HEALTH AND COMMUNITY SERVICES COMMITTEE

Members present:

Mr TJ Ruthenberg MP (Chair)
Ms RM Bates MP
Mr SW Davies MP
Dr AR Douglas MP
Mr DE Shuttleworth MP

Staff present:

Ms S Cawcutt (Research Director)
Mr K Holden (Principal Research Officer)

PUBLIC BRIEFING—HEALTH OMBUDSMAN BILL 2013

TRANSCRIPT OF PROCEEDINGS

TUESDAY, 11 JUNE 2013

Brisbane

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Committee met at 3.30 pm

CLEARY, Dr Michael, Deputy Director-General, Health Services and Clinical Innovation, Queensland Health

SHEEHY, Mr Paul, Director, Special Legislative Projects, Queensland Health

CHAIR: I declare open this public briefing of the Health and Community Services Committee. Our purpose today is to be briefed by officials from Queensland Health on the Health Ombudsman Bill 2013. My name is Trevor Ruthenberg, the member for Kallangur and chair of the committee. At the end of the table is Mr Steve Davies, the member for Capalaba; next to me is Ms Ros Bates, the member for Mudgeeraba; and Mr Dale Shuttleworth, the member for Ferny Grove. I have an apology from Mrs Jo-Ann Miller, the member for Bundamba and deputy chair; and an apology from Mr John Hathaway, the member for Townsville.

Welcome, Dr Cleary and Mr Sheehy. Dr Cleary is the Deputy Director-General of Health Services and Clinical Innovation. Mr Sheehy is Director of Special Legislative Projects. I remind those present that these proceedings are similar to parliament and are subject to Legislative Assembly standing rules and orders. Mobile phones should be turned off or switched to silent, please. Hansard is making a transcript of the proceedings. The committee intends to publish the transcript of today's proceedings unless there is good reason not to.

The Health Ombudsman Bill was introduced into the parliament on 4 June and the committee has invited submissions on the bill by Monday 24 June. The committee will hold a public hearing in the week beginning 8 July to hear from invited witnesses. We are required to report to the parliament on this bill by 12 August.

Dr Douglas, I am going to ask now Dr Cleary and Mr Sheehy to brief us for about 40 minutes and then there will be a period of 20 minutes or so for us to ask questions after that.

Dr DOUGLAS: Thanks.

CHAIR: Dr Cleary, if you would like to commence and, as I say, you have about 40 minutes or so and we will leave 20 minutes or so open for questions.

Dr Cleary: I would like to thank the committee for this opportunity to present an overview of the Health Ombudsman Bill. The Health Ombudsman Bill will overhaul the health complaints management system in Queensland. The new system, as outlined in the Bill—

CHAIR: Sorry, just a second. Can you hear that, Dr Douglas?

Dr DOUGLAS: I can just hear. If he could speak a little bit into the microphone, it would be great. I can only just hear him. I am sorry, Michael. I have been with Michael on the weekend at the rural doctors' conference.

CHAIR: Just speak up a fraction.

Dr Cleary: Okay. Is that a little better, Dr Douglas?

Dr DOUGLAS: That is better, yes. Thank you.

Dr Cleary: I will just recount some of my comments for Dr Douglas. The Health Ombudsman Bill will overhaul the health complaints management system in Queensland. The new system as outlined in the bill will improve the management of complaints from the perspective of patients and consumers, as well as health professionals. The key object of the bill is to better protect the health and safety of the public. The need for this legislation stems from public concerns and a public interest disclosure that serious allegations against medical practitioners were not being adequately investigated. There have also been concerns raised by health professionals about aspects of the existing complaints management system.

In response to these concerns, three independent reports were commissioned. Justice Chesterman was engaged by the Crime and Misconduct Commission after the Parliamentary Crime and Misconduct Committee referred the public interest disclosure to the Crime and Misconduct

Commission to investigate. Subsequently, and subsequent to the Chesterman report being finalised, the Hon. Lawrence Springborg, the Minister for Health, commissioned two further reviews as per the recommendations of Justice Chesterman's review. The first of those reports, as I mentioned, was the Chesterman report. In that report, Justice Chesterman expressed concerns about the way in which serious allegations against medical practitioners were being handled by the Queensland Board of the Medical Board of Australia, including the time taken to progress the complaints. The Chesterman report noted that there are indications that the Queensland Board of the Medical Board of Australia may not adequately respond to the substance of complaints and may too readily find complaints unsubstantiated.

I note that the medical board or the Queensland Board of the Medical Board of Australia is a committee of the Medical Board of Australia and acts under the delegation of the Medical Board of Australia. As such, the Medical Board of Australia is accountable for the decisions made by the Queensland Board of the Medical Board of Australia. One of the recommendations of the Chesterman report was to commission a further investigation to determine whether the Queensland Board had made timely and appropriate responses to complaints. The subsequent report, prepared by a three-person panel led by Dr Kim Forrester, concluded that 363 of the 596 files, or about 60 per cent of the files that they reviewed, were not handled in a manner that was timely, appropriate or in compliance with the legislation. In one case, a matter took six and a half years to be finalised. The panel's conclusion in relation to matters dealt with under the Health Practitioners (Professional Standards) Act was that the outcomes were neither consistent nor predictable based on the nature or clinical significance of the complaints and that the process of the board failed to protect the public, uphold standards of practice and maintain public confidence as required under the Health Practitioners (Professional Standards) Act.

