Parliamentary Committees

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

Subordinate legislation tabled between 30 October & 12 November 2018 Report No. 19

1 Aim of this report

This report summarises the committee's findings following its examination of the subordinate legislation within its portfolio areas tabled between 30 October 2018 and 12 November 2018. It reports on any issues identified by the committee relating to the policy to be given effect by the legislation, fundamental legislative principles and lawfulness. It also reports on the compliance of the explanatory notes with the *Legislative Standards Act 1992*.

2 Subordinate legislation examined:

No.	Subordinate legislation	Date tabled	Disallowance date
156	Health (Drugs and Poisons) Amendment Regulation 2018	30 October 2018	28 March 2019
160	Proclamation made under the *Child Protection Reform Amendment Act 2017*	30 October 2018	28 March 2019
161	Child Protection (Information Sharing) Amendment Regulation 2018	30 October 2018	28 March 2019

2.1 Health (Drugs and Poisons) Amendment Regulation 2018

The objective is to provide authority for certain health practitioners to use medicines and poisons, to fill a service delivery and workforce gap created in isolated practice areas of Queensland.

According to the explanatory notes, the role of Indigenous health workers with isolated practice authorisation (IPA) is now replaced by the (equally qualified and nationally recognised) Aboriginal and Torres Strait Islander health practitioner role. Indigenous workers with IPA could obtain, possess, administer and supply specified schedule 2, 3, 4 or 8 substances. The training and qualifications required to become an Indigenous health worker with IPA are no longer available and the role has been replaced by the role of Aboriginal and Torres Strait Islander health practitioner.[1]

However, this has created a service delivery and workforce gap with the transition to the new role. The explanatory notes state:

> *The amendments will ensure that the delivery of effective and culturally appropriate healthcare to rural and remote communities across Queensland is maintained by transitioning the scheduled medicines authorities held by Indigenous health workers with IPA [Isolated Practice Authorisation] to Aboriginal and Torres Strait Islander health practitioners.*[2]

The amendments commenced on 1 November 2018.

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1 Explanatory notes, p 1.

2 Explanatory notes, p 1.

2.1.1 FLP issues

Provisions

Clauses 5, 11 and 14 require an Aboriginal and Torres Strait Islander health practitioner to administer and supply specified scheduled substances under the oral or written instruction of a dentist, doctor or nurse practitioner, the Drug Therapy Protocol and practice plan.

These references are explained in the explanatory notes:

> *A drug therapy protocol is a document certified by the chief executive of Queensland Health that sets out matters of technical detail for the administration, possession and supply of substances… The Drug Therapy Protocol is monitored and updated when necessary, aligns with the clinical best practice and is published on the Queensland Health website (www.health.qld.gov.au).*
>
> *…*
>
> *A practice plan is approved form developed between an Aboriginal and Torres Strait Islander health practitioner and their clinical supervisor. The practice plan provides a framework for the individual practitioner's clinical practice and any supervision requirements. Together, the practitioner and their clinical supervisor develop the practice plan to individualise the scope of practice specific to the practitioner's employed position. The approved form for the practice plan is published on the Queensland Health website at www.health.qld.gov.au.*[3]

Potential issue of fundamental legislative principle

As acknowledged in the explanatory notes,[4] prescribing requirements by reference to an external document (the Drug Therapy Protocol and the practice plan) may be seen to breach section 4(5)(e) of the *Legislative Standards Act 1992*:

> *Whether subordinate legislation has sufficient regard to the institution of Parliament depends on whether for example the subordinate legislation:*
>
> *(e) allows the sub-delegation of a power delegated by an Act only –*
>
> *(i) in appropriate cases and to appropriate persons, and*
>
> *(ii) if authorised by an Act.*
>
> *Part of the rationale for this issue is to ensure sufficient parliamentary scrutiny of delegated legislative power.*[5]

The significance of dealing with such matters other than by subordinate legislation is that, since the relevant document is not 'subordinate legislation', it is not subject to the tabling and disallowance provisions in Part 6 of the *Statutory Instruments Act 1992*.

