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HEALTH AND COMMUNITY SERVICES COMMITTEE

Members present:

Mr TJ Ruthenberg MP (Chair)
Mrs JR Miller MP (Deputy Chair)
Ms RM Bates MP
Mr SW Davies MP
Dr AR Douglas MP
Mr JD Hathaway MP
Mr DE Shuttleworth MP

Staff present:

Ms S Cawcutt (Research Director)
Ms L Archinal (Principal Research Officer)

PUBLIC HEARING—HEALTH OMBUDSMAN BILL 2013

TRANSCRIPT OF PROCEEDINGS

FRIDAY, 12 JULY 2013

Brisbane

FRIDAY, 12 JULY 2013

Committee met at 10.18 am

ROWAN, Dr Christian, President, Australian Medical Association Queensland

CHAIR: Good morning and welcome. I declare this public hearing of the Health and Community Services Committee open. My name is Trevor Ruthenberg. I am the member for Kallangur and chair of the committee. Right here is Mrs Jo-Ann Miller, member for Bundamba and deputy chair; Mrs Ros Bates, MP, member for Mudgeeraba; I have also got Mr Steve Davies MP, member for Capalaba; Dr Alex Douglas MP, member for Gaven sitting at the end next to Ros there; Mr John Hathaway MP, member for Townsville, to my right; and Mr Dale Shuttleworth MP, member for Ferny Grove.

The committee is examining the Health Ombudsman Bill. Our purpose today is to hear from invited witnesses about the bill. The bill aims to strengthen the health and complaints management system in Queensland. The bill establishes a new statutory position of Health Ombudsman to manage health complaints in Queensland. If the bill is passed the Health Ombudsman will replace the Health Quality and Complaints Commission.

I remind those present that these proceedings are similar to parliament. They are subject to the Legislative Assembly's standing rules and orders. Under the standing orders members of the public will be admitted to or excluded from the hearings at the discretion of the committee. Witnesses are not required to give evidence under oath but I remind witnesses that intentionally misleading the committee is a serious offence. Mobile phones or other electronic devices should now be turned off or switched to silent, please. The committee has resolved that the proceedings of the committee may be broadcast in line with the media broadcasting rules which are available from the committee staff. 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.

Our first witness today is Dr Christian Rowan, president of the Australian Medical Association Queensland. Welcome, sir, and take up to 10 minutes or so if you would like to present an opening statement and then members of the committee will ask questions of you based on the submission from the AMA. Over to you.

Dr Rowan: Good morning, Mr Ruthenberg and fellow committee members and staff. Thank you for the opportunity to address the Health and Community Services Committee on the important issue of the Health Ombudsman Bill 2013. I am the current president of AMA Queensland, the state's peak medical body, which represents over 5,500 medical practitioner members. I am also the Deputy Chief Medical Officer for UnitingCare Health and the Director of Medical Services at St Andrew's War Memorial Hospital; a specialist physician in the discipline of addiction medicine and I am also a qualified medical administrator and am registered with the Medical Board of Australia in this discipline. In addition to this I have worked as a general practitioner in rural and regional Queensland for over 10 years including in locations such as Mungindi and Oakey. This experience in many different parts of the health system provides me with a unique insight into the operation of the health system in Queensland, both publicly and privately and also in primary and secondary care.

As far as our overview is concerned, AMA Queensland has been closely following the events which have led to the introduction of this bill and throughout the process our goal has been to improve the operation of the health system for the benefit of all Queenslanders. To this end we support measures which will improve the safety and the quality of the health system as a whole. We also represent the interests of our members to participate in a fair and transparent health complaints system which resolves complaints in a timely manner. AMA Queensland has many concerns about the Health Ombudsman Bill as it is currently drafted, including that the system may become highly politicised and vulnerable to accusations of conflict of interest unless governance structures which encourage bipartisan decision making and independence from government are put in place; the system will lose clinical credibility and efficacy without more rigorous structures ensuring that expert clinical opinion is sought when decisions are taken; gains made by national registration in introducing Australia wide quality and safety standards may be eroded; health

practitioners may be treated unfairly and denied access to timely appeal decisions where a decision to take immediate action is made; the reputation of practitioners may be damaged unfairly if decisions to take immediate action are published and available indefinitely even where the decision was later found to be flawed. The bill does nothing to remedy problems of delay at QCAT identified by Mr Chesterman in his report and without guaranteed adequate funding will not improve the initial investigation times.

AMA Queensland's goal is safe and effective health care for all Queenslanders. The minister said in his first reading speech that the bill aims to protect the safety and health of the public, promote high standards of practice and service delivery by health service providers and maintain public confidence in the state's health complaints management system. AMA Queensland supports the aims of the health minister to improve health complaints, but has significant concerns that the bill in its current form will have unintended consequences which will reduce the efficacy and credibility of the health complaints system both to the medical profession and to the public.

The Health Ombudsman must be independent of government. Any health complaints system should be looked at in the context of creating a safe and high quality health system which meets the needs of the population. The system must maintain independence from government, incorporate the insight of clinicians into decision making and collaborate to improve quality and safety at a national level. AMA Queensland believes that any health complaints system should be independent from government. However, the current bill does not meet this standard and must be strengthened to increase the Health Ombudsman's independence. The vast majority of health complaints to the Health Quality and Complaints Commission in 2012—55 per cent—emerged from public hospitals. As the administrator of public hospitals in Queensland it is vital that the minister's role of administering the public hospital system is separated from the investigation and adjudication of complaints about incidents that occur in the public hospital system. Both actual conflict of interest and the appearance of conflict of interest in this area will erode public faith in the system. AMA Queensland believes that the sections in this bill which give the minister power to direct the Health Ombudsman to undertake an investigation or inquiry, hire and fire the Ombudsman and the power of the minister to request information about ongoing investigations all contribute to a perception that the Health Ombudsman will not operate independently. AMA Queensland strongly opposes these sections and argues that good governance and public faith in the system will only be well served if these powers are transferred to a bipartisan parliamentary committee. The Health Ombudsman must access expert clinical advice before taking a decision.

In addition to independence from government when making decisions, the Health Ombudsman must have ready access to expert clinical and professional information and advice so that he or she is armed with the best information. Access to clinical input is vital to ensuring that fair decisions are made and that health professionals continue to have faith in the health complaints system. AMA Queensland believes that the bill does not ensure that the Health Ombudsman will always incorporate this vital clinical expertise, skill and insight into his or her decision making. The bill should be strengthened so that the Health Ombudsman is required to consult with clinical experts before taking any decision. AMA Queensland acknowledges that the Health Ombudsman's ability to form advisory committees and panels, section 29, is a positive step. However, there is significant danger that future budgetary pressures will erode the input of any clinical advisory committees or panels as they become expensive to maintain. Without clinical input and leadership into the decision making processes there is a risk of poorer quality decisions and a loss of faith in the system from clinicians. Having clinical leadership in the health complaints system will improve buy-in from clinicians and improve the integrity of the health complaints system ensuring it aligns with the professional and ethical standards of the profession.

Professional standards must be set at a national level with clinical input. In addition, AMA Queensland has concerns that the power in section 288 which allows the minister to prescribe a code of conduct for health professionals will reduce the clinical integrity of the system and will erode the gains made by national registration which improve health care for Queenslanders and all Australians. The Australian Medical Council already has a code of conduct prescribing good medical practice which covers clinical and professional domains. AMA Queensland strongly advocates that safety, quality and professional standards should be set at a national level with strong clinical and professional input. It is inappropriate that a politician should set professional standards for health professionals.

The Health Ombudsman must uphold the principles of natural justice. In addition to concerns about the Health Ombudsman's independence and access to clinical expertise which relate to the efficacy of the system as a whole, AMA Queensland has grave fears for our members' rights to

participate in a health complaints system which treats all participants fairly and upholds the principles of natural justice. AMA Queensland is especially concerned that the power of the Health Ombudsman to take a unilateral decision to impose immediate action does not have sufficient checks and balances. The decision to take immediate action will impact significantly on a medical practitioner's career and livelihood, therefore immediate action decisions must be rare and access to effective, efficient and expedient review of the decision must be guaranteed. AMA Queensland does not believe that the bill as currently written meets these requirements. An immediate action decision is taken by the Health Ombudsman when he or she assesses that a health practitioner represents a clear and present risk to persons or threat to public safety. This restriction on practice must be in place for upwards of a year until investigation is finalised or could be longer if the matter is referred to QCAT. While an immediate action decision may be appealed to QCAT, the rights of the health practitioner to seek a stay of decision have been removed and waiting times for appeals to QCAT may stretch for years, during which time the health practitioner may not be able to work. As many health professionals' registration requires that a practitioner demonstrate recency of practice, this action could effectively end the career of a practitioner even if registration is reinstated by QCAT.

Before the bill is passed the government must guarantee that advice is received from a variety of expert health professionals in the same field as the subject of a complaint before a decision to take immediate action is made. A QCAT review is able to be carried out in a timely manner as well, normally 28 days. AMA Queensland is also very concerned about the power to publish decisions to take immediate action potentially indefinitely. This is especially concerning as a decision to take immediate action may be made unilaterally on the basis of limited information with immediate effect, however the effect of publishing the decision may be irreversible. Publishing decisions on this basis treats health practitioners unfairly and exposes them to loss of income and reputational damage, for which they have no recourse. AMA Queensland strongly opposes these name and shame provisions.

The bill does not address funding issues which contribute to delay. AMA Queensland strongly supports that investigations and decisions are completed in a timely manner. While the bill provides strict time limits for investigations, it will not be possible for the Health Ombudsman to complete investigations within those time limits unless adequate resourcing is allocated to the ombudsman. AMA Queensland seeks assurances that funding will be sufficient to meet the needs of the ombudsman before the bill is passed.

Professional judgement in mandatory notification: the best way to protect the public from practitioners who are suffering impairment is to enable practitioners to seek treatment before a public health or safety issue arises without fear of losing their registration and employment. AMA Queensland is deeply troubled by the declining number of practitioners in Queensland seeking treatment from their peers since the introduction of the requirement for mandatory notification for health practitioners treating health practitioners. AMA Queensland is concerned that this regulatory regime drives underground health issues which could affect performance. This increases the chance that near-miss events which could present an opportunity for performance improvement or healthcare treatment will instead result in adverse patient outcomes. AMA Queensland welcomes the acknowledgement of this issue by virtue of the amendments in section 326 of the bill to the mandatory reporting provisions in section 141 of the Health Practitioner Regulation National Law Act 2009 that would exempt treating health practitioners from making mandatory reports in limited circumstances. However, the amendment does not go far enough and is therefore not sufficient to deter some health practitioners from seeking treatment or those who do seek treatment from divulging all the necessary information to permit appropriate care. Further, as the amendment is inconsistent with the exemption in the relevant legislation in Western Australia, it will create a third legal framework under which medical practitioners will have to operate on this very critical and sensitive issue. AMA Queensland recommends that the bill be amended to adopt the exemption as is written in the legislation in Western Australia.

In summary, AMA Queensland has grave concerns about the Health Ombudsman Bill 2013 as it is currently written. We believe that it does not ensure sufficient independence from government or clinical input into decision making. It does not ensure that health practitioners will be treated fairly and does not always uphold the principles of natural justice. The bill does not ensure that practitioners are, and are seen to be, treated fairly through the complaints-handling process. If this bill proceeds unchanged, AMA Queensland also has concerns that Queensland will be a less attractive place to work for medical practitioners, putting Queensland at a disadvantage in a highly competitive medical workforce market where the state must attract the best and brightest to treat and teach in its hospitals. In summary, I would ask that the committee consider the Health

Ombudsman Bill in the wider context of optimising the performance of creating a quality healthcare system in Queensland and a fair and just system for all participants—medical practitioners, patients and the people of Queensland.

CHAIR: Thank you, Dr Rowan. We will open it up to the committee to ask questions.

Mrs MILLER: Dr Rowan, in short, the AMAQ opposes this bill as it currently stands; is that correct?

Dr Rowan: That is correct.

Mrs MILLER: Thank you.

Ms BATES: Dr Rowan, in your submission at appendix 1, page 12 you state that the bill should limit the circumstances when the Health Ombudsman tells a practitioner's employer about a complaint. When do you think the Health Ombudsman should tell a practitioner's employer, particularly if it may well be known already and there has already been an adverse patient outcome report raised? Wouldn't they then be considered in tandem?

Dr Rowan: We believe that in those decisions due diligence needs to be shown to the information that is obtained before a decision is taken and there also needs to be mandatory consultation with a group of peers so that the most appropriate decision can be taken. As far as the timing of that, it would really depend upon the urgency of the complaint or the nature of the complaint. In relation to the potential for the immediate suspension of a practitioner's registration, if the gravity is so serious that that needs to take place, really that comes down to the operational internal processes and detail of how and when that can occur. But we would say there needs to be mandatory consultation with clinical peers by the Health Ombudsman to ensure they have assessed the fullness of the set of circumstances. Because as soon as they have suspended that practitioner's registration there will be another impact on patients not being seen, and there needs to be a system in place to ensure that those patients can then access clinical care from another service provider. In the fullness of assessing all of those circumstances, there needs to be a consistent and robust system to be able to do that.