The panel's conclusion in relation to matters dealt with by the Queensland Board under the new Health Practitioner Regulation National Law was also of serious concern. Their concerns were that the processes followed by the board, the Queensland Board, did not meet the reasonable expectations that notifications are considered and predictably dealt with in a timely manner, and there were a number of examples where serious notifications indicating that the public was at risk of harm were not handled with the urgency that was required in the particular circumstances, and the process followed by the board demonstrated an inability to effectively prioritise and manage the progression of notifications from the time of receipt to the finalisation of the report being received by the board. A third report was undertaken by Mr Jeffrey Hunter SC. This resulted in six medical practitioners being referred to the Queensland Police Service for investigation into whether or not criminal offences had been committed.

I would now like to provide an overview of the bill for the committee. It is evident from the information that I have provided that the current situation is unacceptable to government and to the Queensland community. In responding to these concerns, the health minister, the Hon. Lawrence Springborg, has introduced into the Queensland parliament the Health Ombudsman Bill. The bill establishes the statutory position of the Health Ombudsman, which will be supported by the Office of the Health Ombudsman. The Health Ombudsman and the Office of the Health Ombudsman will replace the Health Quality and Complaints Commission. The Health Ombudsman will be responsible and accountable for dealing with the most serious complaints against health practitioners.

The organisational arrangements proposed in the bill will mean that there will no longer be role confusion, the diffusion of responsibility between the national boards, the state board and the national agency and the state complaints agency. The bill proposes there will be one person accountable for dealing with serious complaints in Queensland, that is, the Health Ombudsman. This represents a change from the current arrangements where health services complaints may be made to the Health Quality and Complaints Commission or to the national boards. The splitting of complaints management in this manner has led to confusion and delay in the management of complaints. This arrangement will end under the bill. Under the legislation, all health services complaints will be made to the Health Ombudsman. This will include notifications made by health professionals under the Health Practitioner Regulation National Law, as well as complaints from patients and consumers. As a consequence, everyone in Queensland will know that there is one agency to report concerns to about health and that will be the Health Ombudsman.

I would like to move on to discuss the role of the Health Ombudsman. The Health Ombudsman will firstly have a critical role in deciding how complaints are to be managed. The Health Ombudsman will be responsible for oversighting the assessment or triage of all complaints and deciding what action will be taken. This action may include facilitating the local resolution of

matters between the complainant and the health services provider, investigating a complaint, conciliating a complaint with the objective of entering into a confidential binding settlement or referring matters to the national board or other government agency for consideration as appropriate. The Health Ombudsman will also be able to hold an inquiry into any matter.

The critical difference under the bill to the processes that are currently in operation will be that the Health Ombudsman will not refer serious matters about a registered health practitioner to the national boards. They will remain the responsibility of the Health Ombudsman to manage. Under the bill, serious matters are those that indicate professional misconduct or otherwise may be grounds for the suspension or deregistration of a practitioner. The Health Ombudsman may investigate these serious matters with a view of taking disciplinary action against the practitioner.

The bill also establishes the position of Director of Proceedings in the Office of the Health Ombudsman. This position will be held by a lawyer. The role the Director of Proceedings is to consider whether disciplinary matters should be taken to the Queensland Civil and Administrative Tribunal and, if so, to take the proceedings before the tribunal. This independent position ensures that an independent assessment is made of the material prepared during the investigation and before matters are taken to the tribunal. The national boards will continue to deal with less serious professional standards matters and health issues relating to the Health Practitioners Regulation National Law.

The bill will also give powers to the Health Ombudsman to take immediate action against a registered health practitioner on receipt of a complaint if it is necessary to protect the public. The action that may be taken is to suspend the practitioner's registration or impose conditions on the practitioner's registration. This power is similar to the power that the national boards have under national law. The bill provides that generally there will be a show-cause process before taking action. However, if it is necessary to protect the public, the Health Ombudsman can take immediate action prior to the show-cause process being undertaken. This approach reflects the concerns raised in the Forrester report that the requirement to have a show-cause process prior to taking action may hamper rather than facilitate taking immediate action in relation to a practitioner who potentially provides a risk to the public.

I would now like to provide an overview of how the bill enhances the management of health practitioners who are not registered by the national boards. The bill provides, for the first time in Queensland, for the Health Ombudsman to effectively deal with health practitioners who are not registered with the national boards. While the Health Quality and Complaints Commission could receive an investigation and investigate complaints against practitioners, the only action that could be taken was to report on an investigation or refer the matter to another entity.

