



# **Inquiry into the performance of the Health Ombudsman's functions pursuant to section 179 of the *Health Ombudsman Act 2013***

**Report No. 31, 55th Parliament  
Health, Communities, Disability Services and Domestic  
and Family Violence Prevention Committee  
December 2016**



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Health Ombudsman's functions  
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**Report No. 31, 55<sup>th</sup> Parliament**

**Health, Communities, Disability Services and Domestic and Family  
Violence Prevention Committee**

**December 2016**



# Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee

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## Abbreviations and glossary

AHPRA	Australian Health Practitioner Regulation Agency
AHWMC	Australian Health Workforce Ministerial Council
ALA	Australian Lawyers Alliance
AMAQ	Australian Medical Association Queensland
COAG	Council of Australian Governments
the committee	Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee
the department	Queensland Health
HCCC	Health Care Complaints Commission (NSW)
HCCC Act	<i>Health Care Complaints Act 1993 (NSW)</i>
HCEs	Health Complaints Entities
health complaints system	Queensland health service complaints management system – comprising of the Office of the Health Ombudsman, Australian Health Practitioner Regulation Agency and the National Boards
HO Act	<i>Health Ombudsman Act 2013</i>
HQCC	Health Quality and Complaints Commission
HRC	Health Rights Commission
HSCEF	Health Service Chief Executives' Forum
KPI	Key Performance Indicators
MBQ	Medical Board of Queensland
MIGA	Medical Insurance Group Australia
MIPS	Medical Indemnity Protection Society
Minister	Minister for Health and Minister for Ambulance Services
National Boards	Fourteen health practitioner national boards that are responsible for regulating their profession
National Law	<i>Health Practitioner Regulation National Law Act 2009</i>
NCAT	New South Wales Civil and Administrative Tribunal
NRAS	National Registration and Accreditation Scheme

NSW	New South Wales
OHO	Office of the Health Ombudsman
POQA	<i>Parliament of Queensland Act 2001</i>
Professional Councils	Statutory bodies established under the National Law (NSW) to manage complaints about conduct, performance and health matters concerning registered health practitioners practising in NSW
QBMBA	Queensland Board of the Medical Board of Australia
QBNMBA	Queensland Board of the Nursing and Midwifery Board of Australia
QCAT	Queensland Civil and Administrative Tribunal
QMB	Queensland Medical Board
QNU	Queensland Nurses' Union
QPS	Queensland Police Service
Standing Orders	Standing Rules and Orders of the Legislative Assembly of Queensland

## Chair's foreword

On behalf of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee of the 55th Parliament, I present this report on the committee's inquiry into the performance of the Health Ombudsman's functions pursuant to section 179 of the *Health Ombudsman Act 2013*.

This is the committee's first report as part of its monitoring and oversight responsibilities in relation to Queensland's health service complaints management system. The system is comprised of the Office of the Health Ombudsman (OHO), Australian Health Practitioner Regulation Agency (AHPRA) and the national registered health practitioner boards (National Boards).

The management of health service complaints in Queensland underwent a significant shift in 2014 with the establishment of the Office of the Health Ombudsman under the *Health Ombudsman Act 2013* (HO Act) – which transferred investigation of serious professional conduct complaints about health practitioners to the OHO, instead of AHPRA and the National Boards, which deal with such matters in most other Australian jurisdictions.

The committee's inquiry was informed by: the Health Ombudsman's and AHPRA's annual reports and monthly and quarterly performance reports; the OHO's reports on the performance of AHPRA and the National Boards in Queensland; evidence provided by the Health Ombudsman, AHPRA, Queensland Health and stakeholders at the committee's public briefings and hearings; and submissions to the inquiry from stakeholders and concerned citizens.

It is acknowledged that the creation of a new organisation takes time, and the embedding of that organisation into an existing system will always require a period of adjustment.

Significant concerns were raised however, that after two-and-a-half years, the OHO is failing to meet its statutory timeframes. For example, the OHO, in 2015-16, only met its statutory timeframe of seven days to reach an initial decision in 49 per cent of complaints and its statutory timeframe to complete an investigation in one year in 53 per cent of complaints.

In addition to the time taken to consider and finalise complaints, stakeholders also raised concerns regarding a perceived limited use of clinical advice in decisions about complaints, inconsistency between the OHO and AHPRA and the National Boards' data on health service complaints, potential deficiencies in information sharing, and how the OHO engages with stakeholders.

The committee's role in monitoring the health complaints system is to ensure that the public interest is being served.

The committee did not consider it necessary at this stage to make fundamental changes to the health complaints system, as preferred by a number of key stakeholders. The committee instead resolved to use the information and evidence gathered during its inquiry, including the views expressed by stakeholders, to make a number of initial recommendations aimed at improving the performance of the Queensland health complaints system, as well as identifying the areas the committee will focus on during 2016-17, as part of its ongoing monitoring and oversight role.

On behalf of the committee, I would like to thank the Health Ombudsman, and his staff, and representatives of AHPRA and the National Boards for their assistance during the inquiry. Thank you also to those individuals and organisations who lodged written submissions and appeared at the committee's public hearings.

Finally, I would like to thank my fellow committee members and the committee secretariat for their support.

I commend the report to the House.



**Leanne Linard MP**  
**Chair**

## Recommendations

### Recommendation 1

45

The committee recommends that the Queensland Government investigate the merits of amending the *Health Ombudsman Act 2013* to introduce a joint consideration process for health service complaints between the OHO and AHPRA and the National Boards.

In undertaking its investigations, the committee recommends the joint consideration processes in place in New South Wales, under its co-regulatory approach, and other states and territories under the National Registration and Accreditation Scheme.

The committee also recommends that the Queensland Government consider the practicalities of introducing a joint consideration process, including:

- the potential benefits of merging the current initial decision and further assessment stages to create one assessment stage for complaints
- whether the current statutory timeframes for initial decisions and assessment would need to be amended to facilitate a joint consideration process, including with clinical input (where necessary)
- whether the current statutory 14 day timeframe for health service providers and complainants to make submissions and provide requested information is adequate to ensure decision-makers have sufficient information to make informed decisions, and
- how to ensure appropriate clinical input is available and utilised, where necessary, to inform any joint consideration of complaints.

### Recommendation 2

46

The committee recommends that the Queensland Government consider options for ensuring that potentially serious professional misconduct matters, which may also raises issues about a health practitioner's health or performance, are able to be dealt with, as a whole, rather than being split between the OHO and AHPRA and the National Boards.

### Recommendation 3

47

The committee recommends that the Office of the Health Ombudsman, AHPRA and the National Boards produce a joint plan, which identifies the information needs of all parties and any barriers to the sharing of information, and sets out an agreed approach for resolving any data issues that prevent the production of nationally-consistent data about health service complaints.

The committee recommends that the joint plan include agreed implementation dates for the actions identified in the plan.

### Recommendation 4

47

The committee recommends that the Queensland Government consider whether to introduce legislation to make the Health Ombudsman's suggested amendments to the *Health Ombudsman Act 2013* and the *Health Practitioner Regulation National Law Act 2009* (Qld).

# 1 Introduction

## 1.1 Role of committee

The Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee (the committee) is a portfolio committee of the Legislative Assembly.<sup>1</sup> The committee's areas of portfolio responsibility are:

- health and ambulance services
- communities, women, youth and child safety
- domestic and family violence prevention, and
- disability services and seniors.<sup>2</sup>

Section 179 of the *Health Ombudsman Act 2013* (the HO Act) provides that the committee has the following functions in relation to the Queensland health service complaints management system (health complaints system):

- to monitor and review the operation of the health complaints system
- to identify and report on particular ways in which the health complaints system might be improved
- to monitor and review the performance by the Health Ombudsman of its functions under the HO Act
- to monitor and review Australian Health Practitioner Regulation Agency (AHPRA) and the National Boards' (14 registered health practitioner boards) performance of their functions in relation to the health, conduct and performance of registered health practitioners who provide health services in Queensland
- to examine reports of the Health Ombudsman, AHPRA and the National Boards
- to advise the Minister in relation to the appointment of the Health Ombudsman, and
- to report to the Legislative Assembly on any matter referred to the committee by the Legislative Assembly or any other matter about the health complaints system that the committee considers should be brought to the Assembly's attention.

In addition, the committee has oversight responsibility for the Health Ombudsman under the *Parliament of Queensland Act 2001* and the Standing Rules and Orders of the Legislative Assembly (Standing Orders).<sup>3</sup>

The HO Act clarifies that it is not a function of the committee to re-investigate particular complaints or other matters or reconsider a decision, finding or recommendation of the Health Ombudsman, AHPRA or a National Board about a particular complaint or other matter.<sup>4</sup>

Further information about the work of the committee is available on its [website](#).

## 1.2 Reasons for inquiry

This is the committee's first report in relation to its role to monitor and review the Queensland health complaints system since the establishment of the Office of the Health Ombudsman (the OHO) on 1 July 2014.

The committee resolved to undertake an inquiry to broaden its understanding of the health complaints system, including the respective roles of the OHO, AHPRA and the National Boards, and to inform its ongoing monitoring role.

<sup>1</sup> The committee was formerly the Health and Ambulance Services Committee, which was established on 27 March 2015 under the *Parliament of Queensland Act 2001* (POQA) and the Standing Rules and Orders of the Legislative Assembly (Standing Orders). On 16 February 2016, the Parliament amended the Standing Orders, renaming the committee and expanding its areas of responsibility.

<sup>2</sup> POQA, s 88 and Standing Orders, so 194 and sch 6.

<sup>3</sup> POQA, s 88 and Standing Orders, so 194A and sch 6.

<sup>4</sup> *Health Ombudsman Act 2013*, s 179(2).

This report was informed by: the OHO's annual reports and monthly and quarterly performance reports; the OHO's reports on the performance of AHPRA and the National Boards in Queensland; evidence provided at the committee's public briefings and hearings; and stakeholders' views about the functioning of the Queensland health complaints system, including ways in which it might be improved.

The committee has used the information and evidence it has gathered during its inquiry, including the views expressed by stakeholders, to make a number of initial recommendations to the Queensland Government, the Health Ombudsman, AHPRA and the National Boards aimed at improving the performance of the Queensland health complaints system.

The committee has also refined its approach to the monitoring of the Queensland health complaints system and identified the areas it will focus on during the 2016-17 financial year – see section 7 of this report.

### **1.3 Committee's inquiry process**

On 27 June 2016, the committee resolved to conduct an inquiry into the performance of the Health Ombudsman's functions pursuant to section 179 of the HO Act. The terms of reference for the inquiry reflect the committee's statutory responsibilities in relation to the Queensland health complaints system. The terms of reference were:

- the operation of the health complaints system
- ways in which the health complaints system might be improved
- the performance by the Health Ombudsman of functions under the HO Act
- the National Boards' and AHPRA's performance of functions relating to the health, conduct and performance of registered health practitioners who provide health services in Queensland, and
- any other matter about the health complaints system.

During its inquiry, the committee:

- invited submissions from stakeholders. A list of the 55 submissions received and accepted by the committee is at **Appendix A**
- held public briefings on 31 August 2016 and 2 November 2016 attended by the Health Ombudsman, representatives from AHPRA and the National Boards and the President of the Australian Medical Association Queensland (AMAQ). A list of the attendees at the briefings is at **Appendix B**, and
- held public hearings on 12 and 20 October 2016 to hear from invited witnesses. A list of the witnesses who appeared at the hearings is at **Appendix B**.

Copies of the material published by the committee in relation to this inquiry are available on the committee's [website](#).



## 2 Health complaints systems in Australia

### 2.1 National Registration and Accreditation Scheme

#### 2.1.1 Introduction

In 2005 the Productivity Commission recommended the establishment of a national health registration scheme and a consolidated national accreditation scheme.<sup>5</sup> At this time, registration boards in each state and territory were responsible for health practitioner registration, some complaints, disciplinary matters and the management of impaired registrants. In Queensland, the registration boards included the Medical Board of Queensland (MBQ), the Queensland Nursing Council and registration boards for other health professions.<sup>6</sup>

In Queensland, the Health Rights Commission (the HRC) was responsible for receiving, assessing and resolving health service complaints, including conciliation and the investigation of complaints. The HRC was also responsible for identifying and reviewing issues arising out of health service complaints.<sup>7</sup>

The Productivity Commission considered that the fragmented and uncoordinated multiplicity of health practitioner registration boards, with their variable standards, inhibited workforce efficiency and effectiveness, hindered workforce innovation and flexibility across jurisdictional borders, and increased administrative and compliance costs.<sup>8</sup>

The Council of Australian Governments (COAG) agreed, in 2008, to establish the National Registration and Accreditation Scheme (NRAS) for health practitioners in Australia.<sup>9</sup> On 1 July 2010, the NRAS came into effect, with the enactment of *the Health Practitioner Regulation National Law Act 2009* (the National Law) in all states and territories except Western Australia, which joined the NRAS on 18 October 2010. Each state and territory has its own variant of the National Law.

New South Wales (NSW) joined the NRAS in relation to the centralised accreditation of training and courses and the health practitioner registration provisions, however, it opted to retain its existing health complaints system – see section 2.3 of this report.<sup>10</sup> Queensland initially joined the NRAS in its entirety; however, it established its own health complaints system in July 2014, with the establishment of the OHO under the HO Act. Similar to NSW, health practitioners in Queensland continue to be registered under the NRAS – see section 4 of this report.

#### 2.1.2 Key objectives

The key objectives of the NRAS are to:

- provide for the protection of the public by ensuring only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered
- facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or practise in more than one participating jurisdiction
- facilitate the provision of high-quality education and training for health practitioners
- facilitate access to services provided by health practitioners in accordance with the public interest, and
- enable the continuous development of a flexible, responsive and sustainable health workforce and enable innovation in the education of, and service delivery by, health practitioners.<sup>11</sup>

<sup>5</sup> Productivity Commission, *Australia's Health Workforce*, December 2005.

<sup>6</sup> Parliament of Queensland, 54<sup>th</sup> Parliament, Health and Community Services Committee, *Report No.27 – Health Ombudsman Bill 2013*, August 2013, p 5.

<sup>7</sup> *Health Rights Commission Act 1991*, section 10.

<sup>8</sup> Productivity Commission, *Australia's Health Workforce*, December 2005, p 136.

<sup>9</sup> Council of Australian Governments, *Intergovernmental Agreement for a National Registration and Accreditation Scheme for Health Professions*, 2008.

<sup>10</sup> Claudette S. Satchell et. al., 'Approaches to management of complaints and notifications about health practitioners in Australia', *Australian Health Review*, 2016, 40, p 313.

<sup>11</sup> *Health Practitioner Regulation National Law Act 2009* (National Law), s 3(2).

### 2.1.3 Key components

The key components of the NRAS are:

- **National Boards** – one for each of the 14 health professions<sup>12</sup> – responsible for regulating their profession, including establishing qualifications for registration, standards for practice, and education and continuing professional development and policies; approving the accreditation of programs leading to registration; and the registration of health practitioners.

In all states and territories, except NSW and Queensland (post 1 July 2014), the National Boards are also responsible for the management of complaints and notifications against registered health practitioners and students of the registered profession.<sup>13</sup> This involves the investigation, hearing and review of competence, conduct or impairment matters, except in the most serious cases that could result in suspension or cancellation of registration, which are dealt with by tribunals and external panels.

The National Boards may establish state and territory boards to exercise their functions in a jurisdiction, for example the Queensland Board of the Medical Board of Australia (QBMBA) and the Queensland Board of the Nursing and Midwifery Board of Australia (QBNMBA).<sup>14</sup>

The National Boards and their state and territory boards and committees consist of practitioner members and community members appointed by the Australian Health Workforce Ministerial Council (AHWMC).<sup>15</sup>

- **Australian Health Practitioner Regulation Agency (AHPRA)** – supports the regulatory work of the National Boards by providing governance and administrative support to enable the boards to carry out their legislative responsibilities. AHPRA has offices in each state and territory. In particular, AHPRA has the following functions and responsibilities:
  - to publish national registers of practitioners
  - to manage the registration and renewal processes for health practitioners and students around Australia
  - on behalf of the National Boards, to manage investigations into the professional conduct, performance or health of registered health practitioners (except in NSW and Queensland (post 1 July 2014))
  - to work with the health complaints entities in each state and territory to make sure the appropriate organisation deals with community concerns about individual, registered health practitioners
  - to support the National Boards in the development of registration standards, codes and guidelines, and
  - to provide advice to the AHWMC about the administration of the NRAS
- **Accreditation authorities** for each health profession – develop standards for the education and training of health professionals
- **Agency Management Committee** – responsible for overseeing AHPRA policy and ensuring AHPRA functions properly, effectively and efficiently in working with the National Boards. Members are appointed by the AHWMC, and
- **Australian Health Workforce Ministerial Council (AHWMC) and Advisory Council** – AHWMC comprises of Commonwealth, State and Territory Health Ministers and provides high-level decision-making and ministerial oversight of the NRAS. The Advisory Council comprises heads of health departments from the states and territories, and provides independent advice to the AHWMC about NRAS related matters.

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<sup>12</sup> The NRAS comprises of the following 14 National Boards: Aboriginal and Torres Strait Islander Health Practice; Chinese Medicine; Chiropractic; Dental; Medical; Medical Radiation Practice; Nursing and Midwifery; Occupational Therapy; Optometry; Osteopathy; Pharmacy; Physiotherapy; Podiatry; and Psychology.

<sup>13</sup> National Law, s 35.

<sup>14</sup> National Law, s 36.

<sup>15</sup> National Law, s 33.

The NRAS is a profession-based, self-funded model. The National Law provides for AHPRA to enter into a health profession agreement with each National Board to set fees, and for AHPRA to administer a fund on behalf of each National Board.

## 2.2 State and territory health complaints entities

In addition to the NRAS, states and territories have their own Health Complaints Entities (HCEs). The roles and functions of HCEs vary between states and territories. In general, HCEs are responsible for the resolution, including through conciliation, of complaints not relating to the conduct, performance or health of registered practitioners, such as complaints regarding health system issues, service safety, quality improvement, unregistered health practitioners and matters that may lead to financial compensation.<sup>16</sup>

In Queensland, the Health Quality and Complaints Commission (HQCC) performed this role until the establishment of the OHO on 1 July 2014. The OHO is now responsible for some of the roles previously performed by the HQCC including to identify and deal with health service issues and identify and report on systemic issues in the provision of health services, including issues affecting the quality of health services.<sup>17</sup>

## 2.3 NSW health complaints system – co-regulatory approach

As mentioned above, in NSW health practitioners are registered under the NRAS, however, complaints about health practitioners are dealt with under NSW state-based laws. This approach has been described as a co-regulatory model. The key components of the NSW co-regulatory model are:

- the Health Care Complaints Commission (HCCC) – which protect public health and safety by dealing with complaints about health practitioners and organisations<sup>18</sup>
- the Health Professional Councils (Professional Councils) – statutory bodies established under the National Law (NSW) to manage complaints about conduct, performance and health matters concerning registered health practitioners practising in NSW. The Professional Councils mirror the 14 National Boards, and
- the Health Professionals Councils Authority – an administrative unit which provides shared executive and corporate services to the Professional Councils to support their regulatory functions.

In NSW, health service complaints may be made to the HCCC, AHPRA or the relevant Professional Council. All complaints about NSW health practitioners are passed to the HCCC for its consideration.

The HCCC is required to assess a complaint and decide how to proceed with the matter within 60 days of receipt. The *Health Care Complaints Act 1993* (HCCC Act) and the National Law (NSW) provide that the HCCC and relevant Professional Council must consult each other before any action is taken.<sup>19</sup>

After assessing a matter, and consulting the relevant Professional Council, the HCCC may decide to:

- take no further action
- refer the matter for conciliation
- refer the matter to the relevant health service provider for local resolution
- investigate the matter
- refer the matter to the relevant Professional Council, which may lead to a decision by the Council to: require the practitioner to undergo a performance or impairment assessment; caution or reprimand the practitioner; require the practitioner to undertake counselling, further education

<sup>16</sup> Claudette S. Satchell et. al., 'Approaches to management of complaints and notifications about health practitioners in Australia', *Australian Health Review*, 2016, 40, pp 312-313.

<sup>17</sup> *Health Ombudsman Act 2013*, s 25.

<sup>18</sup> *Health Care Complaints Act 1993* (NSW), s 3(2).

<sup>19</sup> *Health Care Complaints Act 1993* (NSW), ss 12 and 22; National Law (NSW), s 145A.

or training; impose conditions on a practitioner's registration; fine the practitioner; or refer the matter to the NSW Civil and Administrative Tribunal (NCAT) to consider disciplinary action,<sup>20</sup> or

- refer the complaint to a more appropriate agency.<sup>21</sup>

Following the investigation of a matter, the HCCC may refer the matter to the director of proceedings to consider whether to refer the matter to NCAT, refer the matter to the relevant Professional Council, make comments to the practitioner (where it has been established that there was poor treatment), or take no further action.<sup>22</sup>

The NCAT may take the following actions against a health practitioner:

- caution or reprimand
- order the withholding of payment or fees for a service
- impose conditions on a practitioner's registration
- order the practitioner to seek medical or psychiatric treatment
- order the practitioner to attend an educational course
- impose a fine, or
- suspend or cancel the practitioner's registration.<sup>23</sup>

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<sup>20</sup> National Law (NSW), s 146B.

<sup>21</sup> *Health Care Complaints Act 1993 (NSW)*, s 20.

<sup>22</sup> *Health Care Complaints Act 1993 (NSW)*, s 39.

<sup>23</sup> National Law (NSW), ss 149-149E.

### 3 Previous reports on the regulation of health practitioners in Queensland

The committee notes that there have been numerous reviews and inquiries concerning the regulation of health practitioners in Queensland over the last decade.

#### 3.1 Davies Inquiry and Forster Review

In 2005 two inquiries were commenced – the *Queensland Public Hospitals Commission of Inquiry*, headed by the Hon Geoffrey Davies AO QC (the Davies Inquiry) and the *Queensland Health Systems Review* (the Forster Review) – both of which examined the conduct of Dr Jayant Patel, a former surgeon at the Bundaberg Base Hospital, and identified deficiencies in the Queensland health complaints system.<sup>24</sup>

#### 3.2 Chesterman Report

In 2012, Mr Richard Chesterman AO RFD QC, a retired Supreme Court Judge, undertook an independent assessment of the regulation of medical practitioners in Queensland (the Chesterman Report).<sup>25</sup>

Mr Chesterman found that allegations that the Queensland Board of the Medical Board of Australia (QBMBA) had completely failed to maintain adequate standards of medical practice were not justified. Mr Chesterman did however, raise concerns about the manner in which the QBMBA discharged its disciplinary functions. In particular, Mr Chesterman raised concerns about how matters that may have constituted criminal misconduct (including patient deaths) had been dealt with, the time taken to complete investigations, and whether complaints were adequately addressed.<sup>26</sup>

Mr Chesterman made a number of recommendations in his report. The recommendations included a review of matters dealt with by the QBMBA and AHPRA to determine whether:

- criminal charges should have been laid in matters where a patient had died or suffered serious bodily harm, and
- the QBMBA made timely and appropriate responses to complaints in line with the objective to protect the public, uphold standards of medical practice and maintain public confidence in the medical profession.<sup>27</sup>

#### 3.3 Hunter Report

In response to the Chesterman Report, the then Minister for Health, Hon Lawrence Springborg MP, appointed Mr Jeffrey Hunter SC to review matters considered by the QBMBA, AHPRA and the former MBQ. Mr Hunter was asked to recommend whether any matters should have been referred to the Queensland Police Service (QPS) for investigation.

