0.04	1	0.03	2	0.07	<b>11</b>	<b>0.10</b>	1	0.01
Medical records	71	2.60	75	3.19	109	3.69	96	3.40	<b>351</b>	<b>3.23</b>	262	2.82
Medication	280	10.25	284	12.09	333	11.28	362	12.82	<b>1259</b>	<b>11.59</b>	1065	11.46
Professional conduct	385	14.09	282	12.01	271	9.18	285	10.09	<b>1223</b>	<b>11.26</b>	947	10.19
Professional health	83	3.04	69	2.94	75	2.54	62	2.20	<b>289</b>	<b>2.66</b>	290	3.12
Professional performance	1107	40.50	901	38.36	1139	38.57	1084	38.39	<b>4231</b>	<b>38.96</b>	3921	42.18
Reports/certificates	52	1.90	42	1.79	55	1.86	71	2.51	<b>220</b>	<b>2.03</b>	165	1.78
Research/teaching/assessment	1	0.04	1	0.04	1	0.03	1	0.04	<b>4</b>	<b>0.04</b>	2	0.02
<b>Total</b>	<b>2733</b>	<b>100</b>	<b>2349</b>	<b>100</b>	<b>2953</b>	<b>100</b>	<b>2824</b>	<b>100</b>	<b>10859**</b>	<b>100</b>	<b>9295</b>	<b>100</b>

\*\*136 of the 10,859 issues raised in complaints did not identify a health service provider, and therefore the issues identified in this table will not equal the sum of 'Number and type of complaints by health practitioner' and 'Number and type of complaints by health service organisation'.



## 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 2013 offence	Medical records	Medication	Professional conduct	Professional health	Professional performance	Reports/certificates	Research/teaching/assessment	Total
Alternative care	1	50	1	-	-	-	-	1	-	-	1	12	-	7	1	-	74
Chinese medicine	-	2	4	-	-	-	2	-	-	2	2	8	-	10	-	-	30
Chiropractor	-	-	1	3	-	1	-	-	-	2	-	15	1	17	1	-	41
Dentistry	2	-	24	16	1	4	24	4	1	20	4	57	5	276	-	1	439
Emergency care	-	6	3	2	2	-	-	-	-	2	1	9	5	38	-	-	68
General medical	65	5	335	26	15	2	26	11	1	78	317	297	58	834	73	1	2144
Medical radiation	-	-	-	-	-	-	-	-	-	-	-	4	-	10	4	-	18
Medical specialty	5	5	59	10	-	1	10	6	-	13	22	54	11	198	33	-	427
Nursing	3	12	27	2	2	-	-	1	2	17	44	202	101	112	-	-	525
Occupational therapy	-	-	-	-	-	-	1	-	-	-	-	9	-	7	8	-	25
Optometry	-	-	3	-	-	-	1	-	-	-	-	6	1	15	3	-	29
Osteopathy	1	-	1	-	-	-	-	-	-	1	-	2	1	4	-	-	10
Other	2	51	17	3	1	1	2	1	4	4	18	222	70	69	4	-	469
Pathology service	-	-	2	-	-	-	-	-	-	1	-	1	-	12	1	-	17
Pharmacy	2	-	11	-	-	2	-	1	-	2	103	42	6	6	-	-	175
Physiotherapy	-	1	4	-	-	-	1	-	1	3	-	25	3	10	1	-	49
Podiatry	-	-	1	1	-	-	3	-	-	-	-	7	3	12	-	-	27
Psychology	2	2	31	8	-	-	9	2	-	15	11	61	16	52	37	1	247
Speech pathology	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0
Surgical	3	-	19	19	1	-	13	3	-	7	5	19	5	223	7	-	324
<b>Total</b>	<b>86</b>	<b>134</b>	<b>543</b>	<b>90</b>	<b>22</b>	<b>11</b>	<b>92</b>	<b>30</b>	<b>9</b>	<b>167</b>	<b>528</b>	<b>1052</b>	<b>286</b>	<b>1912</b>	<b>173</b>	<b>3</b>	<b>5138</b>

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 and information	Consent	Discharge/transfer arrangements	Environment/management of facility	Fees and costs	Grievance processes	Health Ombudsman Act 2013 offence	Medical records	Medication	Professional conduct	Professional health	Professional performance	Reports/certificates	Research/teaching/Assessment	Total
Aged care facility	2	1	20	1	2	21	-	5	-	7	18	5	-	70	-	-	152
Allied health service	3	-	4	-	-	2	5	-	-	2	1	6	-	16	-	-	39
Ambulance service	-	3	10	1	-	-	1	3	-	1	1	-	-	16	-	-	36
Community health service	15	-	14	-	-	5	1	3	-	4	5	9	-	23	4	-	83
Correctional facility	283	-	54	5	2	21	-	6	1	10	471	4	-	417	1	-	1275
Dental service	20	-	29	1	-	5	31	7	-	9	-	9	-	81	-	-	192
Hospital and Health Service	8	-	13	1	2	4	3	3	-	3	3	3	-	35	-	-	78
Laboratory service	2	-	6	1	-	5	15	3	-	3	-	2	-	10	2	-	49
Licensed private hospital	14	-	45	4	16	11	29	14	-	7	17	6	-	110	3	-	276
Medical centre	63	-	101	4	-	26	40	13	1	60	24	20	-	95	11	-	458
Mental health service	14	-	60	20	10	18	-	8	-	9	33	19	-	114	5	-	310
Nursing service	-	-	2	-	-	3	1	1	-	1	1	3	-	1	-	-	13
Other government department	1	-	3	-	-	-	1	2	-	-	-	-	-	2	-	-	9
Other support service	6	-	7	-	-	5	4	-	-	1	4	2	-	11	3	-	43
Pharmaceutical service	2	-	14	2	-	9	10	6	-	1	55	8	-	6	-	-	113
Private organisation	-	4	4	-	-	4	14	1	-	2	-	1	-	17	-	-	47
Public health service	9	-	25	2	5	5	-	3	-	1	5	2	-	39	-	-	96
Public hospital	133	1	341	35	133	77	20	89	-	52	73	52	1	1155	12	1	2175
Residential care service	1	-	1	-	-	2	-	1	-	-	-	1	-	1	-	-	7
Specialised health service	8	-	16	3	-	5	14	11	-	4	4	6	-	33	3	-	107
Administrative service	-	-	1	-	-	1	1	-	-	-	-	-	-	1	-	-	4

Organisation type	Access	Code of conduct for healthcare workers	Communication and information	Consent	Discharge/transfer arrangements	Environment/management of facility	Fees and costs	Grievance processes	Health Ombudsman Act 2013 offence	Medical records	Medication	Professional conduct	Professional health	Professional performance	Reports/certificates	Research/teaching/Assessment	Total
Health information service	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	1
Health promotion service	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
Licensed day hospital	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	1
Optical store	-	-	2	-	-	-	2	1	-	-	-	-	-	3	2	-	10
Paramedical service	-	-	1	-	-	-	1	-	-	-	-	1	-	-	-	-	3
Social work service	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	1
Welfare service	1	-	3	-	-	1	-	1	-	-	-	-	-	-	-	-	6
<b>Total</b>	<b>586</b>	<b>9</b>	<b>778</b>	<b>80</b>	<b>170</b>	<b>231</b>	<b>193</b>	<b>181</b>	<b>2</b>	<b>177</b>	<b>715</b>	<b>159</b>	<b>1</b>	<b>2256</b>	<b>46</b>	<b>1</b>	<b>5585</b>

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	2017–18	2016–17
Assessments started	517	483	496	388	<b>1884</b>	1880
Assessments completed	525	487	464	513	<b>1989</b>	2078

## Assessments completed

### Completed within legislative timeframes

Assessment timeframes	Q1		Q2		Q3		Q4		2017–18		2016–17	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Within legislative timeframes*	390	74.29	357	73.31	325	70.04	367	71.54	<b>1439</b>	<b>72.35</b>	1262	60.73
Outside legislative timeframes	135	25.71	130	26.69	139	29.96	146	28.46	<b>550</b>	<b>27.65</b>	816	39.27
<b>Total</b>	525	100	487	100	464	100	513	100	<b>1989</b>	<b>100</b>	2078	100

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

### Completed assessment timeframes

Assessment timeframes	Q1		Q2		Q3		Q4		2017–18		2016–17	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Within 30 days	278	52.95	272	55.85	245	52.80	254	49.51	<b>1049</b>	<b>52.74</b>	980	47.16
Within 60 days*	158	30.10	116	23.82	105	22.63	139	27.10	<b>518</b>	<b>26.04</b>	437	21.03
Greater than 60 days	89	16.95	99	20.33	114	24.57	120	23.39	<b>422</b>	<b>21.22</b>	661	31.81
<b>Total</b>	525	100	487	100	464	100	513	100	<b>1989</b>	<b>100</b>	2078	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		2017–18		2016–17	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Local resolution	3	0.55	3	0.57	3	0.59	3	0.57	<b>12</b>	<b>0.57</b>	55	2.39
Conciliation	25	4.58	19	3.64	18	3.56	35	6.63	<b>97</b>	<b>4.62</b>	136	5.92
Investigation	26	4.76	24	4.60	26	5.15	30	5.68	<b>106</b>	<b>5.05</b>	63	2.74
Referred to AHPRA and the national boards	92	16.85	68	13.03	57	11.29	38	7.20	<b>255</b>	<b>12.14</b>	419	18.24
Referred to another entity	127	23.26	150	28.74	156	30.89	170	32.20	<b>603</b>	<b>28.70</b>	548	23.86
Immediate registration action	0	0.00	1	0.19	0	0.00	0	0.00	<b>1</b>	<b>0.05</b>	3	0.13
Interim prohibition order	0	0.00	0	0.00	0	0.00	0	0.00	<b>0</b>	<b>0.00</b>	1	0.04
No further action	273	50.00	257	49.23	245	48.51	252	47.73	<b>1027</b>	<b>48.88</b>	1072	46.67
<b>Total</b>	<b>546</b>	<b>100</b>	<b>522</b>	<b>100</b>	<b>505</b>	<b>100</b>	<b>528</b>	<b>100</b>	<b>2101</b>	<b>100</b>	<b>2297</b>	<b>100</b>