Ms BATES: So, in short, if a complaint had been made to the Health Ombudsman about a particular practitioner working in a particular facility, and it was a quite severe allegation, in that case would you approve the hospital administrator knowing about it even if there had not been an adverse patient outcome recorded?

Dr Rowan: Absolutely. They would need to know about that. That is part of the fair, open and transparent way of doing that. However, they need to ensure that due diligence is shown; that they have assessed all the information; and that there has been consultation with clinical peers to understand all of that. As it stands at this stage, the Health Ombudsman may not be a medical practitioner; they may be a legal practitioner. Again, if this person is a legal practitioner, we would say it is even more important that they seek expert clinical advice to be able to make informed decisions.

Ms BATES: Thank you.

Dr DOUGLAS: A good presentation, Christian. I congratulate you and the AMA. Like all things in medicine, the consequences of decisions are the important things. We are in the business of hypotheticals here because the bill is still hypothetical. What do you think will be the consequences of this bill? In list form, maybe five to 10 points, what would you say?

Dr Rowan: The risk is that some decisions can be taken which could have unintended consequences for all involved. So there could be consequences for the individual practitioner where a decision is taken in good faith by the ombudsman but the decision is then overturned, and it is overturned because the ombudsman made a decision without all of the information available. That will have potentially a reputational implication not only for the government and the Health Ombudsman but also for the practitioner involved. There may be decisions taken whereby there has not been adequate planning to put in place processes to deal with the patients that the practitioner would have seen. We know there are problems in relation to the medical workforce at the moment across Queensland. There may be an isolated individual practitioner in a particular speciality who suddenly has action taken against them and, therefore, the relevant hospital and health service is unable to recruit someone very quickly and, therefore, for patients who could have been treated in other ways there is not planning in relation to that.

Certainly there is the risk of practitioners who have health concerns—let us say they might have a psychiatric illness or there might be addiction problems that exist—not seeking treatment. That would be the last thing that we would want as an unintended consequence of this bill in its

current form. We need those people to seek treatment and to be assisted in that way. It is very unclear at the moment whether the resourcing that is going to be allocated to the office of the Health Ombudsman is going to be enough to discharge their functions.

From that perspective and also from the public's perspective of independence, transparency and good governance, at the moment we believe this position needs to be independent of government. The last thing you would want is a public perception that the person could be hired and fired at will by the government or directed to undertake particular functions at the will of the minister. That is a perceptual thing. That is why we believe from a good governance perspective there should be independent, transparent reporting directly through to parliament as opposed to the office of the minister. They are all the things that we see that I have summarised at the end there as being significant risks.

Dr DOUGLAS: Is it possible that the implications of this bill will severely limit certain types of medical practice which is at the forefront of the advancement of practice and may well hinder us in our progress in medicine here in the state?

Dr Rowan: Certainly there may be some practitioners who would think about the kind of case mix that they undertake and the types of services that they provide. They could be at risk for providing those and therefore may elect not to provide particular services or procedures. If there are some perceived negative clinical outcomes, that is seen more as an impairment as opposed to what can happen with clinical practice, which is that there can be consequences or outcomes which, despite everyone's best effort to limit those, do and can occur. Certainly for cardiac surgery, as an example, people can do valve procedures and other cardiac type procedures. Often with the complexity and the level of risk faced by people in their 80s, despite everyone's best efforts to limit the risks to those people of a negative outcome they can still happen by virtue of the type of surgery it is and the age of the patients.

Dr DOUGLAS: Therefore, you are saying by default a lot of those procedures may well only be done in southern capitals because we have changed our legislation to make it severely limiting upon those people?

Dr Rowan: That is possible as a consequence of the legislation.

Mr DAVIES: Dr Rowan, in your written submission you raise concerns about the confidentiality of the personal information of health practitioners being disclosed in reports. What safeguards could be put in place to ensure public safety while protecting your members' interests and reputation?

Dr Rowan: Again, it is the flow of the information and who has access and for what purposes. There is obviously a ministerial code of conduct in relation to the information that is gleaned by the minister for those purposes, and that is covered there. It is my understanding there are provisions in relation to ministerial staff, but I am not an expert in that area. Certainly our concern is what purposes other information that may go there is used for. Again, it is ensuring there is strict accountability in relation to that information. Who has access to it, why and for what purposes? Again, that goes to the heart of good clinical and public governance processes that we want to make sure that is strictly enforced and very clear, very accountable and very transparent so the public and the profession can have confidence in the way that that information is used.

Mr HATHAWAY: Dr Rowan, thanks for your statement and your submission. I note an earlier answer you gave to the member for Bundamba. I want to go back to the overarching objectives of the bill, which are to protect the health and safety of the public and to promote professional, safe and competent practice by health practitioners et cetera. I make the assumption that the AMAQ is not against those in principle.

Dr Rowan: No. We support the intent and the reasoning behind this but not the bill in its current draft. The submission that we have made is addressing specific aspects of the bill in its current draft.

Mr HATHAWAY: I note that most of the aspects you have addressed in your submission and in your statement to the hearing this morning are couched in terms of its impact on practitioners, not patients. I will go a bit further if I may. In regard to the publication of immediate actions potentially taken by the ombudsman, you highlight the risk to your clinicians or practitioners of that being published on a website despite the fact that the current legislation enables AHPRA to do exactly the same. Would you care to comment?

Dr Rowan: What is in the best interests of doctors is in the best interests of patients. There is a combined nexus between the two. We would say that what is in the best interests of patients is also in the best interests of doctors. In relation to provisions to publicly publish the outcome of

investigations and those types of things, what we are saying is that, if the decision is wrong because there has not been the initial input by clinical experts to support the Health Ombudsman in relation to its decision, the risk is a decision can be taken which is then overturned and reversed. The person has gone through a period of time of being suspended. The decision is overturned and at that stage there is no way of recovering all of that damage for all concerned. What we are saying is that, if a decision has to be taken, particularly in those very severe cases where immediate action needs to be taken in relation to a practitioner's registration, as you say, that would be published on the AHPRA site as it is now. But we need to ensure that before the decision is taken all of the available evidence has been assessed and there has been access to appropriate clinical specialists in that area to support the ombudsman in its decision, particularly if the Health Ombudsman is a legal practitioner and may not have a lot of experience or knowledge in relation to the clinical circumstances in assessing that information. At the moment those provisions are discretionary in the sense that they may seek clinical input and advice. We believe that they need to, in a mandatory sense, have that clinical advice and input into that decision-making process.

Mr HATHAWAY: Just in regard to that, I note that we are talking about immediate actions. In your answer just then you indicated that the AHPRA having a review of all the evidence available, in the interests of public safety there may be those occasions where you are not going to have time to assemble all the evidence and, therefore, I am talking about an immediate action taken by the Ombudsman to prevent any potential reoccurrence of the adverse outcome that has initiated the review of the investigation. So we are talking about timeliness. I note at the beginning of your submission and also in your statement today you indicated about trying to have a timely outcome from your practitioners' point of view.

Dr Rowan: If something happens at an individual hospital, as a medical administrator, if there is a serious allegation of some particular form, individual hospitals, in a rapid review process, get people together on a phone line very quickly to take a decision in relation to those things. We see that there is no reason a Health Ombudsman should not be able to do the same—to be able to rapidly get people together to actually have a decision. It is not as if they need to wait hours or days, or months or weeks to do that. There should be provisions where that is immediate and, if it is at that serious end of the spectrum where that needs to happen, that should really be facilitated within an hour or two to be able to do that. But we believe, to protect the Health Ombudsman, to protect the natural justice interests of the practitioner and also to ensure that, having taken that action, as there can be potentially unintended or unassessed or unplanned consequences for what that will mean for patients in the sense that there needs to be adequate provisions in place so that if there were a group of patients in the next few days, let us say, who were going to be operated on by that practitioner—they might have had cancer or something like that—that someone in the system has then found another practitioner who is going to ensure that they get their operations by someone else so that they are not disadvantaged and their malignancy does not spread further as a consequence of delays to their clinical care. So all of that fullness needs to be done at the time. There needs to be a system in place that facilitates all of that occurring.

Mr HATHAWAY: Thank you.

Mrs MILLER: As you know, this government has been intent on slashing and burning the Public Service throughout Queensland.

CHAIR: Jo, get to your question, please.

Mrs MILLER: I am. It is important that I make that particular statement. What would be the view of the AMAQ if the Health Ombudsman was simply attached to the general Ombudsman of Queensland? As you know, the Ombudsman has been a feature of the Queensland government over a few decades now. It is not clear to me where this Health Ombudsman is going to sit. For example, they could simply put the Health Ombudsman side by side with the general Ombudsman and share resources. What would be the AMAQ's view in relation to that?

Dr Rowan: We certainly support a transparent, well-functioning health complaints management system in Queensland. We believe that needs to be adequately resourced. In relation to the events of 2005, with clinical governance failures in Queensland and the subsequent Davies inquiry and Forster review, the Health Quality and Complaints Commission was established and had been resourced as such to undertake those functions. In relation to the Chesterman review and the Forrester report and other things that we have seen recently, we accept that the complaints management system has not worked in a timely and efficient manner and that there are problems there. Therefore, it is the AMAQ's view that any system in Queensland in relation to health complaints management needs to be adequately resourced.

In relation to the draft bill, at this stage it is unclear to us as to what resourcing there is going to be for the Health Ombudsman and the functioning that is going to take place there. We believe that there needs to be adequate resourcing to ensure that the Queensland public has confidence in the health complaints management system and also that the profession can have confidence in the health complaints management system.

Mrs MILLER: But what I am saying is that there is an Ombudsman already set up in Queensland to look at administrative and other matters in relation to all other government departments that also have professionals involved. What I am saying is that the Health Ombudsman could just simply be put under the general Ombudsman's area as well. For example, the general Ombudsman could also be appointed as a Health Ombudsman. I take your point that that has not been fleshed out by this government in any way, but I think that issue is something that the AMA should consider.

Dr Rowan: Certainly, what we would say is that that has not been proposed to us in any way. If that were to occur, we would have concerns around the resourcing to adequately be able to undertake the functioning of having a fair, transparent and accountable health complaints management system.

CHAIR: I would like to investigate a little bit more thoroughly the immediate action with you. Of all of the objections that you have put together, would you agree that the Ombudsman has the capacity within the current bill to address all of that?

Dr Rowan: No, we do not believe that they have the capacity to do all of that. That is what we are saying. We would like to see those provisions addressed and strengthened and that they be articulated very clearly in the legislation.

CHAIR: The premise to my question relates to the difference between what I am asking and what you are proposing. From my understanding of the bill as I read it and in the research that I have done, I do not see anything in the bill that stops the Ombudsman from enacting everything that you have talked about. The difference I am hearing from you is that you would like to see that written in the legislation as opposed to becoming regulation process and procedure within the Ombudsman.

Dr Rowan: We would like to see that the Health Ombudsman Bill, as it is written, is more explicit and that it is very clear for some of those positions, particularly around the clinical consultation, of actually saying that—

CHAIR: But there is nothing in the bill that stops the Ombudsman from putting that process in place, anyway.

Dr Rowan: At their discretion.

CHAIR: Correct.

Dr Rowan: So that is at their discretion. What we are objecting to is that it is discretionary. We believe that it needs to be explicit in the legislation.

CHAIR: But there is sufficient discretionary opportunity for the Ombudsman to address every one of your issues?

Dr Rowan: Discretionary.

CHAIR: Correct.

Mrs MILLER: But it depends on the appointment of the Ombudsman as well.

CHAIR: No, it depends on the discretion of the Ombudsman

Mrs MILLER: It depends on the person who is appointed.

CHAIR: We could go on, but we have others to come along. Dr Christian, can I say thank you and please thank the AMA for their effort. This is part of the robustness of our process and I certainly appreciate your efforts to express your views.

Dr Rowan: Thank you very much.

GABRIEL, Ms Clare, Solicitor, Hall Payne Lawyers, assisting Queensland Nurses Union

SHEPHERD, Mr Jamie, Professional Officer, Queensland Nurses Union

CHAIR: We will run about five minutes longer than we need to just to try to give you a little bit of extra time. Certainly, I invite you to make an opening statement.

Mr Shepherd: The QNU thanks the committee for this opportunity to comment on the Health Ombudsman Bill. We have given serious consideration to the provisions of the bill and, while we believe there are some benefits for health practitioners, there are certain aspects that cause us concern. Here, we outline a few of the relevant matters regarding the bill.

The QNU welcomes amendments to the National Law clarifying mandatory reporting in relation to a second health practitioner's notifiable conduct. We also welcome protection from reprisal action for individuals making a complaint. We welcome more timely decision making, although we believe that some of the proposed time frames may not provide health practitioners with an opportunity to respond to adverse claims. We also welcome greater regulation of unregistered health practitioners.

In respect to unregulated healthcare workers assisting health practitioners, we urge the parliament to consider the enactment of a regulatory framework that has clearly defined education standards and skill competencies that will provide a fair and consistent framework and reference point for the Ombudsman for unregulated healthcare workers and health practitioners alike. There are, however, other aspects of the bill that we feel need further attention.