Under the bill the Health Ombudsman will be able to take serious matters in relation to a health practitioner who is not registered with the national boards to the Queensland Civil and Administrative Tribunal for consideration. The tribunal may order that the practitioner be prohibited from practising or that restrictions be placed on the practitioner's practice. The Health Ombudsman can also take immediate action in relation to the health practitioner who is not registered if it is necessary to protect the public. The Health Ombudsman may prohibit the practitioner from practising or place restrictions on the practitioner's practice. These new arrangements will provide an important protection to the public by preventing or limiting the practices of practitioners who provide a risk to the public and who are currently not registered with one of the national boards.

I would like to make a few comments in relation to transparency and accountability as it is reflected within the act. Transparency and accountability are the hallmark of this legislation. Under the bill the minister will require the Health Ombudsman to regularly report on the performance of the health complaints management system. This reporting will include the performance of the national boards as well as the Health Ombudsman. The critical component of this performance reporting will be reporting on investigations that the ombudsman is currently oversighting or that the boards are progressing. For the first time statutory time frames will be placed on investigations. It will generally be expected that all investigations undertaken by the Health Ombudsman will be completed within 12 months. If this does not occur the Health Ombudsman is required to publicly report on it. If an investigation goes beyond two years, the Health Ombudsman is required to notify the health minister and the parliamentary committee. This arrangement will for the first time give the community an assurance that investigations will be undertaken in a timely way. This is important to complainants and is something that I am sure the committee will endorse.

The Health Ombudsman will be able to obtain information from the national boards in order to report on the management of health complaints and the performance of the overall system. As part of this accountability model, the health minister and the parliamentary committee are given clear

and strengthened roles within the legislation. The health minister and parliamentary committee will be able to obtain information from the Health Ombudsman and the national boards to allow them to monitor the health complaints management system and how it is performing.

Prior to coming to the committee there was an extensive consultation process that was entered into in relation to the development of the bill. As indicated in the explanatory notes for the bill, key stakeholders were consulted on how the current health complaints management system could be strengthened. Stakeholders consulted included the AMA, other health professional associations, Health Consumers Queensland, hospital and health services, the national board, the Health Quality and Complaints Commission, the Private Hospitals Association and other government agencies. Some of these stakeholders were also provided with a confidential consultation draft of the bill for comment. Stakeholders indicated strong support for a number of issues. These included the establishment of a single entry point for complaints; investigations being undertaken in a more timely way; ensuring complainants and health practitioners are better informed of the handling of their complaints; giving the Health Ombudsman power to take immediate action where the public is at risk; notifying employers of serious matters concerning an employee; addressing standard setting through national arrangements; and strengthening the oversight of the health complaints management system by both the minister and the parliamentary committee. I have met with many of these stakeholders and would like to sincerely thank them for the time and effort that they have put into their submissions. The targeted consultation provided an opportunity for stakeholders to gain a more detailed understanding and many of the proposals that were put to us by those stakeholders have been incorporated into the draft bill.

I believe that it would be appropriate at this juncture to clarify a few matters that were raised during the consultation. Firstly I would like to discuss the independence of the Health Ombudsman. It is essential that the Health Ombudsman act independently, impartially and in the public interest. The bill requires this. The bill states that the Health Ombudsman is not subject to the direction of any other person other than the Minister for Health and even then only in very specific circumstances and they relate principally to governance and organisational management. As with the Health Quality and Complaints Commission, the health minister may direct the Health Ombudsman to undertake an investigation or an inquiry. This power, of course, does not in any way suggest that the minister can direct how the investigation is undertaken or the inquiry organised. As such, the independence of the Health Ombudsman in undertaking an investigation or inquiry is assured.

Under the bill, the health minister is responsible for overseeing the effective and efficient administration of the health complaints management system. Similarly, from the parliament's perspective, the parliamentary committee is responsible for monitoring and reviewing the operation of the health complaints management system. To enable the minister and the parliamentary committee to perform these functions they can require the Health Ombudsman and the national boards to provide them with relevant information. This will address these significant barriers that were identified last year when the health minister sought information on how health complaints agencies were responding to serious allegations against health practitioners. Timely, accurate and relevant information is fundamental to being able to assure transparency and accountability of the Health Ombudsman's office. The Health Ombudsman is both independent in performing their functions and accountable for the outcomes.

The second question that has arisen in the consultation process relates to how the Health Ombudsman will obtain clinical advice in undertaking investigations under the act. The bill provides that the Health Ombudsman may obtain advice on clinical matters or on health consumer matters as the Health Ombudsman considers appropriate. This advice may be provided by having a panel of individuals from whom advice can be sought or by establishing committees for a particular purpose. Staff members in the Office of the Health Ombudsman will also be able to provide advice on clinical, health consumer and legal matters. It is up to the Health Ombudsman to decide the best way to perform these functions under the act and how best to seek this advice.

The findings of the recent reports has shown that the use of a medical board model to assess the conduct of medical practitioners for serious matters has failed to adequately protect the public. It is apparent from the reports that the potential professional conflict of interest in medical practitioners performing this role is something that will need to be addressed and is done so as part of this act. This is different to the models that have been in place in Queensland. The assessment needs to be undertaken by an independent Health Ombudsman informed by clinical advice.

