Parliamentary Committees

# Public Health (Infection Control) Amendment Bill 2017

Report No. 37, 55th Parliament
Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee
May 2017

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

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## Abbreviations and glossary

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| the Act | *Public Health Act 2005* |
| ADAQ | Australian Dental Association Queensland |
| ALA | Australian Lawyers Alliance |
| AMAQ | Australian Medical Association Queensland |
| the Bill | Public Health (Infection Control) Amendment Bill 2017 |
| chief executive | Chief executive of Queensland Health |
| the committee | Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee |
| the department | Department of Health |
| declared health service | A service provided to a person that is intended to maintain, improve or restore the person's health and involves the performance of an invasive procedure or an activity that exposes the person or another person to blood or another bodily fluid – *Public Health Act 2005*, section 148 |
| DHAA | Dental Hygienists Association of Australia |
| FLPs | Fundamental legislative principles |
| HCF | Health care facility means a facility at which a declared health service is provided and includes—<br>(a) mobile premises associated with the facility, and<br>(b) other premises or places at which persons employed or otherwise engaged at the facility provide declared health services for the facility<br>*Public Health Act 2005*, section 149 |
| ICMP | Infection control management plan |
| the Minister | Minister for Health and Minister for Ambulance Services |
| OHO | Office of the Health Ombudsman |
| POQA | *Parliament of Queensland Act 2001* |
| Private health facilities | A private hospital or a day hospital which is not funded by the State - *Private Health Facilities Act 1999*, sections 8 to 10 |
| QNMU | Queensland Nurses and Midwives' Union |
| Standing Orders | Standing Rules and Orders of the Legislative Assembly |

Note: All Acts are Queensland Acts, unless specified.

## 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 examination of the Public Health (Infection Control) Amendment Bill 2017.

The Bill amends the *Public Health Act 2005* to strengthen the existing infection control framework, in light of shortcomings in the framework identified by the Department of Health when responding to a recent incident involving substandard infection control practices at a Brisbane dental clinic.

The committee's task was to consider the policy to be given effect by the Bill, and whether the Bill has sufficient regard to the fundamental legislative principles in the *Legislative Standards Act 1992*. The fundamental legislative principles include whether legislation has sufficient regard to the rights and liberties of individuals and to the institution of Parliament.

This report summarises the committee's examination of the Bill, including the views expressed in submissions and information provided by the department.

The committee has recommended that the Bill be passed.

On behalf of the committee, I would like to thank those individuals and organisations who provided written submissions and the department for providing the information requested by the committee.

Finally, I would like to thank my fellow committee members for their contributions, and the committee secretariat for their support during the examination of the Bill.

I commend the report to the House.

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

## Recommendations



The committee recommends that the Public Health (Infection Control) Amendment Bill 2017 be passed.



The committee recommends that the Minister for Health and Minister for Ambulance Services clarifies during the second reading debate how the Department of Health will:

- assure itself that a health care facility has complied with an improvement or directions notice and is, therefore, able to provide health services to patients in a safe manner, and
- notify a health care facility, in a timely manner, that the department is satisfied that the facility has complied with the notice.



The committee recommends that the Minister for Health and Minister for Ambulance Services informs the House, during the second reading debate, why a decision was taken not to enable operators to apply to the Queensland Civil and Administrative Tribunal to review decisions to issue notices.

# 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.[1] 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.[2]

The committee is responsible for examining each Bill in its portfolio areas to consider:

- the policy to be given effect by the legislation, and
- the application of fundamental legislative principles (FLPs).[3]

Further information about the committee's work can be found on its webpage.

## 1.2 Referral and committee's process

On 21 March 2017, the Minister for Health and Minister for Ambulance Services, Hon Cameron Dick MP (the Minister), introduced the Public Health (Infection Control) Amendment Bill 2017 (the Bill) into the Legislative Assembly. The Bill was referred to the committee on 21 March 2017, and the committee was required to report to the Legislative Assembly by 15 May 2017.

During its examination of the Bill, the committee:

- invited submissions from stakeholders and the public; a list of the six submissions received and accepted by the committee is at **Appendix A**
- held a public briefing on 6 April 2017. A list of the witnesses who appeared at the briefing is at **Appendix B**, and
- requested, and received, written advice from the Department of Health (the department) on the Bill and issues raised in submissions.

The material published relating to this inquiry is available on the committee's webpage.

## 1.3 Outcome of committee considerations

Standing Order 132(1) requires the committee to recommend whether the Bill should be passed.

After its examination of the Bill and consideration of the information provided by the department and submitters, the committee recommends that the Bill be passed.

**Recommendation 1**

The committee recommends that the Public Health (Infection Control) Amendment Bill 2017 be passed.

[1] The committee was formerly the Health and Ambulance Services Committee, which was established on 27 March 2015 under the *Parliament of Queensland Act 2001* (the 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.

[2] POQA, section 88 and Standing Orders, Standing Order 194 and schedule 6.

[3] POQA, section 93(1).

# 2 Background to the Bill

## 2.1 Current infection control framework

The *Public Health Act 2005* (the Act) provides for a regulatory framework for controlling infection risks at *health care facilities*[4] (HCFs) which provide a *declared health service*, including*:*

- public hospitals and ambulance services
- dental clinics
- medical practitioners' private rooms
- acupuncturists and Chinese medicine practitioners
- sexual health services
- home nursing services
- midwifery services outside the hospital environment
- pathology and blood collection services
- retrieval services, and
- vaccine services.[5]

A *declared health service* is defined as a service provided to a person that is intended to maintain, improve or restore the person's health and involves the performance of an invasive procedure or an activity that exposes the person or another person to blood or another bodily fluid.[6]

The department estimated there are thousands of HCFs to which the Act applies in Queensland, including facilities operated by Hospital and Health Services (HHSs) and approximately 600 dental practices.[7]

In his Introductory Speech, the Minister stated that:

> *Because of the inherent risk of patients and staff at these facilities coming into contact with infectious bloodborne diseases such as hepatitis and HIV, the Act already requires people involved in performing declared health services to take reasonable precautions and care to minimise infection risks.*[8]

The Act also requires the owner or operator of an HCF to develop and implement an infection control management plan (ICMP). An ICMP is a documented plan to prevent or minimise the risk of infection for persons receiving services at an HCF, persons employed or engaged by an HCF, or other persons at risk of infection at an HCF.[9]

The infection control framework provided for in the Act does not apply to *private health facilities* (ie private hospitals and day hospitals).[10] The *Private Health Facilities Act 1999*, and the associated Infection Control Standard, regulates infection control in private health facilities. Similar to the Act, the Infection Control Standard requires private health facilities to develop an ICMP.[11]

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4 *Health care facility* is defined as a facility at which a *declared health service* is provided and includes—(a) mobile premises associated with the facility; and (b) other premises or places at which persons employed or otherwise engaged at the facility provide declared health services for the facility*, Public Health Act 2005*, section 149.