Where there is an extrinsic document (such as the protocol and the plan) incorporated into the legislative framework of the State, it is not reproduced in full in subordinate legislation, and where changes to that document can be made without the content of those changes coming to the attention of the House, it may be argued that the document (and the process by which it is incorporated into the legislative framework) has insufficient regard to the institution of Parliament.

Currently, the Drug Therapy Protocol and practice plan are not contained in the subordinate legislation in their entirety, and as such their content does not come to the attention of the House.

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3 Explanatory notes, p 4.

4 Explanatory notes, p 4.

5 Office of the Queensland Parliamentary Counsel, *Fundamental Legislative Principles: the OQPC Notebook,* p170.

Request for advice

The committee sought information on:

- how the regulation has sufficient regard to the Institution of Parliament
- the development, maintenance and oversight of the Drug Therapy Protocol and practice plan
- the reasons the Drug Therapy Protocol and practice plan are excluded from subordinate legislation, and
- the safeguards in place regarding the administration and supply of scheduled substances via such documents.

Departmental advice

Queensland Health provided the following responses to the committee's request for further information.

Regard to the Institution of Parliament

Section 4(5)(e) of the *Legislative Standards Act 1992* states that whether subordinate legislation has sufficient regard to the institution of Parliament depends on whether the subordinate legislation allows the subdelegation of a power delegated by an Act only in appropriate cases and to appropriate persons, and if authorised by an Act.

Clauses 5, 11 and 14 of the Health (Drugs and Poisons) Amendment Regulation 2018 (the Amendment Regulation) authorise the Aboriginal and Torres Strait Islander health practitioner (the practitioner) practising in an isolated practice area to supply an S2 poison, S3 poison or a restricted drug or administer an S2 poison, S3 poison, a restricted drug or a controlled drug under the Drug Therapy Protocol — Aboriginal and Torres Strait Islander health practitioner — Isolated Practice Area and Practice plan, and on the oral or written instruction of a doctor or nurse practitioner.

The Department of Health considers the subdelegation is appropriate and justified as Drug Therapy Protocols (DTPs) and Practice plans set out matters of technical detail and because there is significant rigour surrounding the development of these documents. The DTP and Practice Plan are monitored and updated regularly, with consideration given to the healthcare needs of specific patient populations, how care can be provided in a timely and safe manner and the individual skills, qualifications and experience of the practitioner.

DTPs are documents made under various sections of the Health (Drugs and Poisons) Regulation 1996, endorsed by the Queensland Chief Health Officer and certified by the chief executive of Queensland Health. DTPs set out matters of technical detail for the administration, possession and supply of substances. For example, DTPs include the route of administration, the specific dose, quantity, duration and restrictions placed on substances and the circumstances in which they may be administered. DTPs are reviewed every two years, or earlier as required and maintained through the Primary Clinical Care Manual as the approved health management protocol. The DTP is published on the Queensland Health website (www.health.qld.qov.au).

A Practice plan is an approved form developed and signed by a practitioner and their clinical supervisor and approved by the relevant Hospital and Health Service or Aboriginal Community Controlled Health Service delegate. The Practice plan states the circumstances and conditions for the practitioner to administer or supply a poison, restricted drug or a controlled drug. The practitioner and their clinical supervisor develop the Practice plan to individualise the scope of practice specific to the practitioner's employed position and identifies specific referral and escalation points and supervision requirements. The Practice plan must be updated annually, at a minimum. The approved form for the Practice plan is published on the Queensland Health website (www.health.qld.qov.au).[6]

[6] Queensland Health, correspondence dated 13 March 2019, attachment, p 1.

Development, maintenance and oversight of the Drug Therapy Protocol and practice plan

Extensive consultation occurred during the development of the DTP and Practice plan. Stakeholders consulted included the Queensland Aboriginal and Islander Health Council, Australian Medical Association (Queensland), Queensland Nurses and Midwives' Union, Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, Apunipima Cape York Council and the Rural and the Remote Clinical Support Unit.