The third area I would like to outline in terms of the Health Ombudsman role in dealing with issues is how the ombudsman will deal with systemic issues. The bill enables the Health Ombudsman to deal with systemic issues whether or not they relate to a complaint. The Health Ombudsman may investigate systemic or system-wide issues and publicly report on a matter. It is also open to the Health Ombudsman to hold an inquiry into a system-wide issue. The bill states that system-wide issues can include the quality of health services as is the case with the current legislation.

Finally I would like to comment on timeliness of complaints management, which is a key policy component of this legislation. Time frames are specified for assessment, local resolution and investigation. As I have indicated previously, a performance reporting system is to be put in place to publicly report on performance including time frames. In closing, I would like to thank the committee for the time and for the opportunity to present to you this afternoon on the Health Ombudsman bill. Thank you.

CHAIR: Thank you, Dr Cleary. Mr Sheehy, would you like to make a statement or add any other details?

Mr Sheehy: I will indicate a few matters of more detail that will be of interest to the committee. Firstly, the bill will be repealing the Health Quality and Complaints Commission Act and will also be repealing the Health Practitioners (Disciplinary Proceedings) Act. Just so that everyone is clear, the Health Practitioners (Professional Standards) Act was recently renamed the Health Practitioners (Disciplinary Proceedings) Act and that act will now be repealed. That act deals with some procedural matters for QCAT and also matters related to the appointment of assessors to support QCAT. Those remaining provisions will be repealed and, where relevant, transferred across to the Health Ombudsman Bill.

I would also like to explain how the amendments to the national health practitioner law act will work. Under the Health Practitioner Regulation National Law Act there is a schedule which is adopted and the schedule is known as the health practitioner national law. As you would be aware, Queensland is the host jurisdiction for that national law and other jurisdictions, apart from Western Australia, adopt that schedule by reference. The amendments that we are making are not amending the national law as such, therefore that will not impact on other jurisdictions. What the bill does is to modify how the national law will work in Queensland. Essentially, the key modifications that are made relate to part 8 of the national law which deals with disciplinary matters for registered health practitioners. The two key changes that are being made, as Dr Cleary indicated, are that all notifications will go to the Health Ombudsman rather than the national board and that all serious matters will be considered by the Health Ombudsman rather than the national boards. There are a number of consequential amendments to that, but in essence they are the two main variations that the bill makes to the application of the national law in Queensland.

The bill will also be providing for the transfer of a specified amount of registrants' fees. The intention here is that as the functions that are now performed by the national boards will be undertaken by the Health Ombudsman then the fees that are paid by Queensland registrants for that purpose will come across to the Health Ombudsman. Essentially what we are saying is that the funding needs to follow the function. The base funding provided by the state government for the other services currently undertaken by the Health Quality and Complaints Commission will continue. The amount of fees to be transferred will be decided by the Minister for Health. There is a requirement in the act that the minister consult with other ministers and also with the national boards in determining what that transferred amount should be.

I would also draw your attention to section 25 of the national law relating to mandatory notifications. It is a small but significant change to the mandatory notification provisions. Under the national law there is a requirement for health practitioners to notify the board—it is a mandatory requirement—of particular matters. That relates to matters such as sexual misconduct or if there is an indication that a health practitioner is practising in a way that could be a serious risk to consumers. There has been concern for a while amongst medical groups that this has been maybe discouraging medical practitioners who have an impairment, who have a mental illness that is affecting their practice or drug or alcohol abuse, from seeking treatment. What the bill does is make, as I say, a small but significant variation to that mandatory notification. It does have quite significant limits on it. It can only arise if a health practitioner is treating another health practitioner for an impairment such as alcohol or drug abuse. If the matter relates to professional misconduct then that has to be reported, there is no exception for that. The test that the bill provides is that if the health practitioner is satisfied that the practitioner is not a future risk to the public then that mandatory reporting requirement can be waived. If, for example, a practitioner agrees to go on a rehabilitation

program, perhaps limit his or her practice, and the treating practitioner forms the view that that practitioner will not be a risk to the public then that extra exception has been put in the bill. As I say, the purpose of that is to not discourage practitioners who have a health issue from seeking treatment. So I draw that to your attention. It is a relatively small provision, but it is a significant policy issue.

In relation to functions of the Health Ombudsman, Dr Cleary has gone through those quite extensively. There are a number of areas where the provisions will be simplified. Any person can make a health service complaint. The national law refers to notifications which is equivalent to what the HQCC Act would call a complaint. All complaints and all notifications go to the Health Ombudsman. That can be a person who has received a service, it could be another health practitioner or it could be a representative complaint—so a parent or a carer making a complaint. Then it is the responsibility of the Health Ombudsman to triage and determine the best action to take. A number of the functions in the bill are similar to those of the HQCC—the ability to assess complaints, to facilitate local resolution of complaints, to conciliate complaints. Those provisions are essentially similar to what is in the current act.