Mr Hunter identified six medical practitioners he considered should have been investigated to see whether criminal offences had been committed.<sup>28</sup>

<sup>24</sup> Forster P, *Queensland Health Systems Review – Final Report*, September 2005.

Davies G, *Queensland Public Hospitals Commission of Inquiry*, November 2005.

<sup>25</sup> Parliamentary Crime and Misconduct Committee, *A report of the Crime and Misconduct Commission's assessment of a public interest disclosure*, Report No.87, July 2012, pp 1-3.

<sup>26</sup> Parliamentary Crime and Misconduct Committee, *A report of the Crime and Misconduct Commission's assessment of a public interest disclosure*, Report No.87, July 2012, Appendix, pp 40-46.

<sup>27</sup> Parliamentary Crime and Misconduct Committee, *A report of the Crime and Misconduct Commission's assessment of a public interest disclosure*, Report No.87, July 2012, Appendix, pp 47-48.

<sup>28</sup> Hunter J R, *Review of files held by the Medical Board of Queensland, Queensland Board of the Medical Board of Australia and the Australian Health Practitioner Regulation Agency*, 28 February 2013, p 1.

### 3.4 Forrester Report

In addition, the then Minister for Health appointed a panel in 2013, led by Dr Kim Forrester, to review files of the QBMBA, AHPRA and the former MBQ to determine whether they were achieving their primary objective of protecting the public by ensuring medical practitioners were competent to practice.

The panel found:

- delays in the timeliness of notifications (complaints) progressing from receipt through the various assessment and disciplinary processes to a final decision by the Board
- a lack of consistency and predictability of outcomes in the Board's decisions across notifications of a similar nature, and
- considerable delays and inconsistencies in a significant number of files due to cross-jurisdictional referral, consultation and information-sharing obligations imposed under the existing legislation.<sup>29</sup>

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<sup>29</sup> Forrester K, Davies E and Houston J, *Chesterman Report Recommendation 2 Review Panel* (The Forrester Report), 5 April 2013, p 74.

## 4 Operation of the Queensland health complaints system – a co-regulatory approach

### 4.1 Introduction

Prior to 1 July 2014, health service complaints handling in Queensland was divided between:

- AHPRA and the National Boards – responsible for all complaints about the conduct, health or performance of registered health practitioners, and
- HQCC – responsible for the management of complaints about health service organisations and complaints about individual health service providers.

Similar to the current health complaints system, this scheme involved significant consultation and the cross-referral of complaints between AHPRA and the National Boards and the HQCC.

In response to the issues about the regulation of medical practitioners in Queensland raised in the Chesterman, Hunter and Forrester reports, the then Minister for Health introduced the Health Ombudsman Bill 2013 into the Legislative Assembly in June 2013. The HO Act subsequently came into effect in March 2014.

The main objects of the HO Act are to:

- protect the health and safety of the public
- promote professional, safe and competent practice by health practitioners and high standards of service delivery by health service organisations, and
- maintain public confidence in the management of complaints and other matters relating to the provision of health services.<sup>30</sup>

The HO Act provides that the main principle when administering the Act is that the health and safety of the public are paramount.<sup>31</sup>

The main aspects of the HO Act are the introduction of the OHO as the single entry point for health service complaints, additional statutory timeframes for key decisions in the complaints process and the regulation of unregistered health professionals (eg nutritionists, masseuses, naturopaths, homeopaths, dieticians, social workers and speech pathologists).

The HO Act also provides that all serious matters about registered health practitioners are to be dealt with by the OHO, with the option for the OHO to refer less serious matters to AHPRA and the National Boards. In doing so, the HO Act fundamentally changed the responsibility for the most serious professional conduct complaints against health practitioners – from AHPRA and the National Boards to the OHO. The HO Act also established state-based oversight and monitoring of the performance of the OHO, AHPRA and the National Boards in Queensland.

The OHO, AHPRA and the National Boards have a shared responsibility for managing complaints about registered health practitioners and upholding the paramount guiding principle of protecting the health and safety of the public.<sup>32</sup> Health practitioners continue to be registered under the NRAS administered by AHPRA and the National Boards in Queensland.

<sup>30</sup> *Health Ombudsman Act 2013*, s 3.

<sup>31</sup> *Health Ombudsman Act 2013*, s 4.

<sup>32</sup> AHPRA and National Boards, submission 48, p 2.

## 4.2 Establishment of the Office of the Health Ombudsman

The current Health Ombudsman was appointed by the Governor-in-Council, on the recommendation of the Minister for Health, for a four year term in January 2014. The OHO commenced operation on 1 July 2014.<sup>33</sup>

The main functions of the OHO are to:

- receive health service complaints and take relevant action to deal with them under the HO Act
- identify and deal with health service issues by undertaking investigations, inquiries and other relevant action
- identify and report on systemic issues in the way health services are provided, including issues affecting the quality of health services
- monitor the AHPRA and the National Boards' performance of their functions relating to the health, conduct and performance of registered health practitioners who provide health services in Queensland
- provide information to the public, health practitioners and health service organisations about providing health services in a way that minimises health service complaints and resolving health service complaints
- report to the Minister and the parliamentary committee about the administration of the health complaints system, the performance of the Health Ombudsman's functions and the performance of AHPRA and the National Boards' functions relating to the health, conduct and performance of registered health practitioners who provide health services in Queensland, and
- publish reports about the health complaints system.<sup>34</sup>

## 4.3 Overview of the Queensland health complaints system

The following section provides an overview of the Queensland health complaints system, including a description of the respective roles of the OHO, AHPRA and the National Boards.

### 4.3.1 Health service complaints

Unique to Australian health complaints systems, the OHO is the single point of entry for all health service complaints in Queensland. Under the Queensland health complaints system, all *health service complaints* are made to the OHO – either orally or in writing.<sup>35</sup> A health service complaint is defined as a complaint about a health service<sup>36</sup> or other service provided by a health service provider.<sup>37</sup>

The Health Ombudsman advised that the definition of *health service* is very broad, encompassing '... all registered health practitioners (such as doctors, nurses, dentists, etc.), as well as unregistered health practitioners (such as masseuses, nutritionists, counsellors, etc.) and any health service organisation delivering health services'.<sup>38</sup> The definition of *health service* also includes support services, such as business support (catering, cleaning or laundry), clinical support (pathology or blood management services) and corporate support (human resource management and information and communication technology support).<sup>39</sup>

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<sup>33</sup> *Health Ombudsman Act 2013*, ss 245 and 247.

<sup>34</sup> *Health Ombudsman Act 2013*, s 25.

<sup>35</sup> *Health Ombudsman Act 2013*, s 11 and 33.

<sup>36</sup> The term *health service* is defined as a service that is, or purports to be, a service for maintaining, improving, restoring or managing people's health and wellbeing. A health service may be provided to a person at any place including a hospital, residential care facility, community health facility or home – *Health Ombudsman Act 2013*, s 7.

<sup>37</sup> *Health Ombudsman Act 2013*, section 31.

<sup>38</sup> Health Ombudsman, submission 45, p 4.

<sup>39</sup> Health Ombudsman, submission 45, p 4.



### 4.3.2 Health service complaint processes

The HO Act provides that, within seven days of receiving a complaint, the OHO must make an initial decision about whether to accept the complaint and take particular relevant action,<sup>40</sup> or take no further action (eg, if the complaint is considered frivolous, vexatious, trivial, not made in good faith, is misconceived or being adequately dealt with by another appropriate entity).<sup>41</sup>

The HO Act provides that the OHO may take the following *relevant actions* in relation to a complaint:

<b>Immediate action:</b>	<p>The OHO may, as an interim step to protect public health or safety, take immediate registration action to suspend, or impose conditions on a registered health practitioner's registration.</p> <p>The OHO may, if satisfied on reasonable grounds that it is necessary to protect public health or safety, issue an interim prohibition order to an unregistered health practitioner prohibiting the practitioner from providing a health service or imposing restrictions on the provision of any health service by the practitioner.</p> <p>After taking immediate action, the OHO must decide to investigate the matter, refer the matter to AHPRA and the National Boards (if the matter relates to a registered health practitioner), or refer the matter to the director of proceedings.<sup>42</sup></p>
<b>Local resolution:</b>	<p>The OHO may attempt to facilitate the local resolution of a complaint between the complainant and relevant health service provider. The local resolution of a complaint may result in an explanation or an apology from the relevant health service provider. In addition, the health service provider may agree to change its practice, policies or procedures to improve its services.</p> <p>If the complaint is not resolved within 30 days, the OHO must decide whether to take another relevant action or take no further action. The Health Ombudsman may extend the 30 day timeframe by a further period of up to 30 days.<sup>43</sup></p>
<b>Assessment:</b>	<p>The OHO may decide to assess a complaint to obtain and analyse information relevant to the complaint and decide the most appropriate way to further deal with it. An assessment may include: analysing information and submissions; communicating with the complainant and relevant health service provider; and consulting with an entity with relevant technical expertise.</p> <p>A complainant or health service provider must respond to an invitation to make a submission or request for information (eg, patient files and records) within 14 days.</p> <p>The OHO must complete its assessment within 30 days. The Health Ombudsman may extend the period for assessment by a further period of up to 30 days, if necessary because of the size or complexity of the complaint or time taken to obtain submissions or information.</p> <p>After an assessment, the OHO must decide whether to take no further action or to take another relevant action to further deal with the complaint (eg, investigation, local resolution or referring the matter to AHPRA or another entity).<sup>44</sup></p>

<sup>40</sup> Health Ombudsman Act 2013, s 35.

<sup>41</sup> Health Ombudsman Act 2013, s 44.

<sup>42</sup> Health Ombudsman Act 2013, ss 57-79.

<sup>43</sup> Health Ombudsman Act 2013, ss 51-56.

<sup>44</sup> Health Ombudsman Act 2013, ss 45-50.

<b>Conciliation:</b>	<p>Voluntary conciliation is privileged and confidential and is a forum to resolve complaints by open and direct discussion and negotiation between the parties. Conciliation is suited to more complex complaints, which require detailed explanations or confidential dispute resolution.<sup>45</sup></p> <p>Possible outcomes from conciliation include: an explanation from the health service provider; a change in practice, policy and procedure; an apology or compensation (limited to out-of-pocket expenses and/or corrective treatment costs).<sup>46</sup></p> <p>The OHO (non-statutory) performance target is four months to assess the viability of successful conciliation.</p>
<b>Investigation:</b>	<p>The OHO has broad powers to investigate complaints, including the power to require information, enter premises and seize items with a warrant.<sup>47</sup> An investigation may be about the subject of a complaint, a possible systemic issue about the provision of a health service, or any other matter. In addition, the Minister may direct the OHO to investigate a matter.<sup>48</sup></p> <p>An investigation must be completed within one year after the decision to investigate. The Health Ombudsman may extend the one year period for additional periods of up to three months. Any extensions must be recorded in a public register on the OHO's website.<sup>49</sup></p> <p>If an investigation is not completed within two years, the Health Ombudsman must notify the Minister and the parliamentary committee, stating why the investigation has not been completed.<sup>50</sup></p> <p>After an investigation, the OHO must decide whether to take no further action or take another relevant action.<sup>51</sup></p>
<b>Referral to AHPRA and National Boards:</b>	<p>The OHO may refer a complaint to AHPRA and the National Boards, unless it is a serious matter. A serious matter is one that indicates:</p> <ul style="list-style-type: none"> <li>• the practitioner may have behaved in a way that constitutes <i>professional misconduct</i>,<sup>52</sup> or</li> <li>• another ground may exist for the suspension or cancellation of the practitioner's registration.<sup>53</sup></li> </ul> <p>The OHO must consult with AHPRA prior to referring any matter and provide AHPRA with all relevant information about the matter.<sup>54</sup></p> <p>Further details about how AHPRA and the National Boards deal with complaints referred to them is at section 4.3.3.</p>

<sup>45</sup> *Health Ombudsman Act 2013*, ss 134-150.

<sup>46</sup> Office of the Health Ombudsman (OHO) website, *Conciliating a complaint*, accessed on 10 November 2016 from <http://www.oho.qld.gov.au/health-consumers/the-complaints-process/conciliating-a-complaint/>

<sup>47</sup> *Health Ombudsman Act 2013*, ss 186-244.

<sup>48</sup> *Health Ombudsman Act 2013*, s 81.

<sup>49</sup> *Health Ombudsman Act 2013*, s 85; the OHO's investigation register is available at <http://www.oho.qld.gov.au/news-updates/investigations-register/>

<sup>50</sup> *Health Ombudsman Act 2013*, s 85.

<sup>51</sup> *Health Ombudsman Act 2013*, s 90.

<sup>52</sup> The term *professional misconduct* is defined as: unprofessional conduct by the practitioner that amounts to conduct that is substantially below the standard reasonably expected of a registered health practitioner of an equivalent level of training or experience; more than one instance of unprofessional conduct that, when considered together, amounts to conduct that is substantially below the standard reasonably expected of a registered health practitioner of an equivalent level of training or experience; or conduct of the practitioner, whether occurring in connection with the practice of the health practitioner's profession or not, that is inconsistent with the practitioner being a fit and proper person to hold registration in the profession – National Law, s 5.

<sup>53</sup> *Health Ombudsman Act 2013*, s 91.

<sup>54</sup> *Health Ombudsman Act 2013*, s 91.

<b>Referral to another entity:</b>	The OHO may refer a matter to another entity, such as the QPS, the Office of the State Coroner, the Crime and Corruption Commission, Medicare, the Therapeutic Goods Administration or the Australian Federal Police. <sup>55</sup>
<b>Referral to the director of proceedings and QCAT:</b>	<p>The OHO may decide to refer a complaint to the director of proceedings for consideration as to whether to refer the matter to the Queensland Civil and Administrative Tribunal (QCAT).<sup>56</sup></p> <p>If a matter is referred to QCAT, the tribunal may decide, in relation to a matter concerning a registered health practitioner to: caution or reprimand the practitioner; impose a condition on a practitioner's registration; require the practitioner to pay a fine; suspend the practitioner's registration for a specified period; or cancel the practitioner's registration and disqualify the practitioner from applying for registration indefinitely or a period of time.<sup>57</sup></p> <p>If QCAT decides that an unregistered health practitioner poses a serious risk to persons, it may make an order: prohibiting the practitioner from providing any health services or a stated health service; or imposing restrictions on the provisions of any health service or stated health service.<sup>58</sup></p>

### 4.3.3 Referral to AHPRA and National Boards

AHPRA must deal with complaints referred to it by the OHO under the National Law (Queensland). The National Law (Queensland) provides that AHPRA must immediately refer a complaint to the relevant National Board, and the board must, within 60 days, conduct a preliminary assessment of the matter.

The National Board must decide:

- whether the matter relates to a person who is a health practitioner registered by the board, and
- whether the referred matter relates to a matter that is a ground for notification (eg practitioner's professional conduct is of a lesser standard than reasonably expected, the practitioner has an impairment or the practitioner's knowledge, skill or judgment is below the standard reasonably expected).<sup>59</sup>

A National Board may decide to:

- take no further action – if, for example, the board reasonably believes the matter is frivolous, vexatious, misconceived or lacking in substance
- take immediate action – suspend or impose conditions on a practitioner's registration, accept an undertaking from the health practitioner, or accept the surrender of the practitioner's registration, if the board reasonably believes the action is necessary, as an interim step, to protect public health or safety while the matter is being dealt with by the board
- investigate the matter – the board must direct an appropriate person (AHPRA employee) to conduct the investigation. Investigations are to be conducted as quickly as practicable, having regard to the nature of the matter to be investigated, or
- require a practitioner to undergo a health assessment or a performance assessment – the board may require a practitioner to undergo a health assessment, if it reasonably believes the practitioner has, or may have, an impairment or a performance assessment, if it reasonably believes the way the practitioner practises the profession is, or may be, unsatisfactory.

<sup>55</sup> *Health Ombudsman Act 2013*, s 92.

<sup>56</sup> *Health Ombudsman Act 2013*, ss 101-105.

<sup>57</sup> *Health Ombudsman Act 2013*, s 107.

<sup>58</sup> *Health Ombudsman Act 2013*, s 113.

<sup>59</sup> National Law (Queensland), ss 149 and 150.

After investigating a matter, or considering a health or performance assessment report, a National Board may decide to:

- take no further action
- refer the matter to another entity, including the OHO
- take one of the following actions: caution the practitioner; accept an undertaking from the practitioner; or impose conditions on the practitioner's registration (eg supervised practice or a requirement to undertake further education), or
- establish a health or a performance and professional standards panel to hold a private hearing on a matter – a panel may impose conditions on a practitioner, suspend the practitioner's registration, caution or reprimand the practitioner or ask the Board to refer the matter to QCAT.<sup>60</sup>

***Notifying the Health Ombudsman of serious matters***

A National Board must notify the Health Ombudsman, if it forms the reasonable belief based on a complaint or for any other reason, that a practitioner has behaved in a way that constitutes *professional misconduct* or there is another ground for the suspension or cancellation of a practitioner's registration – a serious matter.

The Health Ombudsman must then decide whether to ask the National Board to refer the matter to the Health Ombudsman or to continue to deal with the matter. If the National Board is asked to continue to deal with a serious matter, it may refer the matter to QCAT.<sup>61</sup>

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<sup>60</sup> National Law (Queensland), ss 167 and 177 - 192.

<sup>61</sup> National Law (Queensland), ss 193 and 193A.

## 5 Performance of the Health Ombudsman's functions

This section discusses the performance of the Health Ombudsman's functions since the establishment of the OHO on 1 July 2014.

Comparisons are also made, where appropriate, with the previous health complaints system in Queensland (pre-1 July 2014) and the co-regulatory system in NSW. The committee considers that whilst not directly comparable, these two systems are the closest systems to the current scheme in Queensland, and are therefore useful when discussing the performance of the current Queensland health complaints system.

During the committee's inquiry, stakeholders raised concerns about the OHO's non-compliance with statutory timeframes, in particular the 30 day timeframe for the assessment of complaints and the one year period for the investigation of complaints.<sup>62</sup> Stakeholders highlighted the significant adverse impact that the failure to deal with complaints in a timely manner has on patients, and their families, and on health practitioners who are the subject of complaints.<sup>63</sup>

The committee notes that the OHO reported lengthier timeframes for the conclusion of complaint processes in 2015-16 across almost every category of complaint action.<sup>64</sup> Levels of compliance with statutory timeframes and time-based organisational targets were also down on the previous year and on comparable HQCC compliance rates.

The Health Ombudsman has attributed delays to high numbers and complexity of matters, and delays in receiving information from parties or in sourcing the necessary independent clinical advice required to appropriately assess matters.<sup>65</sup> In addition, the Health Ombudsman stated legislative amendments to improve the efficient operation of the co-regulatory system, coupled with appropriate resourcing of the OHO, would 'ensure that I am able to meet my statutory timeframes'.<sup>66</sup>

### 5.1 Initial challenges in the operation of the Office of the Health Ombudsman

The Health Ombudsman acknowledged that there had been challenges in establishing the OHO. The Health Ombudsman explained that when the OHO started operation it took on almost 300 existing matters from AHPRA and the HQCC.<sup>67</sup>

The Health Ombudsman advised that in the first six months of operation the OHO also managed 3,700 contacts, made 1,750 complaints decisions, undertook 1,200 assessments, made 319 local resolution decisions, managed 30 conciliations and undertook 202 investigations.<sup>68</sup>

In addition to a large initial workload, the Health Ombudsman stated that Queensland Health's (the department) assessment of the OHO's staffing requirements had significantly underestimated the workload of the OHO.<sup>69</sup> The Health Ombudsman advised that:

*These staffing and workload issues had an impact over the first 12 months of operation and beyond. Identifying resource gaps and recruiting, training and establishing staff within the organisation all had to occur concurrently with the management of increasing volumes of complaints and investigations. This led to backlogs in matters and had flow-on effects into 2015-16.*<sup>70</sup>

<sup>62</sup> See, for example, submissions 3, 5, 7, 21, 27, 38 and 52.

<sup>63</sup> Submissions 1, 3, 7, 27, 38, 39, 40, 42 and 55; Georgie Haysom, Head of Advocacy, Avant, *Public Hearing Transcript*, 20 October 2016, p 14.

<sup>64</sup> OHO, *Annual Report 2015-16*, October 2016, p 15.

<sup>65</sup> OHO, *Annual Report 2014-15*, August 2015, p 18; OHO, *Annual Report 2015-16*, 2016, pp 17 and 32; Health Ombudsman, submission 45, p 7.

<sup>66</sup> Health Ombudsman, *correspondence*, 28 October 2016, p 8.

<sup>67</sup> Health Ombudsman, submission 45, p 7.

<sup>68</sup> Health Ombudsman, submission 45, p 7.

<sup>69</sup> Health Ombudsman, submission 45, p 7.

<sup>70</sup> Health Ombudsman, submission 45, p 8.

The Health Ombudsman also stated that uncertainty around funding has meant that decisions about the resourcing of the OHO have not been able to be made in a timely manner or with any certainty. The Health Ombudsman stated that with significant increases in the volume of complaints and pressures of both timeliness and quality, certainty around funding is essential.<sup>71</sup>

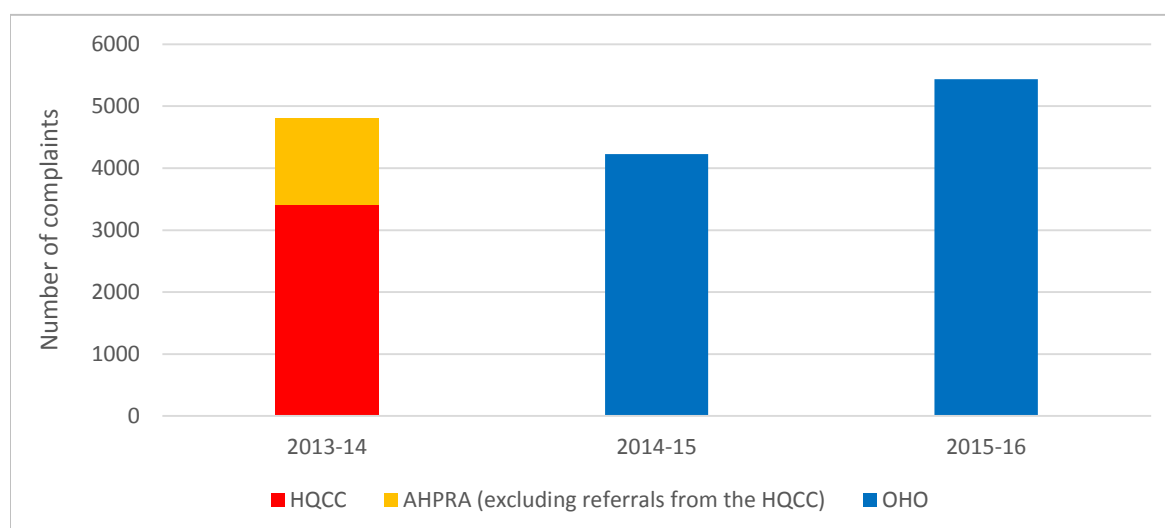
The department advised that it is currently considering options for future costing methodologies to be applied to the legislative requirement for an annual funding transfer between AHPRA and the OHO, following issues raised by AHPRA about the methodologies applied in the first two years since the OHO was established.<sup>72</sup> See section 5.14 of this report for further details about the funding of the OHO.