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

## Local resolution

### Local resolutions started and completed

Local resolutions this year	Q1	Q2	Q3	Q4	2017–18	2016–17
Local resolutions started	359	309	328	309	<b>1305</b>	1123
Local resolutions completed	344	316	345	259	<b>1264</b>	1150

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

#### Completed within legislative timeframes

Local resolution timeframes	Q1		Q2		Q3		Q4		2017–18		2016–17	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Within legislative timeframes*	338	98.26	307	97.15	322	93.33	259	100	<b>1226</b>	<b>96.99</b>	1102	95.83
Outside legislative timeframes	6	1.74	9	2.85	23	6.67	0	0.00	<b>38</b>	<b>3.01</b>	48	4.17
<b>Total</b>	<b>344</b>	<b>100</b>	<b>316</b>	<b>100</b>	<b>345</b>	<b>100</b>	<b>259</b>	<b>100</b>	<b>1264</b>	<b>100</b>	<b>1150</b>	<b>100</b>

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

## Completed local resolution timeframes

Local resolution timeframes	Q1		Q2		Q3		Q4		2017–18		2016–17	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Within 30 days	320	93.02	271	85.76	282	81.74	229	88.42	<b>1102</b>	<b>87.18</b>	996	86.61
Within 60 days*	23	6.69	41	12.97	56	16.23	30	11.58	<b>150</b>	<b>11.87</b>	149	12.96
Greater than 60 days	1	0.29	4	1.27	7	2.03	0	0.00	<b>12</b>	<b>0.95</b>	5	0.43
<b>Total</b>	<b>344</b>	<b>100</b>	<b>316</b>	<b>100</b>	<b>345</b>	<b>100</b>	<b>259</b>	<b>100</b>	<b>1264</b>	<b>100</b>	<b>1150</b>	<b>100</b>

\*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		2017–18		2016–17	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Resolved	268	77.91	249	78.80	286	82.90	208	80.31	<b>1011</b>	<b>79.98</b>	959	83.39
Not resolved	45	13.08	44	13.92	33	9.57	33	12.74	<b>155</b>	<b>12.26</b>	151	13.13
Complaint withdrawn	31	9.01	17	5.38	19	5.51	14	5.41	<b>81</b>	<b>6.41</b>	40	3.48
Local resolution did not commence*	0	0.00	6	1.90	7	2.03	4	1.54	<b>17</b>	<b>1.34</b>	N/A	N/A
<b>Total</b>	<b>344</b>	<b>100</b>	<b>316</b>	<b>100</b>	<b>345</b>	<b>100</b>	<b>259</b>	<b>100</b>	<b>1264</b>	<b>100</b>	<b>1150</b>	<b>100</b>

\*The office began capturing and reporting this data from August 2017 onwards.



## Decisions for matters that were not resolved

Type of relevant action	Q1		Q2		Q3		Q4		2017–18		2016–17	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Assessment	1	2.22	2	4.55	0	0.00	0	0.00	<b>3</b>	<b>1.94</b>	2	1.32
Conciliation	0	0.00	0	0.00	0	0.00	0	0.00	<b>0</b>	<b>0.00</b>	0	0.00
Investigation	0	0.00	0	0.00	0	0.00	0	0.00	<b>0</b>	<b>0.00</b>	0	0.00
Referred to AHPRA and the national boards	0	0.00	2	4.55	4	12.12	2	6.06	<b>8</b>	<b>5.16</b>	5	3.31
Referral to another entity	0	0.00	0	0.00	0	0.00	0	0.00	<b>0</b>	<b>0.00</b>	0	0.00
Immediate action	0	0.00	0	0.00	0	0.00	0	0.00	<b>0</b>	<b>0.00</b>	0	0.00
No further action	44	97.78	40	90.91	29	87.88	31	93.94	<b>144</b>	<b>92.90</b>	144	95.36
<b>Total</b>	<b>45</b>	<b>100</b>	<b>44</b>	<b>100</b>	<b>33</b>	<b>100</b>	<b>33</b>	<b>100</b>	<b>155</b>	<b>100</b>	<b>151</b>	<b>100</b>

# Conciliation

## Conciliations started and closed

Conciliations this year	Q1	Q2	Q3	Q4	2017–18	2016–17
Conciliations started	28	20	21	34	<b>103</b>	142
Conciliations closed	24	38	20	46	<b>128</b>	135

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. 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	2017–18	2016–17
Party/ies agreed to participate	19	14	12	20	<b>65</b>	80
Party/ies did not agree to participate	12	20	7	20	<b>59</b>	62

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		2017–18		2016–17	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
0–3 months	1	8.33	1	5.56	0	0.00	4	15.38	<b>6</b>	<b>8.70</b>	7	9.59
3–6 months	5	41.67	11	61.11	4	30.77	9	34.62	<b>29</b>	<b>42.03</b>	40	54.79
6–9 months	5	41.67	3	16.67	4	30.77	6	23.08	<b>18</b>	<b>26.09</b>	24	32.88
9–12 months	0	0.00	1	5.56	2	15.38	4	15.38	<b>7</b>	<b>10.14</b>	2	2.74
12+ months	1	8.33	2	11.11	3	23.08	3	11.54	<b>9</b>	<b>13.04</b>	0	0.00
<b>Total</b>	12	100	18	100	13	100	26	100	<b>69</b>	<b>100</b>	73	100

### Outcomes

Conciliation outcomes	Q1		Q2		Q3		Q4		2017–18		2016–17	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Successful	8	66.67	16	88.89	10	76.92	16	61.54	<b>50</b>	<b>72.46</b>	53	72.60
Not successful	4	33.33	2	11.11	3	23.08	10	38.46	<b>19</b>	<b>27.54</b>	20	27.40
Ended by Health Ombudsman	0	0.00	0	0.00	0	0.00	0	0.00	<b>0</b>	<b>0.00</b>	0	0.00
<b>Total</b>	12	100	18	100	13	100	26	100	<b>69</b>	<b>100</b>	73	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 wasn't reached

Type of relevant action	Q1		Q2		Q3		Q4		2017–18		2016–17	
	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	2	100.00	3	100.00	10	100.00	19	100.00	20	100.00
<b>Total</b>	4	100.00	2	100.00	3	100.00	10	100.00	19	100	20	100

This data relates to matters where the conciliation process was completed.

## Open conciliation timeframes

Conciliations open as at end of period	Q1		Q2		Q3		Q4		Q4 2016–17	
	Number	%	Number	%	Number	%	Number	%	Number	%
0–3 months	25	38.46	15	31.91	20	41.67	26	72.22	31	50.82
3–6 months	21	32.31	12	25.53	8	16.67	6	16.67	13	21.31
6–9 months	7	10.77	9	19.15	8	16.67	1	2.78	10	16.39
9–12 months	6	9.23	5	10.64	6	12.50	1	2.78	3	4.92
12+ months	6	9.23	6	12.77	6	12.50	2	5.56	4	6.56
<b>Total</b>	65	100	47	100	48	100	36	100.00	61	100

The table above includes matters 'on hold'. As at 30 June 2018, 10 matters were on hold, including 3 matters that had been open for less than 3 months, 4 matters that had been open for 3–6 months, 1 matter that had been open for 6–9 months and 2 matters that had been open for more than 12 months.

## Investigation

During 2017–18, as part of the office's commitment to continual improvement in transparency of data, changes were made to reporting methodology within the Investigations division. This may mean there are minor variances to the figures in previous monthly and quarterly reports.

Other causes of variance are:

- a new investigation being commenced as a result of an existing investigation identifying a new health service provider. In these situations timeframes and commencement date will be recorded as the commencement date of the original investigation
- an investigation decision being rescinded
- matters amalgamated under section 40(2) of the Act being separated into individual investigations.

### Investigations started and closed

Investigations this year	Q1	Q2	Q3	Q4	2017–18	2016–17
Investigations open at start of quarter	394	361	227	195	<b>N/A</b>	N/A
Investigations started	53	60	51	49	<b>213</b>	247
Investigations closed	91	119	86	91	<b>387</b>	209
Investigations amalgamated under section 40(2)	0	73	1	0	<b>74</b>	0

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

Investigation closed	Q1		Q2		Q3		Q4		2017–18		2016–17	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
0–3 months	5	5.49	21	17.65	15	17.44	19	20.88	<b>60</b>	<b>15.50</b>	25	11.96
3–6 months	9	9.89	9	7.56	11	12.79	11	12.09	<b>40</b>	<b>10.34</b>	28	13.40
6–9 months	10	10.99	9	7.56	5	5.81	10	10.99	<b>34</b>	<b>8.79</b>	20	9.57
9–12 months	12	13.19	16	13.45	8	9.30	7	7.69	<b>43</b>	<b>11.11</b>	14	6.70
12–24 months	35	38.46	37	31.09	31	36.05	27	29.67	<b>130</b>	<b>33.59</b>	69	33.01

Investigation closed	Q1		Q2		Q3		Q4		2017–18		2016–17	
24+ months	20	21.98	27	22.69	16	18.60	17	18.68	80	20.67	53	25.36
<b>Total</b>	91	100	119	100	86	100	91	100	387	100	209	100

## Outcomes

Closed investigation outcome	Q1		Q2		Q3		Q4		2017–18		2016–17	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Matters recommended for referral to Director of Proceedings*	39	39.39	70	55.56	54	60.00	40	40.82	203	49.15	80	38.28
Referred to AHPRA	18	18.18	25	19.84	13	14.44	11	11.22	67	16.22	47	22.49
Referred to another agency	7	7.07	4	3.17	3	3.33	12	12.24	26	6.30	8	3.83
No further action	35	35.35	27	21.43	20	22.22	33	33.67	115	27.85	72	34.45
Referred to legal services**	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	2	0.96
Conciliation	0	0.00	0	0.00	0	0.00	2	2.04	2	0.48	N/A	N/A
<b>Total</b>	99	100	126	100	90	100	98	100	413	100	209	100

\*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 Coroners Court—concludes their own processes.