DTPs are documents made under various sections of the Health (Drugs and Poisons) Regulation, endorsed by the Queensland Chief Health Officer and certified by the chief executive of Queensland Health. DTPs are published on the department's website and reviewed every two years, or earlier as required and maintained through the Primary Clinical Care Manual as the approved health management protocol.

A Practice plan is an approved form developed and signed by a practitioner and their clinical supervisor and approved by the relevant Hospital and Health Service or Aboriginal Community Controlled Health Service delegate. The Practice plan is reviewed annually, at a minimum. The approved form for the Practice plan is published on the department's website.

The DTP specifies that to the extent necessary to perform duties under the Practice Plan, a practitioner may administer or supply the poison or drug in accordance with the health management protocol. The Primary Clinical Care Manual contains the principal health management protocols to be used in rural and remote ambulatory care settings by the practitioner.

A health management protocol is required and must be available to the practitioner to administer the DTP, as identified in section 1.4 and 2 of the DTP. Appendix 3 of the DTP specifies the minimum requirements for a health management protocol, including review requirements, and the content required in a health management protocol. The health management protocol must be endorsed by the chief executive of a Hospital and Health Service or a non-Queensland Health employing organisation.

The Primary Clinical Care Manual (9th Edition) is the principal clinical reference and policy document for health professionals working in diverse and rural and remote health service settings and contains clinical guidelines and health management protocols. This includes health management protocols for Rural and Isolated Practice Registered Nurses, Authorised Indigenous Health Workers (Aboriginal and Torres Strait Islander health workers with Isolated Practice Area authorisation), Aboriginal and Torres Strait Islander health practitioners, and Authorised Sexual and Reproductive Health and Immunisation Registered Nurses. From 1 November 2018, the health management protocol specified that for Authorised Indigenous Health Workers it should also be taken as being the health management protocol for Aboriginal and Torres Strait Islander health practitioners. This will be specified in Edition 10 due for release March/April 2019.

The Primary Clinical Care Manual supports best practice in rural and remote health care. It is widely used across Queensland in all health sectors, and is recognised as the peak clinical protocol in other states. The Primary Clinical Care Manual has a controlled copy available through the Queensland Government publications website and is rigorously reviewed by a panel of clinical experts. It is required to be updated every two years to ensure the interventions recommended in the Primary Clinical Care Manual are evidence based and in accordance with the Health (Drugs and Poisons) Regulation. At a minimum, the review must be undertaken by a multidisciplinary team including a medical practitioner, registered nurse and pharmacist. Outcomes of these reviews are considered and inform the biennial republication of the document following endorsement by the chief executive of Queensland Health.[7]

[7] Queensland Health, correspondence dated 13 March 2019, attachment, pp 2-3.

Reasons the Drug Therapy Protocol and practice plan are excluded from subordinate legislation

Contemporary clinical practice and the conditions and needs of the clients in the rural and remote sector change over time, influencing clinical decision making and health management protocols. If the detail included in the DTP and Practice plan were included in subordinate legislation, the legislation may have difficulty keeping pace with changes to complex health requirements and the need for health services to respond rapidly to changing health concerns.

It is considered appropriate to not include the DTP and Practice plan in subordinate legislation as the Aboriginal and Torres Strait Islander health practitioner is a highly regulated workforce with additional legislative obligations under the Health Practitioner Regulation National Law and clinical governance arrangements.

The practitioner is bound by their obligations under the National Law. The Aboriginal and Torres Strait Islander Health Practitioner Board of Australia has set qualification requirements for the purposes of registration. The scheduled medicines authorities within the Health (Drugs and Poisons) Regulation and the DTP were developed in line with the specific competencies of Aboriginal and Torres Strait Islander health practitioners attained through the approved qualification.

The clinical governance structure in place in Queensland for the role has additional levels of control and offers the ability to restrict and reduce scope of practice more than any other nationally registered health practitioner. The clinical governance framework for the role in Queensland includes clinical governance guidelines, scope of practice documentation, and a competency assessment tool available on the Queensland Health website.

Clinical governance includes requirements for national registration, pre-employment screening, competency assessment, development and endorsement of the required Practice plan, professional indemnity, re-entry clinical skills assessments, clinical supervision, monitoring and professional development, clinical audits and regular scope of practice reviews.