## 5.2 Complaints received and accepted

During 2015-16, the OHO received 9,351 contacts, of which 5,435 were complaints and 3,911 were enquiries.<sup>73</sup> This compares to 4,229 complaints received by the OHO in 2014-15 and a combined 4,809 complaints received in 2013-14 by the HQCC (3,416) and AHPRA (1,393, excluding 982 notifications referred from the HQCC) – see Figure 1.<sup>74</sup>

The OHO made a complaint decision in relation to 4,970 of the received complaints in 2015-16, of which 3,691 or approximately 80 per cent were accepted.<sup>75</sup> This compared to an acceptance rate of 90 per cent for the 3,448 decisions made by the OHO in 2014-15.<sup>76</sup>

**Figure 1: Health service complaints received in Queensland, 2013-14 to 2015-16**



Source: OHO, *Annual Report 2015-16*, 2016, p 15; HQCC, *Annual Report 2013-14*, 2014, pp 13-14; AHPRA and the National Boards, *Regulating health practitioners in Queensland: Annual Report Summary 2013/14*, AHPRA, 2014, p 24.

<sup>71</sup> Health Ombudsman, *Tabled Paper*, 31 August 2016, p 10.

<sup>72</sup> Queensland Health, submission 23, p 4.

<sup>73</sup> OHO, *Annual Report 2015-16*, 2016, p 15.

<sup>74</sup> Health Quality and Complaints Commission (HQCC), *Annual Report 2013-14*, 2014, p 12; AHPRA and the National Boards, *Regulating health practitioners in Queensland: Annual Report Summary 2013/14*, AHPRA, 2014, p 24.

<sup>75</sup> AHPRA and the National Boards, *Queensland: Annual Report Summary 2013/14*, AHPRA, 2014, p 24.

<sup>76</sup> OHO, *Annual Performance Report 2014-15*, 2015, p 6.

### 5.3 Initial decisions on complaints

The OHO is required, within seven days of receiving a complaint, to make an initial decision about whether to accept the complaint and take particular relevant action or take no further action.<sup>77</sup>

In 2015-16, the OHO reached an initial decision within the seven day statutory timeframe in 49 per cent of complaints. This represents a reduction from the 67 per cent of complaints the OHO reached an initial decision about within seven days in 2014-15.<sup>78</sup>

The Health Ombudsman advised that there had been a notable increase in the number of complaints in Queensland since 1 July 2014 – a 28 per cent increase in complaints in 2015-16 compared to 2014-15.

The Health Ombudsman advised that the increased volume of complaints affected the OHO's ability to meet the statutory timeframes,<sup>79</sup> and that, in response, the OHO has implemented a number of strategies, including:

- structural changes to teams to more effectively manage incoming complaints
- improved processes for quickly identifying and escalating complaints that identify serious risks to the health and safety of the public – resulting in decisions to take immediate action and/or to investigate
- refined case management processes
- expanded internal performance reporting to increase accountability and oversight, and
- team capability improvements from on-the-job experience and structured training programs.<sup>80</sup>

The OHO stated that it would continue to refine its processes, further develop its electronic case management system and identify the necessary level of resourcing to enable it to meet the statutory timeframe for initial decisions on complaints.<sup>81</sup>

Table 1 provides a breakdown of the initial decisions taken by the OHO in 2015-16 following the preliminary assessment of complaints.

<b>Table 1: OHO initial decision outcomes in 2015-16</b>	
<b>Outcome</b>	<b>Percentage</b>
Further assessment	41%
Local resolution	27%
Referred to AHPRA and National Boards	26%
Referred for investigation	3%
Referred to another entity	2%
Referred for conciliation or potential immediate action	1%

Source: OHO, *Annual Report 2015-16*, 2016, p 16.

<sup>77</sup> *Health Ombudsman Act 2013*, s 35.

<sup>78</sup> OHO, *Annual Report 2015-16*, 2016, p 15.

<sup>79</sup> Health Ombudsman, submission 45, p 8.

<sup>80</sup> OHO, *Annual Report 2015-16*, 2016, p 28; Health Ombudsman, submission 45, p 12.

<sup>81</sup> OHO, *Annual Report 2015-16*, 2016, p 15.

During the committee's inquiry stakeholders raised concerns about the potential duplication of work and resources where matters are referred at the initial decision stage for assessment and/or investigation, and then subsequently referred to AHPRA and the National Boards where the matter is then assessed, and may be investigated, again.<sup>82</sup>

The Health Ombudsman stated that the OHO has implemented more efficient processes for the earlier identification of matters appropriate for referral directly to local resolution, investigation, immediate action or AHPRA without the need for formal assessment. The Health Ombudsman stated:

*These changes have meant that only the more complex matters needing further analysis (and, potentially, independent clinical advice) now enter assessment. Earlier referral has produced faster resolutions for complainants, more timely risk assessment and escalation of complaints, and more cost-effective complaint management.*<sup>83</sup>

The Health Ombudsman stated that during 2015-16, the OHO's processes have continued to be refined, allowing for quicker referral of appropriate matters to AHPRA, including the appointment of additional dedicated referral staff.<sup>84</sup>

The Health Ombudsman advised that from January to September 2016, 1,041 (42 per cent) of the complaints about registered practitioners were referred to AHPRA at the initial decision-making stage.<sup>85</sup> The Health Ombudsman advised that there is no duplication of work when complaints are referred straight to AHPRA at the initial decision-making stage.<sup>86</sup>

#### 5.4 Immediate action decisions

AHPRA and the National Boards raised concerns that the relatively low number of immediate action decisions taken by the OHO demonstrated that it may not be taking appropriate and sufficient steps to protect the health and safety of the Queensland public.<sup>87</sup>

AHPRA and the National Boards indicated that in 2014-15, the OHO took immediate registration action five times in relation to medical practitioners, however, the OHO took no immediate registration action against medical practitioners between July 2015 and May 2016. By contrast, AHPRA and the National Boards stated the QBMBA took immediate action against 21 medical practitioners during the same period.<sup>88</sup>

More recent data shows that in 2015-16, the OHO took 38 immediate actions in relation to 26 individual practitioners, building on 17 immediate actions taken in 2014-15. This comprised of: 11 immediate registration actions against registered practitioners to suspend or impose conditions on their registration; 24 interim prohibition orders to unregistered health practitioners prohibiting or restricting their right to provide health services; and three corresponding interstate prohibition orders issued to interstate practitioners preventing practice in Queensland.<sup>89</sup>

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<sup>82</sup> See, for example, submissions 3, 7, 21, 27, 37, 38, 41, 42 and 52; Dr Zappala, President, Australian Medical Association Queensland (AMAQ), *Public Briefing Transcript*, 31 August 2016, p 3; Claire Gabriel, Hall Payne Lawyers, *Public Hearing Transcript*, 12 October 2016, p 2; Georgie Haysom, Avant, *Public Hearing Transcript*, 20 October 2016, p 14.

<sup>83</sup> Health Ombudsman, submission 45, p 13.

<sup>84</sup> Health Ombudsman, submission 45, p 9.

<sup>85</sup> Health Ombudsman, *correspondence*, 28 October 2016, p 2.

<sup>86</sup> Leon Atkinson-MacEwan, Health Ombudsman, *Public Briefing Transcript*, 2 November 2016, p 12.

<sup>87</sup> AHPRA and the National Boards, submission 48; Martin Fletcher, Chief Executive Officer, AHPRA, *Public Briefing Transcript*, 31 August 2016, p 10; Kym Ayscough, Acting Chief Executive, AHPRA, *Public Briefing Transcript*, 2 November 2016, p 2.

<sup>88</sup> AHPRA and the National Boards, submission 48, p 9.

<sup>89</sup> OHO, *Annual Report 2015-16*, 2016, p 28.



## 5.5 Assessments

The OHO completed 1,897 assessments in 2015-16, compared to 1,886 assessments completed in 2014-15. In comparison in 2013-14, the HQCC reported 959 assessment decisions.<sup>90</sup>

Stakeholders raised concerns about the length of time taken by the OHO to complete assessments of complaints.<sup>91</sup>

The committee notes that just under a third of assessments in 2015-16 (32 per cent) were completed within the legislated timeframe – that is, within 30 days (27 per cent) or within 60 days where a 30 day extension had been granted (five per cent). In 2014-15, 61 per cent of assessments were completed within this timeframe.<sup>92</sup>

The majority of assessments undertaken by the OHO, in 2015-16, resulted either in no further action being taken (42 per cent or 903), or in referrals to AHPRA and the National Boards (38 per cent or 811), with a small proportion being referred to local resolution, conciliation or investigation (14 per cent) – see Table 2.

<b>Table 2: OHO assessment outcomes in 2015-16</b>	
<b>Outcome</b>	<b>Percentage</b>
No further action	42%
Referred to AHPRA and National Boards	38%
Referred to another entity	6%
Local resolution	5%
Conciliation	5%
Investigation	3%
Immediate action	1%

Source: OHO, *Annual Report 2015-16*, 2016, p 18.

In 2014-15, 30 per cent (615) of assessments resulted in no further action being taken and 35 per cent of assessments (720) resulted in referrals to AHPRA and the National Boards.<sup>93</sup>

## 5.6 Local resolution

In 2015-16, the OHO completed 1,242 local resolutions – an increase of 80 per cent from 2014-15 (691), and more than double the 618 'early resolution' cases managed by the HQCC in 2013-14.

The OHO reported that the increase was due largely to process improvements allowing for earlier identification of complaints suitable for direct referral to local resolution.<sup>94</sup>

Of the local resolutions completed by the OHO in 2015-16, approximately 90 per cent were carried out within the legislated 30 day or extended 60 day timeframe, compared to 97 per cent in 2014-15.

<sup>90</sup> OHO, *Yearly Performance Report 2015-16*, 2016, p 10; HQCC, *Annual Report 2013-14*, 2014, p 15.

<sup>91</sup> See, for example, submissions 3, 5, 21 33 and 38; Beth Mohle, State Secretary, Queensland Nurses' Union (QNU), *Public Hearing Transcript*, 12 October 2016, p 1; Sarah Atkinson, Australian Lawyers Alliance, *Public Hearing Transcript*, 20 October 2016, p 5.

<sup>92</sup> OHO, *Annual Report 2015-16*, 2016, p 17.

<sup>93</sup> OHO, *Yearly Performance Report 2015-16*, 2016, p 11.

<sup>94</sup> OHO, *Annual Report 2015-16*, 2016, p 19.

In 2013-14, the HQCC resolved 99 per cent of early resolution cases within its 30 day statutory period, at an average of 20 days for completed cases.<sup>95</sup>

The OHO's annual report stated that both the proportion of complaints for which a resolution was reached, and the proportion finalised within the statutory timeframe represented a significant achievement, given the increased volume of complaints managed through local resolution.<sup>96</sup>

Approximately 86 per cent of the local resolutions carried out in 2015-16 resulted in a resolution being reached between the complainant and the health service provider;<sup>97</sup> in keeping with the 88 per cent resolved in 2014-15. In 2013-14, the HQCC reported that 98 per cent of equivalent early resolutions were resolved 'to the satisfaction of our agency'.<sup>98</sup>

## 5.7 Investigations

The Health Ombudsman advised that since its establishment in July 2014, the OHO has commenced 606 investigations and completed 228 investigations.<sup>99</sup>

In 2015-16, the OHO commenced 249 investigations and completed 163 investigations. This marked a significant increase on the 65 investigations completed by the OHO in 2014-15 (of 357 commenced),<sup>100</sup> and 106 investigations closed by the HQCC in 2013-14.<sup>101</sup>

The HO Act provides that investigations must be completed within one year from the decision to commence an investigation – although extensions may be granted by the Health Ombudsman of periods of up to three months, due to the nature and complexity of a matter.<sup>102</sup>

A significant number of stakeholders raised concerns about the time taken by the OHO to complete investigations.<sup>103</sup>

Approximately 53 per cent of investigations completed by the OHO in 2015-16 were compliant with the one year statutory timeframe.<sup>104</sup> This figure includes both complaints-based investigations and other systemic or serious investigations initiated by or referred to the OHO. In 2015-16, 23 per cent of investigations were completed in six months, 33 per cent in nine months and 53 per cent in one year.<sup>105</sup>

This compares with a 72 per cent compliance rate for investigations closed by the OHO in 2014-15, and a 94 per cent compliance rate reported by the HQCC for investigations carried out under its jurisdiction in 2013-14.<sup>106</sup> The HQCC also reported an average time to closure for 2013-14 investigations of 131 days.<sup>107</sup>

As at 30 June 2016, approximately 53 per cent of the OHO's 295 open investigations (excluding 76 paused matters with an external agency, such as the QPS) were already in excess of one year, compared to 24 per cent at the conclusion of 2014-15.<sup>108</sup> Of the 164 investigations open for in excess of one year, as recorded in the public register as at December 2016, 35 per cent had been open for in excess of two years.<sup>109</sup>

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<sup>95</sup> HQCC Annual Report 2013-14, 2014, p 14.

<sup>96</sup> OHO, *Annual Report 2015-16*, 2016, p 19.

<sup>97</sup> OHO, *Yearly Performance Report 2015-16*, 2016, p 12.

<sup>98</sup> HQCC, *Annual Report 2013-14*, 2014, p 14.

<sup>99</sup> Health Ombudsman, submission 45, p 14.

<sup>100</sup> OHO, *Yearly Performance Report 2015-16*, 2016, p 17.

<sup>101</sup> HQCC, *Annual Report 2013-14*, 2014, p 16.

<sup>102</sup> *Health Ombudsman Act 2013*, section 85.

<sup>103</sup> See, for example, submissions 3, 5, 7 21, 38, 41 and 52.

<sup>104</sup> OHO, *Annual Report 2015-16*, 2016, p 24.

<sup>105</sup> Health Ombudsman, submission 45, p 14.

<sup>106</sup> OHO, *Annual Report 2015-16*, 2016, p 24; HQCC, *Annual Report 2013-14*, 2014, p 17.

<sup>107</sup> HQCC, *Annual Report 2013-14*, 2014, p 17.

<sup>108</sup> OHO, *Annual Report 2015-16*, 2016, p 23; Health Ombudsman, submission 45, p 14.

<sup>109</sup> OHO, *Investigation Register*, [www.oho.qld.gov.au/news-updates/investigations-register](http://www.oho.qld.gov.au/news-updates/investigations-register), last accessed 14 December 2016.

In its 2015-16 annual report, the OHO noted that 49 per cent of the investigations in excess of one year that were closed in 2015-16 were investigations originally started by AHPRA and transferred to the OHO in 2014-15, as part of the establishment of the new co-regulatory arrangement in Queensland.<sup>110</sup>

The OHO noted that the 'disproportionate workload' created by 124 matters transferred from AHPRA in 2014-15 'created challenges during the office's first two years'.<sup>111</sup> In 2015-16, only 14 matters were transferred from AHPRA – a lower level of transfers, which the OHO expects to continue in the future. The OHO stated that the combination of these 'legacy matters' and the number of new investigations being commenced 'created a backlog' which has impacted the OHO's investigations timeframes.<sup>112</sup> As at 30 June 2016, 96 matters transferred from AHPRA remained open.<sup>113</sup>

The OHO advised that it has established a temporary investigations team dedicated to 'legacy matters', with a view to significantly reducing their numbers in 2016-17.<sup>114</sup>

The OHO noted that for every three new investigations commenced in 2015-16, two investigations were closed. In 2014-15, the opened-to-closed ratio was more than five to one.<sup>115</sup> The OHO stated, in its annual report:

*While the office strives to complete investigations as quickly as possible, it is important to ensure there is a balance between timeliness and the quality of decisions, particularly when dealing with more serious matters.*

*By their nature, the more serious matters require careful investigation and consideration. In 2015–16, 54 per cent of the office's investigations related to either illegal practice, sexual misconduct, other forms of misconduct, unauthorised prescription of medication or boundary violations.*<sup>116</sup>

Approximately 45 per cent of concluded 2015-16 investigations were closed with no further action, while 35 per cent were referred to AHPRA or another agency and 15 per cent were deemed to be serious complaints that may be suitable for referral to QCAT, and were recommended for referral to the director of proceedings.<sup>117</sup> This marked a significant increase in referrals to the director of proceedings in 2015-16, up from just three matters in 2014-15 (five per cent of closed investigations), to 24 matters involving 18 practitioners.<sup>118</sup>

AHPRA and the National Boards, and certain stakeholders, raised concerns that a limited number of referrals to QCAT may indicate that the OHO was not appropriately discharging its responsibility to protect the health and safety of the public.<sup>119</sup>

The committee notes that during 2014-15, no matters were directed to QCAT for hearing.<sup>120</sup> However, in 2015-16, the director of proceedings referred five practitioners to QCAT, with decisions about whether to refer the remaining 13 practitioners to QCAT expected to be made by the director of proceedings in 2016-17.<sup>121</sup>

<sup>110</sup> OHO, *Annual Report 2015-16*, 2016, p 24.

<sup>111</sup> OHO, *Annual Report 2015-16*, 2016, p 24.

<sup>112</sup> OHO, *Annual Report 2015-16*, 2016, p 24.

<sup>113</sup> OHO, *Annual Report 2015-16*, 2016, p 24.

<sup>114</sup> OHO, *Annual Report 2015-16*, 2016, p 24.

<sup>115</sup> OHO, *Annual Report 2015-16*, 2016, p 23.

<sup>116</sup> OHO, *Annual Report 2015-16*, 2016, p 24.

<sup>117</sup> OHO, *Yearly Performance Report 2015-16*, 2016, p 18.

<sup>118</sup> OHO, *Yearly Performance Report 2015-16*, 2016, p 23.

<sup>119</sup> AHPRA and the National Boards, submission 48; Claire Gabriel, Hall Payne Lawyers, *Public Hearing Transcript*, 12 October 2016, p 3.

<sup>120</sup> OHO, *Annual Report 2014-15*, 2015, p 31; HQCC, *Annual Report 2013-14*, 2014, p 15.

<sup>121</sup> OHO, *Yearly Performance Report 2015-16*, 2016, p 23.

## 5.8 Conciliations

The OHO commenced 122 conciliations in 2015-16, and closed 88. In 2014-15, 65 conciliations were closed by the OHO and in 2013-14, the HQCC closed 95 conciliations.<sup>122</sup>

While a legislated timeframe is not established for conciliations, the OHO and HQCC have both reported against internal performance targets.

In 2013-14, the HQCC had a service standard target of closing 100 per cent of complaints in conciliation within one year – up from a previous target of 60 per cent in 2012-13, on the recommendation of the former Health and Community Services Committee.<sup>123</sup>

In 2015-16, the OHO reported that 'the office has a conciliation timeframe target of four months to assess the viability of a successful conciliation'.<sup>124</sup>

Approximately 34 per cent of the 88 conciliations closed by the OHO in 2015-16 were closed within four months, compared to 16 per cent in 2014-15. All 88 (100 per cent) of these conciliations were closed within one year, while approximately 84 per cent of conciliations closed in 2014-15 were closed within one year, and 60 per cent of HQCC conciliations closed in 2013-14 were closed within one year.<sup>125</sup>

As conciliation is a voluntary process, parties cannot be compelled to participate. Where parties chose to participate, 75 per cent were conciliated successfully in 2015-16.<sup>126</sup> In 2014-15, similarly, 76 per cent of conciliations were successful.<sup>127</sup> In 2013-14, the HQCC reported successful outcomes for 60 per cent of conciliations.<sup>128</sup>

## 5.9 Referrals to AHPRA and the National Boards

In 2015-16, the OHO referred 3,121 matters relating to 1,993 health practitioners to AHPRA. This represents a significant increase from the 1,387 matters relating to 948 practitioners referred to AHPRA in 2014-15.<sup>129</sup>

The OHO stated that process improvements have allowed referrals to be made earlier in the complaints process, which has led to more timely resolution for complainants and practitioners, more timely risk assessments and a more cost effective complaint management system. A further key improvement has been the development of secure online referral portals between OHO and AHPRA.<sup>130</sup>

Under the HO Act, AHPRA must notify the OHO of all serious matters relating to registered health practitioners. In 2015-16, AHPRA notified the OHO of 33 matters identified as serious. Of these, the Health Ombudsman requested 12 to be referred to the OHO and determined that 19 should continue to be dealt with by the National Boards. Two matters were still to be decided as at 30 June 2016.<sup>131</sup>

This represents a significant reduction on the 86 matters identified by AHPRA as serious in 2014-15, 37 of which were referred to the OHO and 48 remained with the National Boards, with one matter yet to be decided as of 30 June 2015.<sup>132</sup>

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<sup>122</sup> OHO, *Yearly Performance Report, 2015-16*, 2016, p 14; HQCC, *Annual Report 2013-14*, 2014, p 15.

<sup>123</sup> HQCC, *Annual Report 2013-14*, 2014, p 12; HQCC, *Annual Report 2012-13*, 2013, p 74.

<sup>124</sup> OHO, *Annual Report 2015-16*, 2016, p 21.

<sup>125</sup> OHO, *Annual Report 2015-16*, 2016, p 21.

<sup>126</sup> OHO, *Annual Report 2015-16*, 2016, p 22.

<sup>127</sup> OHO, *Yearly Performance Report, 2015-16*, 2016, p 15.

<sup>128</sup> HQCC, *Annual Report 2013-14*, 2014, p 16.

<sup>129</sup> OHO, *Annual Report 2015-16*, 2016, p 36.

<sup>130</sup> OHO, *Annual Report 2015-16*, 2016, p 36.

<sup>131</sup> OHO, *Annual Report 2015-16*, 2016, p 36.

<sup>132</sup> OHO, *Annual Report 2015-16*, 2016, p 36.

### 5.10 Internal decision reviews and complaints to the Queensland Ombudsman

In 2015-16, the OHO's review team commenced 201 and finalised 216 requests to review a decision taken by the OHO. Reviews were conducted for 162 (75 per cent) of the 216 finalised requests, with decisions upheld for 128 decisions (79 per cent). For the 25 per cent of requests that were closed without conducting a review, the OHO reported that there were either no grounds identified for the review; it was not a reviewable decision; or the review request was withdrawn.<sup>133</sup>

In 2013-14, in comparison, the HQCC received 130 requests to have a decision reviewed internally, with valid grounds for review identified for 44 of the 115 finalised requests (38 per cent).<sup>134</sup>

Complaints about the actions and decisions of the OHO can also be made to the Queensland Ombudsman. In 2015-16, 68 complaints were made to the Queensland Ombudsman about the OHO, which represents an increase of 16 complaints from the 42 complaints made to the Queensland Ombudsman in 2014-15 – see Table 3.<sup>135</sup>

Table 3: Complaints made to the Queensland Ombudsman		
Financial Year	Entity	No. of complaints received
2012-13	HQCC	92
2013-14	HQCC	67
2014-15	OHO	42
2015-16	OHO	68

Source: Queensland Ombudsman, submission 8, p 1.