5 *Public Health Act 2005*, Chapter 4; Department of Health (department), *Correspondence*, 4 May 2017, p 1.

6 *Public Health Act 2005*, section 148.

7 Department, *Correspondence*, 4 May 2017, p 2.

8 Queensland Parliament, Record of Proceedings, 21 March 2017, p 596.

9 *Public Health Act 2005*, section 152.

10 *Public Health Act 2005*, section 150; *private health facility* is defined as a private hospital or a day hospital which is not funded by the State, *Private Health Facilities Act 1999*, sections 8 to 10.

11 *Public Health Facilities Act 1999*, section 12; Queensland Health, *Infection control standard*, version 3, 1 September 2016, accessed on 13 April 2017 from https://www.health.qld.gov.au/__data/assets/pdf_file/0022/444136/phfa-standard-infection-control.pdf

## 2.2 Potential shortcomings in current framework

The explanatory notes state that a recent incident involving substandard infection control practices at a Brisbane dental clinic highlighted shortcomings in the existing infection control framework.[12] This incident involved a dental clinic, which had:

- re-used single-use items, including without sterilising those items
- inadequately sterilised other items on which bacteria were found
- inadequately trained staff, and
- an inadequate ICMP.[13]

The incident raised a siginificant risk of infection of patients and staff at the clinic. The department advised that it contacted the majority of the 5,000 patients who had attended the clinic, since it opened in 2014, to alert them of the risk that they had potentially acquired a bloodborne virus.[14]

Ultimately, the department, with the agreement of Brisbane City Council as co-regulator, was able to issue a *public health order*[15] closing the clinic until specified remedial measures had been implemented to the department's satisfaction.[16]

At the public briefing, the department advised that it had recently received a complaint alleging substandard infection controls at another dental clinic.[17]

The potential shortcomings in the current framework identified by the department are as follows:

- the power to issue a public health order under the Act is shared between the State and local government – although the department was able to secure Brisbane City Council's consent to issue a public health order in the recent dental clinic incident, the requirement to negotiate with a second regulator creates undue administrative complexity and may cause delays in taking action
- while the framework requires HCFs to take reasonable care to minimise infection risks, it does not provide any guidance about the substantive standards which HCFs are expected to meet in satisfying this obligation or provide a mechanism for the department to work with HCF operators to identify and improve substandard infection control practices
- the framework does not adequately support compliance monitoring and investigation, for example it does not include a power for authorised persons to enter an HCF without first giving 24 hours' notice or to compel HCFs to disclose information about their infection control practices, and
- the framework is not directly enforceable, with no penalties for non-compliance or specific powers to compel HCFs to take remedial action.[18]

The explanatory notes state that these shortcomings 'potentially limit the ability of Queensland Health as a regulator to minimise unsatisfactory and unsafe infection control practices, or to identify and subsequently take swift remedial action in response to such practices'.[19]

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12 Public Health (Infection Control) Amendment Bill 2017, explanatory notes (explanatory notes), p 1.

13 Dr Jeannette Young, Chief Health Officer and Deputy Director-General, Prevention Division, Department, *Public Hearing Transcript*, 6 April 2017, p 4.

14 Dr Jeannette Young, Department, *Public Hearing Transcript*, 6 April 2017, pp 4 and 5.

15 *Public Health Act 2005*, section 21 provides for an authorised person (local government or State) to give a person a public health order requiring the recipient to take action to remove, reduce, control or prevent a risk to public health from a public health risk.

16 Explanatory notes, p 2.

17 Dr Jeannette Young, Department, *Public Hearing Transcript*, 6 April 2017, p 2.

18 Explanatory notes, p 2; Department, *Correspondence – written briefing*, 28 March 2017, p 1.

19 Explanatory notes, p 1.

# 3 Examination of the Bill

## 3.1 Objectives of the Bill

The explanatory notes state that the Bill amends the Act 'to strengthen the statutory infection control framework for health care facilities (HCFs)' by providing that:

- mandatory training, competency and infection control standards may be prescribed by regulation
- an *authorised person*[20] may require the operator of an HCF to produce, or amend, their ICMP
- an authorised person may enter premises to investigate infection risks without prior notice, and
- penalties may be imposed for non-compliance and that the department may direct the operator of an HCF to take remedial action or cease performing a particular health service.[21]

In addition, amendments are proposed to the *Public Health Regulation 2005* to empower the department to act urgently in response to an identified public health risk arising from deficient infection control practices, without first seeking agreement from the relevant local government.[22]

In his Introductory Speech, the Minister stated that:

> *These amendments will minimise the chance of infection risks arising by supporting health care facilities to improve their infection control practices and will enable timely, proportionate action to be taken to reduce and remove risks, which have arisen.*[23]

As mentioned in section 2.1, the Bill's provisions would apply to HCFs, which provide declared health services, eg public hospitals, medical and dental practices and acupuncture clinics, but would not apply to *private health facilities* (ie private hospitals and day hospitals).

## 3.2 Consultation during the development of the Bill

The explanatory notes state that 'Due to the urgency of the required amendments, affected HCFs have not been consulted specifically on the proposed amendments'. The department advised, however, that it had engaged in a range of activities to raise awareness by HCFs of their existing infection control obligations.[24]

## 3.3 Submitters' general comments

The majority of submitters supported the general approach of the Bill.[25] However, the Queensland Nurses and Midwives' Union (QNMU), Australian Dental Association Queensland (ADAQ) and Australian Medical Association Queensland (AMAQ) had some reservations about the proposed amendments.