The Practice plan is required to define the individual practitioner's scope of practice which is specific to their registration status (including any notations, conditions or undertakings), job description, clinical setting in which they work, consumer needs, available supervision and their individual skills and experience. It is in an approved form and its use is strengthened by a guide to completing the Practice plan, which is available on the department's website. The Practice plan identifies practice requirements and restrictions, supervision arrangements and individual scheduled medicine authorities. The initial Practice plan must be completed following a clinical skills competency assessment and is agreed to by the clinical supervisor, and endorsed by the approved health service delegate. The Practice plan is reviewed annually and is closely linked with clinical and professional development requirements.

The DTP is developed by a panel of clinical experts and includes the scheduled medicines' circumstances and conditions of use and must be used in conjunction with a health management protocol. The list of drugs and poisons has undergone a rigorous review process and can be amended, if required, based on proven clinical decisions. The DTP is endorsed by the Queensland Chief Health Officer, certified by the chief executive of Queensland Health and published on the department's website.[8]

Safeguards in place regarding the administration and supply of scheduled substances

The Practice plan enables a framework to support the variation of individual scopes of practice. The scope of practice is defined and agreed by the practitioner and the credentialed clinical supervisor, then considered and approved by the Hospital and Health Service or Aboriginal Community Controlled Health Service delegate.

The individual clinical skills assessment undertaken to inform the development of the Practice plan includes a comprehensive assessment of competencies in clinical assessment and use of medicines,

[8] Queensland Health, correspondence dated 13 March 2019, attachment, pp 3-4.

including calculations, medicines handling and storage. A copy of the assessment is to be attached to the Practice plan for consideration prior to endorsement.

The Department of Health in partnership with the Torres and Cape Hospital and Health Service and TAFE North as the National Board accredited education provider has developed a standardised scheduled medicines refresher workshop, which includes an assessment component. Completion of the program will be required for any practitioner who has not completed their pre-entry scheduled medicines training within a clinical setting.

The DTP is developed by clinical leaders taking into consideration elements such as safety, access requirements, education and clinical support required for the practitioner. Only after consideration of a wide range of safety factors, are the substances approved to be included on the schedule list that may be accessed by an authorised practitioner and included in the individual Practice plan.

The practitioner is an effectively positioned workforce to provide readily accessible and culturally safe health care to Aboriginal and Torres Strait Islander people. Queensland is committed to closing the health gap between Aboriginal and Torres Strait Islanders and non-Indigenous Australians and the implementation of the Aboriginal and Torres Strait Islander Health Practitioner role with scheduled medicines authority will provide improved access to quality health care in remote and disadvantaged areas of Queensland.[9]

Committee comment

In considering whether it was appropriate for matters to be dealt with by an instrument that was not subordinate legislation, and therefore not subject to parliamentary scrutiny, committees have considered the importance of the subject dealt with, the commercial or technical nature of the subject-matter, and the practicality or otherwise of including those matters entirely in subordinate legislation.[10]

The committee notes the justifications provided in the Explanatory Notes and the Department of Health's further advice, and accepts that it is appropriate for practical reasons for the circumstances and conditions for Aboriginal and Torres Strait Islander health practitioners to administer or supply a poison, restricted drug or a controlled drug to be set out in a document other than subordinate legislation (the Drug Therapy Protocol and the practice plan).

In all the circumstances, the committee is satisfied that there is sufficient justification for the incorporation, by reference, of the external documents and for any breach of fundamental legislative principle.

2.1.2 Explanatory notes

The explanatory notes tabled with the regulations comply with the requirements of section 24 of the *Legislative Standards Act 1992*.

2.2 Proclamation made under the *Child Protection Reform Amendment Act 2017*

The objective is to fix a commencement date of 29 October 2018 for certain provisions of the *Child Protection Reform Amendment Act 2017* (the Act).

The Act makes amendments, among other things, to the *Child Protection Act 1999*. These are the provisions that commenced on 29 October 2018.[11]

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9 Queensland Health, correspondence dated 13 March 2019, attachment, p 4.