Similar to the National Law, under the objects of the bill we seek the inclusion of a requirement that the Ombudsman's actions are transparent and fair and that restrictions are only imposed on health practitioners if it is necessary to ensure safe quality health care. We note that, while some of the time frames in the bill may hasten decision making, they may not afford practitioners the opportunity to make considered responses to complaints made against them. The QNU submits that the Ombudsman's office should be empowered to permit extension to the statutory time frames in appropriate circumstances.

While we acknowledge the need in appropriate cases for regulators to be able to take prompt action, we contend that the immediate action provision should afford the practitioner an opportunity to respond before action is taken in relation to their registration. The QNU is concerned that the bill as it stands has the effect of abrogating natural justice and unfairly shortcutting procedural fairness for practitioners.

The bill provides that the Queensland Civil and Administrative Tribunal—QCAT—is not permitted to grant a stay of a decision to take immediate action or issue an interim prohibition order. We contend that QCAT should be empowered to undertake these actions in accordance with established legal criteria and be appropriately resourced to do so. The QNU believes that the privilege against self-incrimination in relation to inquiries undertaken by the Ombudsman should not be removed. The QNU is concerned by the suggestion that investigation reports fully identifying health practitioners and including confidential information may be made publicly available and we seek the removal of provisions in the bill that will allow this inappropriate intrusion into a practitioner's privacy.

We note that the explanatory notes state that regulating unregistered practitioners will only incur modest additional cost. We are concerned that, given the number of unregistered practitioners who are likely to be captured by the legislation, that the fees for registered practitioners may be increased in order to cross-subsidise these practitioners. Although the scheme is supposed to be cost neutral for the government, we fail to see how this will occur without additional funding, particularly given the number of new unregistered practitioners and the commitment to short turnaround times for complaint matters. Our members strongly oppose any further rise in registration fees, particularly given the 40 per cent increase that occurred last year. Despite assurances that national registration would produce economies of scale, the NMBA provided no evidence to support the increase. We welcome further discussion with the committee. Thank you.

CHAIR: Thank you. Would you like to make a statement?

Ms Gabriel: No. I am from Hall Payne Lawyers. We are retained by the QNU to assist its members from time to time in responding to AHPRA and Nursing and Midwifery Board matters. So we have quite a lot of experience in dealing with the practicalities. I have come along to assist with any questions that may come.

CHAIR: Thank you. Committee members, any questions?

Mr DAVIES: My question is the same question that I asked Mr Rowan before regarding privacy. You just mentioned it before. I am looking for the nexus between ensuring protection of the public safety as far as releasing of information but also protecting your members. How do you see that working?

Mr Shepherd: The current system with AHPRA and the National Law sees where a practitioner has had any sort of restrictions placed on their practice, that is publicly available on the national register. We do not see any reason for the details of an investigation to be published on a public register, as that would encroach and inappropriately intrude into the practitioner's privacy. With the current system, as it works now, where a practitioner has had action taken as a result of a health matter, the circumstances of the undertakings or conditions imposed on that practitioner are held confidential and are not publicly available on the register.

Mr DAVIES: So what about the public safety aspect, though?

Ms Gabriel: The public safety aspect, I think, is covered by the publication on the register of any restrictions against their registration. The restrictions against the registration come as a consequence of, at present, proven allegations that have an impact on a practitioner's fitness, competence, or health that might affect their practice. So the public safety is protected by the publication of those restrictions, if there are any, on the public register. I do not think the public interest is necessarily served by the publication of, for example, full investigation reports that might include extremely personal information of the practitioner. Those allegations may or may not be proven in the end. They may have just been material considered during the course of the investigation. But if the allegations are then substantiated and actions taken as a result, those restrictions are published on the register and the public is protected in that way.

Mr Shepherd: And the National Law has the current capacity to engage a practitioner into an undertaking not to practise until an investigation is complete, which provides certainly a high level of protection for the public.

Mrs MILLER: So the QNU does not support this bill as it is currently drafted?

Mr Shepherd: We support the intent of the bill but, as it is currently drafted, we believe it has some shortcomings.

Mrs MILLER: So we have now the doctors and the nurses opposed to this bill before the parliament. Thank you.

Mr Shepherd: We certainly support the checks and balances that maintain the safety and quality of care for the Queensland public.

Mrs MILLER: Yes, I understand that, but you do not support the bill as it is currently drafted.

Mr Shepherd: Correct.

Mrs MILLER: Thank you.

Ms BATES: I understand your concerns about a full report being published on the internet. I am imagining you are looking at something similar to what the CMC does in that, if there is an adverse report, it keeps it to an absolute minimum. It does not go into the details of what was looked at during that course of the complaint. Is that what you are meaning? Rather than going into the nuts and bolts of the actual investigation, you would like to see just the summary. Is that what you mean?

Mr Shepherd: No, what we are saying is that the current provisions under the National Law for the publication of findings and actions taken against practitioners is adequate for the protection of the public.

Ms BATES: Right.

Ms Gabriel: There are, of course, learnings that can come from the deidentified publication of a summary of an event and what action was taken and things like that. Certainly, other practitioners as a whole I think can learn from those sorts of short summaries. But obviously, the QNU's position is that the public interest is adequately protected by the provisions under the current National Law, which provide for the publication of conditions or undertakings of a practitioner's registration but not investigation reports or anything of that nature.

Ms BATES: I also note in your submission that you were concerned about things being posted on the internet that can stay there forever even if the decision has been reversed. That is obviously a valid concern of yours?

Mr Shepherd: Yes.

Ms BATES: Thank you.

Dr DOUGLAS: Thank you, Jamie. I think this is a very good submission. I am interested in the issue of timeliness. In fact, I think you have explained very well the difficulty with trying to put a short time frame on what is often a very complex situation. Certainly, nurses, for one, know all of those sorts of things in great detail. I am sitting here beside one. I am interested to know whether you believe that the bill can be altered in such a way that would address those concerns.

Ms Gabriel: I think the overarching position is that the Queensland public and the Australian public is arguably better served by the national scheme as it currently stands, because there is that national consistency. So I think it is better served in that way with that national consistency. I am certainly pleased to see that the intent of the bill is to maintain a national registration scheme. Going backwards from a national registration scheme would be a very backward step indeed. So I am very pleased to see that the national registration scheme is being maintained. But I think there is a lot of benefit in keeping a national disciplinary scheme as well. So I think, ultimately, that is a good scheme.

Certainly, there have been shortcomings, as identified in the Forrester report, but those are perhaps not legislative failures, I would argue, but things that could perhaps be fixed by better processes within AHPRA, a better triage of complaints that come in and arguably more resourcing for AHPRA.

Dr DOUGLAS: Excuse me if I am paraphrasing you or anything, but are you actually saying—which is, in fact, what I see—that this is a backward step rather than a forward step?

Ms Gabriel: That would be my view.

Dr DOUGLAS: Yes. Thank you.

Mr Shepherd: And I would concur with my colleague's comments in that I do not believe that there are any failings within the National Law as it is written. It is about the implementation of the law, particularly with regard to the resourcing of AHPRA. Before I joined the Queensland Nurses Union, I spent several months as a senior health and performance officer with the Australian Health Practitioner Regulation Agency and from my experience there were certainly issues with the resourcing of the agency to be able to have the capacity to deal with investigations and matters in a timely manner.

Mr HATHAWAY: Thank you, Mr Shepherd, for your presentation. On page 13 of your report you indicate that you have reservations or concerns about the Ombudsman providing information to an employee for one of your members. Are there any circumstances where you think that that transmission of information on one of your members to their employer would be warranted?

Mr Shepherd: I would defer to my colleague, thank you.

Ms Gabriel: When allegations are made against a practitioner, they are only allegations at that point. They may sound very serious at first blush, but it is appropriate that a practitioner has an opportunity to provide their response to that before action is taken in response, in my view, and then a decision is made. If the allegations are substantiated, action is taken accordingly. At that point, when the allegations have been substantiated, it is then appropriate to communicate those findings in some way to people who have a relevant interest in knowing them. So an employer of a health practitioner is obviously somebody who has an interest in whether or not their employee has restrictions against their practice. That, I think, is uncontroversial. But where allegations are unproven, I would say that practitioners must have an opportunity to respond to those allegations before they are communicated more broadly, because they are only allegations at that point.

Mr HATHAWAY: Just by way of follow-up, I do not think it necessarily means that the legislation permits information to be passed to an employer prior to the respondent practitioner having had some chance at first addressing the complaint made against them.

Ms Gabriel: I may be wrong, Mr Hathaway, but I believe it does allow for that communication, which is one of the reasons for the concern.

Mr HATHAWAY: I will rephrase the question. Do you believe that the legislation as it stands at the moment dictates that the employer must be made aware of an allegation against one of its employees prior to that employee having had a chance to do an initial first response to the complaint?

Ms Gabriel: I would need to have a look at the legislation. I do not believe it is a 'must', from memory; I think it is a 'may'.

Mr HATHAWAY: So in other words we get back to this discretionary process of whether the horse is in front of the cart or otherwise; correct?

Ms Gabriel: I believe it is a 'may', but I will just double-check.

Mr Shepherd: Just within the explanatory notes, yes, the bill does require the Health Ombudsman to notify an employer of where they have decided to take action in response to a matter. It is not clear about whether that action is taken before or after the practitioner has had the opportunity to respond.

Ms Gabriel: Just quickly reviewing the legislation there, it talks about the Health Ombudsman must inform the employer if immediate action is taken. As the AMA discussed, as you are aware, immediate action can be taken before obtaining a response from a practitioner, which is one of our reasons for concern. So there is that possibility.

CHAIR: We are coming up to the end of our time. Mr Shuttleworth, do you have a question?

Mr SHUTTLEWORTH: Obviously, I was listening quite intently to the discussion—the previous presentation and this. My main concern is if the complaint is not of a clinical nature but it is of an ethical or moral nature. Then surely, by not taking those immediate actions, we are almost negligent in allowing it. Whether it is a situation that has occurred, or at least it has been alleged, it could be nipped in the bud quite quickly. I had written a note to look at myself what level of complaint against doctors is largely clinical versus ethical, or process. I think we would have to be very careful to ensure that we did not circumvent any possible action to bypass very quickly a non-clinical concern. How do you see that playing out?

Mr Shepherd: The National Law currently has capacity, of course, to take immediate action but it also includes the capacity for the practitioner to have the opportunity to respond. That response time frame can be very short. It could be one or two days if need be. But it does give the practitioner an opportunity to explain the situation and what occurred and the nature of the events.

CHAIR: I would like to follow up a little bit on this immediate action. Clause 4, the paramount guiding principle, states—

(1) the main principle for administering this Act is that the health and safety of the public are paramount.

I do not think anyone disputes that. I think that is something that we all get on board with. I then go to clause 58, which is the one that talks about immediate action. It states—

The health ombudsman may take immediate registration action under this division in relation to a registered health practitioner if—

(a) the health ombudsman reasonably believes...

The definition of 'reasonable' is well understood and well established. Then there are two subparagraphs there—

... reasonably believes that—

(i) because of the practitioner's health, conduct or performance, the practitioner poses a serious risk to persons; and

(ii) it is necessary to take the action to protect public health or safety.

By reading this, what I am understanding is that there is a better to be safe than sorry aspect to this if, for example—and I am just pulling out a case; I do not know if this is real, I am just saying—there is surgery to be conducted tomorrow but there is reasonable evidence to suggest that the person conducting the surgery has done something that they should not, irrespective of whether it is clinical, or ethical. I see this as a better to be safe than sorry approach. It immediately allows the Ombudsman to say, 'This is a little bit tight,' or in other instances, 'This is pretty solid' and so, therefore, immediate action is taken. As I am understanding this particular point—and your point is not lost on me in regard to natural justice—I am saying that, if I am the patient, I do not have the information and knowledge that potentially the Ombudsman would have. Therefore, I find some comfort in the fact that they can say, 'We are done here until we can establish what is going on.'

Ms Gabriel: I would say a couple of things in response to that. First of all, the immediate action test is an appropriately high test, I think, for when immediate action is justified. So there is that high test. There is the immediacy of the risk and things like that. So there are certainly circumstances where very prompt action is appropriate in relation to practitioners. But you talk, for example, about surgery happening the next day. Immediate actions can be extremely short in their response time for practitioners. It could be a matter of hours. I do not have personal experience of that, but I understand that that has occurred with the current processes as they stand at the moment. So it is a matter of AHPRA getting on the phone to the practitioner saying, 'We have this complaint. What do you say about it?' If there is a quick and easy answer, then no action. They

might take other action or they might delay taking action, but if there are concerns and there is no good explanation, under the current legislation there is power to take that action even after allowing that very brief period for response.

CHAIR: So this power is not dissimilar to the power that currently exists with AHPRA?

Ms Gabriel: It is dissimilar in that it can allow for an abrogation of natural justice. They can take action without seeking any response under the current health—

CHAIR: Again, I acknowledge that what I am about to ask you is discretionary, but what stops the Ombudsman from following a similar procedure under this legislation?

Ms Gabriel: We would certainly hope that the Ombudsman would follow the show cause procedure in most, if not all, cases. But just allowing that very brief period for response, it is the difference between allowing natural justice and not allowing it.

CHAIR: But there is nothing that stops the Ombudsman from ensuring that that is addressed anyway.