Where a matter is referred under section 193A(4) of the National Law, 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](http://www.oho.qld.gov.au).

### Active investigation timeframes

Active investigations as at end of period	Q1		Q2		Q3		Q4		Q4 2016–17	
	Number	%	Number	%	Number	%	Number	%	Number	%
0–3 months	47	14.87	43	21.83	37	23.72	39	32.77	44	12.94
3–6 months	34	10.76	23	11.68	31	19.87	15	12.61	41	12.06
6–9 months	35	11.08	22	11.17	13	8.33	21	17.65	47	13.82
9–12 months	41	12.97	18	9.14	15	9.62	9	7.56	40	11.77
12–24 months	109	34.49	62	31.47	43	27.56	26	21.85	N/A	N/A
24+ months	50	15.82	29	14.72	17	10.90	9	7.56	N/A	N/A
12+ months*	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	168	49.41
<b>Total</b>	316	100	197	100	156	100	119	100	340	100

\*In 2016–17 *all* active investigations open more than 12 months were categorised as '12+ months'. Changes to reporting methodology in 2017–18 has resulted in these matters being separated into two categories.



## Paused investigation timeframes

Paused investigations as at end of period	Q1		Q2		Q3		Q4		Q4 2016–17	
	Number	%	Number	%	Number	%	Number	%	Number	%
0–3 months	2	4.44	3	10.00	4	10.26	2	5.88	4	7.41
3–6 months	8	17.78	7	23.33	7	17.95	10	29.41	5	9.26
6–9 months	2	4.44	5	16.67	8	20.51	3	8.82	13	24.07
9–12 months	11	24.44	1	3.33	6	15.38	6	17.65	4	7.41
12–24 months	21	46.67	9	30.00	9	23.08	8	23.53	N/A	N/A
24+ months	1	2.22	5	16.67	5	12.82	5	14.71	N/A	N/A
12+ months*	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	28	51.85
<b>Total</b>	45	100	30	100	39	100	34	100	54	100

\*In 2016–17 *all* paused investigations open more than 12 months were categorised as ‘12+ months’. Changes to reporting methodology in 2017–18 has resulted in these matters being separated into two categories.

## Open investigation timeframes

Open investigations as at end of period	Q1		Q2		Q3		Q4		Q4 2016–17	
	Number	%	Number	%	Number	%	Number	%	Number	%
0–3 months	49	13.57	46	20.26	41	21.03	41	26.80	48	12.18
3–6 months	42	11.63	30	13.22	38	19.49	25	16.34	46	11.68
6–9 months	37	10.25	27	11.89	21	10.77	24	15.69	60	15.23
9–12 months	52	14.40	19	8.37	21	10.77	15	9.80	44	11.17
12–24 months	130	36.01	71	31.28	52	26.67	34	22.22	143	36.29
24+ months	51	14.13	34	14.98	22	11.28	14	9.15	53	13.45
<b>Total</b>	361	100	227	100	195	100	153	100	394	100

## Open investigation categories

Investigation category of open investigations as at end of period	Q1	Q2	Q3	Q4
Health service complaint	247	151	120	96
Systemic issue	37	26	22	12
Another matter*	77	48	52	43
Matters identified for further investigation**	0	2	1	2
<b>Total</b>	<b>361</b>	<b>227</b>	<b>195</b>	<b>153</b>

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

\*\*Matters referred for further investigation by the Health Ombudsman under section 105 of the Act following referral to Director of Proceedings.

## 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	2017–18	2016–17
Recommendations monitoring cases started	3	4
Recommendations monitoring cases closed	2	2

### Health service provider recommendations 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	2017–18	2016–17
Recommendations monitoring cases started	0	9
Recommendations monitoring cases closed	4	6

### Open recommendations monitoring case timeframes

Timeframes*	2017–18		2016–17	
	Number	%	Number	%
Less than 6 months	3	60.00	1	12.50
6–12 months	0	0.00	6	75.00
More than 12 months	2	20.00	1	12.50
<b>Total</b>	<b>5</b>	<b>100</b>	<b>8</b>	<b>100</b>

\*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 2018.

## 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 QCAT for a determination.

### Matters referred to the Director of Proceedings by practitioner type

Practitioner type	Q1		Q2		Q3		Q4		2017–18		2016–17	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Chinese medicine practitioner	0	0.00	1	1.72	1	1.82	1	2.63	3	1.71	0	0.00
Chiropractor	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	1	1.79
Dentist	2	8.33	2	3.45	1	1.82	1	2.63	6	3.43	2	3.57
Medical practitioner	5	20.83	15	25.86	10	18.18	9	23.69	39	22.29	24	42.86
Medical practitioner and dentist	0	0.00	0	0.00	0	0.00	1	2.63	1	0.57	0	0.00
Medical radiation practitioner	0	0.00	1	1.72	1	1.82	0	0.00	2	1.14	0	0.00
Optometrist	0	0.00	0	0.00	1	1.82	0	0.00	1	0.57	0	0.00
Pharmacist	1	4.17	7	12.07	3	5.45	2	5.26	13	7.43	3	5.36
Physiotherapist	1	4.17	0	0.00	3	5.45	0	0.00	4	2.29	0	0.00
Podiatrist	0	0.00	0	0.00	1	1.82	0	0.00	1	0.57	1	1.79
Psychologist	3	12.50	4	6.90	1	1.82	0	0.00	8	4.57	2	3.57
Registered nurse	6	25.00	22	37.93	22	40.00	20	52.63	70	40.00	19	33.93
Registered nurse and midwife	0	0.00	1	1.72	0	0.00	0	0.00	1	0.57	1	1.79
Advanced care paramedic	1	4.17	1	1.72	1	1.82	0	0.00	3	1.71	0	0.00
Assistant in nursing	0	0.00	1	1.72	1	1.82	1	2.63	3	1.71	0	0.00
Audiologist	0	0.00	0	0.0	2	3.64	0	0.00	2	1.14	0	0.00
Dental assistant	0	0.00	0	0.00	0	0.00	1	2.63	1	0.57	0	0.00
Holding out as a psychologist	0	0.00	0	0.00	1	1.82	0	0.00	1	0.57	0	0.00
Holding out as a registered nurse	1	4.17	1	1.72	0	0.00	0	0.00	2	1.14	0	0.00
Massage therapist	3	12.50	2	3.45	3	5.45	2	5.26	10	5.71	1	1.79
Natural therapist	0	0.00	0	0.00	1	1.82	0	0.00	1	0.57	0	0.00
Social worker	0	0.00	0	0.00	1	1.82	0	0.00	1	0.57	0	0.00
Student nurse	0	0.00	0	0.00	1	1.82	0	0.00	1	0.57	1	1.79
Unregistered chiropractor	1	4.17	0	0.00	0	0.00	0	0.00	1	0.57	1	1.79
<b>Total</b>	24	100	58	100	55	100	38	100	175	100	56	100

## Matters currently with the Director of Proceedings by practitioner type

Practitioner type as at end of period	Q1		Q2		Q3		Q4		Q4 2016–17	
	Number	%	Number	%	Number	%	Number	%	Number	%
Chinese medicine practitioner	0	0.00	1	0.85	2	1.28	2	1.28	0	0.00
Chiropractor	1	1.41	1	0.85	1	0.64	1	0.64	1	1.85
Dentist	4	5.63	5	4.27	6	3.85	7	4.49	2	3.70
Medical practitioner	26	36.62	37	31.62	45	28.85	49	31.41	25	46.30
Medical practitioner and dentist	0	0.00	0	0.00	0	0.00	1	0.64	0	0.00
Medical radiation practitioner	0	0.00	1	0.85	2	1.28	2	1.28	0	0.00
Optometrist	0	0.00	0	0.00	1	0.64	0	0.00	0	0.00
Pharmacist	3	4.23	10	8.55	12	7.69	7	4.49	2	3.70
Physiotherapist	1	1.41	1	0.85	2	1.28	1	0.64	0	0.00
Podiatrist	1	1.41	1	0.85	2	1.28	2	1.28	1	1.85
Psychologist	4	5.63	8	6.84	9	5.77	7	4.49	4	7.41
Registered nurse	21	29.58	39	33.33	52	33.33	60	38.46	15	27.78
Registered nurse and midwife	1	1.41	1	0.85	0	0.00	0	0.00	1	1.85
Advanced care paramedic	1	1.41	2	1.71	3	1.92	2	1.28	0	0.00
Assistant in nursing	0	0.00	1	0.85	2	1.28	3	1.92	0	0.00
Audiologist	0	0.00	0	0.00	2	1.28	2	1.28	0	0.00
Dental assistant	0	0.00	0	0.00	0	0.00	1	0.64	0	0.00
Holding out as psychologist	0	0.00	0	0.00	1	0.64	1	0.64	0	0.00
Holding out as registered nurse	1	1.41	1	0.85	1	0.64	1	0.64	0	0.00
Massage therapist	4	5.63	6	5.13	9	5.77	3	1.92	1	1.85
Natural therapist	0	0.00	0	0.00	1	0.64	1	0.64	0	0.00
Social worker	0	0.00	0	0.00	1	0.64	1	0.64	0	0.00
Student nurse	1	1.41	1	0.85	1	0.64	1	0.64	1	1.85
Unregistered chiropractor	2	2.82	1	0.85	1	0.64	1	0.64	1	1.85
<b>Total</b>	<b>71</b>	<b>100</b>	<b>117</b>	<b>100</b>	<b>156</b>	<b>100</b>	<b>156</b>	<b>100</b>	<b>54</b>	<b>100</b>

\*In March 2018 a matter involving a medical practitioner was referred to the Director of Proceedings. In May 2018 this decision to refer to the Director of Proceedings was revoked.