### 5.11 Client satisfaction

In February 2016, the OHO implemented an ongoing client satisfaction survey to gather feedback from complainants, health service providers and other stakeholders on their experience with the OHO.

The OHO's 2015-16 annual report details the results from the 133 survey responses received, in which respondents provided ratings along a five-point scale for various statements (strongly disagree, disagree, neutral, agree and strongly agree).<sup>136</sup> A number of these statements align with equivalent measures engaged by the HQCC in client satisfaction surveys conducted in 2013-14 and earlier years.

In relation to their overall satisfaction with the OHO's handling of their complaint, approximately 66 per cent of 2016 survey respondents agreed or strongly agreed that they were satisfied with the way their complaint was handled.<sup>137</sup> This exceeds the 56 per cent of 2013-14 HQCC survey respondents who agreed or strongly agreed that their complaint was handled well.<sup>138</sup>

<sup>133</sup> OHO, *Annual Report 2015-16*, 2016, p 33.

<sup>134</sup> HQCC, *Annual Report 2013-14*, 2014, p 19.

<sup>135</sup> Queensland Ombudsman, submission 8.

<sup>136</sup> The OHO reported that 50 per cent of responses were from the complainant who received the health service, 29 per cent were from the health service provider who responded to the complaint; 12 per cent were from an individual who complained on behalf of someone else; and 9 per cent were from other sources. See: OHO, *Annual Report 2015-16*, 2016, p 38.

<sup>137</sup> OHO, *Annual Report 2015-16*, 2016, p 38.

<sup>138</sup> HQCC, *Annual Report 2013-14*, 2014, p 10.

In relation to entity staff, approximately 84 per cent of 2016 survey respondents agreed or strongly agreed that OHO staff were professional and respectful,<sup>139</sup> while in 2013-14, 88 per cent agreed or strongly agreed that HQCC staff were polite and 79 per cent agreed or strongly agreed that staff were professional.<sup>140</sup>

Approximately 76 per cent of 2016 respondents were satisfied (strongly agreed or agreed) that they had received good quality service from the OHO,<sup>141</sup> while in 2013-14 the HQCC recorded a general client satisfaction level of 77 per cent.<sup>142</sup>

In terms of timeliness, 73 per cent of 2016 respondents were satisfied that OHO staff met the timeframes they set,<sup>143</sup> while 77 per cent of 2013-14 respondents were satisfied that the HQCC managed complaints in a timely manner.<sup>144</sup>

Lastly, approximately 60 per cent of 2013-14 respondents reported that they were satisfied with the outcome of their complaints process and 71 per cent agreed that they were given clear reasons for the decision made,<sup>145</sup> while in 2016:

- 59 per cent agreed or strongly agreed with the statement 'I believe the outcome was fair and reasonable', and
- 67 per cent agreed or strongly agreed with the statement 'I understand how the outcome was reached'.<sup>146</sup>

## 5.12 Systemic investigations, monitoring and quality assurance

In addition to managing health service complaints, the OHO is responsible for:

- identifying and reporting on systemic issues relating to health service provision and the effectiveness of parts of Queensland's health system
- providing recommendations for improvements to the health sector, and
- commencing its own investigations.<sup>147</sup>

In 2015-16, the OHO commenced 27 systemic and facility-based investigations, and continued a number of other such investigations initiated in 2014-15.<sup>148</sup>

The OHO also commenced eight own-motion systemic investigations in 2015-16 (investigations initiated by the Health Ombudsman without a complaint), focussing on medication management, failure to notify the Health Ombudsman of notifiable conduct, patient admission and transfer, and the quality of health service delivery in the areas of audiology, maternity services and correctional services.<sup>149</sup>

The OHO also monitors and reports on the implementation of recommendations arising from investigations, as well as monitoring compliance with the outcomes of any immediate actions and certain *reportable events* – a defined list of serious clinical incidents where patients are unintentionally harmed or unexpectedly die while receiving healthcare.<sup>150</sup> Following such reportable events, a root cause analysis may be compiled which includes information about what happened, how and why it happened and what corrective actions have been identified to prevent it happening again.<sup>151</sup>

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<sup>139</sup> OHO, *Annual Report 2015-16*, 2016, p 38.

<sup>140</sup> HQCC, *Annual Report 2013-14*, 2014, p 20.

<sup>141</sup> OHO, *Annual Report 2015-16*, 2016, p 38.

<sup>142</sup> HQCC, *Annual Report 2013-14*, 2014, p 12.

<sup>143</sup> OHO, *Annual Report 2015-16*, 2016, p 38.

<sup>144</sup> HQCC, *Annual Report 2013-14*, 2014, p 20.

<sup>145</sup> HQCC, *Annual Report 2013-14*, 2014, p 20.

<sup>146</sup> OHO, *Annual Report 2015-16*, 2016, p 38.

<sup>147</sup> Health Ombudsman, submission 45, p 16.

<sup>148</sup> OHO, *Annual Report 2015-16*, 2016, p 29.

<sup>149</sup> OHO, *Annual Report 2015-16*, 2016, p 29.

<sup>150</sup> OHO, *Annual Report 2015-16*, 2016, p 30.

<sup>151</sup> OHO, *Annual Report 2015-16*, 2016, p 31.

The OHO made 19 recommendations relating to six health service providers in 2015-16, and at 20 June 2016, 63 per cent of these recommendations were fully implemented (11) or partially implemented (1); and seven were yet to be implemented (37 per cent). A further 61 recommendations made by other agencies, including the State Coroner, 45 (74 per cent) were fully implemented, seven (12 per cent) partially implemented, and nine (15 per cent) were still to be implemented.<sup>152</sup> In 2014-15, the OHO monitored just one recommendation arising from an OHO investigation, with the recommendation implemented by the end of that financial year.<sup>153</sup>

In comparison, the HQCC made a total of 141 recommendations in 2013-14, of which 52 per cent were fully implemented (65) or partially implemented (8); a further 48 per cent were not yet due to be implemented; and a total of 20 recommendations (14 per cent) were overdue or were not implemented.<sup>154</sup>

As at 30 June 2016, 41 Queensland practitioners were being monitored – 22 registered practitioners and 19 unregistered practitioners.<sup>155</sup> As at 30 June 2015, the OHO was monitoring the compliance of 10 registered practitioners and 5 unregistered practitioners and had 'detected and responded to a number of suspected non-compliance events by registered health practitioners'.<sup>156</sup>

Further, during 2015-16, the OHO received and reviewed 159 root cause analysis reports,<sup>157</sup> compared to 168 reports received in 2014-15.<sup>158</sup> The OHO noted in its 2015-16 annual report that a change to the *Hospital and Health Boards Act 2011* has made the selection of the root cause analysis process optional, as opposed to mandatory – though any analysis undertaken must be supplied to the OHO.

The OHO noted:

*Evidence suggests that fewer root cause analysis reports are being conducted, which means the office will have even less visibility of potential systemic risks and trends over time. This is a matter of concern and will be subject to further exploration in 2016–17 to ensure that emerging issues can be identified quickly.*<sup>159</sup>

### 5.13 Monitoring and reporting on the performance of AHPRA and the National Boards

One of the Health Ombudsman's statutory functions is to monitor AHPRA and the National Boards' performance in relation to the health, conduct and performance of registered health practitioners who provide health services in Queensland.

The Health Ombudsman stated that his role in monitoring the performance of AHPRA and the National Boards is important, as it:

- encourages transparency and accountability by AHPRA and the National Boards on their performance
- highlights areas for improvement in the performance of those functions, and
- provides information and assurance to the public about the performance of AHPRA and the National Boards in Queensland of their roles in the overall health complaints system.<sup>160</sup>

<sup>152</sup> OHO, *Annual Report 2015-16*, 2016, p 30.

<sup>153</sup> OHO, *Annual Report 2014-15*, 2015, p 34.

<sup>154</sup> HQCC, *Annual Report 2013-14*, 2014, p 18.

<sup>155</sup> OHO, *Annual Report 2015-16*, 2016, p 30.

<sup>156</sup> OHO, *Annual Report 2014-15*, 2015, p 34.

<sup>157</sup> OHO, *Annual Report 2015-16*, 2016, p 31.

<sup>158</sup> OHO, *Annual Report 2014-15*, 2015, p 34.

<sup>159</sup> OHO, *Annual Report 2015-16*, 2016, p 31.

<sup>160</sup> Health Ombudsman, submission 45, p 17.

In 2015-16, the OHO:

- published quarterly performance monitoring reports based on data provided by AHPRA
- finalised an assurance framework to explore identified performance issues in more depth, including commencing an assurance activity into the management of practitioners with impairments by AHPRA and the National Boards, and
- continued an assurance activity commenced in 2014-15 that resulted from a review of a practitioner subject to AHPRA's monitoring program who was able to breach the imposed conditions on their registration more than 191 times.<sup>161</sup>

#### **5.14 Budget, staffing and expenditure**

The OHO has three funding streams:

- a grant from the Queensland Government to fund the OHO's functions outlined at section 25 of the HO Act (eg to receive and take relevant action on health service complaints, identify and report on systemic health service issues, including the quality of health services and to monitor the performance of AHPRA and the National Boards)
- own source revenue, and
- funding from AHPRA – a proportion of registration fees paid by health practitioners in Queensland is transferred from AHPRA to the OHO – in 2014-15, AHPRA provided \$4.5 million and in 2015-16, AHPRA provided \$4.203 million.<sup>162</sup>

In 2015-16, the OHO had an operational budget of \$14.618 million. This compares with an initial budget allocation of \$10.245 million for the OHO in 2014-15, which was supplemented by an additional \$4.5 million in regulatory funding allocated in September 2014 from AHPRA, to accompany the transfer of regulatory responsibilities from AHPRA (for a cumulative \$14.725 million total).<sup>163</sup>

In 2012-13 and 2013-14, in comparison, the HQCC reported operating budgets of \$10.426 million and \$10.191 million respectively (see Table 4).<sup>164</sup>

The OHO's actual expenditure reached \$16.758 million in 2015-16 – a budget overspend of 15 per cent, and a significant increase on the \$14.003 million and \$14.367 million in expenditure respectively recorded by the OHO in 2014-15 and HQCC in 2013-14.<sup>165</sup> This ultimately resulted in the OHO reporting an operating deficit of \$2.581 million for 2015-16.<sup>166</sup>

The major reason for the variation between the OHO's budgeted and actual expenditure in 2015-16 was the commencement of 24 additional complaint management and investigation officers to manage the increasing number of complaints received by the OHO.<sup>167</sup>

In accommodating these and other additional employees, the OHO's full-time staffing contingent increased from a reported 94 full-time equivalent (FTE) employees as at 30 June 2015, to 125.56 FTE employees (as at 30 June 2016).<sup>168</sup> This constituted staffing growth of approximately 34 per cent for the organisation from 2014-15 to 2015-16, and also a significant rise over and above the 55 to 60 FTE employees engaged by the HQCC in its final two years of operation.<sup>169</sup>

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<sup>161</sup> OHO, *Annual Report 2015-16*, 2016, p 30.

<sup>162</sup> Queensland Health, submission 23, p 3; OHO, *Annual Report 2015-16*, 2016, p 56.

<sup>163</sup> OHO, *Annual Report 2014-15*, 2015, p 81.

<sup>164</sup> Queensland Government, *Queensland Budget 2013-14, Service Delivery Statements – Health Quality and Complaints Commission*, 2014, p 238.

<sup>165</sup> OHO, *Annual Report 2014-15*, 2015, p 56.

<sup>166</sup> OHO, *Annual Report 2015-16*, 2016, p 72.

<sup>167</sup> Queensland Government, *Queensland Budget 2016-17, Service Delivery Statements – Office of the Health Ombudsman*, 2016, p 223; OHO, *Annual report 2015-16*, 2016, p 56.

<sup>168</sup> Queensland Government, *Queensland Budget 2015-16, Service Delivery Statements – Office of the Health Ombudsman*, 2015, p 265.

<sup>169</sup> HQCC, *Annual Report 2013-14*, 2014, p 44; HQCC, *Annual Report 2012-13*, 2013, p 63.



<b>Table 4: Staffing, expenditure levels and performance, HQCC and OHO, 2012-13 to 2015-16</b>				
	<b>HQCC</b>		<b>OHO</b>	
	2012-13	2013-14	2014-15	2015-16
<b>Staffing and expenditure</b>				
Budgeted expenditure	\$10.426 million	\$10.191 million	\$10.245 million (revised upwards to \$14.745million)	\$14.618 million
Actual expenditure	\$9.934 million	\$14.367 million	\$14.003 million	\$16.758 million
Operating result: surplus/(deficit)	\$0.367 million	(\$1.670 million)	\$0.742 million	(\$2.581 million)
Employee expenses	\$7.303 million	\$8.617 million	\$10.762 million	\$13.961 million
FTE employees <sup>1</sup>	59.4	55.8	94	125.56
<b>Performance ratios</b>				
Actual expenditure proportion of budgeted expenditure	95%	141%	137% of initial budget 95% of revised budget	115%
Employee expenses per FTE employee	\$122,936	\$154,418	\$114, 489	\$111,190
Complaints received per FTE employee	74.4	61.2	45.0	43.3
Investigations closed per FTE employee	1.2	1.9	0.69	1.3

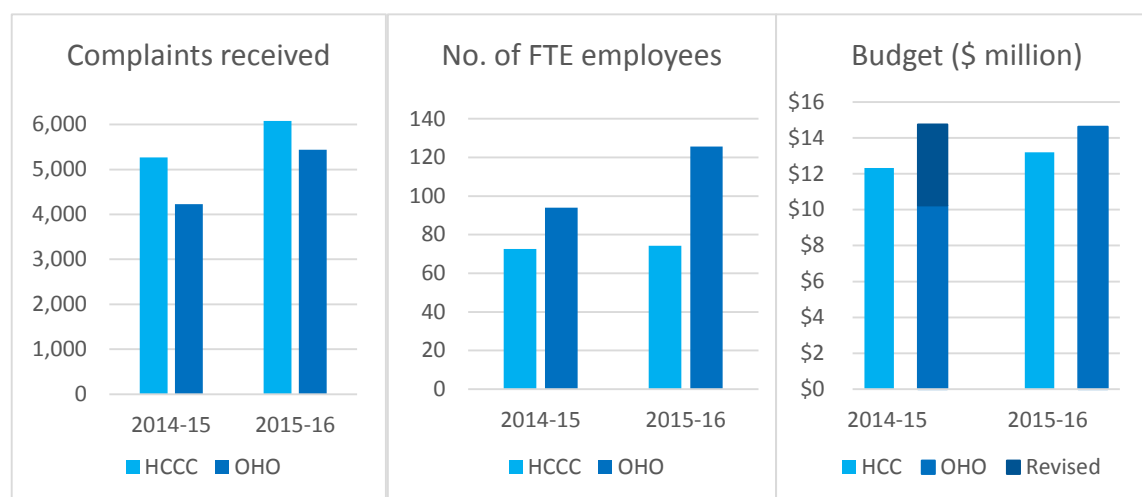
<sup>1</sup> FTE employees as at 30 June.

Source: HQCC, Annual Report 2012-13, 2013; HQCC, Annual Report 2013-14, 2014; Queensland Budget 2013-14, Service Delivery Statements – Health Quality and Complaints Commission, 2014, p 238; OHO, Annual Report 2014-15, 2016; OHO, Annual Report 2015-16, 2016; Queensland Budget 2015-16, Service Delivery Statements – Office of the Health Ombudsman, 2015.

### 5.15 Comparison with NSW co-regulatory system

The HCCC in NSW is generally recognised as the most similar and easily comparable system to the Queensland health complaints system.<sup>170</sup> In operation for over 20 years, compared to the OHO's relatively recent establishment, the HCCC has fewer staff and a smaller budget than the OHO, but handles a larger number of complaints annually – see Figure 2 and Table 5.

**Figure 2: HCCC and OHO complaints received, FTE employees and budget**



Source: HCCC, Annual Report 2014-15, 2015; HCCC, Annual Report 2015-16, 2016; OHO, Annual Report 2014-15, 2015; HCCC, Annual Report 2015-16, 2016.

#### 5.15.1 Complaints and assessments

The HCCC is not required to reach an initial decision within seven days (as is the OHO), conducting a longer, single assessment phase within a statutory 60 day period.<sup>171</sup>

Approximately 93 per cent of complaints were assessed by the HCCC within 60 days in 2014-15, and 86 per cent in 2015-16. The HCCC also reported that the average number of days taken to assess a complaint was 47 days.<sup>172</sup> This compares to the OHO's compliance rates of 67 per cent and 49 per cent for preliminary complaint decisions (seven days) in 2014-15 and 2015-16; and 61 per cent and 32 per cent respectively for further assessments (30 days or 60 days with extension) in 2014-15 and 2015-16.

An additional 14 per cent of assessments conducted by the OHO in 2014-15 and 13 per cent in 2015-16 were completed within 60 days but *without* the grant of an extension, taking totals to 75 per cent (2014-15) and 55 per cent (2015-16) of assessments conducted within 60 days for comparative purposes.

This is, however, still considerably lower than the proportion of assessments finalised by the HCCC in this period, and OHO figures are notably specific to the assessment phase and do not include days spent in preliminary assessment or 'triage' stage.

The OHO's 2015-16 annual report also highlighted the average duration of assessment for the 430 complaints open at 30 June 2016 was 83 days.<sup>173</sup>

<sup>170</sup> Martin Fletcher, Chief Executive Officer, AHPRA, *Public Briefing Transcript*, 31 August 2016, pp 15-16; Leon Atkinson-MacEwen, Health Ombudsman, *Public Briefing Transcript*, 2 November 2016, pp 14-15.

<sup>171</sup> Health Care Complaints Commission (HCCC), *Annual Report 2015-16*, November 2016, p 6.

<sup>172</sup> HCCC, *Annual Report 2015-16*, 2016, p 11.

<sup>173</sup> OHO, *Annual Report 2015-16*, 2016, p 17.

### 5.15.2 Investigations

The HCCC also completes a larger number of investigations annually than the OHO and at higher rates of completion within their equivalent 12 month statutory timeframe. Approximately 87 per cent and 85 per cent of HCCC's investigations were completed within one year in 2014-15 and 2015-16 respectively, compared with the OHO's 12 month compliance rates of 72 per cent and 53 per cent for investigations completed in same periods.

<b>Table 5: HCCC and OHO complaint management, staffing and expenditure, 2014-15 and 2015-16</b>				
	<b>HCCC (NSW)</b>		<b>OHO (Qld)</b>	
	2014-15	2015-16	2014-15	2015-16
<b>Complaint Management and Activities</b>				
Complaints received	5,266	6,075	4,229	5,435
Complaints assessed	5,002	5,805	Initial decisions: 3,546 Assessments: 1,886	Initial decisions: 4,970 Assessments: 1,897
Complaints assessed within 60 days (%) <sup>1</sup>	93%	86%	61%	32%
Investigations finalised	194	244	65	163
Investigations finalised within one year (%)	87%	85%	72%	53%
Independent clinical advice engaged (no. of occasions/reports)	221	247	n.a.	186
<b>Staffing and expenditure</b>				
FTE employees <sup>2</sup>	72.6	74.3	94	125.6
Budget	\$12.317 million	\$13.199 million	\$10.245 million (revised upwards to \$14.745million) <sup>3</sup>	\$14.618 million
Expenditure	\$12.487 million	\$13.357 million	\$14.003 million	\$16.758 million
Employee expenses	\$8.915 million	\$8.755 million	\$10.762 million	\$13.961 million

<sup>1</sup> OHO assessment compliance rate reflects the combined proportion of assessments conducted within 30 days or within 60 days with an extension. Calculations are specific to the assessment phase and do not include days spent in preliminary assessment.

<sup>2</sup> New South Wales staff figures represent average FTE employees over the year. Queensland figures represent FTE employees as at 30 June.

<sup>3</sup> The OHO's initial 2015-16 Budget of \$10.245 million was supplemented with an additional \$4.5 million in regulatory funding allocated in September 2014, to accompany the transfer of regulatory responsibilities from AHPRA.

Source: HCCC, Annual Report 2014-15, 2015; HCCC, Annual Report 2015-16, 2016; OHO, Annual Report 2014-15, 2015; OHO, Annual Report 2015-16, 2016.

## 6 Suggested improvements to the Queensland health complaints system

During the committee's inquiry, stakeholders raised a number of consistent issues about the performance of the Queensland health complaints system, and suggested a number of ways in which the system might be improved.

A number of the issues and suggestions raised by stakeholders have led to the committee making some initial recommendations aimed at improving the performance of the Queensland health complaints system – see section 7 of this report. The committee intends to consider further the information provided by stakeholders, as part of its ongoing monitoring role.

This section of the report provides a brief summary of suggested ways to improve the Queensland health complaints system.

### 6.1 Clarity of roles and less duplication of work between the OHO, AHPRA and National Boards

Under the Queensland health complaints system, the OHO, AHPRA and the National Boards are jointly responsible for dealing with complaints.

The committee understands that, in essence, the OHO is responsible for the least serious matters (those which may be resolved via local resolution or conciliation) and the most serious (eg professional misconduct). While AHPRA and the National Boards are responsible for complaints about the health, conduct and performance of registered health practitioners, which fall between these categories, and are referred by the OHO.

Some stakeholders considered that the HO Act and the National Law (Queensland) could be amended to provide greater clarity about the structure of the Queensland health complaints system and the respective roles and responsibilities of the OHO, AHPRA and the National Boards.<sup>174</sup>

Such stakeholders stated that greater clarity would reduce:

- potential 'double-handling' (whereby complaints are assessed and, on occasion, investigated by the OHO and then subsequently referred to AHPRA and the National Boards where they are assessed, and potentially investigated, again)
- the number of complaints being referred between the organisations a number of times, and
- resultant delays in the resolution of complaints.<sup>175</sup>

Stakeholders considered that greater collaboration and more direct referrals from OHO to AHPRA at the earlier stages of the complaints process would help to reduce duplication of work and delays.<sup>176</sup>

Other stakeholders considered that the OHO could make better use of its powers to take no further action in relation to a complaint, at the initial decision stage, to reduce the potential for duplication.<sup>177</sup>

Certain stakeholders, and AHPRA, raised concerns that any duplication of work may lead to increased costs which would ultimately be borne by registered health practitioners in Queensland, via increased registration fees, and may result in additional costs to the broader health complaints system overall.<sup>178</sup>

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<sup>174</sup> See, for example, submissions 3, 7, 21, 40 and 52; Sarah Atkinson, ALA, *Public Hearing Transcript*, 20 October 2016, p 2.