Ms Gabriel: That would certainly be the hope, yes.

Mr Shepherd: There is nothing to prevent it but there is nothing in the law to mandate it.

CHAIR: The prevention, in my understanding, would be the high standard that is required before it can be taken.

Mr Shepherd: Yes, and the immediate action and response from the practitioner can be taken under the National Law within hours.

Ms Gabriel: Within a very brief period of time.

Mr Shepherd: And the National Law mandates that a response be required.

CHAIR: We are going to go around on this. I guess I am coming at it from a slightly different angle from what you are. We have run out of time. Mr Shepherd, thank you for both the submission and for attending, and Ms Gabriel, I thank you also for attending. We are going to take a 10-minute break. We will be back at 11.25 am.

Proceedings suspended from 11.14 am to 11.26 am

TUCKER-EVANS, Mr Mark, Chair, Health Consumers Queensland

CHAIR: The hearing of the Health and Community Services Committee is now resumed. I welcome Mr Mark Tucker-Evans, the chair of Health Consumers Queensland. I invite you to make an opening statement, Mr Tucker-Evans.

Mr Tucker-Evans: Thank you, Mr Ruthenberg, and members of the committee for the opportunity to address you this morning about this important bill. I am speaking here today in my capacity as chair of Health Consumers Queensland, the peak health consumer organisation representing the interests of health consumers in Queensland. HCQ defines consumers as people who use or are potential users of health services, including their families and their carers. HCQ is committed to a health system that delivers quality and safe health services, providing the right care at the right time and in the right place. The views that I express to you today are the views of HCQ gathered in consultation with our members and shareholders.

I should also declare that I am an assistant commissioner, consumer issues, with the Health Quality and Complaints Commission and chair of the HQCC consumer advisory committee. In addition, I am chief executive of the Council on the Ageing Queensland and executive member of the Queensland Clinical Senate; a director of CheckUP Australia, an independent not-for-profit industry body dedicated to advancing primary health care; vice-president of QCOSS and a member of the advisory council of the Energy and Water Ombudsman Queensland. I provide you this information to demonstrate my engagement across the health and community services sector.

It is HQC's view that the complaints system should be designed with the consumer in mind and in consultation with the consumer. I have outlined in our submission the five elements that we believe make up an effective complaints handling system. The first is culture. Complaints should be viewed in a positive light and as a tool to identify issues with an individual and/or system and to enable remedial action to be undertaken to prevent harm to consumers in the future. The second is around principles. An effective complaints handling system must be modelled on the principles of fairness, accessibility, responsiveness, efficiency and integration. The third is around people. Complaints handling staff must be skilled and professional. The fourth is around the process. The seven stages of complaint handling are, initially, to acknowledge the complaint, then to assess it, to plan what you are going to do about it, carry out the investigation, respond to it, review and then consider the systemic issues that should be clearly outlined. The fifth and final step or element is the analysis. Information about complaints should be examined as part of a continuous process of review and improvement. A strong complaints handling system is built on all five elements.

HCQ supports the main objects of the act to protect the health and safety of the public, to promote professional safe and competent practice by health professionals, to promote higher standards of service delivery by health service organisations and to maintain public confidence in the management of complaints and other matters relating to the provision of health.

HCQ would further recommend the inclusion of oversight and review of an improvement in the quality of health services as is currently in the HQCC Act. An important part of HQCC's functions is around safety and quality monitoring, promoting healthcare rights to all and functions regarding state-wide service, facility health care, and investigating and reporting for improvements. HCQ has for the past five years been working with health services across Queensland and for the past year with hospital and health services and Medicare Locals.

It is fair to say that many health services are still coming to grips with the important role consumers have in designing and delivering health systems—the systems that we want as Queenslanders. I should say that most people do not like to complain. It is even more difficult to complain if you are upset, busy, or think that it will not make a difference. Some complainants simply want an apology. Most want to avoid a similar incident happening to someone else. It is also true that some complainants are out for blood.

We support a single access point for complaints. Managing complaints through a single entity would reduce the confusion for consumers and we would expect that it would also expedite those complaints. However, we have made the point in our submission—and it was made by a previous speaker—that sometimes it is not about the timeliness; it is about getting the right investigation done. Sometimes that takes longer than the bill allows and some people need an advocate to help them through what is a trying experience for the complainant.

It is important that the complaints management system be transparent—I agree with all the other speakers today—but it also needs to respect the confidentiality of all of those involved. That is both the health practitioner and the complainant. We are concerned that there is too strong an emphasis in the bill on prosecutions and believe that it is counterproductive to expect that

prosecutions alone will change any system and serious systemic issues. We have concerns about the process of prosecution and naming and shaming. It is useful to have case summaries, as HQCC has done, to showcase the lessons learned and that may be learned. However, it is most important to deidentify individual practitioners in order to retain dignity, which is a fundamental need and right of all human beings.

Over the past couple of years I have witnessed the commission's increased workload, the development and streamlining of their complaints lodgement, triage, early resolution and conciliation processes. In the main, I believe that HQCC has worked diligently to manage the increased workload with restricted resources. We would like to ensure that the Health Ombudsman builds on the positive work undertaken by the HQCC over the past six or seven years. The HCQ believes that the Ombudsman must be a statutory officer, independent from the minister, reporting directly to parliament.

We support clause 27 of the bill, that in performing the Health Ombudsman function the Health Ombudsman must act independently, impartially and in the public interest. However, clause 28 may lead to some confusion. Clause 28(1) states—

The Minister may give a direction ...

Clause 28(2) states—

Otherwise, the health ombudsman is not subject to direction by anyone about how the health ombudsman performs the health ombudsman's functions.

Finally, we believe that the bill needs to be strengthened to ensure that experienced consumer and clinical advice be sought to inform the Ombudsman's decision making. One way to do this is through an appointment of a standing consumer advisory committee or, as the Energy and Water Ombudsman has done, to establish an advisory council which provides expert advice to the Ombudsman on the effective and efficient conduct and operation of the Ombudsman's scheme. This helps to ensure that the scheme is administered in a manner which is fair and just for consumers and suppliers. The Energy and Water Ombudsman Queensland advisory council monitors the Ombudsman's independence; advises the Ombudsman on policy, procedural and operational issues relating to the act; and advises the Ombudsman on the preparation of budgets, guidelines and annual reports.

The point has been made by a number of other speakers about the resourcing of the Ombudsman. It is absolutely important that any complaints system is well resourced. Thank you.

CHAIR: Thank you. I will open up the hearing to questions from committee members. Mr Hathaway?

Mr HATHAWAY: I just have a question about your organisation. How many individual members and how many corporate members do you have as Health Consumers Queensland?

Mr Tucker-Evans: We have a network of over 350 organisations. Health Consumers Queensland evolved out of a ministerial advisory committee, but for the last nine months it has been working towards being an independent not-for-profit organisation.

Mr HATHAWAY: So of the membership you have, about 350 are corporate members?

Mr Tucker-Evans: No, they are a combination of individual people—

Mr HATHAWAY: And other organisations.

Mr Tucker-Evans: But also organisations—so other organisations such as the Queensland Voice for Mental Health, the Maternity Coalition—

Mr HATHAWAY: Okay. Thank you.

CHAIR: Anybody else?

Ms BATES: Mr Tucker-Evans, welcome. You mentioned on page 2 of your submission the inclusion of oversight, review and improvement in the quality of health services similar to the HQCC Act. What would these benefits be?

Mr Tucker-Evans: I think one of the benefits of the Health Quality and Complaints Commission is that it is about trying to improve the system as a whole. It is not just about looking at the individual who the complaint is about. In fact, the HQCC has released over the last couple of years some very good reports into a series of what may appear unconnected cases but when you join them together they show a trend and by doing that you can take some action.

Ms BATES: Thank you.

Dr DOUGLAS: Thank you very much, Mr Tucker-Evans. I am interested in a couple of things that you have said and some of the things that have been submitted. You made the comment that you felt that people needed to have an advocate in this process. My first question is: are you saying that because of the inherent very legal, adversarial approach that is contained within this type of bill? Is that one of your concerns?

Mr Tucker-Evans: It is one of the concerns, but not all complainants have the capacity to speak for themselves or put their complaint in a way that is easily investigated. So it is about having somebody to walk alongside them and to assist them to have their complaint investigated properly.

Dr DOUGLAS: Right. My second question is along the lines that you have made a point in the submission about the issue with regard to AHPRA and the issue of managing complaints. Do you sense that there are going to be areas of overlap that are going to lead to confusion for consumers and maybe there are going to be difficulties of resolution of conflict due to that problem?

Mr Tucker-Evans: We certainly support the bill in having one single point of access for complaints. We are also conscious of the fact that there has been quite a lot of overlap in the current system with, in some cases, AHPRA reinvestigating what has already been done by the Health Quality and Complaints Commission. So we would want to avoid that at all costs. From a consumer's point of view, they make a complaint to one organisation and they expect that organisation to carry the complaint right through to completion. The important thing is that, throughout the process, the consumer and also the health practitioner is kept fully informed about what the process is and where it is at in that process. In terms of duplication, we would hope that, in fact, the bill would eliminate that. It may need to be strengthened to do that, however.

Dr DOUGLAS: Although you say something differently within the submission with regard to that. am I misreading it? Do you want me to quote what you are saying here?

Mr Tucker-Evans: If you could just point it out?

Dr DOUGLAS: It is actually in paragraph 4 on page 1—

It is critical that the Complaints system be designed with the consumer in mind. There should be a single access point... Managing complaints through a single health complaints entity...Consumers and the provider should be fully informed about the process, possible timeline and outcome and kept informed of progress throughout the process.

Then in the next paragraph—

We understand that the current complaint process which involves both HQCC and AHPRA has resulted in lengthy delays resulting in the complainant becoming even more frustrated and stressed.

But you are happy with the AHPRA process. Is that right? Or you are not happy with it?

Mr Tucker-Evans: What we have tried to say in that submission is that in the current system, where there does appear to be some duplication, we would like to see that eliminated. My understanding is that HQCC and AHPRA have had some very fruitful discussions in recent times to try to streamline the processes. We are not convinced that this bill is going to reduce the duplication.

Dr DOUGLAS: Right, which is what you want, though. You want—

Mr Tucker-Evans: We want duplication reduced—

Dr DOUGLAS: Exactly.

Mr Tucker-Evans: Eliminated, in fact.

Dr DOUGLAS: That is right. So to paraphrase all of that, the bill is not going to reduce duplication.

Mr Tucker-Evans: We cannot see that, in its current state, it will.

Dr DOUGLAS: Thank you.

Mr DAVIES: In your talk before you mentioned the fact that the Health Ombudsman is not subject to direction and you quoted clauses 28(1) and 28(2) and how there seems to be a conflict. But on my reading of clause 28(1) basically the only direction the minister can give is to investigate something. It is not anything more than that. There does not seem to be a conflict when you read this. Apart from that, the Ombudsman is completely independent.

Mr Tucker-Evans: As a number of speakers have indicated already this morning, and we would certainly support that as well, it is absolutely important that the Ombudsman is independent of government, of the minister and reports directly to parliament.

CHAIR: I am just going to follow that up. How does the bill set up that they are not?

Mr Tucker-Evans: I think that there are a number of examples within the bill that leaves it to the discretion of the Ombudsman and that is a concern that we have. We are certainly aware of limited resources and the concern that we have is that limiting resources to the Ombudsman may, in fact, reduce the capacity to examine complaints in a thorough way.

CHAIR: Okay, but I am going to put resources aside. Let us go back to the core issue that we were just discussing, which is that of independence from the minister. How does the bill set up that the Ombudsman is not independent from the minister? The reason I am asking is that I am struggling to understand that.

Mrs MILLER: Can I just answer that, because under the—

CHAIR: Just give me a second.

Mrs MILLER: Yes, but I can answer that quickly.

CHAIR: I am asking Mr Tucker and I will come back to you.

Mrs MILLER: You do not want to know.

Mr Tucker-Evans: We do not believe that the bill as it currently stands is independent. As the previous speaker indicated, the minister is responsible for a great deal of the health system within Queensland—the hospital system et cetera. Therefore, potentially—and I am not saying that it will, but potentially—that could, in fact, limit the independence of the Ombudsman.

CHAIR: That is what I am struggling with. How? I am truly struggling with that last statement that it potentially limits the independence. The bill specifically separates what the Ombudsman can and cannot do from what the minister can and cannot do as a read it. I am struggling to understand how the bill limits the independence of the Ombudsman.

Mrs MILLER: Shouldn't you be asking the minister that?

CHAIR: No. The submission has been made and evidence has been given. So I am trying to understand—

Mrs MILLER: In fairness to Mr Tucker-Evans, every act of parliament under the administrative arrangements of the government has a minister attached to it and that minister is the Minister for Health. Therefore, the Minister for Health is responsible, or will be responsible for this Health Ombudsman under the administrative orders of the Queensland government. I know that is probably foreign to all you new members, but that is the way it stands.

CHAIR: Okay. I will take that on board.

Mrs MILLER: You do not.

CHAIR: What I am trying to understand, though, is that the bill specifically identifies the authority of the Ombudsman and the authority of the minister. What I am struggling with—

Mrs MILLER: And the minister is responsible under the administrative orders for the act of parliament to this parliament and to the cabinet and to the Premier as well. That is how it occurs.