There are strengthened provisions to keep complainants and health service practitioners advised of the progress of complaints. At all key decision-making stages it is a requirement that the Health Ombudsman advise the complainant and the health practitioner. Those stages are at the end of an assessment, at the end of local resolution if it is not successful and at the end of investigation. The only exception to that is if there is a risk that notifying a health provider may put someone at risk of intimidation or if it may jeopardise an investigation and that requirement does not apply. But otherwise there is a requirement to keep the practitioners and the complainants informed. During investigations there is a requirement to provide three-monthly progress reports so again the people involved are aware of what is happening with the complaint.

Dr Cleary did mention that there is a new requirement under this legislation to notify employers of serious matters. There are two cases. One relates to immediate action. If the Health Ombudsman suspends or places conditions on a practitioner's registration then the employer is to be notified. If the Health Ombudsman commences an investigation into a serious matter—so it has gone through an assessment and it is a serious matter—and the Health Ombudsman forms a view that it is serious enough to undertake an investigation then the employer is also notified. The seriousness relates to professional misconduct or otherwise a ground for suspension or cancellation of registration. I will add that for the employer that also includes if a private health facility is giving credentialing to medical practitioners to provide services within that facility, that private health facility is also treated as an employer for the purpose of that particular provision.

Dr Cleary has also mentioned the new provisions related to practitioners who are not registered. Some of you may be aware that a similar model has been put in place in New South Wales and a model has recently been put in place in South Australia. There has also been discussion at a national level about having a consistent approach nationally so this picks up on this concept. As part of that, the bill will recognise orders made by equivalent jurisdictions. If the New South Wales Health Care Complaints Commission made an order then that order would apply as being legally effective in Queensland. The reason for that is that there is a risk that if an order is put in place in New South Wales then the practitioner could just move to Queensland or just move to another jurisdiction. We have covered that off by through regulation applying those laws in Queensland.

The role of the Queensland Civil and Administrative Tribunal under the legislation is very much the same. The decisions that it can make under the national law for registered practitioners will be the same. It will have these additional powers in relation to practitioners who are not registered. We have taken the opportunity to streamline some of the procedural provisions. There were some areas in the existing legislation that were adequately covered under the QCAT legislation itself. Some of the procedural matters have been streamlined.

Finally, I draw your attention to one other provision in the bill. There is reference to prescribed documents. These could be documents such as the national standards put out by the Australian Commission on Safety and Quality in Health Care. These standards can be used as a guide in the legislation. For example, if a complaint has been made, the user of a service may look at the standards to give an indication as to the basis of the complaint and the Health Ombudsman could certainly look at those standards in making decisions about an assessment or in undertaking an investigation to give an indication as to what would be an acceptable standard for a practitioner. That is all I have thank you.

CHAIR: I will open up for questions.

Ms BATES: Thank you Dr Cleary and Mr Sheehy for that information. I have a query about when there is an initial complaint by a patient or a relative in a hospital setting, whether it be public or private. Generally the first point of call is the director of nursing or the executive director and then it goes to the medical advisory board. In some cases—and personally I have had this experience—the decision by the medical advisory board does not reflect the severity of the complaint. Is it true now that patients and relatives, if they have a complaint where it has already gone to the medical advisory board at a hospital, whether it be public or private, can then take it directly to the Health Ombudsman for decision?

Dr Cleary: Thank you very much for the question. You are a correct. Under the bill, the complaints can be accepted by the Health Ombudsman, whether they have been considered or not considered by other entities prior to it being referred to Health Ombudsman. The legislation makes some minor changes to the acceptance of complaints. It extends the time frame. Under the current Health Quality and Complaints Commission legislation there is a one year time frame from the time an incident has occurred or you become aware that something has happened. Under the new legislation it has been extended to two years. If a complaint is received by the Health Ombudsman then that complaint will be assessed and considered, as appropriate.

One of the things that I would hope in the new arrangements is that if a complain does come to the Health Ombudsman they will be able to refer them to the appropriate entity, such as hospital complaints management officer, to have those matters considered locally and, I would anticipate, dealt with appropriately locally. Where that process has failed, then of course a complainant can come back to the Health Ombudsman's office and seek to have those matters reconsidered. I think knowing that the complainant can be considered by the Health Ombudsman will really put a clear message into the system that complaint resolution at a local level is preferred. I think it will encourage complaint resolution at a local level.

Ms BATES: I think it is additional. I think it is a good idea that you have extended the time for people to make complaints. Sometimes even post-surgery it might take a while before any adverse condition arises. Just so I have it clear, if there is an adverse patient outcome reported from a surgical or medical procedure you can go to the medical advisory board and concurrently you could also go to the Health Ombudsman. If you are not satisfied with the outcome from the medical advisory board you can still seek further resolution if it is not resolved at a local level?

Dr Cleary: Yes, that is correct.

Mr DAVIES: What is the implementation timetable for the Health Ombudsman and what arrangements have been set up? Obviously there will have to be a transition from the Health Quality and Complaints Commission and the boards. How long will that take and how will that look?