The ADAQ considered that a more appropriate approach would be to amend the *Health Practitioner Regulation National Law (Queensland)* and/or the *Health Ombudsman Act 2013* to strengthen the infection control framework. The ADAQ suggested that this approach would avoid duplication and any potential conflict caused by creating two regulatory frameworks – the Queensland health service complaints management scheme (comprising of the Australian Health Practitioner Regulation Agency (AHPRA), the National Boards and Health Ombudsman) and the department under the proposed amendments to the Act.[26]

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[20] An *authorised person* is a public service officer or employer, health service employee or other person prescribed by regulation appointed by the chief executive of the Department of Health, *Public Health Act 2005*, section 377.

[21] Explanatory notes, p 2.

[22] Explanatory notes, p 2.

[23] Queensland Parliament, Record of Proceedings, 21 March 2017, p 597.

[24] Explanatory notes, p 5.

[25] Submissions 1, 2, 3, 5 and 6.

[26] Australian Dental Association Queensland (ADAQ), Submission 4.

In response, the department stated 'The delivery of complex and potentially hazardous health services is often subject to multiple regulatory frameworks'.[27] The department highlighted the different roles and responsibilities of the two regulatory frameworks, and stated that:

> *The complaints framework under the Health Practitioner Regulation National Law and Health Ombudsman Act 2013 supports the safe delivery of health services by regulating the professional performance of health practitioners. By contrast, the infection control framework under the PH Act prevents and minimises infection risks by regulating the organisation and conduct of HCFs more generally.*[28]

The department also advised that:

> *The strengthening of the infection control framework also reflects the increasing corporatisation of health care delivery. While the National Law and* [Health] *Ombudsman Act provide for action to be taken against individual health practitioners, the Bill provides a necessary mechanism to also take action against the corporate entities increasingly involved in health care delivery.*[29]

## 3.4 Measures to minimise the risk of infection

In his Introductory Speech, the Minister stated that '… a key focus of this Bill is minimising emergent infection risks, not just responding to incidents after they have occurred'.[30]

The Bill makes a number of amendments aimed at making the infection control framework under the Act more effective in minimising infection risks.[31]

Currently, section 151 of the Act provides that persons involved in the provision of a declared health service must take reasonable precautions and care to minimise the risk of infection to other persons.[32] The Bill inserts an example into section 151 'to assist persons involved in the provision of such services [declared health services] to better understand and comply with their obligations'.[33] The example provides that:

> *A person may take reasonable precautions and care, for the purposes of discharging their obligations to minimise an infection risk, by complying with the ICMP for the facility at which they are engaged and any other requirements prescribed by regulation.*[34]

Clauses 6 and 7 reframe the existing obligations in the Act for owners or operators of HCFs to develop, implement, resource and periodically review an ICMP for the HCF and to provide appropriate training for staff and agents of the HCF. The provisions provide that an ICMP must be reviewed periodically at appropriate intervals of not more than one year.

The Bill also amends the regulation making power in the Act to provide that the Governor in Council may make regulations about the training and qualifications for a person who is providing a declared health service at an HCF.[35] The department advised that it intends:

> *… to employ this power, together with the existing power to make a regulation prescribing standards for the provision of any service, to prescribe a range of competency, training and*

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27 Department, *Response to issues raised in submissions*, 2 May 2017, p 2.
28 Department, *Correspondence*, 4 May 2017, p 3.
29 Department, *Response to issues raised in submissions*, 2 May 2017, p 2.
30 Queensland Parliament, Record of Proceedings, 21 March 2017, p 597.
31 Department, *Correspondence – written briefing*, 28 March 2017, p 2.
32 *Public Health Act 2005*, section 151.
33 Explanatory notes, p 6.
34 Public Health (Infection Control) Amendment Bill 2017, clause 5; explanatory notes, p 6.
35 Public Health (Infection Control) Amendment Bill 2017, clause 15 amends section 461 of the *Public Health Act 2005*.

> *practice standards which different categories of HCFs must achieve in order to meet their infection control obligations ...*[36]

The department stated that the necessary arrangements to the *Public Health Regulation 2005* are expected to be made during the second half of 2017.[37]

In addition, the department advised that it:

> *… will be working with the dental profession in particular to work through with them the requirements that they will need to meet. Every dental practice will need to have a plan in place that meets certain minimum requirements, so we will work through and then we will audit to make sure that, as a starting point, each practice does have a plan, and then we will go through and make sure that those plans are adequate.*[38]

*Submitters' views and department's response*

The Australian Lawyers Alliance (ALA) supported the obligation for owners or operators of an HCF to develop and implement an ICMP, to review an ICMP at least every 12 months and to ensure that the health services provided at an HCF comply with the ICMP. The ALA considered these provisions 'strengthen[s] the current framework for infection control'.[39]

The Dental Hygienists Association of Australia (DHAA) sought clarification as to whether the requirement at clause 7 for an operator to amend an ICMP applies to all operators of HCFs, regardless of whether they are also the owner of the facility.[40]

The ADAQ raised concerns about the lack of information and guidance, eg templates and examples, in relation to the required content of ICMPs. The ADAQ also sought clarification as to the acceptability of electronic copies, rather than printed copies, of ICMPs.[41]

In response, the department stated that 'It is not feasible for legislation to prescribe the particular form of an ICMP applicable to every setting. However, an ICMP template and step-by-step instructions are available on the Queensland Health website'. [42]

The department confirmed that the requirements at section 154, as inserted by clause 7, only apply to a person who is both the owner and operator of an HCF.[43]

## 3.5 Investigation of suspected breaches and taking relevant action

The Bill amends the Act with the objective of supporting more timely investigation of suspected breaches of the infection control framework. The amendments provide that:

- an authorised person may, by notice, require the operator of an HCF to provide a copy of their ICMP or other information about procedures for preventing or minimising infection risks at the HCF[44]
- an authorised person may, by notice, require the operator of an HCF to amend an ICMP if the authorised person is satisfied it does not comply with the requirements of the Act,[45] eg the ICMP