<sup>175</sup> Submissions 3, 7, 21, 27, 37, 38, 41, 42 and 52; Dr Zappala, President, AMAQ, *Public Briefing Transcript*, 31 August 2016, p 3; Claire Gabriel, Hall Payne Lawyers, *Public Hearing Transcript*, 12 October 2016, p 2; Georgie Haysom, Avant, *Public Hearing Transcript*, 20 October 2016, p 14.

<sup>176</sup> Submissions 7 and 38.

<sup>177</sup> Avant, submission 38; Sarah Atkinson, ALA, *Public Hearing Transcript*, 20 October 2016, p 5.

<sup>178</sup> QNU, submission 21; Beth Mohle, State Secretary, QNU, *Public Hearing Transcript*, 12 October 2016, p 7; Kym Ayscough, Acting Chief Executive Officer, AHPRA, *Public Briefing Transcript*, 2 November 2016, p 3.

## 6.2 Consistent standards, thresholds and regulatory principles for decision-making

A significant number of stakeholders raised concerns about perceived inconsistencies in, and a lack of publicly available information about, the standards, thresholds, processes and regulatory principles used by the OHO to reach decisions about complaints.<sup>179</sup>

Stakeholders stated that such inconsistencies might lead to different outcomes in relation to similar matters, both within Queensland, depending on whether the complaint was considered by the OHO or AHPRA and the National Boards, and with other jurisdictions.<sup>180</sup>

A number of stakeholders, and AHPRA and the National Boards, also raised concerns about the apparent opaque nature of the definitions and thresholds for what constitutes a serious matter to be retained by the OHO, a matter on which no further action is taken, and a matter referred to AHPRA and the National Boards.<sup>181</sup>

For example, AHPRA and the National Boards stated that some complaints referred to the boards by the OHO are considered by the boards to meet the threshold for retention and investigation by the OHO because they are serious matters. When this occurs the boards advise the OHO, which must then decide whether to take the matter back or direct the board to continue to consider it. 'The result is significant duplication, delays and at times multiple referrals of the same matter between the two systems that operate in Queensland'.<sup>182</sup>

Stakeholders considered that the early coordination of activities between the OHO and AHPRA and the National Boards would be easier if a clear and common set of regulatory principles and standards were developed for the consideration of complaints.<sup>183</sup>

## 6.3 Joint consideration of complaints

Stakeholders, and AHPRA and the National Boards, suggested introducing a joint consideration process between the OHO, AHPRA and the National Boards at the earliest stage of the consideration of a complaint.<sup>184</sup> Stakeholders considered that such a process, with appropriate clinical input, could help to reduce duplication of work between the OHO and AHPRA and the National Boards, reduce delays in dealing with complaints and contribute to more informed and consistent decisions about complaints.<sup>185</sup>

Under a joint consideration approach, the OHO and AHPRA and the National Boards would consider jointly what action, if any, should be taken in relation to a complaint (eg, retained by the OHO for investigation, conciliation or local resolution, or referred to AHPRA and the National Boards).

AHPRA recommended a joint consideration process guided by a decision-matrix and principles agreed by the OHO and AHPRA and the National Boards. AHPRA also highlighted the current joint consideration mechanism in NSW, between the HCCC and the relevant Professional Councils, as a model to consider.<sup>186</sup>

<sup>179</sup> See, for example, submissions 1, 5, 6, 7, 21, 27 and 55; Dr Zappala, President, AMAQ, *Public Briefing Transcript*, 31 August 2016, p 7; Martin Fletcher, Chief Executive Officer, AHPRA, *Public Briefing Transcript*, 31 August 2016, p 11.

<sup>180</sup> Submission 5, 7 and 42; Dr Zappala, President, AMAQ, *Public Briefing Transcript*, 31 August 2016, p 8.

<sup>181</sup> Submissions 7, 21 and 48.

<sup>182</sup> AHPRA and the National Boards, submission 48, p 5.

<sup>183</sup> Submissions 1 and 55.

<sup>184</sup> See, for example, submissions 33, 38, 48 and 52; Martin Fletcher, Chief Executive Officer, AHPRA, *Public Briefing Transcript*, 31 August 2016, p 12; Timothy Bowen, Senior Solicitor, Advocacy, Claims and Education, Medical Insurance Group Australia (MIGA), *Public Hearing Transcript*, 20 October 2016, p 8; Georgie Haysom, Avant, *Public Hearing Transcript*, 20 October 2016, p 15; Kym Ayscough, Acting Chief Executive Officer, AHPRA, *Public Briefing Transcript*, 2 November 2016, p 3.

<sup>185</sup> Submissions 1, 7, 38, 48, 52 and 55; AHPRA, *correspondence*, 28 October 2016; Timothy Bowen, MIGA, *Public Hearing Transcript*, 20 October 2016, p 10; Kym Ayscough, Acting Chief Executive Officer, AHPRA, *Public Briefing Transcript*, 2 November 2016, p 5.

<sup>186</sup> AHPRA, *correspondence*, 28 October 2016, pp 2 and 3.

The committee notes that the joint consideration process in NSW is well established, and that the HCCC and the Professional Councils have been able to consider complaints jointly, while still meeting the statutory 60 day timeframe for the assessment of complaints.

The Health Ombudsman did not support the introduction of a joint consideration process, stating that he was '... not aware of any qualitative evidence, nor has any been adduced, that demonstrates the superiority of joint consideration over any other method'. The Health Ombudsman also stated that the 2015 independent review into the NRAS suggested that 'considerable improvement is needed for the National Law model of joint consideration to be effective'.<sup>187</sup>

The committee notes, however, that while the independent review into the NRAS report highlighted concerns about the current NRAS joint consideration process, it did not rule out joint consideration models altogether. Rather, the independent review report recommended that a process be established where complaints and notifications involve a shared assessment of the appropriate means of investigating and addressing the issues between AHPRA and HCEs.<sup>188</sup>

Stakeholders also informed the committee that AHPRA had recently trialed a triage process in South Australia that involved early input into the decision-making process by clinicians, which has 'led to improvement in timeliness of the assessment process'.<sup>189</sup>

The Health Ombudsman, however, expressed the view that Queensland does not need to establish a shared assessment process, as the HO Act already requires consultation on all matters referred to AHPRA and the National Boards.<sup>190</sup> The committee understands, however, that this consultation requirement only applies where the OHO is minded to refer a matter to AHPRA and the National Boards, and not other decisions, such as to take no further action or investigate a matter.

#### **6.4 Assessment – statutory timeframes for providing information**

As part of its assessment of a complaint, the OHO may invite the complainant or relevant health service provider to make a submission about the complaint. The OHO may also require a person to give stated information to the OHO. The timeframes for providing a submission or information must be reasonable, but no more than 14 days after the request is made.<sup>191</sup>

Some stakeholders highlighted that giving health practitioners 14 days to provide information to the OHO during the assessment phase is impractical and does not give practitioners sufficient time to provide a fulsome response.<sup>192</sup> They stated that the timeframe is difficult to comply with for numerous reasons, including that many practitioners store files offsite, some individuals may be on leave or have left their employment, limitations on resources and the need for practitioners to obtain support from professional indemnity insurers and obtain legal advice.<sup>193</sup>

One stakeholder raised concerns that a focus solely on quick processes and decision-making may not provide practitioners the opportunity to make considered responses to complaints made against them, and that the provision of meaningful and relevant supporting or explanatory material benefits both practitioners and regulatory bodies in the prompt and fair resolution of matters.<sup>194</sup>

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<sup>187</sup> Health Ombudsman, *correspondence*, 28 October 2016, pp 3 and 4.

<sup>188</sup> Australian Health Ministers' Advisory Council, *Independent Review of the National Registration and Accreditation Scheme for health professions – Final Report*, December 2014, p 35.

<sup>189</sup> Submissions 7, 33 and 38.

<sup>190</sup> Health Ombudsman, *correspondence*, 28 October 2016, p 4.

<sup>191</sup> *Health Ombudsman Act 2013*, sections 47 and 48.

<sup>192</sup> Submission 3, 5, 7, 21, 29, 33, 35 and 41; Sarah Atkinson, ALA, *Public Hearing Transcript*, 20 October 2016, p 3; Timothy Bowen, MIGA, *Public Hearing Transcript*, 20 October 2016, p 8.

<sup>193</sup> Submissions 3, 29 and 52.

<sup>194</sup> QNU, submission 21, pp 10 and 11.

Another stakeholder noted that in NSW, the HCCC has 60 days to assess a complaint, and practitioners are usually given between 21 and 28 days to respond to a complaint, with scope for an extension if deemed necessary. They supported the OHO being given the time necessary to make appropriate, well-informed and impartial assessment decisions, so long as this approach provides a fair and appropriate amount of time for a practitioner to respond to a complaint.<sup>195</sup>

The Health Ombudsman acknowledged the burden the 14 day maximum timeframe can, from time-to-time, place on health service providers, and stated that he seeks to ensure that providers are assisted to meet the requirements of a notice to provide information.<sup>196</sup>

A number of stakeholders suggested that the Health Ombudsman should have the discretion to permit extensions to the statutory 14 day timeframe to ensure fair and reasonable decisions are made after receipt of relevant material and considered responses.<sup>197</sup> Alternatively, another stakeholder suggested that relevant parties be given 14 business days, rather than calendar days, to respond to a request for information.<sup>198</sup>

## 6.5 Investigations – greater transparency about non-compliance with statutory timeframes

The OHO must keep a publicly accessible register of all investigations that have not been completed within one year.<sup>199</sup> AHPRA and the National Boards stated that, '[t]his transparency is commendable and is a direct result of the implementation of the complaints system in Queensland and the direction that there be greater transparency and accountability for conducting investigations'.<sup>200</sup> In addition, the OHO must notify the committee and the Minister of investigations that have not been completed within two years and provide details of why each investigation has not been completed.<sup>201</sup>

Stakeholders, however, raised concerns about the Health Ombudsman's ability to grant three month extensions for investigations. They noted that there is limited information available about the basis on which these extensions are granted and limited opportunities to challenge the decision to extend the time. Stakeholders suggested there should be a more rigorous examination of the reasons for an investigation to go beyond the one year timeframe by an external body, such as a parliamentary committee, QCAT or the Queensland Ombudsman and a requirement for the OHO to provide the relevant health service provider with the reasons for the extension.<sup>202</sup>

One stakeholder suggested that the current public register of investigations exceeding one year was an 'insufficient measure', and recommended that the OHO publish further information on the register, including the number of previous extensions in relation to an investigation and more detailed information about the reasons for the extension to improve accountability and transparency.<sup>203</sup>

<sup>195</sup> MIGA, submission 33; Timothy Bowen, MIGA, *Public Hearing Transcript*, 20 October 2016, p 9.

<sup>196</sup> Health Ombudsman, submission 45, p 21.

<sup>197</sup> Submissions 3 and 21.

<sup>198</sup> Private Hospitals Association of Queensland, submission 29.

<sup>199</sup> *Health Ombudsman Act 2013*, section 85.

<sup>200</sup> AHPRA and the National Boards, submission 48, p 10.

<sup>201</sup> *Health Ombudsman Act 2013*, section 85.

<sup>202</sup> Submissions 29, 38 and 52; Justine Beirne, Head of Medical Defence and Services, Queensland, Avant, *Public Hearing Transcript*, 20 October 2016, p 15.

<sup>203</sup> Medical Indemnity Protection Society (MIPS), submission 52, p 3.

## 6.6 Greater use of clinical advice

Stakeholders noted that there is no legislative requirement for the Health Ombudsman to seek expert clinical advice, and raised concerns about a potential lack of clinical input into decisions about complaints.<sup>204</sup>

A number of stakeholders considered that clinical input into decision-making about complaints was essential, highlighting the potential for a serious complaint to be resolved, including immediate action to suspend or place conditions on a practitioner's registration, with no clinical input.<sup>205</sup>

Stakeholders also suggested that clinical advice, early in the consideration of a complaint, would improve the speed of complaints handling and reduce duplication.<sup>206</sup> Other stakeholders considered that a lack of clinical input might lead to complex and lengthy investigations being undertaken into baseless complaints.<sup>207</sup>

Concerns were also raised by stakeholders about the process adopted by the OHO for obtaining clinical advice, including selection criteria, and inconsistencies in the provision of information about any clinical advice received to the complainant and relevant health service provider.<sup>208</sup>

Stakeholders stated there needed to be a clearer process for obtaining clinical advice and more transparency in the information provided to practitioners about the clinical advice obtained, including the name of the clinician.<sup>209</sup> It was noted that while reasons for the OHO's decisions generally include a summary of clinical advice received, they do not include what information was provided to the clinical expert, the questions or issues on which the expert was asked to comment, the actual advice provided by the expert, or details of the qualifications of the expert. Stakeholders suggested legislative amendments to require that clinical advice on a matter is provided to relevant parties in a uniform way and contains the information described above.<sup>210</sup>

Other stakeholders recommended the establishment of permanent health professional councils or advisory committees within the structure of the OHO.<sup>211</sup> The committee notes that section 29 of the HO Act provides that the Health Ombudsman may establish advisory committees or panels of appropriately qualified persons to advise him or her about clinical matters or health consumer issues.

The Health Ombudsman advised that the OHO is:

*... committed to sourcing, as required, appropriately qualified practitioners to provide current, independent expert advice about clinical issues, and there is a small team in the office that manages requests for clinical advice. The independent technical advice ensures that decisions are appropriate, credible, robust and transparent. Without the input from these clinicians, the Health Ombudsman would have difficulty assessing whether there is validity to a complex clinical complaint.*<sup>212</sup>

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<sup>204</sup> Submissions 3, 5, 7, 38, 42, 52 and 55; Dr Zappala, President, AMAQ, *Public Briefing Transcript*, 31 August 2016, p 2; Martin Fletcher, Chief Executive Officer, AHPRA, *Public Briefing Transcript*, 31 August 2016, p 11; Sarah Atkinson, ALA, *Public Hearing Transcript*, 20 October 2016, p 2; Timothy Bowen, MIGA, *Public Hearing Transcript*, 20 October 2016, p 10.

<sup>205</sup> Submissions 5 and 7.

<sup>206</sup> AVANT, submission 38; Justine Beirne, Avant, *Public Hearing Transcript*, 20 October 2016, p 16; Sue McKee, Health Service Chief Executive's Forum (HSCEF), *Public Hearing Transcript*, 20 October 2016, p 20.

<sup>207</sup> HSCEF, submission 55.

<sup>208</sup> Submissions 3, 6, 7, 42, 52 and 55; Sarah Atkinson, ALA, *Public Hearing Transcript*, 20 October 2016, p 2.

<sup>209</sup> Sarah Atkinson, ALA, *Public Hearing Transcript*, 20 October 2016, p 2; Sue McKee, HSCEF, *Public Hearing Transcript*, 20 October 2016, p 21.

<sup>210</sup> ALA, submission 3.

<sup>211</sup> AMAQ, submission 7; Sarah Atkinson, ALA, *Public Hearing Transcript*, 20 October 2016, p 6.

<sup>212</sup> Health Ombudsman, submission 45, p 13.



The Health Ombudsman considered that clinical input is not necessary in every matter. The Health Ombudsman stated that 'clinical input ... would be a costly and irrelevant exercise, in the majority of matters that come to my Office'.<sup>213</sup> The committee notes that during 2015-16, the OHO only obtained 186 clinical advice reports in relation to the 2,510 health service complaints it considered.<sup>214</sup>

The Health Ombudsman advised that the selection of a clinical adviser is based on the individual's skills, knowledge and experience in the relevant health specialty.<sup>215</sup> The Health Ombudsman also noted:

*... to be eligible for selection as a clinical advisor to my Office, a clinician must have: an approved professional qualification(s) for the relevant area of clinical practice; a minimum of five years post-graduate experience in general practice, or minimum five years post-fellowship with the relevant specialist college; current clinical practice; current, unconditional (general or specialist) registration with an approved registration board; and no direct or perceived conflict of interest with the parties identified in the complaint matter, which cannot be managed appropriately.*<sup>216</sup>

The Health Ombudsman acknowledged there have been delays in identifying an appropriately experienced and qualified clinician, due to there only being a limited number of practitioners in an area of specialisation and because of conflicts of interest may be difficult to manage. The Health Ombudsman explained that '[i]n these circumstances, an interstate clinical advisor is sourced to ensure conflicts of interests are avoided'.<sup>217</sup>

## 6.7 Split matters – conduct, health and performance matters

The HO Act does not provide the Health Ombudsman with the power to require a health practitioner to undergo a health or performance assessment. This power rests solely with the National Boards.

The committee heard that in some cases this has led to complaints being 'split' between the OHO and the National Boards, with the OHO retaining issues relating to the conduct of the practitioner, and health or performance issues referred to AHPRA and the National Boards.<sup>218</sup>

Stakeholders considered that, in general, the conduct and health aspects of a complaint are related and dependent upon each other. A stakeholder provided the following example:

*A nurse's theft of medication from work is generally entirely related to their own personal health issues – in other words, theft of medication is usually for the practitioner's own use, rather than for resale of other purposes.*<sup>219</sup>

Stakeholders considered that treating these sorts of complaints separately as a conduct matter and a distinct health matter is artificial and fails to take a holistic approach to the situation. Stakeholders, therefore, recommended that such matters should be dealt with by one entity.<sup>220</sup>

AHPRA and the National Boards also raised concerns about the splitting of matters, stating:

*When health and conduct elements are separated, and all relevant information is not shared, concerns may not reach the necessary threshold for action (including for taking immediate action or placing conditions on a practitioner's registration).*<sup>221</sup>

AHPRA and the National Boards stated that if the complaint were kept intact and all relevant information shared it would be easier to see the actual risk of harm to the public and the need to take action.<sup>222</sup>

<sup>213</sup> Health Ombudsman, *correspondence*, 28 October 2016, p 7.

<sup>214</sup> Health Ombudsman, *correspondence*, 28 October 2016, pp 6 and 7.

<sup>215</sup> Health Ombudsman, submission 45, p 13.

<sup>216</sup> Health Ombudsman, *correspondence*, 28 October 2016, p 7.

<sup>217</sup> Health Ombudsman, submission 45, p 13.

<sup>218</sup> Submissions 21 and 33.

<sup>219</sup> QNU, submission 21, p 9.

<sup>220</sup> Submissions 21 and 33; Claire Gabriel, Hall Payne Lawyers, *Public Hearing Transcript*, 12 October 2016, p 2.

<sup>221</sup> AHPRA and National Boards, submission 48, p 5.

<sup>222</sup> AHPRA and National Boards, submission 48.

## 6.8 Consistency of data

A significant number of stakeholders considered that the Queensland health complaints system's ability to drive a robust, evidence-informed regulatory system in Queensland was diminished due to the OHO having its own data collection and reporting systems.

Stakeholders also highlighted the importance of producing nationally consistent data about health practitioners to help identify risks and trends in health complaints and benchmarking between, and within, jurisdictions.<sup>223</sup> AHPRA stated that it had nationally agreed data for every jurisdiction except Queensland.<sup>224</sup>

During its inquiry, the committee heard that the data produced by the OHO and provided to AHPRA was inconsistent with the data AHPRA collects nationally. AHPRA also stated that it was frequently unable to reconcile the data provided by the OHO.<sup>225</sup>

AHPRA and the National Boards raised concerns that the different methods of collecting data may lead to fragmentation of the national scheme, and hinder AHPRA's ability to make inter-state comparisons, identify risks and trends, make evidence-based decisions and understand patterns of complaints about health practitioners on a national basis.<sup>226</sup>

The committee understands that the inconsistencies in data arise from the method adopted by the OHO for counting complaints. AHPRA stated that the OHO counts the number of issues raised in a complaint, and there may be multiple issues raised in a single complaint, while the rest of the jurisdictions in the NRAS count the number of complaints against a practitioner.<sup>227</sup>

AHPRA explained that in the counting methodology used by the OHO not all complaints are included in the total count of complaints/matters reported. Similarly, the OHO may report a complaint more than once, if more than one issue is identified in a complaint that is counted. AHPRA and the National Boards stated that this meant there is no correlation between the number of complaints/matters reported by the OHO, the total number of complaints/notifications about health practitioners referred to AHPRA, or the number of notifications recorded by AHPRA as advised by the OHO.<sup>228</sup>

The Director-General of the department concurred that the data reported by OHO does not allow a national comparison of complaints across Australia and that is difficult to reconcile some of the data differences in the OHO performance reports.<sup>229</sup>

The Health Ombudsman informed the committee that he could not understand why AHPRA asserted that the data the OHO provides to AHPRA cannot be used to produce the datasets AHPRA requires. The Health Ombudsman stated he provides:

*AHPRA with information about all complaints received about registered practitioners regardless of whether they are referred or not, to enable AHPRA to maintain a comprehensive picture of a practitioner's notification history. In addition, I also provide advice to AHPRA on matters closed to assist with maintaining this record of a practitioner's history.*<sup>230</sup>

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<sup>223</sup> See for example submissions 1, 5, 7, 38 and 48; Claire Gabriel, Hall Payne Lawyers, *Public Hearing Transcript*, 12 October 2016, p 8.

<sup>224</sup> Martin Fletcher, Chief Executive Officer, AHPRA, *Public Briefing Transcript*, 31 August 2016, p 14.

<sup>225</sup> Kym Ayscough, Acting Chief Executive Officer, AHPRA, *Public Briefing Transcript*, 2 November 2016, p 8.

<sup>226</sup> Kym Ayscough, Acting Chief Executive Officer, AHPRA, *Public Briefing Transcript*, 2 November 2016, p 8; AHPRA and National Boards, submission 48.

<sup>227</sup> Kym Ayscough, Acting Chief Executive Officer, AHPRA, *Public Briefing Transcript*, 2 November 2016, p 8.

<sup>228</sup> AHPRA and the National Boards, submission 48, p 19.

<sup>229</sup> Michael Walsh, Director-General, Queensland Health, *Public Hearing Transcript*, 20 October 2016, p 27.

<sup>230</sup> Health Ombudsman, *correspondence*, 28 October 2016, p 8.