## Decisions made by the Director of Proceedings

### Matters to be referred to the Queensland Civil and Administrative Tribunal

Practitioner type	Q1		Q2		Q3		Q4		2017–18		2016–17	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Dentist	0	0.00	1	12.50	0	0.00	0	0.00	1	1.81	1	7.70
Medical practitioner	2	40.00	2	25.00	0	0.00	3	10.71	7	12.73	3	23.08
Optometrist	0	0.00	0	0.00	0	0.00	1	3.57	1	1.81	0	0.00
Pharmacist	0	0.00	0	0.00	1	7.14	4	14.29	5	9.10	2	15.38
Physiotherapist	0	0.00	0	0.0	2	14.29	1	3.57	3	5.45	0	0.00
Psychologist	3	60.00	0	0.00	0	0.00	1	3.57	4	7.27	0	0.00
Registered nurse	0	0.00	4	50.00	8	57.14	10	35.71	22	40.00	6	46.15
Registered nurse and midwife	0	0.00	0	0.00	2	14.29	0	0.00	2	3.63	1	7.70
Advanced care paramedic	0	0.00	0	0.00	0	0.00	1	3.57	1	1.81	0	0.00
Massage therapist	0	0.00	0	0.00	0	0.00	7	25.00	7	12.73	0	0.00
Student nurse	0	0.00	0	0.00	1	7.14	0	0.00	1	1.81	0	0.00
Unregistered chiropractor	0	0.00	1	12.50	0	0.00	0	0.00	1	1.81	0	0.00
<b>Total</b>	5	100	8	100	14	100	28	100	55	100	13	100

The table above reflects the number of matters for which the Director of Proceedings decided that a referral to QCAT would be appropriate. [NB: The actual filing of a matter with QCAT can occur at a later date—see ‘Disciplinary matters filed in QCAT’ over the page.]

### Matters to be referred back to the Health Ombudsman

Practitioner type	Q1		Q2		Q3		Q4		2017–18		2016–17	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Chinese medicine practitioner	0	0.00	0	0.00	0	0.00	1	12.50	1	6.25	0	0.00
Dentist	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	1	20.00
Medical practitioner	2	100.00	3	100.00	1	33.33	1	12.50	7	43.75	2	40.00
Pharmacist	0	0.00	0	0.00	0	0.00	2	25.00	2	12.50	0	0.00

Practitioner type	Q1		Q2		Q3		Q4		2017–18		2016–17	
Psychologist	0	0.00	0	0.00	0	0.00	1	12.50	1	6.25	0	0.00
Registered nurse	0	0.00	0	0.00	1	33.33	2	25.00	3	18.75	2	40.00
Holding out as a registered nurse	0	0.00	0	0.00	1	33.33	0	0.00	1	6.25	0	0.00
Massage therapist	0	0.00	0	0.00	0	0.00	1	12.50	1	6.25	0	0.00
<b>Total</b>	2	100	3	100	3	100	8	100	16	100	5	100

## Disciplinary matters filed in QCAT

Practitioner type	Q1		Q2		Q3		Q4		2017–18		2016–17	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Dentist	0	0.00	1*	11.11	0	0.00	0	0.00	1	1.92	0	0.00
Medical practitioner	0	0.00	2	22.22	2	14.29	3	10.34	7	13.46	3	25.00
Optometrist	0	0.00	0	0.00	0	0.00	1	3.45	1	1.92	0	0.00
Pharmacist	0	0.00	0	0.00	1	7.14	5	17.24	6	11.54	2	16.67
Physiotherapist	0	0.00	0	0.00	1*	7.14	1	3.45	2	3.85	0	0.00
Psychologist	0	0.00	1	11.11	0	0.00	1	3.45	2	3.85	0	0.00
Registered nurse	0	0.00	4	44.44	7*	50.00	10	34.48	21	40.38	6	50.00
Registered nurse and midwife	0	0.00	0	0.00	2	14.29	0	0.00	2	3.85	1	8.33
Advanced care paramedic	0	0.00	0	0.00	0	0.00	1	3.45	1	1.92	0	0.00
Massage therapist	0	0.00	0	0.00	0	0.00	7	24.14	7	13.46	0	0.00
Student nurse	0	0.00	0	0.00	1	7.14	0	0.00	1	1.92	0	0.00
Unregistered chiropractor	0	0.00	1	11.11	0	0.00	0	0.00	1	1.92	0	0.00
<b>Total</b>	0	N/A	9	100	14	100	29	100	52	100	12	100

\*The Director of Proceedings made two decisions to refer separate matters regarding the same practitioner to QCAT. These matters were filed together as one referral to QCAT.



## 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.

No matters were referred for summary prosecution in 2017–18.

## 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 40 show cause notices issued during 2017–18.

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 21 times in 2017–18.

Practitioner type	Month	Number	Action taken	Reason/s for taking action		
				Health	Conduct	Performance
Chinese medicine practitioner	July	1	Conditions			✓
Enrolled nurse	July	1	Suspension		✓	
Pharmacist	July	1	Conditions		✓	
Pharmacist	July	1	Suspension		✓	
Pharmacist	August	1	Suspension		✓	
Dental practitioner	September	1	Conditions		✓	✓
Dental practitioner	October	1	Conditions		✓	✓
Chinese medicine practitioner	November	1	Conditions			✓
Registered nurse	December	1	Conditions		✓	
Enrolled nurse	December	1	Suspension		✓	
Chinese medicine practitioner	January	1	Conditions			✓
Registered nurse	February	1	Conditions	✓	✓	
Medical practitioner	February	1	Conditions		✓	
Enrolled nurse	February	1	Conditions		✓	
Enrolled nurse	February	1	Suspension		✓	
Registered nurse	March	1	Conditions	✓	✓	

Registered nurse	April	1	Suspension		✓	
Registered nurse	May	1	Suspension		✓	
Registered nurse	June	1	Suspension		✓	
Registered nurse	June	1	Conditions		✓	
Medical practitioner	June	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 2017–18 the Health Ombudsman issued 24 interim prohibition orders. Details for current prohibition orders can be found on the OHO website ([www.oho.qld.gov.au](http://www.oho.qld.gov.au)) on the prohibition order register.

Practitioner type	Month	Number	Action taken	Reason/s for taking action		
				Health	Conduct	Performance
Pathology specimen collector	August	1	Prohibition		✓	
Audiologist	September	1	Restrictions			✓
Dental assistant	September	1	Prohibition		✓	
Massage therapist	September	1	Restrictions		✓	
Massage therapist	October	1	Restrictions			✓
Anaesthetic technician	October	1	Prohibition		✓	
Unregistered enrolled nurse	October	1	Prohibition		✓	
Assistant in nursing	October	1	Restrictions		✓	
Massage therapist	November	2	Prohibition		✓	
Enrolled nurse	December	1	Prohibition		✓	
Assistant in nursing	December	1	Restrictions		✓	
Unregistered nurse	January	1	Prohibition		✓	
Massage therapist	January	1	Prohibition		✓	
Counsellor	January	1	Prohibition		✓	
Enrolled nurse	February	1	Prohibition		✓	
Massage therapist	February	1	Prohibition		✓	
Massage therapist	February	1	Restrictions		✓	
Assistant in nursing	March	2	Prohibition		✓	
Enrolled nurse	April	1	Prohibition		✓	
Massage therapist	May	1	Prohibition		✓	
Assistant in nursing	May	2	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 this month	2017–18	2016–17
Practitioner monitoring cases started	41	64
Practitioner monitoring cases closed	48	12

### Open monitoring cases

#### Timeframes

Open case timeframes	2017–18		2016–17	
	Number	%	Number	%
Less than 6 months	25	27.17	29	29.00
6–12 months	10	10.87	36	36.00
More than 12 months	57	61.96	35	35.00
<b>Total</b>	<b>92</b>	<b>100.00</b>	100	100

#### Immediate action types

Open cases by immediate action type	2017–18		2016–17	
	Number	%	Number	%
Interim prohibition order—restrictions	16	17.39	22	22.00
Interim prohibition order—prohibited	37	40.22	26	26.00
Immediate registration action—conditions	20	21.74	31	31.00
Immediate registration action—suspension	18	19.57	20	20.00
QCAT issued conditions or prohibition	1*	1.09	1*	1.00
<b>Total</b>	<b>92</b>	<b>100.00</b>	100	100

\*Refinements to systems and processes have resulted in the reclassification of one matter as a QCAT issued prohibition order.

## Registered practitioners under monitoring by practitioner type

Practitioner type	2017–18		2016–17	
	Number	%	Number	%
Aboriginal and Torres Strait Islander health worker	0	0.00	1	1.64
Chinese medicine practitioner	1	1.96	2	3.28
Chiropractor	1	1.96	1	1.64
Dental practitioner	3	5.88	3	4.92
Medical practitioner	8	15.69	11	18.03
Medical radiation practitioner	0	0.00	0	0.00
Nursing and midwifery practitioner	34	66.67	37	60.66
Occupational therapist	0	0.00	0	0.00
Optometrist	0	0.00	0	0.00
Osteopath	0	0.00	0	0.00
Pharmacist	0	0.00	1	1.64
Physiotherapist	2	3.92	2	3.28
Podiatrist	0	0.00	0	0.00
Psychologist	2	3.92	3	4.92
<b>Total</b>	<b>51</b>	<b>100.00</b>	<b>61</b>	<b>100</b>

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	2017–18		2016–17	
	Number	%	Number	%
Aboriginal and Torres Strait Islander health worker	1	2.70	0	0.00
Assistant in nursing	7	18.92	3	10.00
Audiologist	2	5.41	2	6.67
Counsellor	1	2.70	2	6.67
Dental assistant	1	2.70	0	0.00
Dental nurse	1	2.70	0	0.00
Former nurse	1	2.70	0	0.00
Holding out*	3	8.11	4	13.33
Medical assistant	1	2.70	0	0.00
Massage therapist	12	32.43	9	30.00
Natural therapist	1	2.70	3	10.00
Naturopath	1	2.70	0	0.00
Paramedic	3	8.11	4	13.33
Personal carer	1	2.70	0	0.00
Social worker	1	2.70	1	3.33
Support worker	0	0.00	2	6.67
<b>Total</b>	<b>37</b>	<b>100</b>	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, is 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

## 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 s91 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 core regulatory agencies is achieved.