CHAIR: Right. I acknowledge that. I also am asking, given the provisions within the bill to provide independence to the Ombudsman, as I understand it, what I am struggling with is how is the Ombudsman not independent from the minister in the decision making and the functioning of the Ombudsman on a day-to-day basis.

Mrs MILLER: Because the director-general also has an involvement as well. The director-general of the department of health will be involved under the administrative arrangements.

Ms BATES: Point of order—

CHAIR: No, we are into conjecture. We will ask another question.

Mrs MILLER: Yes, that would be good.

CHAIR: Mr Tucker-Evans, I am not trying to be aggressive here. I am truly trying to understand where this does not exist. Anyway—

Mrs MILLER: Maybe you should ask your government whip.

CHAIR: Jo—

Ms BATES: Point of order

Mrs MILLER: No, no, that is fair.

Ms BATES: Point of order, this is not an area for debate; that is in the chamber in the House.

CHAIR: Sure.

Ms BATES: And I would respectfully ask that we return to this inquiry.

CHAIR: Back to the questioning. Thank you. I am going to take that. Are there any other questions for Mr Tucker-Evans? If there are not, Mr Tucker-Evans, thank you and thank you for your organisation for their submission to us.

Mr Tucker-Evans: Thank you.

FLETCHER, Mr Martin, Chief Executive Officer, Australian Health Practitioner Regulation Agency

FLYNN, Dr Joanna, Chair, Medical Board of Australia

ROBERTSON, Mr Chris, Director, National Board Services and Queensland, Australian Health Practitioner Regulation Agency

CHAIR: For the purposes of Hansard, I note that Mr Davies has left the room but, as we still have a quorum, we can continue. Welcome, Dr Flynn, welcome Mr Fletcher and welcome Mr Robertson. Thank you for attending and thank you for the submission that you have put forward. I would invite you to make an opening statement of up to 10 minutes or so.

Mr Fletcher: Thank you. I will start off with the opening statement and then I will also invite Dr Flynn to make some comments from the perspective of the Medical Board of Australia. Thank you very much for the opportunity to meet with the committee today. From our perspective, we recognise the resolve of the minister to make quite significant changes to complaint handling in Queensland and we are very keen to play a constructive role, in particular to ensure an effective interface between the new Health Ombudsman and the national registration and accreditation scheme as it works in Queensland.

Just to give you a little bit of background on the national registration and accreditation scheme, it is a national scheme that regulates now around 580,000 health practitioners across Australia across 14 different professions. We are not a complaints agency. We are essentially a protective jurisdiction. So our focus is very much on addressing standards and concerns about health practitioners that go to questions of patient and public safety. Our major functions really relate to issues such as professional standards for registration, dealing with what are called notifications under the national scheme, which go to concerns about health, performance or conduct in relation to registered health practitioners and also a set of arrangements in relation to accreditation of educational pathways to registration.

There are quite distinct entities in the national scheme. There are the 14 national boards. As I said, Dr Flynn is the chair of the Medical Board of Australia. It is really the boards that make the key decisions in relation to standards and the regulatory policy of the scheme. It is the boards, through their various state boards and committees, that make the decisions about individual practitioners in terms of registration or notification matters. AHPRA as the national organisation essentially administers the national scheme on behalf of the boards. We obviously work very closely in partnership with those boards. We have an office in every state and territory, including our office here in Queensland, and Mr Robertson has oversight of our operations here in Queensland.

It is probably important to add is that we are not a Commonwealth scheme. We are not created by an act of the federal parliament. We are created by an act of parliament in every state and territory. The scheme is self-funded. What I mean by that is that it is the fees that health practitioners pay on an annual basis to renew their registration are the only source of income that we have. The national scheme is set up on the basis that each profession must pay its own way in relation to the full costs of regulation in the scheme and there is no cross-subsidisation between professions in terms of the cost of regulation.

You would have seen our submission to your committee and we have provided a joint submission on behalf of AHPRA and the national boards. There are probably just a couple of points that I would like to highlight from my perspective and then I will hand over to Dr Flynn. As we say in the submission, this change would see Queensland become a coregulatory jurisdiction for the purposes of the Health Practitioner Regulation National Law Act in dealing with notifications. It is our understanding that that change would have no impact on other states and territories and, as you are aware, there is already an example of a coregulatory model in place in New South Wales.

We welcome the strong focus on patient safety and public safety as the focus of the Health Ombudsman draft legislation. As I have said earlier, that very much resonates with the protective nature of the objectives of the national scheme. I think we are very much focused also on highlighting the importance of the interface between how the new arrangements work in Queensland with how the national scheme works in Queensland. Of course, that goes to questions of not only the legislative framework but also very much the practical issues of how it works day to day and the administrative arrangements and IT systems. So our focus is very much on making sure that there is a smooth interface and that there are not unintended consequences or additional

complexity that is unhelpful in terms of the objectives of what the minister is seeking to achieve here. I think we have some good experience from the New South Wales coregulatory model that can be drawn upon in terms of some of the lessons of what works well.

We highlight in our submission our understanding of the funding arrangements in relation to the Ombudsman—both the fact that we understand that this is intended to be cost neutral to government, that there is an expectation that boards in the national scheme on behalf of their professions will pay for what they otherwise would have done in relation to serious matters if the new arrangements did not exist. I really want to perhaps emphasise here that, ultimately, if the model in Queensland does cost more, that ultimately would be a cost that would have to be borne by registrants. There is not another source of funding that we have. Our only funding comes from those registration fees that are paid by health practitioners. I think the costs of the scheme are obviously a very important focus.

I think our other major area of interest is around the transition arrangements. It is only three years literally last week—1 July—that we transitioned to the national scheme here in Queensland. I think certainly some of the challenges that we have had in Queensland relate to some of the complexities of that transition. So we are very keen to ensure that the transition to the new Health Ombudsman arrangements is as smooth as it possibly can be and, again, that there are no unintended consequences or risks and that there is a time and process around that to make sure that it works as well as it can. Again, I think we come to this with some good lessons learned, if you like, from the experience of the transition from 1 July 2010. I will pause there and just invite Dr Flynn to make a few comments from the perspective of the Medical Board of Australia.

CHAIR: Thank you.

Dr Flynn: As Mr Fletcher said, I am the chair of the national board. I am a general practitioner based in Victoria. There are just short of 100,000 doctors in the national scheme. So against the 580,000 you can see that proportion. But over 50 per cent of the notifications about practitioners under the national scheme are about doctors. It is also true to say that matters about doctors are often more complex and involve high risk to the public.

There are significant differences of opinion about what is the best system in Australia for handling health complaints and I am concerned that we have not yet answered that question before making legislative change. So we have two models, the New South Wales model and the national model, but there is a difference between a complaints process seeking to resolve complaints on behalf of complainants and professional regulation, which is about protection of the public and ensuring professional standards. I think some of the thinking about that has not really been done.

So changing the legislation in Queensland is not the board's preferred option. We certainly acknowledge that there were concerns about the way in which the Medical Board and AHPRA were carrying out their role. There were significant time line lags. We have invested a lot of time, people, money and resources in that in the last 12 to 18 months and, in fact, the situation is improving. Our preferred option would be that that be allowed to continue. Nonetheless, we recognise that the minister is responsible for the health system in Queensland and has a strong view that changes need to be made. So that said, I think we need to talk about how to make that work effectively.

That then I think means that we have to be very clear about roles and responsibilities. A lot of that needs to be worked through in the implementation plan, which is really not part of the legislative brief. But we strongly support retention of the powers that the existing boards have. I am sure you are aware that, for medicine, we have a state board in each state and territory which deals with all of the matters to do with individual practitioners in each state and territory for a number of reasons—the importance of local knowledge of context and responsiveness but also in order to manage the workload.

We are concerned about the risk of discontinuity and lack of national consistency if another scheme is brought in, particularly if the Health Ombudsman has a role in setting professional standards. It is a little unclear about whether that role exists but the national board has a code of conduct for all doctors in Australia, which has been in existence for about five years. It is well known and well accepted and I think it would be risky to have different sorts of messages for different practitioners about what the accepted standards of practice are.

We think that the protection of the public is paramount and that it is very important in contemporary medical regulation, as in other health practitioner regulation, that decisions are made with an appropriate input from both clinicians and community members. If you look around the world at how these regulatory functions are carried out, essentially they are a balance—somewhere between fifty-fifty and two-thirds/one-thirds clinicians, in our case doctors, physios or pharmacists

and the other third to a half community members—and that brings the appropriate balance and that is the best practice model of how to apply professional standards. We have some concerns about how that will play out and we believe that there are opportunities in the working relationship between the Health Ombudsman and the board and AHPRA to use the knowledge and access to clinical input and community members that we have in the boards to continue to contribute to that role. But we also understand the need for clarity. As your previous witness said, consumers expect that if they make a complaint to an organisation, that is the organisation that deals with it. That is one of the things, I think, that is unclear in the present system—not just in Queensland—and it needs to be clarified.

So in short, it is not our preferred model but we are very committed to trying to make it work. We think that it is very important that there is still professional and community involvement in setting standards and making decisions about what is appropriate conduct. Thank you.

CHAIR: Thank you. Mr Robertson, would you like to make a statement?

Mr Robertson: No. Thank you.

CHAIR: Okay. I will open it up to the committee if they would like to ask questions.

Ms BATES: Thank you for coming. Mr Fletcher, in your submission you suggested that the current members of national boards could provide clinical advice to our Health Ombudsman. How do you propose that this would work?

Mr Fletcher: I think what we are proposing is that essentially it will be important to have a clear interface between the Ombudsman and the national scheme as it works here in Queensland—so boards and AHPRA. We understand that, under the legislation, it is expected that the Ombudsman would retain the more serious matters to deal with, but we would expect through a process of consultation and discussion that less serious matters—perhaps matters that relate to health impairment or performance—would be dealt with by the boards and then committees that exist here in Queensland.

I think the one issue that we have raised in our submission is that at the moment the legislation as it is currently framed does not give the Ombudsman any discretion to refer more serious matters to the boards. We understand the reasoning for that, so our only comment would be whether there would be any discretion for the Ombudsman in some circumstances to be able to refer more serious matters to make use, as Dr Flynn has said, then of the established mechanisms of clinical and community involvement in existing boards and committees, because all of our existing boards and committees have this combination of both clinical and community involvement.

Ms BATES: Thank you.

CHAIR: Mrs Miller?

Mrs MILLER: Mr Fletcher, you spoke about the self-funding model in relation to registration fees.

Mr Fletcher: Yes.

Mrs MILLER: Could this bill result in the increase of registration fees for your professions?

Mr Fletcher: I cannot answer that question but, as I understand the way the model is constructed, or as the legislation is proposed, each of the professions would pay what they would otherwise have paid for dealing with those serious matters as though the national scheme was doing that. So to the extent to which this model costs less, there may not be a cost pressure, to the extent that this model costs more, there may well be a pressure on fees for some practitioners here in Queensland.

Dr DOUGLAS: Could I just go one further on the funding thing. I am actually a GP, as well. It was great to hear you say that you are a GP practising in Victoria. I am at the Gold Coast. I am curious about the funding. In your submission you have clearly stated that 'if the costs become higher as a result of the functions being undertaken' and your only income is from our fees that are paid and, also, 'We note that the explanatory notes for the Bill indicate that implementation is intended to be cost neutral for government'. Therefore, by adding an extra layer in it must be more expensive, mustn't it, so in fact the fees will have to go up?

Mr Fletcher: I think there are two issues we have made there. Firstly, we understood that there was no expectation that the national scheme would pay for the set-up and establishment costs of the new Ombudsman, so there would not be a call on fees in relation to that. I go back to my understanding of how the legislation is currently drafted, that we would be paying for what we would otherwise have done if the Ombudsman did not exist. So it will come down to what the

components of that cost are in terms of how that is calculated, and we note in the legislation there is a consultation process that occurs around that, but ultimately it is a decision of the minister. So if the model is more expensive here in Queensland, the only source of funding ultimately we have will be the fees that registrants pay. But I cannot tell you now whether it will be more expensive or whether it will be the same or, indeed, whether it will be less.

CHAIR: Mr Fletcher, I have a follow-up question. I understand the closest model to this bill that currently exists is in New South Wales. What is the experience there in regard to the maintenance of national standards? I do not know the answer and that is why I am asking the question.

Dr Flynn: We have a very good cooperative working relationship with the health professions council and the Medical Council of New South Wales. The Medical Council of New South Wales is set up under the New South Wales legislation, a mixture of medical practitioners and community members. Essentially, they adopt the national board's code of conduct and standards. The Health Care Complaints Commission in New South Wales does not attempt to set standards for practitioners. It investigates and prosecutes, but it does not issue standards.

CHAIR: Under this bill, my understanding is that the Ombudsman—and again I acknowledge this is a discretionary authority—could adopt—I think it is clause 288—those standards as part of the national negotiation by regulation?