Dr Cleary: The transition planning has commenced and we are looking at the development of a plan. Obviously putting that into action will require the bill to have been considered by parliament. So there is some work that is being undertaken but the finalisation of that will really rest on the finalisation of the legislation with parliament.

The planning process that we have established is firstly to look at the appointment of an ombudsman as early as possible and to seek to have that appointment undertaken rapidly. I think the appointment of the ombudsman who will be oversighting this area is a key part of the process. The next component of that will be the second stage which will be the establishment of the office of the Health Ombudsman. Again that is something that the Health Ombudsman would rightly have a significant role in.

We have been fortunate to have visited New South Wales which has a similar co-regulatory arrangement and spoken at length to the commissioner there. They have a structure that they have had in place for probably about seven years which appears to be a very effective arrangement in terms of the organisational design. I would think that we would benefit from having further conversations with the New South Wales commissioner. Obviously, the transition from the existing arrangements to the new arrangements will need to be undertaken in a very careful manner so that we make sure that all of the possible eventualities of any transition are considered before we make the transition. I would anticipate that it will take us until the middle of next year before we see that transition occur.

One of the things that the committee may wish to consider is seeing whether the New South Wales commissioner would be available to provide some input into the system that they have in place in New South Wales. We certainly found it extremely valuable to visit and meet with him and his key staff in terms of being able to take into account what they have learnt over the last seven years ago as they have implemented a co-regulatory system.

Mr SHUTTLEWORTH: Dr Cleary, you mentioned that the ombudsman would, under extreme circumstances, issue an order to basically suspend practice immediately. Obviously there is a capacity for the ombudsman to deal with an individual practitioner. What about dealing with the practitioner's employer? You said that you would notify the employer. What if the employer still allowed the practice to occur beyond that point, how would you deal with the organisation or the employer itself?

Dr Cleary: The provision to allow the ombudsman to take immediate action was very carefully constructed. If I can give you an example of, for example, a surgeon who may have been employed in a public hospital and where, through a series of events, it became obvious that that surgeons registration in America or some other country had not been continued and they had been stopped from providing certain types of procedures then the ombudsman has the power to take action to immediately suspend that person's registration or to put requirements on the person's registration to stop them from continuing to provide specified services.

If they breach that provision then there are sanctions that are contained within the act that allow the ombudsman to assure themself that those provisions have been met. In terms of the organisation, if the organisation continues to allow that practice to occur there are also provisions in the legislation to allow the ombudsman to provide advice to the hospital.

There are overlaying pieces of legislation here. The private hospitals licensing arrangement is separately managed through legislation that is overseen by the Chief Health Officer. If the Chief Health Officer were contacted in relation to a matter such as that the licence of the private hospital would be something that the Chief Health Officer would need to consider.

That would have bearing, of course, on the hospital's ability to allow a practitioner to continue to operate. Within the public hospital system, the director-general of Health has similar abilities to provide direction to public hospitals. So I think in terms of the practitioner there are certainly appropriate safeguards built into the legislation to allow the ombudsman to manage a practitioner in those circumstances. Having regard to the legislative framework in Queensland, with both the private and the public sector, either the director-general of Health or the Chief Health Officer can take action against hospitals as is deemed appropriate.

CHAIR: Dr Douglas, would you like to ask a question?

Dr DOUGLAS: I have three questions. They are merely points of clarification. The first question is on qualifications. Possibly I did not hear it. I have the bill and I have read it. Can you just clarify the skill set? Is it defined within the bill what the ombudsman may have or what is required? I say so because what has been specified is that there will be an element of supervision possibly. There is no reference committee? Is that what I am hearing?

Mr Sheehy: The bill itself does not specify any particular qualifications for the job. It is open. We appreciate you would want a person with a range of skills to enable this function to be performed efficiently and effectively. It would really be up to the implementation arrangements to establish an appropriate position description. To pick up on the themes in the bill, clearly we need someone who is able to manage a complex area independently, impartially and in the public interest, as the act requires; to be able to call on appropriate advice as appropriate—clinical advice, legal advice, health consumer advice; and pull that together and make sound decisions, with the overriding objective of protecting the health and safety of the public. The short answer is that the bill does not specify the types of skills. That is something that would be fleshed out as part of the implementation and the appointment process.

Dr DOUGLAS: You talked about reference committees that the person would be maybe supervising. Is it defined what that reference committee might be?

Mr Sheehy: I am sorry, could I clarify that?

Dr DOUGLAS: I heard it mentioned a couple of times that if someone was deemed to be engaging in suspect practice there would be some sort of observation process. It could be some sort of vague thing. I thought I heard that there would be a reference to someone. Is there a reference committee being defined? Is that specified in the bill?

Dr Cleary: When we were developing the bill we consulted with a number of groups and there were discussions around whether there was a need for a high-level clinical advisory committee or clinical advisory group to be established. Having consulted with a number of groups, the minister formed the view that it would be better to have a facilitative piece of legislation where the power was there for the Health Ombudsman to establish committees or panels that would allow the Health Ombudsman to undertake their role without being specific. There are a number of

reasons for that. We were moving into an area where we had both registered health professionals and unregistered health professionals. So the registered health professionals management, which has been undertaken by the national boards or the state boards of the national boards, may not always be available because there would be unregistered health professionals who are not covered under that arrangement.