The Health Ombudsman stated that he had offered to send OHO staff members to AHPRA to help resolve the issue, assistance that AHPRA acknowledged. The Health Ombudsman stated that he would be willing to consider how the OHO collects or defines data to allow Queensland data to be nationally comparable, but noted that any changes may take time, for example if changes to information technology systems were needed.<sup>231</sup>

## 6.9 Information sharing

AHPRA and the National Boards raised concerns that there is no statutory obligation to share information about complaints received by the OHO that are not referred to AHPRA and the National Boards. In particular, AHPRA and the National Boards stated that it does not receive contextual information from the OHO about matters that are not accepted by the OHO or where no further action is taken, as it relates to practitioners.<sup>232</sup>

AHPRA and the National Boards stated that it was appropriate for the boards to have full visibility of complaints to identify patterns in practitioners' conduct or behaviour and to take early intervention before more serious events occur which may place the public at risk.<sup>233</sup>

The Health Ombudsman noted that the HO Act requires him to provide all of the material gathered regarding a practitioner:

*... in relation to matters that I have either assessed or investigated, not only are boards provided with all of the information; they are also provided with my reasons, explaining why, on the information to hand, the matter is now best suited to be dealt with by a board.*<sup>234</sup>

The committee notes that the OHO has agreed to provide AHPRA and the National Boards with more data about those complaints where the OHO decides to take no further action.<sup>235</sup>

In addition, the Health Ombudsman highlighted the challenges OHO staff have experienced accessing AHPRA's data, so they can understand a practitioner's history.<sup>236</sup>

The Health Ombudsman explained that AHPRA uses a database to store practitioner information. OHO staff can access this data, but only if they use one of the few licences the OHO holds to access it. If OHO staff cannot use one of the licences to access the data they must instead take screenshots, which is an inefficient process:

*... if you have five, six or seven years worth of history about a practitioner, that means that a lot of screen shots have to be done. It is a very clunky system just to get information about one practitioner that we can then put into our system that is unfortunately a point-in-time snapshot. Every time we get more information or another complaint about that practitioner, we have to go back and double-check that there has not been anything that has changed.*<sup>237</sup>

## 6.10 Stakeholder engagement

Stakeholders sought more constructive and collaborative working relationships with the Health Ombudsman and the OHO to discuss the operation and performance of the Queensland health complaints system.<sup>238</sup>

<sup>231</sup> Health Ombudsman, *correspondence*, 28 October 2016; Kym Ayscough, Acting Chief Executive Officer, AHPRA, *Public Briefing Transcript*, 2 November 2016, p 8.

<sup>232</sup> AHPRA and National Boards, submission 48; Martin Fletcher, Chief Executive Officer, AHPRA, *Public Briefing Transcript*, 31 August 2016, p 17.

<sup>233</sup> AHPRA and National Boards, submission 48, p 5.

<sup>234</sup> Health Ombudsman, *Public Briefing Transcript*, 2 November 2016, p 12.

<sup>235</sup> AHPRA, *correspondence*, 28 October 2016.

<sup>236</sup> Health Ombudsman, *correspondence*, 28 October 2016.

<sup>237</sup> Health Ombudsman, *Public Briefing Transcript*, 2 November 2016, p 19.

<sup>238</sup> Submissions 7, 38, 39 and 52; Beth Mohle, State Secretary, QNU, *Public Hearing Transcript*, 12 October 2016, p 3; Dr Zappala, President, AMAQ, *Public Briefing Transcript*, 31 August 2016, p 6; Timothy Bowen, MIGA, *Public Hearing Transcript*, 20 October 2016, pp 8 and 11.

For example, Avant raised concerns that it has 'not been able to engage directly with the Health Ombudsman himself with a view to working collaboratively to improve complaints handling processes'.<sup>239</sup> Similarly the QNU expressed a concern that there was not a formal mechanism to discuss potential systemic issues, and suggested that regular quarterly meetings with the Health Ombudsman, similar to meetings it has with AHPRA to discuss 'trends and what are the issues and how we can make the system work better', would be useful.<sup>240</sup>

In response to the above concerns, the Health Ombudsman stated that he cannot engage with stakeholders about individual matters, and highlighted the need to avoid any perception of bias arising from his meeting with stakeholders.<sup>241</sup> The Health Ombudsman explained that his senior staff attend a range of meetings with practitioners' representatives and other key stakeholder groups where operational matters are discussed regularly. The Health Ombudsman also provided details of the number of meetings and stakeholder forums he and his staff had attended since 1 July 2014.<sup>242</sup>

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<sup>239</sup> Avant, submission 38, p 7.

<sup>240</sup> QNU, *Public Hearing Transcript*, 12 October 2016, pp 3-4.

<sup>241</sup> Leon Atkinson-MacEwen, Health Ombudsman, *Public Briefing Transcript*, 2 November 2016, p 22.

<sup>242</sup> Health Ombudsman, *correspondence*, 28 October 2016, p 9.

## 7 Committee's initial recommendations and ongoing monitoring of the system

### 7.1 Introduction

The committee notes AHPRA's, and some stakeholders', calls for fundamental changes to the HO Act to reduce role confusion, duplication of work, and delays in the resolution of complaints.<sup>243</sup>

The committee notes however, that while stakeholders called for changes to the health complaints system it was not suggested that the previous HQCC model should be reinstated. The Australian Lawyers Alliance explicitly opposed the reinstatement of the HQCC model, advising that 'there were problems with that model'.<sup>244</sup> While AHPRA recommended against the 'wholesale replacement of the current model', instead suggesting 'building on specific strengths of the current arrangement'.<sup>245</sup>

The committee considers that it would be premature to fundamentally change the health complaints system in Queensland. The committee does, however, have significant concerns about the OHO's performance against its statutory timeframes in relation to the handling of complaints.

The committee acknowledges the impact that the high volume of 'legacy matters' referred from AHPRA and HQCC in July 2014, and recent increases in the number of complaints received have had on the operation of the OHO. The committee also acknowledges the hard work undertaken by the Health Ombudsman, and his staff, in establishing a new health complaints body.

The committee notes, however, that the OHO is consistently failing to meet its statutory timeframes. This includes non-compliance with the statutory timeframes for reaching an initial decision on a matter (49 per cent of matters decided within seven days), the assessment of a matter (32 per cent within 60 days (including with a 30 day extension), and the investigation of a matter (53 per cent within one year).

The committee also notes that the OHO's compliance with statutory timeframes has decreased since 2014-15, its first year of operation, despite an increase in its actual expenditure to approximately \$16.8 million and an increase in full time equivalent staff from 94 to 125 in 2015-16.

In comparison, and while acknowledging the differences between the models and that the HCCC in NSW is a much more mature body, the committee notes that the HCCC is able to complete approximately 90 per cent of its assessments within 60 days and approximately 85 per cent of investigations within one year, despite handling more complaints and having fewer staff and a lower budget than the OHO.

The committee notes the differing views expressed by stakeholders about the potential causes of the OHO's non-compliance with statutory timeframes. However, the committee considers that the reasons for these performance issues are not clear-cut, especially in a complex regulatory environment, with overlapping responsibilities and potential duplication between organisations. The committee also notes that previous health complaints bodies in Queensland, (including the HQCC), and AHPRA and the National Boards, at the national level, have experienced similar performance issues.

The committee's role in monitoring the health complaints system is to ensure that the public interest is being served. The committee, therefore, considers that further investigation is required to determine the underlying reasons for the performance issues currently experienced by the health complaint system, and their potential impact on the health and safety of Queenslanders.

<sup>243</sup> See, for example, QNU, submission 21; Dr Zappala, President, AMAQ, *Public Briefing Transcript*, 31 August 2016, p 4; Martin Fletcher, Chief Executive Officer, AHPRA, *Public Briefing Transcript*, 31 August 2016, p 10.

<sup>244</sup> Sarah Atkinson, Australian Lawyers Alliance, *Public Briefing Transcript*, 20 October 2016, p 4.

<sup>245</sup> Martin Fletcher, Chief Executive Officer, AHPRA, *Public Briefing Transcript*, 31 August 2016, p 10.

As an initial step, however, the committee has made a number of recommendations to the Queensland Government, the Health Ombudsman, AHPRA and the National Boards aimed at improving the performance of the Queensland health complaints system.

The committee has also identified a number of areas on which it will focus during the 2016-17 financial year, as part of its ongoing monitoring and oversight role.

## 7.2 Committee's initial recommendations

### 7.2.1 Joint consideration process

The committee notes the differing views about the benefits that the introduction of a joint consideration process may have to the handling of health service complaints in Queensland.

The committee recommends that the Queensland Government investigate the merits of amending the HO Act to introduce a joint consideration process between the OHO and AHPRA and the National Boards. In undertaking its investigations, the committee recommends that the Queensland Government examine the joint consideration processes currently in place in NSW, under its co-regulatory approach, and the other states and territories in the NRAS.

The committee also recommends that the Queensland Government consider the practicalities of introducing a joint consideration process, including:

- the potential benefits of merging the current initial decision (seven days) and assessment (30 days, with the option of a 30 day extension) stages to create one assessment stage for complaints
- whether the current statutory timeframes for initial decisions and assessment would need to be amended to facilitate a joint consideration process, with appropriate clinical input, for example, the NSW scheme provides 60 days for the assessment of a complaint
- whether the current statutory 14 day timeframe for health service providers and complainants to provide a submission or requested information is adequate to ensure decision-makers have sufficient information on which to make informed decisions, and
- how to ensure clinical input is available and utilised, where necessary, to inform a joint consideration process.

#### Recommendation 1

The committee recommends that the Queensland Government investigate the merits of amending the *Health Ombudsman Act 2013* to introduce a joint consideration process for health service complaints between the OHO and AHPRA and the National Boards.

In undertaking its investigations, the committee recommends the joint consideration processes in place in NSW, under its co-regulatory approach, and other states and territories under the National Registration and Accreditation Scheme.

The committee also recommends that the Queensland Government consider the practicalities of introducing a joint consideration process, including:

- the potential benefits of merging the current initial decision and further assessment stages to create one assessment stage for complaints
- whether the current statutory timeframes for initial decisions and assessment would need to be amended to facilitate a joint consideration process, including with clinical input (where necessary)
- whether the current statutory 14 day timeframe for health service providers and complainants to make submissions and provide requested information is adequate to ensure decision-makers have sufficient information to make informed decisions, and
- how to ensure appropriate clinical input is available and utilised, where necessary, to inform any joint consideration of complaints.

### **7.2.2 Split matters – conduct, health and performance**

The committee shares stakeholders' concerns about the splitting of matters into conduct and performance or health issues, with the latter issues being referred to AHPRA and the National Boards.

The committee notes that the splitting of matters is, in part, a result of the lack of powers in the HO Act for the Health Ombudsman to require a health practitioner to undergo a health or performance assessment to ascertain the extent of any impairments or performance issues.

The committee understands that the intention of the HO Act was for AHPRA and the National Boards to continue to be responsible for the health and performance of health practitioners. However, the HO Act also intended that the OHO should deal with all serious matters.

The committee considers that these two separate intentions are brought into conflict, for example, where a potentially serious conduct matter (eg dishonestly obtaining prescription drugs) may also relate to a practitioner's impairment (eg drug addiction). Currently, in these circumstances, the complaint may be split with the OHO retaining the conduct element of the complaint and the health and performance issues being referred to AHPRA and the National Boards.

The committee recommends that the Queensland Government consider options for ensuring that potentially serious professional misconduct matters, which may also raise issues about a health practitioner's health or performance, are able to be dealt with, as whole, rather than being split between the OHO and AHPRA and the National Boards.

#### **Recommendation 2**

The committee recommends that the Queensland Government consider options for ensuring that potentially serious professional misconduct matters, which may also raises issues about a health practitioner's health or performance, are able to be dealt with, as a whole, rather than being split between the OHO and AHPRA and the National Boards.

### **7.2.3 Nationally-consistent data and information sharing**

The committee shares stakeholders' views about the importance of ensuring that nationally consistent data can be produced about health service complaints, practitioner conduct and wider health service issues. The committee also acknowledges the importance of information sharing between OHO, AHPRA and the National Boards, given their joint responsibility for protecting public health and safety in Queensland.

The committee acknowledges the many challenges that arise when establishing a new organisation, and that it can take time to fully understand and refine the data it needs to collect, and how it can make such data accessible to other organisations. However, the committee considers that the issues around data consistency and information sharing should not have remained unresolved after two-and-a-half years.

The committee notes the recent commitments from both the Health Ombudsman and AHPRA and the National Boards to resolve any issues in relation to information sharing and the data provided by the OHO to AHPRA to enable the production of nationally consistent data.

In order to ensure that this momentum is maintained, the committee recommends that OHO and AHPRA and the National Boards produce a joint plan, which identifies the information needs of all parties and any barriers to the sharing of information, and sets out an agreed approach for resolving any data issues that prevent the production of nationally consistent data about health service complaints. The committee also recommends that the joint plan include agreed implementation dates for the actions outlined in the plan.

The committee requests joint quarterly progress updates from the OHO and AHPRA and the National Boards outlining the action taken that quarter and proposed future steps to resolve any issues.



### **Recommendation 3**

The committee recommends that the Office of the Health Ombudsman, AHPRA and the National Boards produce a joint plan, which identifies the information needs of all parties and any barriers to the sharing of information, and sets out an agreed approach for resolving any data issues that prevent the production of nationally-consistent data about health service complaints.

The committee recommends that the joint plan include agreed implementation dates for the actions identified in the plan.

#### **7.2.4 Health Ombudsman's suggested legislative amendments**

During the committee's inquiry, the Health Ombudsman suggested a number of amendments to the HO Act and the National Law (Queensland) – see **Appendix C**.

The committee has considered the suggested amendments, which, in the main, are aimed at addressing practical issues and some uncertainty the OHO has experienced since the introduction of the HO Act. The committee understands that the Health Ombudsman has shared his suggested amendments with the Minister. The Health Ombudsman's suggestions include legislative amendments to:

- correct potential deficiencies in the HO Act
- provide clarity around timeframes and legislative requirements
- provide flexibility in dealing with issues from complaints to ensure all relevant parties can be included in the process of local resolution or conciliation, and
- remove uncertainty or barriers to the effective sharing of information to ensure that the health and safety of the public are protected.<sup>246</sup>

The committee recommends that the Queensland Government consider whether to introduce legislation to make the Health Ombudsman's suggested amendments to the HO Act and the National Law (Queensland).

### **Recommendation 4**

The committee recommends that the Queensland Government consider whether to introduce legislation to make the Health Ombudsman's suggested amendments to the *Health Ombudsman Act 2013* and the *Health Practitioner Regulation National Law Act 2009* (Qld).

<sup>246</sup> Health Ombudsman, submission 45, p 11.

### **7.3 Key areas of focus for the committee's ongoing monitoring role**

In undertaking its inquiry, the committee has identified the following areas on which it will focus during 2016-17, as part of its ongoing monitoring role:

- the number of complaints not dealt with within the statutory timeframes and the reasons for non-compliance, including the statutory timeframes for initial decisions, further assessment and investigation
- the number of investigations the Health Ombudsman gives the committee notice of for not being completed within two years
- the number of immediate action decisions taken by the Health Ombudsman
- the number of complaints referred to AHPRA and the National Boards at the initial decision stage, the assessment stage and following an investigation
- the number of potentially serious matters identified by the National Boards and the number of those matters that the Health Ombudsman requests back and those he directs should be retained by the National Boards, and
- the number of matters referred to the director of proceedings for consideration for referral to QCAT and the number of matters ultimately referred to QCAT.

The main focus of this inquiry has been on the performance of the Health Ombudsman's functions. In 2016-17, the committee intends to examine, in more detail, AHPRA and the National Board's performance in relation to the health, conduct and performance of health practitioners providing a health service in Queensland.

## Appendix A – List of submitters

Sub #	Submitter
001	Jenny Namkoong
002	Associate Professor Michael Greco
003	Australian Lawyers Alliance
004	Confidential
005	Royal Australasian College of Medical Administrators
006	Russell Broadbent
007	Australian Medical Association Queensland
008	Queensland Ombudsman
009	Confidential
010	Confidential
011	Ron Bond
012	Confidential
013	Janice Crosbie
014	Julie Bury
015	Confidential
016	Confidential
017	Confidential
018	Confidential
019	Confidential
020	Office of the Public Advocate
021	Queensland Nurses' Union
023	Queensland Health
024	Confidential
025	Confidential
026	Confidential
027	Health Professionals Australia Reform Association
028	Confidential
029	Private Hospitals Association of Queensland Inc.
030	Confidential
031	Queensland Mental Health Commission
032	Australasian College of Dermatologists
033	Medical Insurance Group Australia
034	Confidential

<b>Sub #</b>	<b>Submitter</b>
035	Australian College of Rural and Remote Medicine
036	Confidential
037	Health Consumers Queensland
038	Avant Mutual Group
039	Doctors' Health Advisory Services (Q)
040	Frank New
041	Children's Health Queensland
042	Royal Australasian College of Surgeons
043	Anne Awabdy
044	Australasian College for Emergency Medicine
045	Office of the Health Ombudsman
046	West Moreton Hospital and Health Service
048	Australian Health Practitioner Regulation Agency
049	Confidential
050	Confidential
051	Confidential
052	Medical Indemnity Protection Society Ltd.
053	Australian Association of Massage Therapists
054	Dr Donna-Louise McGrath
055	Health Service Chief Executives' Forum

## Appendix B – Witnesses at public briefings and hearings

### Public briefing – Wednesday 31 August 2016

Dr Chris Zappala – President, Australian Medical Association Queensland

Mr Martin Fletcher – Chief Executive Officer, AHPRA

Dr Susan O'Dwyer – Medical Practitioner Member, Queensland Board of the Medical Board of Australia

Ms Tracey Stenzel – Acting Queensland State Manager, AHPRA

Mr Leon Atkinson-MacEwen, Health Ombudsman

### Public hearing – Wednesday 12 October 2016

Ms Beth Mohle – State Secretary, Queensland Nurses' Union

Ms Claire Gabriel – Hall Payne Lawyers

Mr Mark Tucker-Evans – Chair, Health Consumers Queensland

Ms Melissa Fox – General Manager, Health Consumers Queensland

### Public hearing – Thursday 20 October 2016

Ms Sarah Atkinson – Australian Lawyers Alliance

Mr Timothy Bowen – Senior Solicitor, Advocacy, Claims and Education, Medical Insurance Group Australia

Ms Justine Beirne – Head of Medical Defence and Services, Queensland, Avant Mutual Group

Ms Georgie Haysom – Head of Advocacy, Avant Mutual Group

Ms Sue McKee – Chief Executive, West Moreton Hospital and Health Service, Queensland Health Service Chief Executives' Forum

Mr Michael Walsh – Director-General, Queensland Health

### Public briefing – Wednesday 2 November 2016

Ms Kym Ayscough – Acting Chief Executive Officer, AHPRA

Ms Rose Kent – Queensland State Manager, AHPRA

Dr Susan O'Dwyer – Medical Practitioner Member, Queensland Board of the Medical Board of Australia

Mr Leon Atkinson-MacEwen, Health Ombudsman

**Appendix C – Health Ombudsman's suggested amendments to the *Health Ombudsman Act 2013* and the *Health Practitioner Regulation National Law Act 2009 (Qld)***

## Suggested amendments to the Health Ombudsman Act 2013 and the Health Practitioner Regulation National Law Act 2009

Current HO Act Provision	Proposed HO Act Provision (changes in red)	Rationale
<p><b>Section 31 Meaning of a health service complaint:</b></p> <p>A health service complaint is a complaint about a health service or other service provided by a health service provider.</p>	<p><b>Section 31 Meaning of a health service complaint:</b></p> <p>A health service complaint is a complaint about a health service or other service provided by a health service provider, <i>or about the health, conduct or performance of the health service provider.</i></p>	<p>There is inconsistency between the National Law and the HO Act and the role of the Health Ombudsman to deal with complaints about 'professional misconduct' which involve matters of fitness and propriety that fall outside the definition of a complaint about a 'health service or other service provided'.</p> <p>This amendment would clarify the meaning of a health service complaint and remove the inconsistency.</p>
<p><b>Section 35 Deciding how to proceed</b></p> <p>(1) Within 7 days after receiving a complaint, the health ombudsman must—</p> <p>(a) decide—</p> <p>(i) to accept the complaint and take particular relevant action to deal with the matter of the complaint; or</p> <p>(ii) to take no further action in relation to the complaint; and</p> <p><i>Note— See section 44 for the grounds on which the health ombudsman may decide to take no further action on a complaint.</i></p> <p>(b) give notice of the decision to the complainant and relevant health service provider under section 278.</p> <p>(2) In determining for subsection (1) the number of days that have elapsed since the health ombudsman received a complaint, any days on which there is an outstanding requirement under section 34 are not counted.</p>	<p><b>Section 35 Deciding how to proceed</b></p> <p>(1) Within 7 days after receiving a complaint, the health ombudsman must decide—</p> <p>(a) to accept the complaint and take particular relevant action to deal with the matter of the complaint; or</p> <p>(b) to take no further action in relation to the complaint; and</p> <p><i>Note— See section 44 for the grounds on which the health ombudsman may decide to take no further action on a complaint.</i></p> <p>(2) <i>Within 7 days after deciding to accept a complaint or to take no further action in relation to the complaint, the health ombudsman must give notice of the decision to the complainant and relevant health service provider under section 278.</i></p> <p>(3) In determining for subsection (1) the number of days that have elapsed since the health ombudsman received a complaint, any days on which there is an outstanding requirement under section 34 <i>and any days on which there are</i></p>	<p>Currently the requirement to accept within 7 calendar days, when read with section 38 of the <i>Acts Interpretations Act 1954</i>, means that there are a range of timeframes that follow when a complaint is received, depending on whether it is received over a weekend, on a public holiday, and/or whether there are intervening public holidays within the 7 calendar day timeframe. Changing "7 days" to "5 business days" will simplify the counting requirement and provide absolute clarity around the statutory timeframes for assessing complaints.</p> <p>Under s.35(1)(a)(i) of the Act, the Health Ombudsman is required to accept AND consult within 7 days where the Health Ombudsman is referring a matter to AHPRA or another government entity (as sections 91 and 92 respectively of the HO Act require the Health Ombudsman to consult with the AHPRA or another government entity prior to referral of a matter to AHPRA or that entity).</p> <p>Approximately 20 per cent of complaints are referred directly from the acceptance stage to AHPRA. While consultation with AHPRA is efficient, AHPRA are not required to meet the current 7 calendar day timeframe. As a result, all of the matters that require consultation with AHPRA</p>

Current HO Act Provision	Proposed HO Act Provision (changes in red)	Rationale
	<p><i>consultations with either the National Agency or another government entity in relation to a referral of a complaint to either the National Agency or another government entity</i> are not counted.</p>	<p>cannot be completed within the 7 calendar day time frame allotted to the decision to accept and take either a relevant action or no further action.</p> <p>Section 34 of the HO Act allows for the gathering of additional information from a complainant and, where that information has not yet been received, the HO Act allows for that time not to be counted as part of the 7 calendar days (as the provision of information by a complainant is a process outside of the Health Ombudsman's control). As the time spent in consultation with AHPRA or another government entity is time outside of the Health Ombudsman's control, a similar provision that allows for that time period not to be counted within the 7 calendar period is also appropriate.</p>
<p><b>38 Meaning of relevant action</b></p> <p>...</p> <p>(3) Each of the following is a relevant action for dealing with a matter relating to a health service other than as part of a health service complaint—</p> <p>(a) taking immediate action under part 7;</p> <p>(b) investigating the matter under part 8;</p> <p>(c) referring the matter to the National Agency or an entity of the State, another State or the Commonwealth under part 9;</p> <p>(d) referring the matter to the director of proceedings under part 10, division 2 for decision about whether to refer the matter to QCAT;</p> <p>(e) carrying out an inquiry into the matter under part 12</p>	<p><b>38 Meaning of relevant action</b></p> <p>...</p> <p>(3) Each of the following is a relevant action for dealing with a matter relating to a health service other than as part of a health service complaint—</p> <p>(a) <i>assessing the complaint under part 5</i></p> <p>(b) taking immediate action under part 7;</p> <p>(c) investigating the matter under part 8;</p> <p>(d) referring the matter to the National Agency or an entity of the State, another State or the Commonwealth under part 9;</p> <p>(e) referring the matter to the director of proceedings under part 10, division 2 for decision about whether to refer the matter to QCAT;</p> <p>(f) carrying out an inquiry into the matter under part 12</p>	<p>Currently, when a matter is notified to the Health Ombudsman from the Queensland Police Service, the matter must be dealt with under s. 38 (3) as the referral is not a "health service complaint".</p> <p>As these matters vary in seriousness and require information to be gathered, the Health Ombudsman is currently only able to gather that information under the part 8 investigation powers. In many cases, the additional information gathered indicates that the matter should be referred to the relevant National Board to be dealt with, or dealt with by the Health Ombudsman under another relevant action more suitable to non-serious matters (for example, local resolution).</p> <p>Investigation in these circumstances is not the most suitable approach but is, as indicated, the only way to enliven information gathering powers. The inclusion of the ability to assess a matter would enliven information gathering powers more suited to determining the most appropriate course of action to deal with the matter.</p>