Mr Fletcher: All health practitioners in Queensland will continue to be registered nationally. In order to be registered nationally, they will need to meet the registration standards for their profession. Those standards are national and they are set by each of the national boards and, ultimately, approved by the ministerial council which brings together all of the health ministers around Australia. In addition, boards have roles in relation to setting guidelines and providing policy advice that are designed to help practitioners understand how they meet those and perform. So the code of conduct is, for example, one example of that. It is our expectation and understanding that that would continue to be the guiding framework in relation to how the performance and conduct of practitioners is considered. That would obviously be very important, because part of the whole purpose of the national scheme was to achieve national consistency in these areas. Of course, national consistency is also important because of mobility, because part of the idea of being able to register in the national scheme is you can register once and then within your scope of practice you can practice Australia-wide.

Mrs MILLER: Can I just ask in relation to your comment, Dr Flynn, about being cooperative in relation to this legislation. I note that the Queensland medical board was virtually bullied into resigning their positions and that there was an emergency meeting of the medical board in Melbourne, I understand, when all that sort of fracas was occurring. I am interested to know, I suppose, the context of that, given that there were very honourable medical practitioners who were on the medical board. Certainly some of them advised me that they believed that they had no option but to resign, because the minister put them in that dreadful position. I am just wondering how you intend to work cooperatively given the extraordinary intervention in basically having these wonderful medical practitioners resign or be sacked from their positions on the Queensland medical board?

Dr Flynn: I think it is important to recognise the purpose of the role of the medical board and AHPRA and of the health complaints entity, which is to protect the public. Whatever feelings and history there might be, we need a functional system that ensures good standards of professional practice and effective health care complaints systems in Queensland.

Mrs MILLER: I will be watching it with great interest.

Dr DOUGLAS: That is a very good point that was made. One does not always agree with the decisions of medical boards, but by and large they are always supported. Having said that, I was interested in your comments about what is going on nationally; the idea of cooperation. I am not certain whether I distilled out of what you were trying to say whether this bill is a step backward or is it jumping the gun?

Dr Flynn: When the national scheme was developed, we had different health care complaints arrangements in each state and territory. Some people felt that it would be important to rationalise how we should be dealing with health care complaints at the time that the national scheme was established, but it was recognised that it was a complex enough transition and we should let the existing arrangements run. I would prefer to see a serious national examination of the appropriate arrangements for health care complaints versus or beside the appropriate professional standards regulation and agreement about what is the right model, what bits should be funded by the profession and what bits should be funded by government from revenue, and that that be looked

at nationally and we agree to a model. My sense is that debate has not yet happened and this is coming to another solution. I think it is important that we are clear about what problem we are trying to fix before we change legislation.

Dr DOUGLAS: We have a bit of a learn curve. With regards to when AHPRA was formed, the New South Wales government—or whatever—decided they would retain part of their investiture and there was a lot of debate. Certainly as a medical practitioner I was not supportive of what they were doing. I thought it was wrong. I think the majority of the medical profession felt the same thing. What has been learned from that experience and has this been shared? Is it not being reflected in what is happening now?

Dr Flynn: I have a couple of comments. There is an Australian Research Council funded project going on, comparing the experience of people going through the complaints processes in New South Wales with the other jurisdictions. It is a big project. I think it has a three-year time line. That will endeavour to answer those questions. I think it is also important to recognise that a change of this nature and the size of the change from the previous state based regulation into the national scheme, from 87 different bits of legislation to one piece of legislation, although we are three years down the track it is really relatively early. It is essentially a 10-year change process. We cannot compare an established 10 years plus the history of the New South Wales system against the early phases of the national and AHPRA system.

Dr DOUGLAS: Thank you.

CHAIR: We are hard against time and, as we do not have any burning questions, I thank you all for attending. Please thank your organisation for their submission to this committee. Thank you very much.

HERBERT, Adjunct Professor Cheryl, Chief Executive Officer, Health Quality and Complaints Commission

STITZ, Dr Russell, Commissioner, Health Quality and Complaints Commission

CHAIR: I welcome to the microphones Dr Russell Stitz, the Commissioner, and Professor Cheryl Herbert, the Chief Executive Officer, of the Health Quality and Complaints Commission. Thank you both for attending and thank you for your submission. Dr Stitz, would you like to give an opening statement of up to about 10 minutes?

Dr Stitz: I thank you for the opportunity to expand on our submission regarding the bill. The Health Quality and Complaints Commission fully supports the improved complaints processes outlined in the bill. We believe that the complaints and practitioner disciplinary action will be addressed in a more timely and effective manner as a result of that component of the bill. However, based on history and on the HQCC data we have identified a number of potential risks in the current structure of the bill. I need to go back through a bit of the history and forgive me if you already know all of this.

Between 1992 and 2006, in Queensland complaints were handled by the Health Rights Commission and when individual practitioner failures occurred those identified cases were referred to the respective boards. The HQCC Act was legislated in 2006 following the Forster review and the Davies Royal Commission, both of which addressed the system and practitioner failures which had resulted in a series of adverse outcomes at Bundaberg Hospital. We need to emphasise that the significant system and administrative failures at that time have been overshadowed by Dr Patel's errors, many of which could have been avoided by better health service processes. That is important to note.

As a consequence, the HQCC was designed to transition the complaints processes into the HQCC, but to add an external regulatory safety and quality role. There are two components. There is the actual practitioner component and there is the health service component, which is a system process. We know that approximately 10 per cent of adverse outcomes in health are related to practitioner failures and 90 per cent are related to system failures. The HQCC was designed at least to address that 90 per cent component.

The HQCC legislation is detailed and prescriptive in contradistinction to the current Health Ombudsman Bill. It enshrines the independence of the HQCC, which reports to the parliamentary committee. The HQCC has no punitive power, particularly to discipline health practitioners and that is appropriate. But it does have coercive powers to monitor health services and also monitor health practise in all of Queensland, not just in the public system. In other words, it is a holistic health care responsibility.

In particular, the HQCC legislation incorporates a statement that all health practitioners and all health providers in Queensland have a duty to improve health care. That is section 20. All of us have a duty to do that under the HQCC Act. The HQCC's access to expertise is also facilitated by a governing commission, which consists of the commissioner and assistant commissioners in its medicine, nursing, allied health, law, consumer matters and administration. In addition, the HQCC Act defines that there has to be a clinical and consumer advisory committee. In the bill that is currently before you, section 29 states that the Health Ombudsman may establish committees and panels to advise about clinical or health matters, but this is discretionary.

You have already heard about the National Law introduced into 2009, but I just need to expand on a couple of points for you. The Australian Health Practitioner Regulation Agency was an administrative agency to support the boards. Soon after the reforms were introduced, the Medical Board of Australia in particular immediately delegated the disciplinary and regulatory matters to the state board because it was believed that that was the best place to address practitioner failures.

New South Wales, as you have heard, were the exception to that rule and they kept their previous process, but I need to point out that a lot of those co-regulatory processes have been incorporated in the current bill. But bear in mind that in New South Wales there is a separately funded Clinical Excellence Commission to look at the broader health service, safety and quality issues. In the health reforms that were introduced in 2010, the Australian Commission on Safety and Quality in Health Care was given a responsibility for defining national standards of health care—not the standards of accreditation and training that is part of the registration process but the standards of delivery of health care, and currently there are 10 national standards. We were previously well ahead of that and we had nine standards in Queensland. We have retired six of those because they were redundant and synchronous with the national standards. So essentially in

the process of monitoring those standards the Australian Commission on Safety and Quality in Health Care will actually have accreditation processes of institutions that deliver health care, but they are not actually going to monitor the health outcomes. They will be accrediting processes. The HQCC currently has the authority to monitor health outcomes. That is not defined in the new bill.

Generally speaking, we have had a good relationship with AHPRA. We certainly had some practical problems initially, particularly in terms of duplication issues. AHPRA would often completely reinvestigate and have separate expert witnesses. There were timeliness problems and there was also a difference of opinion sometimes between the severity of the restriction that was placed on the health practitioner. It is fair to say that the two organisations had already progressed down the line of solving some of those issues, but this current bill will obviously be a solution for that particular component of it.

The following risks have been identified. Firstly, ensuring public accountability—that is, enshrining the independence of the Health Ombudsman in the legislation, and we will certainly expand on that for you, ensuring consumer and clinical advice and input at all levels of the Health Ombudsman's governance and operations. Secondly, measuring and managing healthcare risks across the whole of health care in Queensland—that is, we actually analyse and look for healthcare improvements. Complaints are an opportunity for improvement in health care, so we need to maintain that in the current legislation and we need to make sure that the Health Ombudsman is prescriptively able to monitor patterns of healthcare delivery so that we get better health care, or otherwise we run the risk of another Bundaberg in the future. Thirdly, safeguarding service levels and expertise. Currently because we are not transitioning directly our staff into the new organisation, the Health Ombudsman organisation, we are losing good people already because of that uncertainty. The CEO, Adjunct Professor Cheryl Herbert, will expand on these risks for you and propose some possible solutions which I think are very important. Thank you.

CHAIR: Thank you. Professor Herbert?

Prof. Herbert: Thank you. Firstly in ensuring public accountability, public accountability is core to an effective complaints management system. An independent and impartial Health Ombudsman is the cornerstone of the external health system governance framework. There is a potential with this bill and a perceived risk and conflict of interest inherent in the Health Ombudsman reporting to the Minister for Health, the minister responsible for Queensland's largest healthcare provider, both to this committee and to previous committees. Even under HQCC legislation there was public perception that at times HQCC was not independent, particularly as it sought its legislative change and any financial arrangements through the department of health or previously Queensland Health. I note that Mark Tucker-Evans was asked a question related to the independence. Just to maybe add some light to that, the bill as written contains conflicting provisions about the independence of the Health Ombudsman and the role of the minister. For example, the minister's role to oversee the performance of the Health Ombudsman in clause 18 is contrary to clauses 27 and 28, which provide that the Health Ombudsman must act independently and impartially. I think we have just outlined that that needs to just be reviewed.

Consumer complaints about health services offer an important opportunity for healthcare providers to reflect on and improve their services at an individual, practitioner, organisational and systemic levels. HQCC also recognises the importance of clinical advice and input to ensuring effective and fair decision making on healthcare complaints and identification of potential healthcare improvements. Modern health care is very complex, and changing rapidly with the introduction of new clinical services, procedures and definitely with technologies. There is so much about to happen. Expert clinical advice on the management of complaints and investigations is critical if the Health Ombudsman is to achieve the objects of the bill. While the bill, as written, allows for the establishment of advisory committees and panels noted in clause 29, it does not mandate these committees or panels and there is little guidance on their roles and functions. Our view is that these legislative mechanisms for consumer and clinical advice, input and engagement are essential for the government's aims and to ensure that the Health Ombudsman operates effectively. We note that a lot has been said this morning about discretionary arrangements. In our experience, this opens risks to the public. These need to be explicit in the legislation, not discretionary. We have found over seven years that the grey areas—ones that are open to interpretations—are inherently risky and very costly to ask for Crown law advice.

With regard to measuring and managing risk, the transition from the former Health Rights Commission to the HQCC following the events of Bundaberg in 2005 and the two major health systems reviews that followed, one of which I was very much part of in the evenings in my old position, focused on health practitioner and health systems failure. By contrast, this bill focuses on

practitioner complaints and a disciplinary approach rather than three key elements for an effective complaint management: resolution for the complainant and the healthcare provider, which is absolutely important; health service improvement at an individual level but at a health service and a health systems level; and disciplinary action, where appropriate.

Currently—I have outlined this previously to the committee—while awaiting the outcome of disciplinary action or where serious systemic health service issues arise, we, the HQCC, can require immediate remedial action through a quality improvement and action plan through section 20 of our act which requires all Queensland providers to establish, maintain and implement reasonable processes to improve the quality of their health services. Under the bill, should disciplinary steps be unsuccessful, the result may be that no action is taken to improve the health services at a practitioner level, at a service level or at a systemic level.

Health complaints entities across Australia and New Zealand regard HQCC legislation as leading the sector in quality improvement and identification of risks through complaints, patterns of individuals, of service and of systems. HQCC sees the removal of the legislative duty of a healthcare provider to improve their services as a major retrograde step for Queensland. Any move back to a reactive complaint management model with a focus on individual practitioners rather than investigating systemic failures again puts the community at risk of another health system failure such as the one that occurred in Bundaberg in 2005.

Finally, I want to talk about safeguarding service standards. While the bill stipulates that the Health Ombudsman is the legal successor of the HQCC, the bill makes no provision for the transition of staff of the HQCC to the Health Ombudsman. This presents the HQCC with considerable challenges in terms of maintaining a skilled and experienced complaint and investigation management workforce. There is no job where there is no job certainty. The HQCC has now lost six key personnel. Some 10 per cent of our workforce has gone since the Health Ombudsman was announced, and many more are signalling their intent to transition to other places. The implications for service standards and continuity are significant, with the risk that the HQCC will no longer be able to meet community demand for its services or legislated and strategic targets.

HQCC has significant expertise built over seven years in the health complaints management arena and is seen as an industry leader, especially, as I have said, in the areas of quality improvement and identification of risk to protect the people of Queensland. Presently, HQCC is not an integral part to the planning for the Health Ombudsman which is being led by the department of health. We recommend that HQCC's expertise be sought to build on its success and its learnings from the management of over 40,000 complaints and inquiries. HQCC does not support the bill as it presently is drafted, particularly the omission of the focus on the provider duty to improve and the lack of prescriptive consumer and clinical advice and also the lack of transition of well-known expertise of HQCC staff. Thank you.