[36] Explanatory notes, p 11.
[37] Department, *Correspondence – written briefing*, 28 March 2017, p 2.
[38] Dr Jeannette Young, Department, *Public Briefing Transcript*, 6 April 2017, p 6.
[39] Australian Lawyers Alliance (ALA), Submission 6.
[40] Dental Hygienists Association of Australia (DHAA), Submission 3.
[41] ADAQ, Submission 4.
[42] Department, *Response to issues raised in submissions*, 2 May 2017, p 3.
[43] Department, *Response to issues raised in submissions*, 2 May 2017, p 3.
[44] Public Health (Infection Control) Amendment Bill 2017, clause 9 inserts new section 156A into the *Public Health Act 2005*.
[45] Public Health (Infection Control) Amendment Bill 2017, clause 9 inserts new section 156B into the *Public Health Act 2005*.

does not include details of the infection risks associated with the HCF and the measures taken to prevent or minimise infection risks[46]

- an authorised person may issue an improvement notice requiring the owner or operator of an HCF to take specified action to address an infection risk within a specified period[47]
- an owner or operator of an HCF, who reasonably believes they have complied with an improvement notice, may inform the authorised person of their belief. If the authorised person is satisfied that the notice has been complied with, they may record the date of compliance on a copy of the notice and, if asked, give a copy of the dated notice to the owner or operator[48]
- the chief executive of the department (chief executive) may issue a directions notice requiring an HCF to cease providing a particular declared health service for a stated period up to 30 days, while steps are implemented to remedy an identified infection risk. The chief executive may, prior to the expiry of the directions notice, extend the effect of a directions notice by a further stated period of up to 30 days[49]
- the chief executive may apply to the Magistrates Court to further extend the effect of a directions notice where the remedial action is not taken as directed[50]
- an operator of an HCF, who reasonably believes they have complied with a directions notice, may inform the chief executive of their belief. If the chief executive is satisfied that the notice has been complied with, they may record the date of compliance on a copy of the notice and, if asked, give a copy of the dated notice to the operator[51]
- an authorised person may enter an HCF immediately, without prior notice, if they reasonably believe immediate entry is necessary to prevent or minimise an imminent risk of infection to a person at the HCF,[52] and
- an authorised person may enter premises to check a water service provider's compliance with an improvement notice issued in relation to their obligations relating to the supply of unsafe drinking water or recycled water which is not fit for use.[53]

*Submitters' views and department's response*

Requirement to amend ICMPs

The ALA supported the new investigation and monitoring powers proposed by the Bill, in particular the power to require HCFs to amend their ICMPs, for authorised persons to enter HCFs without prior notice, and the issuing of improvement and directions notices.[54]

However, the ALA considered that the requirement, at clause 9, new section 156B of the Act, for an authorised person to state in a notice the way an ICMP must be amended was too onerous. The ALA stated

[46] *Public Health Act 2005*, section 155.

[47] Public Health (Infection Control) Amendment Bill 2017, clause 10 inserts new sections 156C to 156D into the *Public Health Act 2005*.

[48] Public Health (Infection Control) Amendment Bill 2017, clause 10 inserts new section 156D into the *Public Health Act 2005*.

[49] Public Health (Infection Control) Amendment Bill 2017, clause 10 inserts new sections 156E to 156I into the *Public Health Act 2005*.

[50] Public Health (Infection Control) Amendment Bill 2017, clause 10 inserts new section 156G into the *Public Health Act 2005*.

[51] Public Health (Infection Control) Amendment Bill 2017, clause 10 inserts new section 156I into the *Public Health Act 2005*.

[52] Public Health (Infection Control) Amendment Bill 2017, clause 13 amends section 390 of the *Public Health Act 2005*.

[53] Public Health (Infection Control) Amendment Bill 2017, clause 12 amends section 388A of the *Public Health Act 2005*.

[54] ALA, Submission 6.

that the current drafting of the provision suggested 'that the authorised officer is required to rewrite the ICMP, so that it complies with the Act rather than the operator of the health care facility'. [55]

In response, the department stated that the Bill is intended to support HCFs, including, by enabling authorised persons to provide guidance to operators of HCFs about improving deficient ICMPs. The department advised, however, that 'the statutory obligation to have a compliant ICMP in place is borne by the owner or operator of the HCF'. [56]

Issuing of improvement and directions notices

The AMAQ, while supporting the use of improvement and directions notices in serious cases, questioned what the threshold will be for issuing notices. The AMAQ considered that improvement and directions notices '… should be used to help strengthen and improve adherence to the infection control network and be used as a means to help address serious systematic breaches' and should only be issued 'where there is clear evidence of serious or multiple breaches of the ICMP'. The AMAQ raised concerns that improvement or directions notices will be issued for one off breaches and even vexatious or relatively minor complaints.[57]

The AMAQ suggested there should be more focus on guidance, the provision of standards and correction of minor infringements without closing HCFs. The AMAQ stated that the Bill was silent 'on how positive guidance and support will be provided, the nature and threshold of minor versus serious breaches and what actions for minor infringements might be taken'.[58]

The ADAQ raised concerns about potential delays between the time an owner or operator of an HCF informs the department that they have complied with an improvement or directions notice, and the department recording the date of compliance and providing the dated notice to the owner or operator. The ADAQ stated that:

> *There is the potential for a long period to run from the time of the operator's belief and compliance, the Chief Executives' recording the date of compliance and therefore triggering the end of the directions notice. The affected practitioner may well be unable to earn an income in this time.*[59]

The ADAQ recommended that a timeframe, eg 14 days, be included in the Bill for the authorised person or chief executive to reach a decision on whether an HCF has complied with a notice, 'so that affected registrants can be assured that a decision will be made in a time period that is definable'.[60]

The DHAA suggested that the requirement to provide a copy of a dated improvement or directions notice, once complied with, to the owner or operator of an HCF should be standard practice, rather than only on request.[61]

The department stated that the issuing of an improvement notice is not intended as a punitive measure. Rather, such notices are one of a range of measures to assist the operators and staff of HCFs understand and comply with their statutory obligations, and to enable the department to work with HCFs in improving deficient practices.[62]

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55 ALA, Submission 6.
56 Department, *Response to issues raised in submissions*, 2 May 2017, p 4.
57 AMAQ, Submission 5.
58 AMAQ, Submission 5.
59 ADAQ, Submission 4.
60 ADAQ, Submission 4.
61 DHAA, Submission 3.
62 Department, *Response to issues raised in submissions*, 2 May 2017, p 4.