Current HO Act Provision	Proposed HO Act Provision (changes in red)	Rationale
<p><b>44 Decision to take no further action on a matter</b></p> <p>(1) At any time, the health ombudsman may decide to take no further action on a health service complaint or other matter if the health ombudsman reasonably considers—</p> <p>(a) the complaint or other matter—</p> <p>(i) is frivolous, vexatious, trivial or not made in good faith; or</p> <p>(ii) is misconceived or lacking in substance; or</p> <p>(iii) is being adequately dealt with by another appropriate entity; or</p> <p>(iv) has been resolved or otherwise appropriately finalised by the health ombudsman or another appropriate entity; or</p> <p>(v) despite reasonable efforts by the health ombudsman or another appropriate entity, cannot be resolved; or</p> <p>...</p>	<p><b>44 Decision to take no further action on a matter</b></p> <p>(1) At any time, the health ombudsman may decide to take no further action on a health service complaint or other matter if the health ombudsman reasonably considers—</p> <p>(a) the complaint or other matter—</p> <p>(i) is frivolous, vexatious, trivial or not made in good faith; or</p> <p>(ii) is misconceived or lacking in substance; or</p> <p>(iii) is being adequately dealt with <i>by the health ombudsman or</i> by another appropriate entity; or</p> <p>(iv) has been resolved or otherwise appropriately finalised by the health ombudsman or another appropriate entity; or</p> <p>(v) despite reasonable efforts by the health ombudsman or another appropriate entity, cannot be resolved; or</p> <p>...</p>	<p>This would allow the Health Ombudsman the discretion to take no further action in relation to a complaint where the same complaint has already been received from another person and is being dealt with.</p>

Current HO Act Provision	Proposed HO Act Provision (changes in red)	Rationale
<p><b>49 Period for completing assessment</b></p> <p>(1) The health ombudsman must complete the assessment within 30 days after deciding to carry out the assessment.</p> <p>(2) However, the health ombudsman may extend the period for assessing the complaint by a further period of up to 30 days if necessary because of—</p> <p>(a) the size or complexity of the complaint; or</p> <p>(b) the time taken to obtain submissions under section 47 or information under section 48.</p>	<p><b>49 Period for completing assessment</b></p> <p>(1) The health ombudsman must complete the assessment within 30 <i>business</i> days after deciding to carry out the assessment.</p> <p>(2) However, the health ombudsman may extend the period for assessing the complaint by a further period of up to 30 <i>business</i> days if necessary because of—</p> <p>(a) the size or complexity of the complaint; or</p> <p>(b) the time taken to obtain submissions under section 47 or information under section 48; or</p> <p>(c) <i>the time taken to consult with an entity with relevant technical expertise about the matter of the complaint.</i></p>	<p>A period of 30 days (for a standard assessment) can include 8 weekend days – resulting in the OHO only having 22 days to assess a complaint.</p> <p>Additionally, the HO Act provides up to 14 days to allow for complaint information to be provided to the Health Ombudsman, leaving 8 days to assess a complaint (assuming the Health Ombudsman sends out notices on the same day it is received, allocated and accepted for assessment; and all the information requested by the Health Ombudsman arrives within the 14 day timeframe).</p> <p>Given the necessary administrative work, information gathering and external consultation processes, a change to 30 business days will allow for those processes to occur and for a thorough and considered assessment of the (often copious) complaint material.</p>
<p><b>52 How local resolution may be achieved</b></p> <p>(1) The purpose of taking action under this part is to facilitate resolution of the complaint between the complainant and relevant health service provider as quickly as possible and with minimal intervention by the health ombudsman.</p> <p>(2) To facilitate resolution of the complaint, the health ombudsman may take the actions the health ombudsman considers appropriate including, for example—</p> <p>(a) analysing information provided with the complaint; and</p> <p>(b) considering submissions received under section 53 from the complainant or relevant health service provider; and</p>	<p><b>52 How local resolution may be achieved</b></p> <p>(1) The purpose of taking action under this part is to facilitate resolution of the complaint between the complainant and relevant health service provider as quickly as possible and with minimal intervention by the health ombudsman.</p> <p>(2) To facilitate resolution of the complaint, the health ombudsman may take the actions the health ombudsman considers appropriate including, for example—</p> <p>(a) analysing information provided with the complaint; and</p> <p>(b) considering submissions received under section 53 from the complainant, relevant health service provider <i>and other parties with a sufficient relevant interest in the matter</i>; and</p>	<p>The legislation currently only provides for local resolution between a health service provider and complainant. There is some uncertainty regarding the position where other parties, such as an employer, may wish to be involved in the local resolution process.</p> <p>In many instances, it may be the employer and not the practitioner themselves that is the party that can resolve the complaint.</p> <p>It is proposed that these provisions be amended to allow the Health Ombudsman to engage with and seek submissions from parties with a sufficient interest in the matter.</p> <p>It should be noted that there are a number of provisions that allow for interested parties to be involved in a conciliation process in other Queensland legislation (see for example: s.407 of the <i>Residential Tenancies and Rooming Accommodation Act 2008</i>; s.252E of the <i>Body Corporate and Community Management Act 1997</i>;</p>

Current HO Act Provision	Proposed HO Act Provision (changes in red)	Rationale
<p>(c) analysing information obtained under section 54 from the complainant, relevant health service provider and others; and</p> <p>(d) facilitating meetings and other communications between the complainant and relevant health service provider; and</p> <p>(e) facilitating agreement on a course of action between the complainant and relevant health service provider.</p> <p><b>53 Submissions</b></p> <p>(1) The health ombudsman may give a notice to the complainant or the relevant health service provider inviting submissions about the complaint to be given to the health ombudsman within a stated period.</p> <p>(2) The stated period for giving submissions must be reasonable but must not be more than 14 days after the notice is given.</p> <p>(3) The health ombudsman must consider each submission received within the stated period.</p>	<p>(c) analysing information obtained under section 54 from the complainant, relevant health service provider and others; and</p> <p>(d) facilitating meetings and other communications between the complainant and relevant health service provider <i>and other parties with a sufficient relevant interest in the matter</i>; and</p> <p>(e) facilitating agreement on a course of action between the complainant and relevant health service provider.</p> <p><b>53 Submissions</b></p> <p>(1) The health ombudsman may give a notice to the complainant or the relevant health service provider <i>or other parties with a sufficient relevant interest in the matter</i> inviting submissions about the complaint to be given to the health ombudsman within a stated period.</p> <p>(2) The stated period for giving submissions must be reasonable but must not be more than 14 days after the notice is given.</p> <p>(3) The health ombudsman must consider each submission received within the stated period.</p>	<p>and ss 159 and 163 of the <i>Anti-Discrimination Act 1991</i>).</p>
<p><b>55 Period for attempting resolution</b></p> <p>(1) The health ombudsman must try to resolve the health service complaint within 30 days after deciding to try local resolution.</p> <p>(2) The health ombudsman may extend the period for taking action under this part to resolve the complaint by a further period of up to 30 days if—</p> <p>(a) it has not been possible to resolve the complaint within the period mentioned in subsection (1) because of the time taken to obtain submissions under section 53 or information under section 54; or</p>	<p><b>55 Period for attempting resolution</b></p> <p>(1) The health ombudsman must try to resolve the health service complaint within 30 <i>business</i> days after deciding to try local resolution.</p> <p>(2) The health ombudsman may extend the period for taking action under this part to resolve the complaint by a further period of up to 30 <i>business</i> days if—</p> <p>(a) it has not been possible to resolve the complaint within the period mentioned in subsection (1) because of the time taken to obtain submissions under section 53 or information under section 54; or</p>	<p>Consistent with earlier recommendations this change would allow for a more realistic period of time to complete negotiations as 8 of the 30 days are potentially weekends. In addition, the majority of complaints moving into local resolution are from Intake. This means that in the first 14 days, information has to be sourced and negotiation cannot commence until the Health Ombudsman has received all information relevant to the complaint.</p> <p>If all information required is received within 14 days and we add the 8 days that are weekends, the Health Ombudsman effectively has only have 8</p>



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<p>(b) the complaint has not been resolved within the period mentioned in subsection (1) but the health ombudsman believes the complaint may be resolved under this part within the extended period.</p>	<p>(b) the complaint has not been resolved within the period mentioned in subsection (1) but the health ombudsman believes the complaint may be resolved under this part within the extended period.</p> <p><i>(3) In determining for subsections (1) and (2) the number of days that have elapsed since the health ombudsman decided to try local resolution or extended the period for taking action, any days during which the matter is referred for action to the National Agency or another government entity are not counted.</i></p>	<p>days available to conduct meaningful negotiations and achieve local resolution.</p> <p>While the Health Ombudsman is able to extend time for another 30 days, the primary legislative focus is on completing local resolution within 30 days. 30 business days would allow the required reasonable timeframe for this to be achieved.</p> <p>If simultaneous referral to AHPRA or other entity and local resolution occurs, one or both parties often will not agree to engage in local resolution until the issues referred to AHPRA or another entity are resolved. These are processes out of the Health Ombudsman's control. As the time spent while a matter is referred to AHPRA or another government entity is time outside of the Health Ombudsman's control, a provision that allows for that time period not to be counted within the 30 + 30 local resolution timeframe is appropriate.</p>
<p><b>62 Period of immediate action</b></p> <p>(1) A decision of the health ombudsman to take immediate registration action in relation to a registered health practitioner takes effect on the day the notice under section 60 is given to the practitioner or, if a later day is stated in the notice, the later day.</p> <p>(2) The decision continues to have effect until the earlier of the following happens—</p> <p>(a) QCAT sets aside the decision—</p> <p>(i) on application by the practitioner for a review of the decision; or</p> <p>(ii) on referral of the matter to QCAT by the director of proceedings on the health ombudsman's behalf;</p> <p>(b) the health ombudsman revokes the suspension or removes the conditions (whichever is relevant) under section 65.</p>	<p><b>62A Monitoring and reporting on health practitioners' compliance with the immediate registration actions taken</b></p>	<p>The HO Act does not provide an explicit power to allow the Health Ombudsman to monitor and report on a practitioner's compliance with an immediate action decision. Currently reporting provisions have to be included in the conditions placed on a registered practitioner. Where a practitioner is suspended, however, or where an unregistered practitioner is restricted or prohibited, it is extremely difficult to impose a positive obligation to provide information for compliance purposes.</p> <p>Moreover, once a matter is referred to the Director of Proceedings for consideration in relation to referring the practitioner to QCAT, the Health Ombudsman has no powers to gather further information around compliance with immediate registration actions taken. In order to enliven information gathering powers, the Health Ombudsman has to commence an own-motion investigation into the practitioner, solely for the purpose of monitoring compliance.</p>

Current HO Act Provision	Proposed HO Act Provision (changes in red)	Rationale
		<p>A new provision clarifying the Health Ombudsman's ability to monitor and report on a practitioner's compliance with immediate registration action will ensure that the Health Ombudsman can effectively protect the health and safety of the public.</p>
<p><b>63 Application to QCAT for review</b></p> <p>(1) If the health ombudsman decides to take immediate registration action in relation to a registered health practitioner, the practitioner may apply, as provided under the QCAT Act, to QCAT for a review of the decision.</p> <p>(2) If the health ombudsman gives a notice to the practitioner under section 61(3)(b)(i) confirming the decision to take the immediate registration action, an application to QCAT for a review of the decision may be made within 28 days after that notice is given.</p>	<p><b>63A Changing or reviewing of conditions</b></p>	<p>Currently there are no provisions for the Health Ombudsman to review conditions imposed on a practitioner, nor are there provisions for a practitioner to apply for a review of conditions imposed upon them.</p> <p>The National Law provides for the changing or removing conditions or undertaking on application by a registered health practitioner or student to a National Board, changing conditions on the Board's initiative and the National Board's removal of condition or revocation of undertaking.</p> <p>An amendment to the HO Act to include similar provisions to the National Law would provide practitioners with an avenue to have their conditions reviewed, and for the Health Ombudsman to change a practitioners conditions on HO's initiative.</p> <p>Where a matter appears serious at initial lodgement of the complaint, the most appropriate relevant action under s. 35 of the HO Act is investigation. Upon initial investigation, information may be obtained that suggests that the matter is also one which gives rise to reasonable belief of serious risk, where the Health Ombudsman may determine that it is necessary to act to protect the health and safety of the public.</p> <p>If immediate action is taken under the current provision, the HO Act could be construed to require that the matter must be referred under (b) or (c) because an investigation was already underway prior to the immediate action commencing (as there is no explicit power to continue with the existing investigation).</p>
<p><b>64 Health ombudsman must immediately take further relevant action</b></p> <p>Immediately after deciding to take immediate registration action in relation to a registered health practitioner, the health ombudsman must—</p> <p>(a) start an investigation under part 8 about the matter giving rise to the immediate registration action; or</p> <p>(b) refer the matter to the National Agency or an entity of the State, another State or the Commonwealth under part 9; or</p> <p>(c) refer the matter to the director of proceedings under part 10, division 2.</p>	<p><b>64 Health ombudsman must immediately take further relevant action</b></p> <p>Immediately after deciding to take immediate registration action in relation to a registered health practitioner, the health ombudsman must—</p> <p>(a) start <b>or continue</b> an investigation under part 8 about the matter giving rise to the immediate registration action; or</p> <p>(b) refer the matter to the National Agency or an entity of the State, another State or the Commonwealth under part 9; or</p> <p>(c) refer the matter to the director of proceedings under part 10, division 2.</p>	



Current HO Act Provision	Proposed HO Act Provision (changes in red)	Rationale
<p><b>65 Health ombudsman may end immediate registration action</b></p> <p>(1) This section applies if, at any time after taking immediate registration action in relation to a registered health practitioner, the health ombudsman is satisfied the immediate registration action is no longer necessary on the grounds mentioned in section 58.</p> <p>(2) The health ombudsman must—</p> <p>(a) revoke the suspension or remove the conditions (whichever is relevant); and</p> <p>(b) give notice of the revocation or removal to—</p> <p>(i) the registered health practitioner; and</p> <p>(ii) the relevant National Board; and</p> <p>(iii) if the immediate registration action was taken in response to a complaint—the complainant.</p>	<p><b>65A Health ombudsman may amend immediate registration action</b></p> <p>(1) This section applies if, at any time after taking immediate registration action in relation to a registered health practitioner, the health ombudsman is able to form a reasonable belief that the practitioner poses a serious risk to the health and safety of the public but that the action that is necessary to protect the health and safety of the public should be amended.</p> <p>(2) The health ombudsman must—</p> <p>(a) give notice of the proposed amendment to the registered health practitioner; and</p> <p>(b) invite the practitioner to make a submission to the health ombudsman, within a stated period of at least 7 days, about the proposed action.</p> <p>(3) The practitioner may make submissions orally or in writing.</p> <p>(4) The health ombudsman must have regard to any submissions made by the practitioner within the stated period before deciding whether to amend the immediate registration action in relation to the practitioner.</p>	<p>This amendment will clarify the meaning of the words within this provision and will better reflect the often near concurrent processes around investigation and immediate action.</p> <p>At present, the Health Ombudsman can only end an immediate registration action if the Health Ombudsman is satisfied the action is no longer necessary on the grounds mentioned in s.58. The grounds in s.58 are the threshold test, namely, (i) because of the practitioner's health, conduct or performance, the practitioners poses a serious risk; and (ii) it is necessary to take action to protect the public health and or safety.</p> <p>This means that the Health Ombudsman is prevented from amending the immediate registration action decision (for example, amend conditions imposed) unless the grounds no longer exist, which is unlikely to be the case. This is because the serious risk and need to protect public health and safety are still present albeit in a different form that require amending the sanction.</p> <p>It should be noted that recourse to s 24AA of the Acts Interpretation Act 1954 to remake the decision is not available in any case where the amendment would be detrimental to the practitioner.</p>
<p><b>73 Period of interim prohibition order</b></p> <p>(1) An interim prohibition order takes effect on the day it is given to the health practitioner or, if a later day is stated in the order, the later day.</p> <p>(2) The order continues to have effect until the earlier of the following happens—</p>	<p><b>73A Monitoring and reporting on health practitioners' compliance with the interim prohibition order issued</b></p>	<p>The HO Act does not provide an explicit power to allow the Health Ombudsman to monitor and report on a practitioner's compliance with an interim prohibition order. Currently it is extremely difficult to impose a positive obligation in an order to provide information for compliance purposes.</p> <p>Moreover, once a matter is referred to the Director of Proceedings for consideration in relation to</p>

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<p>(a) QCAT sets aside the decision to issue the order—</p> <p>(i) on application by the practitioner for a review of the decision; or</p> <p>(ii) on referral of the matter to QCAT by the director of proceedings on the health ombudsman's behalf;</p> <p>(b) the health ombudsman revokes the order under section 76.</p>		<p>referring the practitioner to QCAT, the Health Ombudsman has no powers to gather further information around compliance with interim prohibition orders. In order to enliven information gathering powers, the Health Ombudsman has to commence an own-motion investigation into the practitioner, solely for the purpose of monitoring compliance.</p> <p>A new provision clarifying the Health Ombudsman's ability to monitor and report on a practitioner's compliance with an order will ensure that the Health Ombudsman can effectively protect the health and safety of the public.</p>
<p><b>75 Health ombudsman must immediately take further relevant action</b></p> <p>Immediately after issuing an interim prohibition order to a health practitioner, the health ombudsman must—</p> <p>(a) start an investigation under part 8 about the matter giving rise to the issue of the order; or</p> <p>(b) refer the matter to an entity of the State, another State or the Commonwealth under part 9; or</p> <p>(c) refer the matter to the director of proceedings under part 10, division 2.</p>	<p><b>75 Health ombudsman must immediately take further relevant action</b></p> <p>Immediately after issuing an interim prohibition order to a health practitioner, the health ombudsman must—</p> <p>(a) start <i>or continue</i> an investigation under part 8 about the matter giving rise to the issue of the order; or</p> <p>(b) refer the matter to an entity of the State, another State or the Commonwealth under part 9; or</p> <p>(c) refer the matter to the director of proceedings under part 10, division 2.</p>	<p>Where a matter appears serious at initial lodgement of the complaint, the most appropriate relevant action under s. 35 of the HO Act is investigation. Upon initial investigation, information may be obtained that suggests that the matter is also one which gives rise to satisfaction on reasonable grounds that the practitioner poses a serious risk, where the Health Ombudsman may determine that it is necessary to act to protect the health and safety of the public.</p> <p>If immediate action is taken under the current provision, the HO Act could be construed to require that the matter must be referred under (b) or (c) because an investigation was already underway prior to the immediate action commencing (as there is no explicit power to continue with the existing investigation).</p> <p>This amendment will clarify the meaning of the words within this provision and will better reflect the often near concurrent processes around investigation and immediate action.</p>
<p><b>76 Health ombudsman may revoke order</b></p> <p>(1) This section applies if, at any time after issuing an interim prohibition order to a health practitioner, the health ombudsman is satisfied the order is no</p>	<p><b>76A Health ombudsman may amend order</b></p> <p>(1) <i>This section applies if, at any time after issuing an interim prohibition order to a health practitioner, the health ombudsman is satisfied on reasonable</i></p>	<p>At present, the Health Ombudsman can only end an interim prohibition order if the Health Ombudsman is satisfied the order is no longer necessary on the grounds mentioned in s.68. The grounds in s.58 are the threshold test, namely, (i) because of the</p>



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<p>longer necessary on the grounds mentioned in section 68.</p> <p>(2) The health ombudsman must—</p> <p>(a) revoke the order; and</p> <p>(b) give notice of the revocation to the practitioner and, if the interim prohibition order was issued in response to a complaint, to the complainant.</p>	<p><i>grounds that the practitioner poses a serious risk to the health and safety of the public but that the action that is necessary to protect the health and safety of the public should be amended.</i></p> <p><i>(2) The health ombudsman must—</i></p> <p><i>(a) give notice of the proposed amendment to the registered health practitioner; and</i></p> <p><i>(b) invite the practitioner to make a submission to the health ombudsman, within a stated period of at least 7 days, about the proposed amendment.</i></p> <p><i>(c) give notice of the confirmed amendment to the practitioner and, if the interim prohibition order was issued in response to a complaint, to the complainant.</i></p> <p><i>(3) The practitioner may make submissions orally or in writing.</i></p> <p><i>(4) The health ombudsman must have regard to any submissions made by the practitioner within the stated period before deciding whether to amend the order in relation to the practitioner.</i></p>	<p>practitioner's health, conduct or performance, the practitioner poses a serious risk; <u>and</u> (ii) it is necessary to take action to protect the public health and or safety.</p> <p>This means that the Health Ombudsman is prevented from amending the order (for example, to alter the restrictions imposed) unless the grounds no longer exist, which is unlikely to be the case.</p> <p>This is because the serious risk and need to protect public health and safety are still present albeit in a different form that require amending the sanction.</p> <p>It should be noted that recourse to s 24AA of the Acts Interpretation Act 1954 to remake the decision is not available in any case where the amendment would be detrimental to the practitioner.</p>
<p><b>84 Progress reports</b></p> <p>The health ombudsman must, at not less than 3 monthly intervals, give a notice of the progress of an investigation to—</p> <p>(a) any health service provider being investigated; and</p> <p>(b) if the investigation relates to a health service complaint, the complainant.</p>	<p><b>84 Progress reports</b></p> <p><i>(1) The health ombudsman must, at not less than 3 monthly intervals, give a notice of the progress of an investigation to—</i></p> <p><i>(a) any health service provider being investigated; and</i></p> <p><i>(b) if the investigation relates to a health service complaint, the complainant.</i></p> <p><i>(2) A requirement under this Act to give a notice under this section does not apply if the health service provider or complainant has advised the health ombudsman (orally or in writing) that the health service provider or complainant waives compliance with the requirement.</i></p>	<p>A substantial number of matters subject to investigation are effectively paused pending the outcome of external proceedings (Queensland Police Service investigations or court proceedings).</p> <p>An amendment of this nature is designed to alleviate a considerable administrative burden in the provision of quarterly updates on matters subject to investigation by an external entity.</p>