Consultation matters	Q1	Q2	Q3	Q4	2017–18	2016–17
Matters consulted on*	580	555	542	561	<b>2238</b>	2080
Matters referred	557	524	539	525	<b>2145</b>	2060
Matters retained by the office**	9	18	13	15	<b>55</b>	43
Decisions pending	N/A	N/A	N/A	N/A	<b>13</b>	N/A

\*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.

\*\*Under certain circumstances additional information may be received in the course of consultation resulting in the office retaining carriage of the matter and/or taking other relevant action.

## Source of proposed referral

Source	Q1		Q2		Q3		Q4		2017–18		2016–17	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Intake and triage	441	76.03	401	72.25	408	75.28	458	81.64	<b>1708</b>	<b>76.32</b>	1607	78.30
Assessment	112	19.31	115	20.72	102	18.82	76	13.55	<b>405</b>	<b>18.10</b>	397	18.13
Conciliation	0	0.00	0	0.00	0	0.00	0	0.00	<b>0</b>	<b>0.00</b>	0	0.00
Local resolution	5	0.86	9	1.62	8	1.48	7	1.25	<b>29</b>	<b>1.30</b>	21	1.10
Investigations	22	3.79	25	4.50	17	3.14	14	2.50	<b>78</b>	<b>3.49</b>	49	2.16
Internal review	0	0.00	5	0.90	7	1.29	6	1.07	<b>18</b>	<b>0.80</b>	6	0.31
<b>Total</b>	<b>580</b>	<b>100</b>	<b>555</b>	<b>100</b>	<b>542</b>	<b>100</b>	<b>561</b>	<b>100</b>	<b>2238</b>	<b>100</b>	<b>2080</b>	<b>100</b>

## 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 complaints 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	31–60 days	>61 days
Intake and triage	1703	4	0	0	1
Assessment	33	31	92	136	113
Local resolution	1	2	10	14	2
Conciliation	0	0	0	0	0
Investigation	3	5	1	0	69
Internal review	0	0	0	0	18
<b>Total</b>	<b>1740</b>	<b>42</b>	<b>103</b>	<b>150</b>	<b>203</b>

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

## Consultation duration

Consultation duration	Q1		Q2		Q3		Q4		2017–18		2016–17	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
0–3 days	550	95.32	459	82.55	467	87.29	416	74.69	<b>1892</b>	<b>85.03</b>	1927	93.14
4–7 days	22	3.81	91	16.37	57	10.65	136	24.42	<b>306</b>	<b>13.75</b>	149	6.58
8–11 days	2	0.35	6	1.08	9	1.68	3	0.54	<b>20</b>	<b>0.90</b>	4	0.28
12+ days	3	0.52	0	0.00	2	0.37	2	0.36	<b>7</b>	<b>0.31</b>	0	0.00
<b>Total</b>	<b>577</b>	<b>100</b>	<b>556</b>	<b>100</b>	<b>535</b>	<b>100</b>	<b>557</b>	<b>100</b>	<b>2225</b>	<b>100</b>	<b>2080</b>	<b>100</b>

## AHPRA referrals by practitioner type

Practitioner type	2017–18		2016–17		2015–16	
	Number	%	Number	%	Number	%
Aboriginal and Torres Strait Islander health	0	0.00	1	0.05	1	0.05
Chinese medicine practitioner	17	0.79	16	0.78	13	0.65
Chiropractor	27	1.26	34	1.65	21	1.05
Dental practitioner	215	10.02	179	8.69	178	8.93
Medical practitioner	1135	52.91	1169	56.75	1111	55.75
Medical radiation practitioner	5	0.23	6	0.29	15	0.75
Nursing and midwifery practitioner	476	22.19	452	21.94	443	22.23
Occupational therapy	11	0.51	15	0.73	13	0.65
Optometrist	11	0.51	8	0.39	9	0.45
Osteopath	2	0.09	2	0.10	3	0.15
Pharmacist	130	6.06	77	3.74	66	3.31
Physiotherapist	23	1.07	23	1.12	24	1.20
Podiatrist	17	0.79	8	0.39	9	0.45
Psychologist	68	3.17	61	2.96	77	3.86
Unregistered practitioner	0	0.00	0	0.00	10	0.50
Student practitioner	8	0.37	9	0.44	N/A	N/A
<b>Total</b>	<b>2145</b>	<b>100</b>	<b>2060*</b>	<b>100</b>	<b>1993</b>	<b>100</b>

\*2016–17 figures have been altered to allow student practitioner referrals to be reported as a separate category. Total referrals for the 2016–17 year remain the same. Information on the referral of student practitioners is not available for 2015–16.

## Number of issues referred to AHPRA by practitioner type

Registered practitioner type	Access	Communication and information	Consent	Discharge/transfer arrangements	Environment/management of facility	Fees and costs	Grievance process	Medical records	Medication	Professional conduct	Professional health	Professional performance	Reports/certificates	Research/teaching / assessment	Total
Aboriginal and Torres Strait Islander health	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0
Chinese medicine practitioner	-	3	-	-	-	1	-	2	1	9	-	9	-	-	25
Chiropractor	-	-	4	-	1	-	-	2	-	17	2	14	-	-	40
Dental practitioner	-	15	14	-	2	2	1	13	2	38	6	208	-	1	302
Medical practitioner	17	150	34	10	2	4	3	49	179	136	54	918	34	1	1591
Medical radiation practitioner	-	-	-	-	-	-	-	-	-	2	1	3	-	-	6
Nursing and midwifery practitioner	1	20	5	2	-	-	-	21	52	177	150	154	-	-	582
Occupational therapist	-	1	-	-	-	-	-	-	-	8	-	3	3	-	15
Optometrist	-	-	-	-	-	-	-	-	-	4	1	6	-	-	11
Osteopath	-	-	-	-	-	-	-	1	-	-	1	2	-	-	4
Pharmacist	-	11	-	-	2	-	1	2	94	23	9	5	-	-	147
Physiotherapist	-	-	-	1	-	-	-	2	-	11	5	9	-	-	28
Podiatrist	-	1	-	-	-	1	-	-	-	5	5	14	-	-	26
Psychologist	-	9	-	-	-	1	-	5	-	32	18	21	4	1	91
Student practitioner	-	-	-	-	-	-	-	-	-	3	6	-	-	-	9
<b>Total</b>	<b>18</b>	<b>210</b>	<b>57</b>	<b>13</b>	<b>7</b>	<b>9</b>	<b>5</b>	<b>97</b>	<b>328</b>	<b>465</b>	<b>258</b>	<b>1366</b>	<b>41</b>	<b>3</b>	<b>2877</b>

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

## Gender

Gender	2017–18	
	Number	%
Female	2958	48.48
Male	2999	49.15
Prefer not to specify	15	0.25
Unknown	130	2.13
<b>Total</b>	<b>6102</b>	<b>100</b>

## Age

Age	2017–18	
	Number	%
Less than 18	311	5.10
18–24 years	353	5.78
25–34 years	1086	17.80
35–44 years	1229	20.14
45–54 years	1067	17.49
55–64 years	761	12.47
65–74 years	525	8.60
More than 75 years	429	7.03
Unknown*	341	5.59
<b>Total</b>	<b>6102</b>	<b>100</b>

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

## Location of healthcare consumers

Location of healthcare consumers	2017–18	
	Number	%
Brisbane	2517	41.25
Central West	6	0.10
Darling Downs	189	3.10
Far North	329	5.39
Fitzroy	196	3.21
Gold Coast	710	11.64
Mackay	134	2.20
North West	20	0.33
Northern	277	4.54
South West	20	0.33
Sunshine Coast	337	5.52
West Moreton	122	2.00
Wide Bay–Burnett	577	9.46
Outside Queensland	246	4.03
Unknown	422	6.92
<b>Total</b>	<b>6102</b>	<b>100</b>

## Location of health service providers

Location of health service providers	2017–18	
	Number	%
Brisbane	3384	45.31
Central West	7	0.09
Darling Downs	223	2.99
Far North	377	5.05
Fitzroy	211	2.83
Gold Coast	849	11.37
Mackay	163	2.18
North West	16	0.21
Northern	352	4.71
South West	30	0.40
Sunshine Coast	457	6.12
West Moreton	73	0.98
Wide Bay–Burnett	616	8.25
Outside Queensland*	104	1.39
Unknown	607	8.13
<b>Total</b>	<b>7469</b>	<b>100</b>

Health service provider location is taken from the primary address of the provider recorded in the OHO case management system.

\*Complaints can be made about health service providers from other states who have provided health services in Queensland. This could include locums from other states or territories and providers who used to live in Queensland but have since moved elsewhere.