10 See the Office of the Queensland Parliamentary Counsel, *Fundamental Legislative Principles: the OQPC Notebook,* pp 155-156, and Scrutiny of Legislation Committee, *Alert Digest 1999/04,* p.10, paras 1.65-1.67.

11 *The Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee tabled its report on the Bill for that Act in September 2017. See* Health, Communities, Disability Services

The commencing provisions relate to:

- ensuring positive long-term outcomes for children, young people and their families, including achieving improved permanency outcomes
- recognising the right of Aboriginal and Torres Strait Islander people to self-determination, including supporting Aboriginal and Torres Strait Islander children in developing and maintaining connections with their family, community and culture
- facilitation for Aboriginal and Torres Strait Islander families, the participation of the child and child's family in decision making by providing for the role and function of an Independent Entity for the child
- improving the support available to young people transitioning from care to independence
- enabling information sharing, including the making of guidelines about information sharing under the act.[12]

2.2.1 Fundamental legislative principle issues

No issues of fundamental legislative principle were identified.

2.2.2 Explanatory notes

The explanatory notes tabled with the regulations comply with the requirements of section 24 of the *Legislative Standards Act 1992*.

2.3 Child Protection (Information Sharing) Amendment Regulation 2018

The objective is to facilitate the effective participation of the Department of Aboriginal and Torres Strait Islander Partnerships (DATSIP) in the modernised information sharing regime under the *Child Protection Act 1999* by including DATSIP as a 'prescribed entity' for the purposes of the information sharing provisions under the Act.

The new information sharing framework allows for prescribed entities to give information to the chief executive or an authorised officer where the holder reasonably believes the information will help the receiver undertake case planning for a child or assess and respond to the care needs of a child in need of protection, or a child who may become in need of protection.

The Act provides that a prescribed entity may include the chief executive of another entity that provides a service to children or families and is prescribed by regulation.

DATSIP currently shares family background information about relevant children with the Department of Child Safety, Youth and Women (DCSYW) to support DCSYW to make decisions about kinship placements for children in need of protection. DATSIP also provides a service that supports people of Aboriginal or Torres Strait Islander descent in researching their family and cultural history. [13]

2.3.1 Fundamental legislative principle issues

No issues of fundamental legislative principle were identified.

2.3.2 Explanatory notes

The explanatory notes tabled with the regulations comply with the requirements of section 24 of the *Legislative Standards Act 1992*.

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and Domestic and Family Violence Prevention Committee, Report No 45, 55th Parliament, December 2017, *Child Protection Reform Amendment Bill 2017*.

12 Explanatory notes, SL 2018 No. 160, pp 1-2.

13 Explanatory notes, SL 2018 No. 161, pp 1-2.

3 Committee consideration of the subordinate legislation

The committee has examined the policies to be given effect by the subordinate legislation within its portfolio areas tabled between 30 October 2018 and 12 November 2018 and its lawfulness.

The committee identified inconsistencies with fundamental legislative principles (FLPs) in relation to the Health (Drugs and Poisons) Amendment Regulation 2018. Specifically, these inconsistencies were with matters to be dealt with by an instrument that was not subordinate legislation. The committee considered the justification for the inconsistencies with FLPs provided in the explanatory notes and further advice provided by the Department of Health. The committee is satisfied that there is sufficient justification for the incorporation, by reference, of the external documents and for any breach of fundamental legislative principle.

No other inconsistencies were identified with the remaining subordinate legislation.

The explanatory notes tabled with all of the regulations and proclamations examined comply with part 4 of the *Legislative Standards Act 1992*.

4 Recommendation

The committee recommends that the House notes this report.

Chair

March 2019

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

Chair	Mr Aaron Harper MP, Member for Thuringowa
Deputy Chair	Mr Mark McArdle MP, Member for Caloundra
Members	Mr Michael Berkman MP, Member for Maiwar
	Mr Marty Hunt MP, Member for Nicklin
	Mr Barry O'Rourke MP, Member for Rockhampton
	Ms Joan Pease MP, Member for Lytton