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<p><b>Section 90 - Notice of decision after investigating a matter</b> After completing an investigation of a matter, the health ombudsman must --</p> <p>(a) decide --</p> <p>(i) to take particular relevant action to further deal with the matter; or</p> <p>(ii) to take no further action in relation to the matter; and</p> <p>(b) give notice of the decision --</p> <p>(i) if the investigation relates to a health service complaint--to the complainant and relevant health service provider under section 278; or</p> <p>(ii) otherwise--to any health service provider being investigated.</p>	<p><b>Section 90 - Notice of decision after investigating a matter</b> After completing an investigation of a matter, the health ombudsman must --</p> <p>(a) decide --</p> <p>(i) to take <i>or continue</i> particular relevant action to further deal with the matter; or</p> <p>(ii) to take no further action in relation to the matter; and</p> <p>(b) give notice of the decision --</p> <p>(i) if the investigation relates to a health service complaint--to the complainant and relevant health service provider under section 278; or</p> <p>(ii) otherwise--to any health service provider being investigated.</p>	<p>This is to take into account circumstances where a matter is being investigated and where immediate action has been taken.</p>
<p><b>91 Referral to National Agency</b></p> <p>(1) The health ombudsman may refer a health service complaint or other matter concerning a registered health practitioner to the National Agency, unless the matter indicates that—</p> <p>(a) the practitioner may have behaved in a way that constitutes professional misconduct; or</p> <p>(b) another ground may exist for the suspension or cancellation of the practitioner's registration.</p> <p>Note— A matter mentioned in paragraph (a) or (b) may be referred to the director of proceedings who may refer it to QCAT on the health ombudsman's behalf under section 103.</p>	<p><b>91 Referral to National Agency</b></p> <p>(1) The health ombudsman may refer a health service complaint or other matter concerning a registered health practitioner to the National Agency, unless the matter indicates that—</p> <p>(a) the practitioner may have behaved in a way that constitutes professional misconduct; or</p> <p>(b) another ground may exist for the suspension or cancellation of the practitioner's registration.</p> <p>Note— A matter mentioned in paragraph (a) or (b) may be referred to the director of proceedings who may refer it to QCAT on the health ombudsman's behalf under section 103.</p>	<p><b>Proposed new section 1a:</b> Currently the Health Ombudsman is unable to refer matters to AHPRA that amount to professional misconduct or where there is another ground for suspension or cancellation of registration – s. 91(1).</p> <p>This becomes extremely problematic when it comes to a health impairment, which may be a ground for suspension or cancellation in its own right.</p> <p>Under s. 91(1) the Health Ombudsman must retain health impairment matters even though the health ombudsman does not have statutory powers to deal with impairment (the National Law provides powers to Boards to manage health assessments (div 9, part 8) and health panels (div 11 part 8)).</p> <p>The proposed amendment would provide a discretion to the Health Ombudsman to refer a</p>

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<p>(2) The health ombudsman must consult with the National Agency about the proposed referral before referring the matter.</p> <p>(3) When referring the matter, the health ombudsman must give the National Agency all relevant information that the health ombudsman has about the matter, including, for a health service complaint—</p> <p>(a) details of the complaint, the complainant and the relevant health service provider; and</p> <p>(b) if the health ombudsman intends to start or continue conciliating the complaint while or after the National Agency or a National Board deals with it—that fact.</p> <p>(4) In this section—information includes a submission.</p>	<p>(1a) The health ombudsman may refer a health service complaint or other matter concerning a registered health practitioner to the National Agency where it relates to an issue of health.</p> <p>(2) The health ombudsman must consult with the National Agency about the proposed referral before referring the matter.</p> <p>(3) When referring the matter, the health ombudsman must give the National Agency all relevant information that the health ombudsman has about the matter, including, for a health service complaint—</p> <p>(a) details of the complaint, the complainant and the relevant health service provider; and</p> <p>(b) if the health ombudsman intends to start or continue conciliating the complaint while or after the National Agency or a National Board deals with it—that fact.</p> <p>(3a) The health ombudsman may take other relevant action or no further action after the National Agency has completed its actions on a complaint.</p> <p>(4) In this section— information includes a submission.</p>	<p>serious health impairment to the relevant National Board (which is equipped to deal with such matters).</p> <p><b>Proposed new section 3a:</b> After the National Agency has completed their processes and informed the health ombudsman of the outcome, another relevant action may still be required to finally resolve the complaint. The most probable relevant actions in these cases would be either local resolution or conciliation.</p> <p>While the National Agency may have satisfied one aspect of the complaint, the Health Ombudsman may still be able to assist the parties to resolve other aspects of the complaint (for example, an apology, corrective costs, policy/process changes, refunds etc).</p> <p>As s.91 presently reads, there is no power to move a matter into another relevant action after the National Agency has completed its actions. This omission defeats the legislative objective of fully dealing with a complaint and resolving (where possible) all issues associated with a complaint.</p>
<p><b>92 Referral to other government entities</b></p> <p>(1) The health ombudsman may refer a health service complaint or other matter to an entity of the State, another State or the Commonwealth with functions that include dealing with the matter.</p> <p>(2) The health ombudsman may refer a matter concerning a registered health practitioner to the co-regulatory authority for a co-regulatory jurisdiction if—</p>	<p><b>92 Referral to other government entities</b></p> <p>(1) The health ombudsman may refer a health service complaint or other matter to an entity of the State, another State or the Commonwealth with functions that include dealing with the matter.</p> <p>(2) The health ombudsman may refer a matter concerning a registered health practitioner to the co-regulatory authority for a co-regulatory jurisdiction if—</p>	<p>After the other entity has completed their processes and informed the Health Ombudsman of the outcome, another relevant action may still be required to finally resolve the complaint. The most probable relevant actions in these cases would be either local resolution or conciliation.</p> <p>While the other entity may have satisfied one aspect of the complaint, the Health Ombudsman may still be able to assist the parties to resolve other aspects of the complaint (for example, an apology).</p>

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<p>(a) the matter happened in the co-regulatory jurisdiction; or</p> <p>(b) the practitioner's principal place of practice is in the co-regulatory jurisdiction.</p> <p>(3) The health ombudsman must consult with the entity about the proposed referral before referring the matter.</p>	<p>(a) the matter happened in the co-regulatory jurisdiction; or</p> <p>(b) the practitioner's principal place of practice is in the co-regulatory jurisdiction.</p> <p>(3) The health ombudsman must consult with the entity about the proposed referral before referring the matter.</p> <p><b>(3a) The health ombudsman may take other relevant action or no further action after the other state entity has completed its actions on a complaint.</b></p>	<p>corrective costs, policy/process changes, refunds etc).</p> <p>As s.92 presently reads, there is no power to move a matter into another relevant action after the other entity has completed its actions. This omission defeats the legislative objective of fully dealing with a complaint and resolving (where possible) all issues associated with a complaint.</p>
	<p><b>Part 10 QCAT costs</b></p> <p>The HO Act is silent in regards to costs. In the event of immediate action or disciplinary proceedings before QCAT, the question of costs is to be determined by the provisions in the QCAT Act (see ss100 and 102). Under this scheme, the Health Ombudsman is not guaranteed costs where successful, and may be subject to adverse costs where unsuccessful – even in immediate action which, given its urgent and protective nature, is an oddity.</p>	<p>In the legal professional regulatory area (which is also a purely protective jurisdiction) there are special costs protections in Qld, NSW and Victoria. The purpose of these costs scheme is to permit the decision maker to take protective actions with knowledge that they have some cost protections. In this way, the fear of an adverse costs order should not affect the decision making under the Act.</p> <p>The legal professional regulatory schemes:</p> <ol style="list-style-type: none"> <li>1. Ensure that the regulator receives costs where they are successful except where exceptional circumstances exist.</li> <li>2. Allow the regulator to claim costs even where unsuccessful if the tribunal is satisfied that the proceedings arose from the failure of the practitioner to cooperate with the regulator or for some other exceptional reason.</li> <li>3. Protect the regulator from adverse costs orders where unsuccessful, except in special circumstances.</li> </ol> <p>The need for protection is clear in relation to the timely taking of immediate action by the regulator. In those cases, the Health Ombudsman is making</p>



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		<p>decisions based on limited information under tight timeframes. In those cases, it should be very rare for an adverse cost order to be made. This should be reflected in the legislation.</p> <p>There is a range of costs provisions in the regulatory sphere:</p> <ol style="list-style-type: none"> <li>1. At one end of the spectrum, a successful prosecution by ASIC allows ASIC to claim not only legal costs but investigatory costs also (see also s. 462 of the <i>Legal Profession Act 2007 (Qld)</i>).</li> <li>2. The Tribunal has the discretion to make orders as to costs as considered appropriate (same as section 195 of the National Law). This provision does not appear in the Qld National Law.</li> <li>3. The current QCAT sections on costs. In <i>Medical Board of Australia v Wong</i> [2016] QCAT 54, the Tribunal applied sections 100 and 102 and made an order for costs. Significantly, this order was by consent. In NSW, costs follow the event in HCCC proceedings in the Tribunal: see <i>HCCC v Philipiah</i> [2013] NSWCA 342.</li> </ol> <p>The HO Act currently only provides for conciliation between a health service provider and complainant. There is some uncertainty regarding the position where other parties, such as an employer, may wish to be involved in the conciliation process. In many instances, it may be the employer and not the practitioner themselves that is the party making compensation and other payments.</p> <p>If the provision was expanded to permit the Health Ombudsman to allow parties with a sufficient interest in the matter to participate in the conciliation, this would facilitate the provision of information to all those parties relevant to the conciliation process, and would ensure that they are</p>
<p><b>138 Conciliation functions</b></p> <p>(1) The health ombudsman may assign 1 or more conciliators to conciliate the health service complaint.</p> <p>(2): The function of a conciliator assigned to the complaint is to encourage settlement of the complaint by—</p> <p>(a) arranging negotiations between the complainant and relevant health service provider; and</p> <p>(b) assisting in the conduct of the negotiations; and</p> <p>(c) assisting the complainant and relevant health service provider to reach agreement; and</p>	<p><b>138 Conciliation functions</b></p> <p>(1) The health ombudsman may assign 1 or more conciliators to conciliate the health service complaint.</p> <p>(2): The function of a conciliator assigned to the complaint is to encourage settlement of the complaint by—</p> <p>(a) arranging negotiations between the complainant and relevant health service provider <i>and other parties with a sufficient relevant interest in the matter</i>; and</p> <p>(b) assisting in the conduct of the negotiations; and</p>	

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(d) assisting in the resolution of the complaint in any other way.	(c) assisting the complainant and relevant health service provider <i>and other parties with a sufficient relevant interest in the matter</i> to reach agreement; and (d) assisting in the resolution of the complaint in any other way.	bound by the conciliation privilege requirements and/or the conciliation contract.  There are a number of examples of similar provisions in other legislation (see for example: s.407 of the <i>Residential Tenancies and Rooming Accommodation Act 2008</i> , s.252E of the <i>Body Corporate and Community Management Act 1997</i> , ss163 and/or 159 of the <i>Anti-Discrimination Act 1991</i> ).
<b>186 Functions of authorised persons</b> An authorised person has the following functions— (a) to carry out activities for the purpose of an investigation by the health ombudsman under part 8; (b) to investigate, monitor and enforce compliance with this Act.	<b>186 Functions of authorised persons</b> An authorised person has the following functions— (a) to carry out activities for the purpose of an investigation by the health ombudsman under part 8; (b) to investigate, monitor and enforce compliance with this Act. <i>(c) to carry out activities for the purpose of monitoring health practitioner's compliance with immediate actions taken by the health ombudsman under part 7</i>	Consistent with other proposed amendments, this will provide additional coverage for authorised persons to monitor compliance with immediate actions taken by the Health Ombudsman under part 7 of the HO Act. This is consistent with the main objective of the HO Act - to protect the health and safety of the public.
<b>228 Power to require information</b> (1) This section applies if an authorised person reasonably believes— (a) an offence against this Act has been committed; and (b) a person may be able to give information about the offence. (2) This section also applies if an authorised person reasonably believes a person may be able to give information about a matter being investigated by the health ombudsman.	<b>228 Power to require information</b> (1) This section applies if an authorised person reasonably believes— (a) an offence against this Act has been committed; and (b) a person may be able to give information about the offence. (2) This section also applies if an authorised person reasonably believes a person may be able to give information about a matter being investigated by the health ombudsman.	<b>Proposed section 3(a):</b> This amendment is proposed to enable the Health Ombudsman to request information (for example, a copy of confidential external review/investigation reports) about the quality of health services and to assess the safety and/or quality of the health services without having to open an investigation. This amendment would also provide a legislative basis for external agencies to release information about the quality of health services.  <b>Proposed section 3(b):</b> This amendment is proposed to clarify the Health Ombudsman's ability to compel a submission. There are significant limitations when conducting a systemic investigation in not being able to invite stakeholders to provide a

Current HO Act Provision	Proposed HO Act Provision (changes in red)	Rationale
<p>(3) The authorised person may, by notice given to the person, require the person to give the authorised person information related to the offence, or matter being investigated, at a stated reasonable time and place.</p> <p>(4) A requirement under subsection (2) is an information requirement.</p> <p>(5) For information that is an electronic document, compliance with the information requirement requires the giving of a clear image or written version of the electronic document.</p> <p>(6) In this section—information includes a document.</p>	<p>(3) The authorised person may, by notice given to the person, require the person to give the authorised person information related to the offence, or matter being investigated, at a stated reasonable time and place.</p> <p><i>(3a) The authorised person may, by notice given to the person, require the person to give the authorised person information for the purposes of assessing the safety and/or quality of health services.</i></p> <p><i>(3b) The health ombudsman may give a notice to the complainant or the relevant health service provider inviting submissions about the safety or quality of the health service to be given to the health ombudsman within a stated period.</i></p> <p><i>(i) The stated period for giving submissions must be reasonable but must not be more than 14 days after the notice is given.</i></p> <p><i>(ii) The health ombudsman must consider each submission received within the stated period.</i></p> <p>(4) A requirement under subsection (2) is an information requirement.</p> <p>(5) For information that is an electronic document, compliance with the information requirement requires the giving of a clear image or written version of the electronic document.</p> <p>(6) In this section—information includes a document.</p>	<p>submission that is protected by the compulsion provisions of s. 228.</p>
<p><b>272 Confidentiality</b></p> <p>(1) This section applies to a person who is or was any of the following persons—</p> <p>(a) the health ombudsman;</p> <p>(b) a staff member of the Office of the Health Ombudsman;</p>	<p><b>272 Confidentiality</b></p> <p>(1) This section applies to a person who is or was any of the following persons—</p> <p>(a) the health ombudsman;</p> <p>(b) a staff member of the Office of the Health Ombudsman;</p>	<p><b>Proposed section 272(1)(g):</b> Currently s. 272 only applies to those persons listed in the section and does not include any other person who has knowledge of confidential information – for example, complainants, third parties (such as witnesses) or health service providers.</p>



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<p>(c) a member of a committee or panel established under section 29;</p> <p>(d) an inquiry member;</p> <p>(e) an authorised person;</p> <p>(f) another person engaged by the health ombudsman to help in the performance of the health ombudsman's functions.</p> <p>(2) The person must not disclose confidential information to anyone else except to the extent the disclosure is permitted under this section.</p> <p>(3) Confidential information may be disclosed in the performance of a function under this Act or to the extent required or permitted under this Act.</p> <p>(4) Confidential information about a person may be disclosed to the person or with the person's consent.</p> <p>(5) Confidential information may be disclosed to any of the following entities if the entity requests it on the basis that provision of the information is necessary to enable the entity to exercise its functions— ...</p> <p>...(8) In this section—</p> <p>confidential information means information that—</p> <p>(a) is not publicly available; and</p> <p>(b) is in a form that identifies a person who—</p> <p>(i) is or was a complainant under this Act or was a complainant under the repealed Act;</p> <p>or</p> <p>(ii) is or was a health service provider or was a provider under the repealed Act; or</p> <p>(iii) was provided with a service by a health service provider or was a user under the repealed Act; or</p>	<p>(c) a member of a committee or panel established under section 29;</p> <p>(d) an inquiry member;</p> <p>(e) an authorised person;</p> <p>(f) another person engaged by the health ombudsman to help in the performance of the health ombudsman's functions;</p> <p><i>(g) any person who receives information obtained in the administration of this Act.</i></p> <p>(2) The person must not disclose confidential information to anyone else except to the extent the disclosure is permitted under this section.</p> <p><i>(2A) The person must not disclose confidential information to a person who makes a complaint who is not the consumer of the health service, except to the extent disclosure is permitted by this section.</i></p> <p>(3) Confidential information may be disclosed in the performance of a function under this Act or to the extent required or permitted under this Act.</p> <p>(4) Confidential information about a person may be disclosed to the person or with the person's consent.</p> <p>(5) Confidential information may be disclosed to any of the following entities if the entity requests it on the basis that provision of the information is necessary to enable the entity to exercise its functions— ...</p> <p>...(8) In this section—</p> <p>confidential information means information that—</p> <p>(a) is not publicly available; and</p> <p>(b) is in a form that identifies a person who—</p> <p>(i) is or was a complainant under this Act or was a complainant under the repealed Act;</p> <p>or</p>	<p>The recommendation is to ensure fairness in the complaints process and to discourage the publishing of correspondence from the Health Ombudsman which identifies a health service provider or which seeks to identify a complainant using social media (and which does not fall within the reprisal provisions of ss. 261 and 262 of the HO Act).</p> <p>A provision to this effect can be seen in s. 705 <i>Legal Profession Act 2007</i>.</p> <p><b>Proposed section 272(2A):</b> The HO Act currently does not differentiate between complainants who are the actual consumer and complainants who are third parties. This currently affects the information that can be disclosed to 'third party complainants'.</p> <p>An amendment would more clearly outline the privacy and confidentiality obligations to consumer complainants and to third party complainants.</p>

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<p>(iv) gave information to the health ombudsman under this Act or to the former commission under the repealed Act; and</p> <p>(c) was acquired by, or may be accessed by, a person in his or her capacity as a person mentioned in subsection (1).</p> <p>disclose includes give access to.</p> <p>former commission means the Health Quality and Complaints Commission in existence under the repealed Act immediately before the commencement of this section.</p> <p>information includes a document.</p> <p>repealed Act means the repealed Health Quality and Complaints Commission Act 2006.</p>	<p>(ii) is or was a health service provider or was a provider under the repealed Act; or</p> <p>(iii) was provided with a service by a health service provider or was a user under the repealed Act; or</p> <p>(iv) gave information to the health ombudsman under this Act or to the former commission under the repealed Act; and</p> <p>(c) was acquired by, or may be accessed by, a person in his or her capacity as a person mentioned in subsection (1).</p> <p>disclose includes give access to.</p> <p>former commission means the Health Quality and Complaints Commission in existence under the repealed Act immediately before the commencement of this section.</p> <p>information includes a document.</p> <p><i>consumer means the person who received the health service.</i></p> <p>repealed Act means the repealed Health Quality and Complaints Commission Act 2006.</p> <p><b>An amendment to provide for mandatory notification of charges of serious offences to the Health Ombudsman by Qld Police Service.</b></p>	
		<p>This is similar to sections 75 and 80 <i>Education (Queensland College of Teachers) Act 2005</i> and ensures that serious offences that may give rise to a reasonable belief of serious risk and the necessity to act and received in a timely manner.</p>



Current National Law Provision	Proposed National Law Provision	Rationale
<p><b>193A Referrals to health ombudsman</b></p> <p>(1) A National Board must refer a matter about a registered health practitioner or student to the health ombudsman to be dealt with under the <i>Health Ombudsman Act 2013</i> if the health ombudsman requests the referral under section 193(2).</p> <p>(2) Also, if a panel has notified the National Board that established the panel that the matter must be referred to a responsible tribunal, the Board must notify the health ombudsman of that fact.</p> <p>(3) If a matter is referred under subsection (1) and the Board notifies the health ombudsman in relation to the matter under subsection (2), the health ombudsman must refer the matter to the responsible tribunal under the <i>Health Ombudsman Act 2013</i>.</p> <p>(4) A National Board may refer another matter about a registered health practitioner or student to the health ombudsman to be dealt with under the <i>Health Ombudsman Act 2013</i> with the health ombudsman's agreement.</p>	<p><b>193A Referrals to health ombudsman</b></p> <p>(1) A National Board must refer a matter about a registered health practitioner or student to the health ombudsman to be dealt with under the <i>Health Ombudsman Act 2013</i> if the health ombudsman requests the referral under section 193(2).</p> <p>(2) Also, if a panel has notified the National Board that established the panel that the matter must be referred to a responsible tribunal, the Board must notify the health ombudsman of that fact.</p> <p>(3) If a matter is referred under subsection (1) and the Board notifies the health ombudsman in relation to the matter under subsection (2), the health ombudsman must refer the matter to the responsible tribunal under the <i>Health Ombudsman Act 2013</i>.</p> <p>(4) <i>In referring a matter to the health ombudsman, a National Board must provide the health ombudsman with all information about a matter that has been referred.</i></p>	<p><b>Proposed section 193A(4):</b> This would clarify the information sharing position, as the current provisions do not require the transfer of all information relating to a matter.</p>
<p><b>219 Disclosure of information to other Commonwealth, State and Territory entities</b></p> <p>(1) A person exercising functions under this Law may disclose protected information to the following entities—</p> <p>(a) the chief executive officer under the <i>Medicare Australia Act 1973</i> of the Commonwealth;</p> <p>(b) an entity performing functions under the <i>Health Insurance Act 1973</i> of the Commonwealth;</p> <p>(c) the Secretary within the meaning of the <i>National Health Act 1953</i> of the Commonwealth;</p> <p>(d) the Secretary to the Department in which the <i>Migration Act 1958</i> of the Commonwealth is administered;</p> <p>(e) another Commonwealth, State or Territory entity having functions relating to professional services</p>	<p><b>219A Disclosure of information to the Health Ombudsman</b></p> <p>A person exercising functions under this Law may disclose protected information to the health ombudsman.</p>	<p>Under s.272(6)(b) of the HO Act, confidential information may be disclosed to the National Board or the National Agency.</p> <p>The reciprocal provision in the National Law is not so direct. Section 219(2) requires a person to be satisfied of certain things. In practice, this requires a MOU between AHPRA/the Boards and the Health Ombudsman. Such a MOU has been often requested, but is not forthcoming.</p> <p>The better solution in a co-regulatory context is to free up the National Agency and Boards and allow them to give information to the Health Ombudsman under the same circumstances as the Health Ombudsman can give to them.</p>

<p>provided by health practitioners or the regulation of health practitioners.</p> <p>(2) However, a person may disclose protected information under subsection (1) only if the person is satisfied—</p> <p>(a) the protected information will be collected, stored and used by the entity to which it is disclosed in a way that ensures the privacy of the persons to whom it relates is protected; and</p> <p>(b) the provision of the protected information to the entity is necessary to enable the entity to exercise its functions.</p>		
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