The legislation has been drafted so that the ombudsman can establish committees and panels as appropriate to allow them to deal with matters. I would envisage some of those will be `standing committees' to allow the ombudsman to operationalise their more strategic work program. Some of them may be panels which are short-term panels which may be drawn together to assess a particular matter. For example, there might be a clinical incident that requires a range of experts to be brought together to assess a particular incident and to provide advice to the Health Ombudsman. It may only meet to discuss a particular incident and then be discontinued thereafter.

The legislation is a facilitatory piece of legislation which gives the ombudsman the ability to create either committees, which may be standing committees, or panels that may be short-term panels to look at specific incidents.

Dr DOUGLAS: You talked about the standing committee. My understanding is that this committee becomes a standing committee of an oversight committee. Is that correct or is that not defined yet, either?

Mr Sheehy: Are you referring to the parliamentary committee?

CHAIR: Dr Douglas, are you talking about the parliamentary committee?

Dr DOUGLAS: The parliamentary committee.

Dr Cleary: The parliamentary committee has a very defined role, as you indicated, in the legislation to oversight the performance and the management of the Health Ombudsman's office. A very important component of that, in my mind, is where there are complaints that go over the two-year time frame, where the ombudsman may be invited to provide an explanation of why that has happened. The second area of importance is in relation to performance management more generally and monitoring the overall performance of the Health Ombudsman's office as outlined in the bill. So I think there are two specific areas. One is the general one of overview of performance and the second is the review of matters where a complaint is resolved.

Dr DOUGLAS: I have two further questions. One is on the issue of confidentiality. It is of great concern amongst the medical people since this has been announced. The idea is that people can be named before they have been found to be guilty. Can you clarify that?

Mr Sheehy: The bill does clarify that if investigation reports are done for the purpose of being referred to QCAT those reports are not publicly disclosed. That has been clarified. It was in response to concerns that were raised during the consultation about how the draft bill was presented. We have responded to that. So there is certainly no intention or no ability—if there is an ongoing investigation that leads to a proceeding before QCAT then the matter needs to go to QCAT and that would then be the forum for taking it forward.

Dr DOUGLAS: Now, you can appeal the QCAT decision, but am I correct that you cannot always appeal it? Is that right?

Mr Sheehy: Well, there are standard appeal provisions under the QCAT legislation.

Dr DOUGLAS: Generally you cannot appeal. That is where it varies to normal QCAT.

Mr Sheehy: It would be my understanding that the decisions we are referring to could be taken to QCAT. So the first stage is if the Health Ombudsman makes a decision—or, as is the case now, if a national board makes a decision—for example, to take immediate action, or a national board can set conditions. So a practitioner under the national law at the moment has a right to take that to QCAT. There is a bit of a mixture in terminology. In some cases it is called a review; it would more commonly be referred to as an appeal. But you can take it to QCAT to have that matter reviewed. Once it goes to QCAT then there is a general right of appeal to go to the Court of Appeal on a decision that QCAT makes.

CHAIR: I am going to ask just a couple of questions. The first one is on the systemic issues. What net are you casting to try to identify those issues under the Health Ombudsman's process? How would that work?

Mr Sheehy: Under the bill the Health Ombudsman has a broad brief to take into account complaints or any other information. So information could spin off from an investigation or there might be some anonymous information that is received that is not clarified as a complaint.

Information may come from another entity. It could come from a national board. So there are no restrictions on the ability of the Health Ombudsman to take into account information from any source, including multiple issues.

If multiple concerns are raised in complaints and other issues, the Health Ombudsman can take it up. The two main ways that can be done are through investigations and possibly inquiries. Inquiries are, as you would expect, more rarely used but the power is there. So an investigation could be undertaken into systemic issues. For example, if concerns about infection control were coming up in various complaints and other information or data that was received, the Health Ombudsman may choose to have a broad investigation into that systemic issue and then issue a public report. The act is clear that that information can be made public. There are provisions in the act dealing with—it may not happen, but in a systemic report if there is any adverse comment around a provider then that provider is to be given an opportunity to respond to that. As I say, that may not be the case in a systemic report, given the nature of that issue. There are also confidentiality obligations. Those powers to investigate and publicly report on systemic issues, including quality related matters, are incorporated into the bill.

CHAIR: The bill also provides that the Health Ombudsman deal with all serious matters. Are you able to give us an example of that, just so we have a feel for what that means?

Mr Sheehy: I will go through the definition and perhaps Dr Cleary can give a more clinical perspective. There are two limbs to it. One is professional misconduct. That is a term that is defined in the national law. That is the most serious level of misconduct and it may lead to deregistration or suspension. There is generally another catch-all that says `another ground', which may lead to suspension or deregistration. So that is what the legislation says. Perhaps Dr Cleary can give some clinical examples of that.