CHAIR: Thank you. We will now have questions from the committee.

Mr HATHAWAY: Thanks very much for your presentation and your submission. The first recommendation in your submission refers to independence, and I think you cited clauses 27 and 28. Specifically, you are talking about direct reporting to the minister. Does clause 25, I think it is, or 26 indicate that the reports made to the minister are sequential as opposed to the parliamentary committee, or is it a concurrent reporting requirement?

Dr Stitz: As far as I am aware, it is not defined, and this is part of the problem with the legislation. It is a sort of a discretionary component whereas our current legislation is much more detailed. I think it needs to be defined, because, as Mrs Herbert said, we already have accusations that we are too close to the department of health. Patently we need to work closely with the department of health to get the best health standards and health outcomes. Nevertheless, it is important that we report and the new Health Ombudsman report to the parliamentary committee, because currently as it is structured if the minister does not like what the Health Ombudsman is doing he can stand down the Health Ombudsman.

Mr HATHAWAY: But it is a dual reporting process. So if you are providing a report to the minister and the parliamentary committee, which you are required to do under this proposed bill, you can provide those reports at the same time.

Dr Stitz: Indeed, and we do that now. Basically, that is not an issue. Sorry, I misunderstood the intent of your question.

Mr HATHAWAY: I am talking about the transparency and independence. In other words, what I am saying is that for the reporting processes this committee and inherently the minister would receive the report at or around the same time as you dispatch it.

Mrs MILLER: They are tabled.

Mr HATHAWAY: Sorry, as the Ombudsman dispatches it.

Dr Stitz: Yes, that is true. Just to clarify that, there is no question that that is the case and that they are tabled in parliament at the same time. That is not what we are talking about when we say that the independence is important; it is the direct control over the function of the Health Ombudsman by the minister alone. That will create risks for government because there will be a perception out there in the media et cetera that the minister is driving this process, and that can be solved fairly simply yet still achieve the aims of the legislation which, as we say, are quite laudable.

Ms BATES: Russell, it is nice to see you again. I would like just a bit of clarification. You mentioned before that the ACHS, whilst we all know it is involved in accreditation, does not currently monitor health outcomes. I just wanted a bit of clarification around that because the Clinical Indicator Program, which is part and parcel of your accreditation fee, can already generate reports now and show trending of comparative data for up to eight years retrospectively. Can you clarify what you meant by that?

Dr Stitz: Yes. When we talk about accreditation, it is a very complex and very resource intensive process, as you well know. What happens is that when you work in a hospital environment—and bear in mind that when we are talking about accreditation this is largely about hospitals—and you go through accreditation there is a flurry of activity amongst all of the clinicians as we try to get the processes in order so that we get the boxes ticked. That is not what I am talking about. What I am talking about and what we believe the HQCC currently does is that we look at the health outcomes for the patients themselves. So there are two components to it. Process is extremely important, and we need to have mechanisms to accredit it. But we also need to be monitoring the outcomes of the health care that we deliver, and we do not currently do that as well as we can.

Ms BATES: From my understanding, under the Clinical Indicator Program each hospital has that ability now. Whether or not they actually utilise it is another thing.

Dr Stitz: Correct.

Mrs MILLER: Thank you for your presentations here today. I take on board completely what you are saying about the independence of the Health Ombudsman, because what happens in a department, as anybody knows, is that any minister and any director-general can control exactly what is happening in any so-called independent commission or whatever through the budgetary processes. It is as simple as that.

In relation to clause 29 of this bill where it says ‘may’ be able to set up committees et cetera, I believe the reason they have ‘may’ in there is that committees cost money. Committees and councils cost money. So I would like your view in relation to that. As soon as a health ombudsman or a person sets up a committee, a council or whatever on any particular area it costs money to administer. It costs money to bring people in. It costs money for those meetings to occur. That is why it is set up as ‘may’ and not ‘must’. It is a cost-saving measure. So I would like your views on that.

The other part I would like your comments on is in relation to what happens in the United Kingdom of course where they have a separate quality assurance commission. So I would like your views on that. I think that you have done absolutely outstanding work in relation to quality assurance. Certainly the medical practitioners that I speak to want to see that continue. In the United Kingdom we have a health ombudsman and we also have a quality assurance commission. I think that that is extremely important, and I would like your position on that.

In relation to cost cutting and funding, can I just say that there is no such thing in government as cost neutral. Never in government is anything cost neutral. I think it has been quite deliberate in fact—

CHAIR: Is there a question?

Mrs MILLER: Yes, there is. Look, I am here asking the witnesses—

Mr HATHAWAY: Then ask the question.

Mrs MILLER: Excuse me. I will ask the question in my own time under the standing orders, and I am about to do that.

Ms BATES: Point of order, Mr Chairman.

Mrs MILLER: You don’t like the truth, do you? Someone who purports to be a nurse and isn’t.

Ms BATES: Excuse me.

CHAIR: Please.

Mrs MILLER: Not a registered nurse. You shouldn't be on this committee.

Ms BATES: Point of order, Mr Chair.

CHAIR: Go ahead.

Ms BATES: This is no place for party political rhetoric. It has absolutely no place in a bipartisan committee.

Mrs MILLER: It is not.

Ms BATES: And I personally take offence to the comments made by the member for Bundamba.

Mrs MILLER: It is true.

Ms BATES: It is also not the subject of this inquiry and I ask that you rule on that, Mr Chair.

CHAIR: I am going to ask you please to withdraw those comments.

Mrs MILLER: I will withdraw them but it is true.

CHAIR: I am going to ask you please—no, I am going to ask you to withdraw the comment. As is our standing orders, I am asking you to withdraw the comment.

Mrs MILLER: I will withdraw the comment. My question in relation to the staffing of the HQCC at present is: do you believe it is deliberate of this government, as it has been sacking thousands of nurses and health officials right across the state—that it is being deliberate in the sense of basically knackering the Health Quality and Complaints Commission in its role as it is currently under the legislation?

Ms BATES: Point of order, Mr Chair.

CHAIR: What is your point of order?

Ms BATES: My point of order is on relevance.

Mrs MILLER: It is relevant.

Ms BATES: The member is making hypothetical statements of which there is no basis in fact and have no relevance to the questions that she is putting.

CHAIR: I am not sure that last question is relevant.

Mrs MILLER: It is. It is relevant.

CHAIR: But I am going to leave Mrs Herbert—

Mrs MILLER: It is the legislation.

CHAIR: Excuse me. Mrs Herbert, if you do not feel comfortable answering that then you are quite within your rights to say so and not answer the last part of that question. I would also ask you to please move fairly quickly through that because we are well over time.

Mrs MILLER: You don't like it, do you?

Prof. Herbert: Regarding the committees, they do cost money but they are extremely valuable. We would like to see, rather than be discretionary, it made quite overt. You are correct: the UK does have the Care Quality Commission as well as the health ombudsman, and there is a health excellence commission in New South Wales as well as the HCCC. So there is great opportunity to make sure that quality is looked at as it is in many places. But our view is to recommend that the quality be incorporated into the Health Ombudsman Bill.

With regard to the staffing, I would say it is very easily remedied by looking at the transition arrangements for us at the moment to capture the staff before we lose them. My fear is that, because the ones who have moved already are going into new positions, they are not likely to apply to the new Health Ombudsman and they are experts in their field.

Dr Stitz: Chair, could I just make one quick comment about the Care Quality Commission in the UK? It has had its problems recently, as some of you probably know, where it has not been performing all that well, and I think it absolutely emphasises the importance of having a parliamentary committee, for example, that oversees these bodies. We at times get quite irritated by what we are asked to do by the parliamentary committee. But, having said that, it is a very important part of good governance that we are kept honest, if you like, in what we are doing and how we are actually using the resources that are available to us because they are finite, as you well know.

CHAIR: Thank you. Mr Shuttleworth, I will take one more and that is it.

Mr SHUTTLEWORTH: In respect of the advisory panels or committees, I seem to recall in one of the last reports that was submitted that the referral to third parties was at least in part a significant contributor to the delay in the resolution of a complaint. I am just wondering what you would recommend in terms of ensuring that if advisory committees were in place how we might compress that?

Dr Stitz: I will make a quick comment if I may, and then maybe Mrs Herbert can you give some detail. There are two different issues. One is actually a case where you are trying to interpret the actual performance of an individual practitioner. Then you need an expert witness who is a peer of that particular practitioner. For example, there is no point in asking a surgeon how a GP performs. That is inappropriate. There is no point in having a regional doctor's performance assessed by a teaching hospital, for example. So that is one issue. The other issue is the wider issue of quality health care in the community, where you need both consumer and clinical input to the governance and the direction, if you like, of where we can improve that health care.

Prof. Herbert: I would just add finally that the sort of advisory panel we are talking about could be an amalgam of clinical and consumer input, as the Energy and Water Ombudsman has—your industry and your consumer input—and I think Mr Tucker-Evans outlined that he had been a member of that. It assists in views that are almost bipartisan across the industry and consumers and it gives a bit of health to decision making.

CHAIR: Thank you. I am going to end this here. Thank you for your submission and thank you for attending today. I now call Dr Michael Cleary, Deputy Director-General, Health Services and Clinical Innovation, and Mr Paul Sheehy, Director, Special Legislative Projects from Queensland Health to the table.

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

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

CHAIR: Dr Cleary and Mr Sheehy, I invite you to make some opening comments.

Dr Cleary: Thank you for the opportunity to appear before the committee again today. The department welcomes the submissions forwarded to the committee by interested stakeholders, and we have had the opportunity to review those. I might just make some general comment first though based on the feedback that you have had from some of the recent groups—in particular the feedback from the national board, the Medical Board of Australia, and AHPRA. Prior to coming here this morning, I have just spent an hour with AHPRA and the national board working with them on the arrangements that they currently have in place to manage the board's functions in Queensland, and that has been an ongoing arrangement that we have had in place for some time. So I was wanting to say that to reassure the committee that there is in fact a very good working relationship between the department of health, as it is now known, and AHPRA, the Medical Board and the HQCC. In terms of the issues raised in the submissions and presentations to the committee, these reflect the issues that we also identified in our two rounds of consultation with the community and stakeholders around the development of the legislation.

The other thing I would state before going on to talk about the specific issues that we have talked through is that this legislation should not be seen in isolation to other legislation that is in place in Queensland. In particular, there has been the introduction almost a year ago now, or a little longer, of the Hospital and Health Boards Act, which created the hospital and health boards as independent statutory bodies and set up the system now for the department of health to have a much more regulatory role rather than the operational role in managing and directing the delivery of health services as it previously did. So the department of health has moved to be a system manager, which has many functions that are akin to a regulatory role as opposed to what was previously the case, which was a direct management role.

We also have the Private Health Facilities Act, which provides oversight of private health facilities in the state. That act creates a substantial role for the Chief Health Officer as the person who is accountable for the management of private hospitals in the state. The reason I mention that is that both of those pieces of legislation provide for that regulatory function to be undertaken by the senior officers—the Chief Health Officer and the director-general—in terms of the management of service provision at that level in both the private and public sector.

I would like to now go on if I could to make some comments in relation to the themes that came through in the submissions to the committee—firstly, the independence and accountability. Some stakeholders have expressed concern about the independence of the Health Ombudsman and expressed the view that the Health Ombudsman should report directly to parliament. The legislation does not in any way compromise the independence of the Health Ombudsman. The Health Quality and Complaints Commission already enables the minister to direct an investigation or inquiry to be undertaken, and this power is replicated in the proposed legislation. Nothing really has changed in that regard.

The ability of the minister to require information to be provided to the minister to allow the minister to oversee the performance of the office of the Health Ombudsman and the performance of the health complaints process in Queensland is also very important. This function is fundamental to the accountability within the system falling to the minister. Removing ministerial accountability and having the Health Ombudsman report directly to parliament would substantially reduce the level of accountability of the health complaints management system.

Secondly, I refer to clinical input. Some stakeholders have raised concerns about how the Health Ombudsman will obtain clinical advice in undertaking investigations and actions under the act. The Health Ombudsman needs to be flexible and able to obtain advice in the best way possible. This advice may be provided through established panels of clinicians, by establishing committees for particular purposes or by directly seeking advice from specialist staff or clinicians.

The legislation should not constrain the Health Ombudsman in this regard. The Health Ombudsman would, of course, be a very senior person of standing in the community. The Health Ombudsman would establish such committees as are deemed necessary. The act provides a facilitatory mechanism for that to occur. The Health Ombudsman would also be seeking clinical

advice around clinical matters. I would expect a senior member of the community with standing would be doing that automatically. But again, the legislation is set up to provide a facilitatory arrangement rather than a more prescriptive arrangement.

Thirdly, I would like to talk a little bit about the concerns around taking immediate action. Some stakeholders have expressed concern that the bill will give powers to the Health Ombudsman to take immediate action in relation to a health practitioner if it is deemed necessary to protect the public. This power is very similar to the power the national boards have under the Health Practitioner Regulation National Law and the state boards formerly had under the previous Health Practitioners (Professional Standards) Act. In this regard, the power is not new.