# Office of the Health Ombudsman Financial Statements

**for the financial year ended 30 June 2018**

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## Office of the Health Ombudsman

### Financial Statements 2017-18

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## Office of the Health Ombudsman

### Statement of Comprehensive Income for the year ended 30 June 2018

		2018 Actual \$'000	2018 Original Budget \$'000	2018 Budget Variance* \$'000	2017 Actual \$'000
	Notes				
<b>Income</b>					
<b>Revenue</b>					
Grants and other contributions	4	20,905	14,368	6,537	18,443
Interest		105	245	(140)	88
Other revenue		58	5	53	28
<b>Total Income</b>		<b>21,068</b>	<b>14,618</b>	<b>6,450</b>	<b>18,559</b>
<b>Expenses</b>					
Employee expenses	5	16,396	12,381	4,015	16,395
Supplies and services	6	3,817	2,085	1,732	3,006
Depreciation		197	130	67	153
Other expenses	7	14	22	(8)	28
<b>Total Expenses</b>		<b>20,424</b>	<b>14,618</b>	<b>5,806</b>	<b>19,582</b>
<b>Operating Result</b>		<b>644</b>	<b>-</b>	<b>644</b>	<b>(1,023)</b>
<b>Total Comprehensive Income</b>		<b>644</b>	<b>-</b>	<b>644</b>	<b>(1,023)</b>

\* An explanation of major variances is included in Note 17.

The accompanying notes form part of these statements.

## Office of the Health Ombudsman

### Statement of Financial Position for the year ended 30 June 2018

	Notes	2018 Actual \$'000	2018 Original Budget \$'000	2018 Budget Variance* \$'000	2017 Actual \$'000
<b>Current Assets</b>					
Cash and cash equivalents	8	996	1,635	(639)	662
Receivables	9	864	283	581	388
Prepayments		262	109	153	188
<b>Total Current Assets</b>		<b>2,122</b>	<b>2,027</b>	<b>94</b>	<b>1,238</b>
<b>Non Current Assets</b>					
Prepayments		12	33	(21)	23
Property, plant and equipment	10	136	104	32	328
<b>Total Non Current Assets</b>		<b>148</b>	<b>137</b>	<b>11</b>	<b>351</b>
<b>Total Assets</b>		<b>2,270</b>	<b>2,164</b>	<b>105</b>	<b>1,588</b>
<b>Current Liabilities</b>					
Payables	11	195	147	48	161
Accrued employee benefits	12	830	558	272	787
Deferred Lease Liability		95	-	95	41
<b>Total Current Liabilities</b>		<b>1,120</b>	<b>705</b>	<b>415</b>	<b>989</b>
<b>Non Current Liabilities</b>					
Deferred Lease Liability		27	156	(129)	120
<b>Total Non Current Liabilities</b>		<b>27</b>	<b>156</b>	<b>(129)</b>	<b>120</b>
<b>Total Liabilities</b>		<b>1,146</b>	<b>861</b>	<b>285</b>	<b>1,109</b>
<b>Net Assets</b>		<b>1,124</b>	<b>1,303</b>	<b>(180)</b>	<b>480</b>
<b>Equity</b>					
Contributed equity		1,394			1,394
Accumulated surplus/deficit		(270)			(914)
<b>Total Equity</b>		<b>1,124</b>			<b>480</b>

\* An explanation of major variances is included in Note 17.

The accompanying notes form part of these statements.

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**Office of the Health Ombudsman****Statement of Changes in Equity  
for the year ended 30 June 2018**

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	2018	2017
	\$'000	\$'000
<b>Contributed Equity</b>		
Balance as at 1st July	1,394	1,394
Balance as at 30 June	1,394	1,394
<b>Accumulated Surplus</b>		
Balance as at 1st July	(914)	109
Operating Result	644	(1,023)
Balance as at 30 June	(270)	(914)

*The accompanying notes form part of these statements.*

## Office of the Health Ombudsman

### Statement of Cash Flows for the year ended 30 June 2018

		2018 Actual	2018 Original Budget	2018 Budget Variance*	2017 Actual
	Notes	\$'000	\$'000	\$'000	\$'000
<b>Inflows:</b>					
Grants and other contributions		20,905	14,288	6,617	18,443
GST collected from customers		10	-	10	7
GST input tax credits from ATO		385	-	385	313
Interest receipts		105	245	(140)	88
Other		20	5	15	17
<b>Outflows:</b>					
Employee expenses		(16,761)	(12,381)	(4,380)	(16,218)
Supplies and services		(3,890)	(2,085)	(1,805)	(3,058)
GST paid to suppliers		(1)	-	(1)	(6)
GST remitted to ATO		(419)	-	(419)	(353)
Other		(14)	(22)	8	(28)
<b>Net cash provided by (used in) operating activities</b>		<b>339</b>	<b>50</b>	<b>289</b>	<b>(795)</b>
<b>Cash flows from investing activities</b>					
<b>Outflows:</b>					
Payments for plant and equipment		(6)	-	(6)	(112)
<b>Net cash used in investing activities</b>		<b>(6)</b>	<b>-</b>	<b>(6)</b>	<b>(112)</b>
<b>Net increase (decrease) in cash held</b>		<b>333</b>	<b>50</b>	<b>283</b>	<b>(906)</b>
<b>Cash at beginning of financial year</b>		<b>663</b>	<b>1,585</b>	<b>(922)</b>	<b>1,569</b>
<b>Cash at end of financial year</b>	<b>8</b>	<b>996</b>	<b>1,635</b>	<b>(639)</b>	<b>663</b>
<i>The accompanying notes form part of these statements.</i>				<b>2018</b>	<b>2017</b>
				<b>\$'000</b>	<b>\$'000</b>
<b>Reconciliation of Operating Result to Net Cash from Operating Activities</b>					
Operating surplus/(deficit)				644	(1,023)
Depreciation expense				197	153
<b>Changes in assets and liabilities:</b>					
(Increase)/decrease in receivables				(476)	(102)
(Increase)/decrease in prepayments				(63)	(69)
Increase/(decrease) in payables				34	14
Increase/(decrease) in accrued employee benefits				42	228
Increase/(decrease) in other current liabilities				54	41
Increase/(decrease) in other non-current liabilities				(93)	(36)
<b>Net cash provided by/(used in) operating activities</b>				<b>339</b>	<b>(795)</b>

\* An explanation of major variances is included in Note 17.

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## ***Office of the Health Ombudsman***

### **NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS 2017-18**

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**Section 1: How We Operate - Our Agency Objectives and Activities**

- Note 1: General Information  
Note 2: Objectives and Principal Activities of the Office of the Health Ombudsman  
Note 3: Basis of Financial Statement Preparation

**Section 2: Notes about our Financial Performance**

- Note 4: Grants and Other Contributions  
Note 5: Employee Expenses  
Note 6: Supplies and Services  
Note 7: Other Expenses

**Section 3: Notes about our Financial Position**

- Note 8: Cash and Cash Equivalents  
Note 9: Receivables  
Note 10: Plant and Equipment and Depreciation Expense  
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Note 12: Accrued Employee Benefits

**Section 4: Notes about Risk and Other Accounting Uncertainties**

- Note 13: Commitments  
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Note 15: Financial Risk Disclosures  
Note 16: Events Occurring after Balance Date

**Section 5: Notes on our Performance compared to Budget**

- Note 17: Budgetary Reporting Disclosures

**Section 6: Other information**

- Note 18: Key Management Personnel (KMP) Disclosures  
Note 19: Related Party Transactions  
Note 20: First Year Application of New Accounting Standards or Change in Accounting Policy  
Note 21: Future Impact of Accounting Standards Not Yet Effective



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## ***Office of the Health Ombudsman***

### **NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS 2017-18**

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#### **1. 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](mailto:info@oho.qld.gov.au).

Amounts shown in these financial statements may not add to the correct sub-totals or total due to rounding.

#### **2. 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.



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## **Office of the Health Ombudsman**

### **NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS 2017-18**

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#### **3. Basis of Financial Statement Preparation**

##### **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 2017.

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 20.

##### **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 2016-17 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.

## Office of the Health Ombudsman

### NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS 2017-18

	2018 \$'000	2017 \$'000
<b>4. Grants and Other Contributions</b>		
Grants from Government	20,905	18,443
<b>Total</b>	<b>20,905</b>	<b>18,443</b>

#### 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).

#### 5. Employee Expenses

##### Employee Benefits

Wages and salaries	12,438	12,106
Employer superannuation contributions	1,601	1,588
Annual leave levy	1,077	1,487
Long service leave levy	268	263

##### Employee Related Expenses

Workers' compensation premium	87	75
Payroll tax	725	705
Other employee related expenses	201	171

<b>Total</b>	<b>16,396</b>	<b>16,395</b>
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	2018 No.	2017 No.
Full-Time Equivalent Employees	131*	132

\* Budgeted FTE as per our Service Delivery Statements are 137 FTE.

#### 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.

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## Office of the Health Ombudsman

### NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS 2017-18

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#### 5. 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 18.

## Office of the Health Ombudsman

### NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS 2017-18

	2018 \$'000	2017 \$'000
<b>6. Supplies and Services</b>		
Property lease and rental	1,387	1,314
Employment agency staff	682	513
Information technology	407	280
Minor plant and equipment	118	150
Supplies and consumables	450	196
Consultants and contractors	430	203
Corporate service charges	168	170
Communications	146	148
Sundry expenses	29	32
<b>Total</b>	<b>3,817</b>	<b>3,006</b>

#### 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.

#### 7. Other Expenses

Insurance	4	4
Queensland Audit Office - external audit fees for the audit of financial statements <sup>(1)</sup>	10	22
Bad debts expense	-	2
<b>Total</b>	<b>14</b>	<b>28</b>

#### Audit Fees

(1) Total audit fees quoted by the Queensland Audit Office relating to the 2017-18 financial statements are \$10K (2017 \$10K). There are no non-audit services included in this amount.