In relation to directions notices, the department stated:

> *The issuing of a directions notice is intended as an intervention of last resort, where less intrusive interventions are not appropriate or have not been effective. For this reason, the Bill limits delegation of the power to issue a notice to senior executives of the department only.* [63]

In response to the ADAQ and DHAA's comments about the provisions in respect of the department confirming an HCF's compliance with an improvement or directions notice, the department advised that:

> *It is an owner's or operator's compliance with an improvement or directions notice which results in that notice ceasing to have effect, rather than the issuing of a record of compliance.*
>
> *Whether the steps taken by an owner or operator of an HCF to comply with an improvement or compliance notice are sufficient is, in the first instance, a question for the owner or operator themselves.* [64]

**Committee comment**

The committee notes the department's comments that, in the first instance, the question of whether an improvement or directions notice has been complied with will be one for the owner or operator of the HCF. The committee also notes the department's comments that it is an owner's or operator's compliance with a notice which results in that notice ceasing to have effect, rather than the department issuing a record of compliance.

However, given the significant health risks involved where an HCF has been issued a notice due to non-compliance with the infection control framework, the committee recommends that the Minister clarifies how the department will assure itself that an HCF has complied with an improvement or directions notice. The committee also recommends that the Minister clarifies how the department will notify HCFs, in a timely manner, that it is satisfied that the HCF has complied with a notice and is, therefore, able to provide health services to patients in a safe manner.

**Recommendation 2**

The committee recommends that the Minister for Health and Minister for Ambulance Services clarifies during the second reading debate how the Department of Health will:

- assure itself that a health care facility has complied with an improvement or directions notice and is, therefore, able to provide health services to patients in a safe manner, and
- notify a health care facility, in a timely manner, that the department is satisfied that the facility has complied with the notice.

Review and appeal mechanisms

The ADAQ stated that there needs to be a right of appeal against the chief executive's decision to issue a directions notice 'because of the catastrophic effect of a directions notice which can result in the closure of a practice'. The ADAQ noted that the Act provides a right of review to the Supreme Court, but considered that this process was 'expensive for affected registrants and can be time consuming'. The ADAQ, therefore, submitted that a right of review to the Queensland Civil and Administrative Tribunal (QCAT), including the option to stay a decision, should be established.[65]

The department confirmed that the decision to issue a directions notice will be reviewable under the *Judicial Review Act 1991* and, therefore, that decision may be stayed or overturned by a court. The

[63] Department, *Response to issues raised in submissions*, 2 May 2017, p 4.
[64] Department, *Response to issues raised in submissions*, 2 May 2017, pp 4 and 5.
[65] ADAQ, Submission 4.

department also advised that 'As a further safeguard against its possible overuse, the Bill limits delegation of this power to senior, appropriately-qualified executives of the department only'.[66]

**Committee comment**

The committee notes submitters' comments about the lack of an inexpensive and timely review mechanism for decisions to issue improvement or decisions notices, including the option for operators to apply to QCAT to review such decisions.

The committee recommends that the Minister informs the House, during the second reading debate, why a decision was taken not to enable operators to apply to QCAT to review decisions to issue notices.

**Recommendation 3**

The committee recommends that the Minister for Health and Minister for Ambulance Services informs the House, during the second reading debate, why a decision was taken not to enable operators to apply to the Queensland Civil and Administrative Tribunal to review decisions to issue notices.

Entry of premises without prior notice

The ADAQ and AMAQ raised significant concerns about clause 13, which provides that an authorised person may enter an HCF, without prior notice, if he or she reasonably believes immediate entry is necessary to prevent or minimise an imminent risk of infection to a person. The ADAQ and AMAQ considered that the entry to an HCF by departmental offices, without notice, could have an extreme effect on staff, patients and the reputation of an HCF.[67]

The ADAQ submitted that public safety needed to be balanced with some safeguards for affected registrants and HCFs. In particular, the ADAQ considered that a high level of diligence by an appropriate person with relevant expertise was required to ensure that the decision to enter an HCF, without notice, is justified in all circumstances.[68] The AMAQ considered that it was '… vital that some notice be provided to a facility to allow for any appropriate provisions to be made'.[69]

In contrast, the ALA considered that the proposed threshold for entry, without notice, was too high. The ALA considered that it could be difficult for authorised persons to identify when there is an imminent risk of infection. The ALA, therefore, suggested that entry to an HCF, without notice, should be permitted to prevent or minimise a probable risk of infection.[70]

In response, the department stated that:

> *Entry without notice will be subject to significant safeguards. An authorised person must have reasonable grounds for believing immediate entry is necessary to prevent or minimise an imminent infection risk before they may enter without notice. This means the power will only be available in exceptional circumstances.*
>
> *Further, to minimise any adverse impacts on patients and the safe delivery of health care services, the legislation prohibits entry into a part of a facility where a patient is consulting a health practitioner or undergoing a procedure.*[71]

In response to the ALA's comments about the threshold for immediate entry being too high, the department stated that given the potentially significant impact entry to an HCF, without notice, may

66 Department, *Response to issues raised in submissions*, 2 May 2017, p 5.
67 ADAQ, Submission 4 and AMAQ, Submission 5.
68 ADAQ, Submission 4.
69 AMAQ, Submission 5.
70 ALA, Submission 6.
71 Department, *Response to issues raised in submissions*, 2 May 2017, p 5.

have on operators, staff and the reputation of HCFs, it is considered that meeting a significant threshold before exercising the power, ie an imminent risk of infection, is justified. [72]

Drafting error

A submitter also noted a drafting error in clause 9 of the Bill. The word 'apples' in the first line of new section 156B of the Act, as inserted by clause 9, should be 'applies'. [73] The department acknowledged the drafting error at clause 9, and stated that it would ask the Office of the Queensland Parliamentary Counsel to correct the error under the *Reprints Act 1992*.[74]