Dr Cleary: There are probably a range of types of matters that would fall into that area. For example, if a health practitioner had an inappropriate relationship with a patient they were treating, that could fall into that category. So boundary issues that may arise could be of that nature. There could be matters where, for example, a surgeon has been deregistered in another country and that needs to be managed by the ombudsman where that may not have been disclosed to the ombudsman or to the medical board when they were registering. And then there would be other serious matters where there may have been inappropriate treatment of patients with adverse outcomes, so where there may be concerns about a particular practitioner's competence.

Although we have not talked about it today, there is a move in this legislation away from complaints management and the management of individual complaints to have the capability of a particular practitioner assessed overall, not necessarily just resolving the complaint. So clinical competence is an important part of that assessment process that would be put in place. So if there is a complaint and the complaint is one where you would be concerned about the competence of a clinician, that allows an arrangement to be put in place to seek to assess the competence and to look at competency based training or upskilling to address that practitioner's competence, as opposed to seeking to resolve a complaint which may in the end resolve the issues that a complainant has but may not redress the practitioner's competence. In my mind, one of the important changes is looking at competency as well as resolving complaints.

CHAIR: I am going to keep going with that line a little bit. What sort of complaints then would be referred to boards, and are you able to give us an example of that?

Mr Sheehy: They are the less serious complaints, and I guess again I will just explain. The legislation really works by the fact that the starting point is that all the complaints and notifications go to the Health Ombudsman. The Health Ombudsman then retains the serious complaints. There also will be—I guess at the lower end there will be issues that are relatively minor, matters that can be resolved through local resolution, and the traditional matters that the Health complaints entities would deal with. So there are the middle range matters, the professional standards type issues which are not serious, and health issues which are not serious enough to get into that deregistration or suspension category. So under the national law, the boards do have various powers. They can establish panels to look at performance and panels to look at health issues, and those panels can then make decisions and make recommendations to the board. So it is that midrange of matters that will remain the responsibility of the boards. Dr Cleary might be able to give some examples, but that is the way the legislation is structured.

Mr SHUTTLEWORTH: My question is sort of along these lines as well. It was a rare occasion that at 6.30 last night I was at home and watched Ray Martin—the source of all truth, I am sure—but along these lines he was talking about a doctor in the ACT. One of the primary issues they had

was the anonymity of their complaints. There was a whole range of medical practitioners and clinicians who felt compelled and wanted to make a complaint against a particular doctor, but without that anonymity they were nervous about doing that. Is there any capacity under this new regime for any complaints to be made in an anonymous way?

Dr Cleary: There are two components to that, and in fact I think we have strengthened this arrangement under the proposed act. Anyone making a notification to the board at the moment—or in this case that would come through to the Health Ombudsman—has that level of protection to have their complaint provided without it being disclosed. The Ombudsman bill has additional provisions in it to provide additional protections where the Ombudsman believes, for whatever reason, that they should not release the name of the complainant. So the Ombudsman does have an additional power to actually consider whether releasing the name of the complainant would be to the disadvantage of the complainant, and I think that is another protection that we have built in.

Mr SHUTTLEWORTH: Just on that too, the current HQCC was going to have an online complaints system that is very close to going live, if not now. Is that going to transition across and would there be, say within that sort of structure, the capacity to make an anonymous entry?

Mr Sheehy: Well, there would be no reason under the legislation why that could not happen if the Health Ombudsman wished to continue on with that model, certainly. As Dr Cleary said, it gives the Health Ombudsman the flexibility to accept complaints orally or in writing. It can be a requirement to ask for a name and address, but the Health Ombudsman does not have to do that. This is a judgement call in terms of assessing the veracity of the information. On the other hand, there may be cases of vexatious complaints. So it is a judgement call on the Health Ombudsman, but the legislation gives the Health Ombudsman the discretion to deal with those matters as is seen appropriate in each case.

CHAIR: We will take one last question and then we will wrap up.

Mr DAVIES: My question was nearly answered there. My question was regarding a follow-on regarding vexatious complaints. We have heard with the HQCC that there have been some people who do not mind making a complaint every now and again. Again in the transition will that information carry across? As far as anonymity goes, that is a challenge there too.

Mr Sheehy: Yes, certainly. As I had indicated, there is a balance there in terms of the Health Ombudsman exercising discretion. The Health Ombudsman would have the clear capacity to take no further action if the Health Ombudsman thought it was vexatious or made in bad faith. That is a ground for taking no further action.

Mr DAVIES: Is there any teeth for the Ombudsman to go the other way with people making vexatious complaints?

Mr Sheehy: In terms of taking action against them? No, other than there is an offence in the act for providing false and misleading information, so that avenue is open. If people are making false complaints, that would be an offence under the act.

CHAIR: Thank you. The time allocated for this public briefing has expired. The committee intends to publish the transcripts of today's proceedings unless there is good reason not to.

Dr Cleary, Mr Sheehy, thank you for your time. You have been most generous with it. Committee members, thank you for your time. I now declare this briefing closed.

Committee adjourned at 4.36 pm