#### 8. Cash and Cash Equivalents

Imprest accounts	1	1
Cash at bank <sup>(2)</sup>	995	661
<b>Total</b>	<b>996</b>	<b>662</b>

(2) Total Cash at bank relating to the 2017-18 financial statements includes the first fortnightly salaries in 2018-19 for \$575K. This is to be paid on the 2nd of July 2018 (this also consists of 1 week of accrued salaries for 2017-18 financial year)

#### 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.

## Office of the Health Ombudsman

### NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS 2017-18

	2018 \$'000	2017 \$'000
<b>9. Receivables</b>		
Trade debtors	52	13
	<hr/> 52	<hr/> 13
GST receivable	142	108
GST payable	(2)	2
	<hr/> 140	<hr/> 110
Long service leave reimbursements	19	12
Annual leave reimbursements <sup>(3)</sup>	653	253
	<hr/> 864	<hr/> 388
<b>Total</b>	<b>864</b>	<b>388</b>

- (3) Total Annual leave reimbursements relating to the 2017-18 financial statements is higher than the previous years due to discrepancies found between our payroll system (Aurion) and finance system (Finance One) concerning Leave Loading. No claims have been made for the Leave Loading takings within our systems - resulting in a higher than anticipated reimbursement for Leave Loading taken.

#### Accounting policy

Receivables are measured 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.

#### 10. Plant and Equipment and Depreciation Expense

At cost plant and equipment	734	728
Less: Accumulated depreciation plant and equipment	(598)	(400)
	<hr/> 136	<hr/> 328
<b>Total</b>	<b>136</b>	<b>328</b>

#### 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.

	2018 \$'000	2017 \$'000
Carrying amount at 1 July	328	368
Acquisitions	5	113
Depreciation for period	(197)	(153)
	<hr/> 136	<hr/> 328
<b>Carrying amount at 30 June</b>	<b>136</b>	<b>328</b>



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## Office of the Health Ombudsman

### NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS 2017-18

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#### 10. 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	18 - 42%

###### 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.

	2018 \$'000	2017 \$'000
<b>11. Payables</b>		
Trade and other creditors	131	120
Accrued expenses	64	41
<b>Total</b>	<b>195</b>	<b>161</b>

## Office of the Health Ombudsman

### NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS 2017-18

#### 11. 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.

	2018 \$'000	2017 \$'000
<b>12. Accrued Employee Benefits</b>		
Salary and wage related	239	232
Annual leave levy payable	485	434
Long service leave levy payable	72	78
Superannuation	31	40
Parental leave payable	3	3
<b>Total</b>	<b>830</b>	<b>787</b>

#### 13. 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	1,403	1,347
Later than one year and not later than five years	345	1,748
<b>Total</b>	<b>1,748</b>	<b>3,095</b>

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.

#### 14. Contingencies

As at 30 June 2018 there are:

- 4 Director of Proceedings (DoP) matters which have been heard but which are awaiting a decision by Queensland Civil Administrative Tribunal (QCAT).
- 55 matters that have been filed in QCAT but not yet heard.
- 4 Immediate Action review matters which have been filed in QCAT but not yet heard.
  - 2 of the 4 active Immediate Action review matters are on hold pending criminal proceedings.
- 1 Immediate Action review matter is awaiting a decision in respect of costs.
- 1 Immediate Action review matter has been heard and an adverse decision against the OHO handed down by QCAT. The OHO are waiting on a decision on costs.

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.

## Office of the Health Ombudsman

### NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS 2017-18

#### 15. Financial Risk Disclosures

##### (a) Financial Instrument Categories

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

Financial Assets	Note	2018 \$'000	2017 \$'000
Cash and cash equivalents	8	996	662
Loans and Receivables at amortised cost - comprising:			
Receivables	9	864	388
<b>Total Financial Assets</b>		<b>1,861</b>	<b>1,050</b>
<b>Financial Liabilities</b>			
Financial liabilities measured at amortised cost - comprising:			
Payables	11	195	161
<b>Total Financial Liabilities at amortised cost</b>		<b>195</b>	<b>161</b>

#### Accounting Policy

##### Recognition

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

##### (b) Financial Risk Management

##### **Risk Exposure**

The office'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 office policy. These policies provide the principals for overall risk management as well as specific areas, and seek to minimise potential adverse effects on the financial performance of the office.



## Office of the Health Ombudsman

### NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS 2017-18

#### 15. Financial Risk Disclosures (contd)

##### (b) Financial Risk Management (contd)

The office provides written principles for overall risk management, as well as policies covering specific areas.

The office'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 Office may incur financial loss as a result of another party to a financial instrument failing to discharge their obligation.	The office is exposed to credit risk in respect of its receivables (Note 9). No financial assets are past due or impaired.
Liquidity Risk	Liquidity risk refers to the situation where the Office may encounter difficulty in meeting obligations associated with financial liabilities that are settled by delivering cash or another financial asset.	The office is exposed to liquidity risk in respect of its payables (Note 11).
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 office is exposed to interest rate risk on the cash held. Changes in interest rates have a minimal effect on the offices operating results.

Risk Exposure	Measurement Method	Risk Management Strategies
Credit risk	Ageing analysis, earnings at risk	The office proactively pursues the recoverability of monies owed to them. Exposure to credit risk is monitored on an ongoing basis.
Liquidity risk	Sensitivity analysis	The office reduces exposure to liquidity risk by ensuring the office 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.
Market risk	Interest rate sensitivity analysis	The office does not undertake any hedging in relation to interest risk. The office reduces its exposure to market risk by holding cash funds in Australian Financial Institutions.

#### 16. Events Occurring after Balance Date

There were no significant events occurring after balance date.

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## Office of the Health Ombudsman

### NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS 2017-18

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#### 17. Budgetary Reporting Disclosures

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

###### (a) Grants and Other Contributions

The 2017–18 budget figures originated from the office's commencement in the 2014–15 financial year. Since the OHO's inception, it has never participated in a Cabinet Budget Review Committee (CBRC) submission process to adjust budget requirements. Consequently, year-on-year the OHO has had to seek gap funding from Queensland Health to ensure business continuity. The gap funding for the 2017–18 financial year was \$6.5 million.

###### (b) Employee Expenses

The 2017–18 budget figures originated from the office's commencement in the 2014–15 financial year. At commencement of the office, the provision of FTE was inadequate. The office ended the first financial year (2014–15) with a workforce of 98 FTE and, more recently, at 30 June 2017 ended with 131 FTE. Our budgeted FTE as stated in the 2018–19 Service Delivery Statements comprises 137 FTE.

The variance between actual and budgeted FTE relates to a number of positions either remaining vacant and not being backfilled or being backfilled by employment agency staff.

###### (c) Supplies and Services

The 2017–18 budget figures originated from the office's commencement in the 2014–15 financial year.

The increase in supplies and services of \$1.732 million is due to higher expenses arising from the growth in the agency's activities requiring:

- The lease of additional office space (increase of approx. \$225,000 when comparing to budgeted 2017–18 financial year figures)
- The use of external agency contractors to backfill vacant positions (increase of approx. \$630,000 when comparing to budgeted 2017–18 financial year figures). This is a process the office is reducing to comply with the Queensland Government employment security policy.
- The use of consultancy services, particularly in the areas of clinical opinion, Crown Law and change management (increase of approx. \$275,000 when comparing to budgeted 2017–18 financial year figures)
- A combined increase of \$602,000 in the following areas:
  - external legal advice
  - special payments on cases awarded against the OHO
  - renewal of software licences, software upgrades and purchase of new plant and equipment
  - property repairs and maintenance

##### Explanation of Major Variances - Statement of Financial Position

###### (d) Cash and Cash Equivalents

The 2017–18 cash budget figure of \$1.635 million originated from the Service Delivery Statements for 2017–18 and is explained in more detail in the Statement of cash flows. The budget figures are not reflective of our current income and expenditure.

###### (e) Receivables

The increase in receivables relates to the following:

- Higher than anticipated reimbursement for Leave Loading taken, accruing to a total claim of \$394,185
- Increase in Annual Leave reimbursements totalling \$95,815
- Increase in GST receivable totalling \$73,000

###### (f) Accrued Employee Benefits

The increase in accrued employee benefits relates to the following:

- Higher than anticipated payment for Leave Loading levy, accruing to a total payment of \$146,426.
- Increase in Annual Leave levy totalling \$39,574
- Increase in Salary and wage related expenses totalling \$86,000

## Office of the Health Ombudsman

### NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS 2017-18

#### 18. Key Management Personnel (KMP) Disclosures

##### Details of Key Management Personnel

Key management personnel (KMP) are those persons having authority and responsibility for planning, directing and controlling the activities of the Office, directly or indirectly, including the Health Ombudsman, Executive Directors and Directors. The Office's Minister is recognised as part of the Office of the Health Ombudsman's KMP, consistent with additional guidelines included in the revised version of AASB 124 *Related Party Disclosures*. That Minister is the Minister for Health and Minister for Ambulance Services.

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 2017-18 and 2016-17. 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 offices 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.

Ministerial remuneration entitlements are outlined in the Legislative Assembly of Queensland's Members' Remuneration Handbook. The Office does not bear any cost of remuneration of Ministers. The majority of Ministerial entitlements are paid by the Legislative Assembly, with the remaining entitlements being provided by Ministerial Services Branch within the Department of the Premier and Cabinet. As all Ministers are reported as KMP of the Queensland Government, aggregate remuneration expenses for all Ministers is disclosed in the Queensland General Government and Whole of Government Consolidated Financial Statements, which are published as part of Queensland Treasury's Report on State Finances.

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.

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## ***Office of the Health Ombudsman***

### **NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS 2017-18**

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#### **18. 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.