## 3.6 Penalties for breaches of framework

The Bill amends the Act to provide that the infection control framework is directly enforceable by creating penalties for breaches of the following existing obligations under the framework:

- a failure by a person involved in the provision of a declared health service to take reasonable precautions and care to minimise the risk of infection (maximum penalty of 1000 penalty units ($121,900))[75]
- failure by the owner or operator of an HCF to have and comply with an ICMP and review an ICMP annually (maximum penalty of 500 penalty units ($60,950)), or to keep a copy of the ICMP in a place which is easily accessible by staff (maximum penalty of 100 penalty units ($12,190))[76]
- failure by the operator of an HCF to provide an authorised person with a copy of an ICMP (maximum penalty of 200 penalty units ($24,380)), or to amend an ICMP, if required by an authorised person (maximum penalty of 500 penalty units ($60,950)), unless the operator has a reasonable excuse[77]
- failure by the owner or operator of an HCF to comply with an improvement notice, unless they have a reasonable excuse (maximum penalties range from 100 ($12,190) to 1000 penalty units ($121,900))[78], and
- failure by the operator of an HCF to comply with a directions notice, unless the operator has a reasonable excuse (maximum penalty of 3000 penalty units ($365,700)).[79]

*Submitters' views and department's response*

The ALA supported the introduction of penalties for non-compliance with the infection control framework.[80]

The QNMU raised concerns about the new offence and penalty at clause 5, which provides that a person involved in the provision of a declared health service who fails to take reasonable precautions and care to minimise the risk of infection commits an offence which attracts a maximum penalty of 1000 penalty units.

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72 Department, *Response to issues raised in submissions*, 2 May 2017, p 5.

73 DHAA, Submission 3.

74 Department, *Response to issues raised in submissions*, 2 May 2017, p 4.

75 Public Health (Infection Control) Amendment Bill 2017, clause 5 amends section 151 of the *Public Health Act 2005*.

76 Public Health (Infection Control) Amendment Bill 2017, clauses 6, 7 and 8 amend sections 153, 154 and 155 of the *Public Health Act 2005*.

77 Public Health (Infection Control) Amendment Bill 2017, clause 9 inserts new sections 156A and 156B into the *Public Health Act 2005*.

78 Public Health (Infection Control) Amendment Bill 2017, clause 10 inserts new section 156C into the *Public Health Act 2005*.

79 Public Health (Infection Control) Amendment Bill 2017, clause 10 inserts new section 156H into the *Public Health Act 2005*.

80 ALA, Submission 6.

The QNMU considered that the new offence attaches blame to an individual and singles out individual health practitioners to make them potentially liable to two sanctions – one by their regulatory body (the Nursing and Midwifery Board of Australia or the Health Ombudsman) and a financial penalty through the Bill. The QNMU suggested that the offence and penalty should only apply to an individual practitioner, where that practitioner has been found to have knowingly caused harm.[81]

The ADAQ raised similar concerns about the broad application of certain proposed offences and penalties. The ADAQ was concerned that the proposals would cover dental assistants and non-registered employees at HCFs. The ADAQ was also concerned about the use of the term 'involved' at clause 5, which it considered would impose duties on employees and remove vicarious liability protections for employees.[82]

The department stated that the new penalties '… have been aligned with similar types of penalties in other acts where we have public health risks – for instance, in terms of safe food or the legionella issue'.[83]

The department also stated that the offence provisions do not impose strict liability. For example, it will be a defence to a charge of failing to take precautions and care to minimise an infection risk if the person charged can establish that the precautions and care they took was reasonable in the circumstances.[84]

In relation to submitters' concerns about clause 5, the department stated that section 151 of the Act already recognises that each person involved in providing a declared health service has a role to play in ensuring that service is provided safely by placing the obligation to minimise and prevent infection risks on individuals. The department advised that:

> *A prosecution for failing to prevent or minimise an infection risk will only be undertaken as a last resort. For this reason, the Bill includes a range of measures to assist the operators and staff of HCFs understand and comply with their statutory obligations, and to enable Queensland Health to work with HCFs to improve deficient practice.*[85]

The department advised, in relation to concerns about individuals receiving two penalties for the same offence, that 'The intent of any overlap is not to punish non-compliant service providers multiple times for a single offence but to engender positive standards of practice across the various different aspects of the regulated field'.[86] The department stated that a similar approach has been taken in other jurisdictions, including the Australian Capital Territory and Northern Territory.[87]

## 3.7 Reporting of infection control incidents

In response to questions from the committee about public reporting of infection control incidents, the department stated that:

> *The Queensland Health annual report publishes aggregate data about compliance activities under the various regulatory frameworks established through the suite of public health and other legislation it administers. This includes aggregated information about the number of complaints received, and investigations, compliance monitoring and enforcement activities undertaken.*[88]

The department also advised that:

> *In addition to this public reporting, Queensland Health also operates an internal compliance reporting system for the suite of public health legislation it administers, including the PH Act.*

81 Queensland Nurses and Midwives' Union, Submission 1.
82 ADAQ, Submission 4.
83 Dr Jeannette Young, Department, *Public Briefing Transcript*, 6 April 2017, p 3.
84 Explanatory notes, p 4.
85 Department, *Response to issues raised in submissions*, 2 May 2017, p 3.
86 Department, *Correspondence*, 4 May 2017, p 3.
87 Department, *Correspondence*, 4 May 2017, p 3.
88 Department, *Correspondence*, 4 May 2017, p 3.

> *Under this system, compliance activities are subject to quarterly compliance reporting to the Chief Health Officer, and annual compliance reporting to the Director-General.*[89]

This internal reporting information is not made publicly available.