## Office of the Health Ombudsman

### NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS 2017-18

#### 18. Key Management Personnel (KMP) Disclosures (contd)

##### 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.

##### 2017-18

Position	Short Term Employee Expenses		Long Term Employee Expenses \$'000	Post-Employment Expenses \$'000	Termination Benefits \$'000	Total Expenses \$'000
	Monetary Expenses	Non-Monetary Benefits				
	\$'000	\$'000				
<i>Health Ombudsman</i>						
Current	266	3	5	15	0	289
Former	195	4	4	21	9	233
<i>Executive Director, Assessment &amp; Resolution</i>						
Current	195	4	4	20	0	223
Temporary Relieving	32	0	1	3	0	36
<i>Executive Director, Investigations</i>						
Current	191	0	4	19	0	214
Temporary Relieving	12	0	0	2	0	14
<i>Executive Director, Legal Services</i>						
Temporary Relieving	169	0	3	12	0	184
Former	116	1	13	13	126	269
<i>Director, Business Innovation</i>						
Current	152	0	3	18	0	173
Temporary Relieving	64	0	1	7	0	72
<b>Total Remuneration</b>	<b>1,392</b>	<b>12</b>	<b>38</b>	<b>130</b>	<b>135</b>	<b>1,707</b>

##### 2016-17

Position	Short Term Employee Expenses		Long Term Employee Expenses \$'000	Post-Employment Expenses \$'000	Termination Benefits \$'000	Total Expenses \$'000
	Monetary Expenses	Non-Monetary Benefits				
	\$'000	\$'000				
<i>Health Ombudsman</i>						
Current	369	-	8	42	-	419
<i>Executive Director, Assessment &amp; Resolution</i>						
Current	193	-	4	20	-	217
<i>Executive Director, Investigations</i>						
Former	203	-	4	19	57	283
Temporary Relieving	89	-	2	7	-	98
<i>Executive Director, Legal Services</i>						
Current	181	-	4	19	-	204
<i>Director, Business Innovation</i>						
Current	150	-	3	18	-	171
<b>Total Remuneration</b>	<b>1,185</b>	<b>0</b>	<b>25</b>	<b>125</b>	<b>57</b>	<b>1,392</b>

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## Office of the Health Ombudsman

### NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS 2017-18

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#### 19. 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 4).

The Office of the Health Ombudsman holds two leases through the Queensland Government Accommodation Office, Department of Housing and Public Works (refer Note 6 and 13).

The Office of the Health Ombudsman has a service level agreement with the Corporate Administration Agency (refer Note 6 - Corporate service charges).

#### 20. 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 2017-18.

##### **Accounting Standards Early Adopted**

No Australian Accounting Standards have been early adopted for 2017-18.

##### **Accounting Standards Applied for the First Time**

No Australian Accounting Standards have been applied for the first time for 2017-18.

#### 21. 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.

##### **AASB 16 Leases**

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

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

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## ***Office of the Health Ombudsman***

### **NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS 2017-18**

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#### **21. Future Impact of Accounting Standards Not Yet Effective (contd)**

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. Agencies will apply the new defined retrospective approach when adopting AASB 16 for the first time, meaning that the 2018-19 contingencies will not be re-stated.

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. The exact impact will not be known until the year of transition. However, assuming the agency's current operating lease commitments (see Note 13) were recognised 'on-balance sheet' at transition, the expected increase in lease liabilities (with a corresponding right-of-use asset) is estimated to be \$1.748M. The reclassification between supplies and services expense and depreciation/interest has not yet been estimated.

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.

## Certification of financial statements

### Management Certificate for the Office of the Health Ombudsman

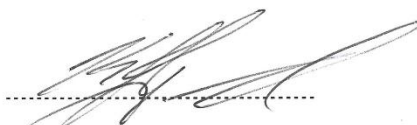
These general purpose financial statements have been prepared pursuant to section 62(1) of the *Financial Accountability Act 2009* (the Act), section 43 of the *Financial and Performance Management Standard 2009* and other prescribed requirements. In accordance with section 62(1)(b) of the Act we certify 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 2018 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: Andrew Brown  
Title: Health Ombudsman

Date: 30/8/2018



Name: Kieran Gard  
Title: A/Director, Business Innovation

Date: 30/08/2018



### 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 (OHO).

In my opinion, the financial report:

- a) gives a true and fair view of the entity's financial position as at 30 June 2018, 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 2018, 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.

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.

#### **Report on other legal and regulatory requirements**

In accordance with s.40 of the *Auditor-General Act 2009*, for the year ended 30 June 2018:

- 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.



31 August 2018

C G Strickland  
as delegate of the Auditor-General

Queensland Audit Office  
Brisbane

## Appendix 6—Open data

Additional annual report disclosures for 2017–18 are published on the Queensland Government's open data website at [www.data.qld.gov.au](http://www.data.qld.gov.au), including expenditure for:

- consultancies
- Queensland Language Services Policy.

No expenditure on overseas travel was incurred during 2017–18.

## Appendix 7—Compliance checklist

Summary of requirement		Basis for requirement	Annual report reference
Letter of compliance	<ul style="list-style-type: none"> <li>A letter of compliance from the accountable officer or statutory body to the relevant Minister/s</li> </ul>	ARRs – section 7	Page 4
Accessibility	<ul style="list-style-type: none"> <li>Table of contents</li> <li>Glossary</li> </ul>	ARRs – section 9.1	Pages 1–2 Pages 77–82
	<ul style="list-style-type: none"> <li>Public availability</li> </ul>	ARRs – section 9.2	Inside front cover
	<ul style="list-style-type: none"> <li>Interpreter service statement</li> </ul>	<i>Queensland Government Language Services Policy</i> ARRs – section 9.3	Inside front cover
	<ul style="list-style-type: none"> <li>Copyright notice</li> </ul>	<i>Copyright Act 1968</i> ARRs – section 9.4	Inside front cover
	<ul style="list-style-type: none"> <li>Information licensing</li> </ul>	<i>QGEA – Information Licensing</i> ARRs – section 9.5	Inside front cover
General information	<ul style="list-style-type: none"> <li>Introductory information</li> </ul>	ARRs – section 10.1	Pages 5–7
	<ul style="list-style-type: none"> <li>Agency role and main functions</li> </ul>	ARRs – section 10.2	Pages 10–12
	<ul style="list-style-type: none"> <li>Machinery of Government changes</li> </ul>	ARRs – sections 31 and 32	N/A
	<ul style="list-style-type: none"> <li>Operating environment</li> </ul>	ARRs – section 10.3	Pages 5–9, 74–75
Non-financial performance	<ul style="list-style-type: none"> <li>Government’s objectives for the community</li> </ul>	ARRs – section 11.1	Pages 18–19, 83–85
	<ul style="list-style-type: none"> <li>Other whole-of-government plans/specific initiatives</li> </ul>	ARRs – section 11.2	N/A
	<ul style="list-style-type: none"> <li>Agency objectives and performance indicators</li> </ul>	ARRs – section 11.3	Pages 18–55
	<ul style="list-style-type: none"> <li>Agency service areas and service standards</li> </ul>	ARRs – section 11.4	Pages 18–19
Financial performance	<ul style="list-style-type: none"> <li>Summary of financial performance</li> </ul>	ARRs – section 12.1	Pages 66–67
Governance—management and structure	<ul style="list-style-type: none"> <li>Organisational structure</li> </ul>	ARRs – section 13.1	Page 13
	<ul style="list-style-type: none"> <li>Executive management</li> </ul>	ARRs – section 13.2	Pages 68–70
	<ul style="list-style-type: none"> <li>Government bodies (statutory bodies and other entities)</li> </ul>	ARRs – section 13.3	N/A

Summary of requirement		Basis for requirement	Annual report reference
	<ul style="list-style-type: none"> <li>Public Sector Ethics Act 1994</li> </ul>	Public Sector Ethics Act 1994 ARRs – section 13.4	Page 61
	<ul style="list-style-type: none"> <li>Queensland public service values</li> </ul>	ARRs – section 13.5	Page 11
Governance—risk management and accountability	<ul style="list-style-type: none"> <li>Risk management</li> </ul>	ARRs – section 14.1	Page 60–61
	<ul style="list-style-type: none"> <li>Audit committee</li> </ul>	ARRs – section 14.2	Page 62
	<ul style="list-style-type: none"> <li>Internal audit</li> </ul>	ARRs – section 14.3	Page 62
	<ul style="list-style-type: none"> <li>External scrutiny</li> </ul>	ARRs – section 14.4	Page 59–60
	<ul style="list-style-type: none"> <li>Information systems and recordkeeping</li> </ul>	ARRs – section 14.5	Page 54
Governance—human resources	<ul style="list-style-type: none"> <li>Strategic workforce planning and performance</li> </ul>	ARRs – section 15.1	Pages 71–72
	<ul style="list-style-type: none"> <li>Early retirement, redundancy and retrenchment</li> </ul>	Directive no.11/12 <i>Early Retirement, Redundancy and Retrenchment</i> Directive no.16/16 <i>Early Retirement, Redundancy and Retrenchment</i> (from 20 May 2016) ARRs– section 15.2	Page 72
Open data	<ul style="list-style-type: none"> <li>Statement advising publication of information</li> </ul>	ARRs – section 16	Page 153
	<ul style="list-style-type: none"> <li>Consultancies</li> </ul>	ARRs – section 33.1	Online
	<ul style="list-style-type: none"> <li>Overseas travel</li> </ul>	ARRs – section 33.2	N/A
	<ul style="list-style-type: none"> <li>Queensland Language Services Policy</li> </ul>	ARRs – section 33.3	Online
Financial statements	<ul style="list-style-type: none"> <li>Certification of financial statements</li> </ul>	FAA – section 62 FPMS – sections 42, 43 and 50 ARRs – section 17.1	Page 150
	<ul style="list-style-type: none"> <li>Independent Auditor’s Report</li> </ul>	FAA – section 62 FPMS – section 50 ARRs – section 17.2	Pages 151–152

FAA Financial Accountability Act 2009

FPMS Financial and Performance Management Standard 2009

ARRs Annual report requirements for Queensland Government agencies









Office of the  
**HEALTH  
OMBUDSMAN**

*Listen. Respond. Resolve.*