## 3.8 Estimated cost of implementation and available resources

The explanatory notes state 'The Bill affects existing statutory processes, and will not involve additional costs outside those already funded through existing budget allocations'.[90]

The department stated that the Bill would not impose additional costs on health care providers who are compliant with the infection control framework and that 'only providers who are breaching the current framework … are likely to incur costs as a result of the Bill'.[91]

In relation to the resources available to the department to implement the infection control framework, the department advised that:

> *Across Queensland Health, there are 145 authorised persons appointed under the PH Act, the majority of whom are employed within public health units based in HHSs. Authorised persons are available to investigate complaints, and identify and action compliance issues as required.*
>
> *In addition, the department undertakes proactive activities to improve stakeholder compliance with public health legislation, including providing online audits of compliance by HCFs with their infection control obligations.*
>
> *If required, additional resources may also be made available on a case-by-case basis to respond to complex emergent issues. For example, the investigation and public health response to the infection control incident at the Carina dental clinic, which lead to the development of the Bill, required the involvement of a variety of specialists from both the department and HHSs.*
>
> *Investigating and responding to complaints and identified issues under the strengthened infection control framework will be incorporated into these existing compliance functions of the department and HHSs.*[92]

The department stated that any future decisions about compliance resources will be made having regard to the number of complaints received and the complexity of issues identified.[93]

89 Department, Correspondence, 4 May 2017, p 3.
90 Explanatory notes, p 3.
91 Department, *Correspondence*, 4 May 2017, p 1.
92 Department, *Correspondence*, 4 May 2017, p 2.
93 Department, *Correspondence*, 4 May 2017, p 2.

# 4 Fundamental legislative principles and explanatory notes

## 4.1 Fundamental legislative principles

Section 4 of the *Legislative Standards Act 1992* states that the fundamental legislative principles (FLPs) are the 'principles relating to legislation that underlie a parliamentary democracy based on the rule of law'. The principles include that legislation has sufficient regard to:

- the rights and liberties of individuals, and
- the institution of Parliament.

The committee has examined the application of the FLPs to the Bill and brings the following potential FLP issues to the attention of the Legislative Assembly.

## 4.2 Rights and liberties of individuals

*Clause 9 – requirement to provide a copy of infection control management plan*

Clause 9 inserts new section 156A into the Act to provide that an authorised person may, by notice, require the operator of an HCF to provide a copy of the HCF's ICMP or other stated information about procedures for preventing or minimising the risk of infection to persons. A failure to provide an ICMP or other requested information, without a reasonable excuse, is an offence attracting a maximum penalty of 200 penalty units ($24,380).

The proposed provision raises potential FLP issues in relation to an individual's rights and liberties regarding appropriate protection against self-incrimination. The committee notes that the principle of protection against self-incrimination is based on the common law principle that an individual accused of an offence should not be obliged to incriminate himself or herself.[94]

The risk of self-incrimination arises because, in providing the ICMP and other required supporting documentation to an authorised person, the operator may expose themselves to a financial penalty, as those documents may reveal inadequacies in their ICMP and non-compliance with the infection control framework.

The explanatory notes state that:

> *… it is essential for the State as a regulator to have access to details of the infection control practices of HCFs, which are crucial to identifying whether infection control risks at particular HCFs are being properly managed, or whether improvements or compliance action by the State are warranted. As these details are peculiarly within the knowledge of the operator of an HCF, as documented in the ICMP and other materials within the operator's control, and cannot be authoritatively sourced from any other source, any potential abrogation of the privilege against exposure to a penalty is justifiable.*[95]

**Committee comment**

The committee considers that, on balance, clause 9 has sufficient regard to the rights and liberties of individuals.

In reaching this view, the committee had regard to the fact that an HCF's ICMP, and other information about procedures at an HCF to minimise infection risks, are documents that are peculiarly within the knowledge of the operator and are documents that the operator is required to keep under the infection control framework. The committee also notes the department's comments that these documents cannot be obtained from other sources than the operator of the HCF.

[94] Office of the Queensland Parliamentary Counsel, *Fundamental Legislative Principles: The OQPC Notebook*, p 52.

[95] Explanatory notes, p 5.

The committee also considers that any risk of self-incrimination is justified when balanced against the objective of ensuring public health and safety by minimising the risk of infection to patients when receiving treatment at HCFs.

*Clause 10 – issuing of directions notices*

Clause 10 inserts new section 156E into the Act to provide that the chief executive may issue the operator of an HCF with a directions notice directing the operator to stop providing a stated declared health service at the HCF for a stated period of not more than 30 days. New section 156F provides that the chief executive may extend the initial 30 day period by a further period of up to 30 days. New section 156G provides that a magistrates court may further extend the period, if the grounds for issuing the original directions notice continue to exist.

Section 4(3)(a) of the *Legislative Standards Act 1992* provides that whether legislation has sufficient regard to rights and liberties of individuals depends on whether the legislation makes rights and liberties, or obligations, dependent on administrative power only if the power is sufficiently defined and subject to appropriate review.

The department confirmed that the decision to issue a directions notice will be reviewable under the *Judicial Review Act 1991* and, therefore, that decision may be stayed or overturned by a court. The committee notes, however, that the amendments do not make provision for an internal review to enable an operator to comment on why a directions notice may be unwarranted or unjustified in the circumstances or to enable an operator to apply to QCAT to review the decision to issue a notice.

Clause 10 also raises potential FLP issues in relation to the right to natural justice, as one element of the principle of natural justice is that something should not be done to a person that will deprive them of some right, interest or legitimate expectation of a benefit without the person being given adequate opportunity to present their case to the decision-maker.

**Committee comment**

The committee brings the potential FLP issues raised by clause 10 to the attention of the Legislative Assembly.

The committee has recommended (Recommendation 3) that the Minister informs the Legislative Assembly, during the second reading debate, why a decision was taken not to enable operators to apply to QCAT to review decisions to issue notices.

*Clause 13 – power to enter premises without prior notice*

Section 390 of the Act provides that an authorised person may enter an HCF, without a warrant, if the facility is open for business or otherwise open for entry, after providing 24 hours' notice to the person in charge of the facility.

Clause 13 amends section 390 to remove the requirement that an authorised person must give 24 hours' notice before entering an HCF.

Section 4(3)(e) of the *Legislative Standards Act 1992* provides that whether legislation has sufficient regard to rights and liberties of individuals depends on whether the legislation confers the power to enter premises, and search for or seize documents or other property, only with a warrant issued by a judge or other judicial officer. The committee notes, however, that strict adherence to this principle may not be required, if the premises are business premises operating under a licence or premises of a public authority.

**Committee comment**

The committee notes that the new power to enter an HCF, without prior notice, is limited to those circumstances where an authorised person reasonably believes immediate entry is require to prevent or minimise an imminent infection risk at the HCF.

The committee also notes the existing safeguards in the Act, which provide that an authorised person may only enter an HCF, without a warrant, when the facility is open for business or otherwise open for entry. The Act also provides that an authorised person may not enter a part of the HCF where a person is undergoing a procedure or is consulting a health practitioner and an authorised person may not seize evidence from the premise without a warrant.

In light of the limitations on the use of the power to enter an HCF, without notice, and the current safeguards in the Act in relation to entering an HCF without a warrant, the committee considers that, on balance, clause 13 has sufficient regard to the rights and liberties of individuals.

## 4.3 Explanatory notes

Part 4 of the *Legislative Standards Act 1992* requires that an explanatory note be circulated when a Bill is introduced into the Legislative Assembly, and sets out the information an explanatory note should contain.

Explanatory notes were tabled with the introduction of the Bill. The explanatory notes are fairly detailed and contain the information required by Part 4 of the *Legislative Standards Act 1992* and a reasonable level of background information and commentary to facilitate understanding of the Bill's aims and origins.

## Appendix A – List of submitters

| Sub # | Submitter |
|---|---|
| 001 | Queensland Nurses and Midwives' Union |
| 002 | Gold Coast Hospital and Health Service |
| 003 | Dental Hygienists Association of Australia |
| 004 | Australian Dental Association Queensland |
| 005 | Australian Medical Association Queensland |
| 006 | Australian Lawyers Alliance |

## Appendix B – Witnesses at public briefing

| **Thursday 6 April 2017** |
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| • Dr Jeannette Young, Chief Health Officer and Deputy Director-General, Prevention Division, Queensland Health<br>• Mr David Harmer, Director, Legislative Policy Unit, Strategic Policy and Legislation Branch, Queensland Health |

## STATEMENT OF RESERVATIONS

## NON GOVERNMENT MEMBERS

The Non Government Members support the passing by the Parliament of the Public Health (Infection Control) Amendment Bill 2017 but do have some reservations which we request the Health Minister to address in his second reading speech.

1) The Australian Dental Association raised the point that under Clause 5 Section 151 headed "General Obligation to minimise infection risks for declared Health Services"... the sentence "A person involved in the provision of a declared health service must take all reasonable precautions and care to minimise the risk of infection to other persons", could lead to unintended consequences.
They point out that one of the examples given in the Bill is that of a registered nurse collecting blood for a blood bank who could be liable in failing to comply with the I.C.M.P. They question whether it is the intention to hold every person liable individually or whether the question of vicarious liability is to apply. Secondly they raise the point that the word "involved" is nebulous and could lead to a wide interpretation drawing the net further than anticipated or required.

   In fact in their submission the ADAQ makes this comment;

   > "that Section 151 as proposed could have the effect of making any person involved in provision of a declared health service liable."

   The Minister needs to clarify, is that the desired outcome? One could certainly envisage circumstances where a person may fall foul by inadvertently not complying yet still be liable under the terms of the Bill.

   Additionally there will be an incentive for owners of premises who are not operators or operators removed from the day to day activities of the HCF shifting blame to employees basis of the example provided in the clause.

2) As stated within the Report of the Committee there is no appeal mechanism contained within the Bill dealing with an Improvement Notice under Clause 10 Section 156C or a Directions Notice under Section 156E and associated sections. This point is highlighted in the submission by Australiana Dental Association of Queensland under the heading Review of the Directions Notice pointing out that a right of appeal should lie to QCAT. The Health Department in their reply state that the matter could be dealt with under the Judicial Review Act by way of Judicial Review. Clearly there are significant costs and time involved in such applications whereas an appeal to QCAT could have the matter dealt with quicker and with less legal costs.

3) The Australian Lawyers Alliance in their submission raise a question in regard to the Clause 9 section 156 B in particular subsection (b). The section deals with the Power of an Authorised person giving notice that requires the operator to amend the I.C.M.P and under subsection 3 (b) that notice is required to state "the way the ICMP must be amended."

The ALA raises the point that this may suggest the Authorised person is to "rewrite the I.C.M.P" and proposes it be amended to read ;

> "the reasons why the authorised person considers the I.C.M.P does not comply with this part."

4) In addition in regard to Clause 13 section 390 the A.L.A question whether the phrase "an imminent risk of infection to a person at the health care facility" poses a difficult threshold and proposes a lower one before allowing entry to a health care facility without notice.

5) In an answer to a question during the Public hearing on the 6th of April 2017 the Chief Health Officer when asked when how many HCFs are there in Queensland stated "They would be in the thousands." During the same public hearing the Chief Health Officer made this comment;

> "Since we have become aware of this as being an issue, we have started doing some audits and we are seeing that there are a number of practices that do not have the plans as required."

It is clear given the full testimony of the Chief Health Officer and the intent of the Bill that Queensland Health will undertake a more active approach in regard the monitoring of infection control practices,

investigating complaints for poor practices, enforcing compliance and requiring non-compliant practices to be rectified.

In a request for further information the Director General was asked to advise what current resources were available (including staff and funding levels) to meet current requirements and if they would be increased due to the Bill.

In answer the Director General said there were 145 Authorised Officers available to investigate complaints and take action under the Public Health Act. He stated "If required, additional resources may also be made available on a case by case basis to respond to emergent issues." Given there will be a greater role for Queensland Health under this Bill and there are thousands of HCF's the answer provided indicates no additional resources nor funding will be made available for what appears to be a much more vigorous and interventionist approach.

One can assume the 145 Authorised Officers are all actively and fully engaged by Queensland Health under an regime that is not as rigorous as proposed so therefore the question must be how will those 145 people cover these thousands of HCF's if as referred to by the Chief Health Officer they "have started doing some audits".

X

Mark McArdle MP
State Member for Caloundra 12/5/2017

X 12/5/2017

Mark Robinson
State Member for Cleveland

X

Sid Cramp
State Member for Gaven