The bill provides that generally there would be a show-cause process before action is taken. However, if it is necessary to protect the public in exceptional circumstances the Health Ombudsman can take immediate action prior to the show-cause process commencing. The Health Ombudsman needs the discretion to take immediate action and to do so without the show-cause process if it is necessary—and I refer to clause 3 in the bill—to protect the health and safety of the public.

Fourthly, I refer to publication of immediate action. Some stakeholders have expressed concern that the bill will enable the Health Ombudsman to publish information about immediate action taken. The Health Practitioner Regulation National Law requires the fact that a registrant has been suspended and the period of suspension to be recorded on the national register. That is in place now. Details of the conditions placed on a registrant must also be placed on the register unless it relates to an impairment matter in which case the national board may only record the fact that there are conditions imposed but not the details of those conditions. Placing relevant information on the Health Ombudsman's website, for example, where immediate actions and decisions have occurred consequential to the Queensland Civil and Administrative Tribunal, will just make this information more available to the public. It is already available through the department of justice website.

I will quickly summarise some of the material which I talked about at the last presentation and which relates to the reason we are here. The Chesterman report noted that there are indications that the Queensland Board of the Medical Board of Australia may not have adequately responded to the substance of complaints and may too readily have found complaints to be unsubstantiated. I would note that the Queensland Board of the Medical Board of Australia is a committee of the Medical Board of Australia and undertakes its activities as authorised by that board.

One of the recommendations of the Chesterman report was to commission further investigations to determine whether the Queensland board had made timely, appropriate responses to complaints. The subsequent report by the three-member panel, led by the Dr Kim Forrester, concluded that 363 of the 596 files they examined—that is about 60 per cent—were not handled in a manner that was timely, appropriate or in compliance with the legislation. In one case a matter took 6½ years to be finalised. The panel concluded, in relation to matters dealt with under the national health practitioners act, that the outcomes were neither consistent nor predictable based on the nature and clinical significance of the complaints and that the processes of the board failed to protect the public, uphold the standards of practice and maintain public confidence as required under the health practitioners act. The panel also concluded that matters dealt with by the Queensland board under the Health Practitioner Regulation National Law were also of concern. The processes followed by the board in these cases did not meet the reasonable expectations that notifications are consistently and predictably dealt with in a timely manner. There were a number of examples where serious notifications indicated that the public was at risk of harm and were not handled with the urgency that was required under the circumstances.

I will move on to close. As indicated in the department's previous presentation to the committee, the Health Ombudsman Bill will overhaul the health complaints management system in Queensland, with the key objective being to better protect the health and safety of the public. Again I go back to clause 3 in the bill. The bill achieves this in a transparent and accountable way. I am happy to take questions from the committee however I might hand over to Mr Sheehy to comment on some of the technical provisions in the bill.

Mr Sheehy: I would like to take this opportunity to clarify some matters that were raised in the presentations here today. There were a number of policy issues that were raised which Dr Cleary has responded to. There were also some ongoing misunderstandings about the legislation which I would like to address.

In relation to setting the prescribed conduct documents, I point out that they are made by the regulation under clause 288. There is that oversight by the parliament. There was some suggestion that they were made only by the minister. They are actually endorsed by regulation so there is parliamentary oversight.

Mrs MILLER: After they are made.

CHAIR: Excuse me; there will be time to ask questions. I have asked for opening statements.

Mrs MILLER: Yes, fair enough, but it is after the regulation is made.

Mr Sheehy: If I can complete my response you will perhaps understand the provisions better. Health practitioners are bound by the national board codes that are put out. That will continue to apply. Nothing has changed. The clause in the bill specifically refers to national standards. What we need to recognise is that the bill goes beyond registered practitioners. It does cover unregistered practitioners and also organisations.

In relation to organisations, we have the national standards put out by the Australian Commission on Safety and Quality in Health Care. They have been endorsed nationally by health ministers. So they could well be endorsed by regulation under clause 288. There are also discussions nationally in relation to having a code of conduct for practitioners that are not registered which is similar to that in New South Wales. Again that could be a matter which is prescribed by regulation under this section. It is more than registered practitioners. To the extent that registered practitioners are currently covered by standards and codes, that will continue.

Concern was expressed about QCAT time frames. That is a matter that QCAT is aware of. There was a backlog of matters presented to QCAT in 2011. That has caused some of the delays. They are aware of that. They are addressing it. The issues in relation to QCAT time frames would apply regardless of whether this bill were in place or not.

There was comment made about the removal of the stay of a decision for immediate action that is currently in place under the Health Practitioners (Disciplinary Proceedings) Act. There has been no change in that regard. A comment was made about the cost of taking on the responsibility for unregistered practitioners given the large number of practitioners who are not registered. The Health Quality and Complaints Commission can currently receive complaints on these matters. The issue is that they cannot take action—they cannot go to QCAT. There has been a national regulatory impact statement undertaken that has concluded that there may be in Queensland something like five or fewer matters that would actually go to QCAT. It was on that basis that the statement was made that the resource impact would be modest. A statement was made that under the provisions a full investigation report in relation to a registered health practitioner could be published. That is not the case. The bill specifically says that if an investigation report is prepared to go to QCAT then it cannot be published.

Questions were raised about an employer being notified before the employee knows about action or has a right of reply. I need to be clear here. There are two instances in which an employer can be notified. The first is in relation to immediate action. There has been discussion around the show-cause process for that. The other way employers are notified is if an investigation has commenced in relation to a serious matter which is a matter which may lead to the suspension or deregistration of a practitioner. In that case, in all likelihood, it would have gone through an assessment process to get to the investigation so certainly the practitioner would have been aware of it and would have had an opportunity to respond as part of the assessment process.

Comment was made that prosecutions alone will not fix the issues. The bill certainly recognises that. There are additional provisions in relation to taking action before QCAT. With one exception, all of the powers that the HQCC currently has are in that bill. The only matter that is not included is the ability to set standards which has been substituted by the prescribed conduct documents. All the existing powers that the HQCC has in relation to undertaking investigations, including dealing with quality matters, are in this bill. It is presented differently—and that is a clear government intention given the issues that Michael Cleary has raised around the problems with the current health complaints management system. It is a matter of emphasis and presentation.

I will respond to the committee member's issue around the administration arrangements order. I would draw the attention of all committee members and those here today to clause 27 of the bill. It is very clear and explicit that the Health Ombudsman is to act independently, impartially and in the public interest. It is a very clear statutory statement. No-one can influence or direct the Health Ombudsman other than in three circumstances. Two of those—investigation and inquiries—are currently in the HQCC Act. There is nothing new there. The third issue relates to requiring information for a minister who is accountable—and the parliamentary committee would have a role.

It is a standard ability to obtain information to enable monitoring functions to occur. I think the concerns around independence are quite misplaced. As I say, the bill is very explicit—other than for those three matters I mentioned; two of which exist currently—that the Health Ombudsman is not subject to the direction of any person.

Issues were raised about fees. As Martin Fletcher indicated, the bill provides that the funding transfer is based on the costs that would have been incurred if APRA had continued to perform these functions and the bill had not commenced. On that basis, the current process for setting fees would continue. There would be no difference in terms of how Queensland is treated under that model. The issue would be about the quantum of funding that went from the APRA to the state.

Issues were also raised about the ability of the Health Ombudsman to monitor health outcomes and the duty to improve quality. All the powers that had HQCC currently has to obtain information, produce reports, do follow-up reports are there. In fact in one case the powers have been strengthened by making it an offence to require a party to respond to a request for implementation. All those powers are there. The duty itself is not there. From a legislative perspective its value is not clear. The duty is to improve quality. It does not set a minimum standard of quality or a benchmark of quality. That duty has been used as a trigger for subsequent action and all those other actions are in the bill.

Comments were made that it may not be possible to take action against organisations. Again I repeat: all the powers that the HQCC has in relation to organisations are in this bill. That will be my response.

CHAIR: I am going to open up questions to committee members. I simply remind you that Schedule 3(o) in our standing orders identifies that 'A committee shall not ask an officer of a department of the Commonwealth or the State to give opinions on matters of policy...' If I feel that that is being done, I will simply rule that question out of order. I call Mr Hathaway.

Mr HATHAWAY: Thank you very much for your presentation to the committee. I am going to ask a question with reference to the mandatory notification requirements. Specifically, a number of the submissions, largely from all the peak clinical bodies—not all, but most—indicated that the exemptions, a la towards the Western Australian model, did not go quite far enough. Can you tell me when framing the legislation why the department did not look at adopting the Western Australian model?

Mr Sheehy: In the government's view, the Western Australian model would go too far. For example, if a practitioner is treating a health practitioner for any matter, whether it is an impairment matter, an injury or whatever the case may be, the exception applies. Secondly, if there were matters raised about professional misconduct there is no obligation to report, and that professional misconduct may or may not be related to the impairment. Any matter could be raised. The discussion between the treating practitioner and the other practitioner is totally closed in terms of the mandatory notification provisions.

What the bill does is focus on the specific problem that was put to us by the medical groups, that is, to encourage health practitioners who want to go forward and do the right thing and clear up their impairment problem, it gives them an incentive to do it. Essentially, if a practitioner comes forward and says, 'I want to get rid of this problem, I want to go on a program and perhaps limit my practice or whatever needs to be done', if the treating practitioner forms the view that there is no serious risk to the public then there is no obligation to report. The government has made it quite clear that if a matter of professional misconduct comes up, then that does not need to be reported, because that is the most serious matter of conduct and that should not be excluded.

Mr HATHAWAY: Dr Cleary?

Dr Cleary: This was a matter that we had extensive discussions with the various stakeholder groups around. Personally, as a medical practitioner I think is a very balanced position to have taken. It is obviously a government policy position, but I believe it is a very balanced position. It also is consistent with, again, clause 3 in the bill, which is to protect the health and safety of the public and that is the overriding requirement. I think the provision that has now been developed really ensures that the protection of the health and safety of the public is the bar that really has to be reached. Then, if that is not going to be compromised, there are provisions that allow for variation in the notification process, but it really does come back to the protection of the health and safety of the public.

Mrs MILLER: What is the staff establishment of the proposed Health Ombudsman's office?

Dr Cleary: The process that we are entering into from here is to establish a project, if you like, to transition from the current arrangements to future arrangements. The specifics around the staffing for the Health Ombudsman's office will be developed as part of that, as will many of the other matters that have been discussed with the committee today. We have already commenced some discussions with both AHPRA and early discussions with the Health Quality and Complaints Commission around the sorts of things that should be considered as part of that transition.

The only other thing I could probably add would be when we had the opportunity to visit the commission in New South Wales, which is a co-regulatory jurisdiction and has a similar arrangement, they have a staff of about 75, which is very similar to the current staffing in the Health Quality and Complaints Commission in Queensland, but their distribution of staff across the various internal units is different. They have 12 or 15 staff, I think, in the assessments and intake area, about 15 to 18 in the conciliation team, I think about 12 or 15 in the investigations team and a number of lawyers in their prosecutions team.

I think it is a body of work that we will need to do as part of our implementation. We will be appointing a project director shortly to start the planning and the necessary activities to allow that transition to occur, one of which is the identification of an appropriate staff structure and to put that back to us to look at.

Mrs MILLER: It just seems amazing to me that it can be claimed that this legislation is cost neutral, whereas being a former public servant I know that there is normally an implementation plan that goes forward in relation to any new legislation, so I find your answer very 'Sir Humphrey'. But I will go on. In relation to the Health Quality and Complaints Commission, have there been any discussions in relation to transitioning officers from the HQCC across to this proposed new organisation, given the fact that the HQCC has a lot of staff leaving because there is no certainty?

Dr Cleary: There have been discussions with the HQCC around the provisions of the legislation and that has been a broad-ranging discussion around how will we transition the information systems or documents through to what may happen with—

Mrs MILLER: My question is in relation to staffing.

CHAIR: He is getting to it.

Dr Cleary: Certainly we did discuss the staffing arrangements. The government's policy position is that this is a new statutory entity and a statutory authority and will be established as part of that arrangement. The current government policies and guidelines will apply in the establishment of that arrangement. As you have heard this morning, and I was in the committee when it was identified, the HQCC has quite a substantial knowledge base in terms of management of complaints. There may be, however, a different skill set required in terms of the balance of the way the Health Ombudsman's office is established. There are certainly new functions to be established, such as the prosecutions area where that will need to be looked at. But I think this is, again, a body of work that will be considered as part of the transition planning that will be undertaken.

Mrs MILLER: Just in relation to this bill, if it does become an act, when do you think that the act will be proclaimed and, therefore, that the Health Ombudsman will be functioning and working?

CHAIR: Dr Cleary, if you are uncomfortable answering that, you can let that go.

Mrs MILLER: He knows the answer.

Dr Cleary: I was just about to say that the proclamation of the legislation is obviously a decision for government. However, this is a complex area and the transition planning that we will be doing will no doubt identify what the steps would be to have an effective transition and that will, I believe, then inform government's decision around the date for proclamation. I would also suggest, but it will be part of the transition planning, that there will necessarily be a ramping-up stage, which will be an incremental establishment of the various functions of the Health Ombudsman subsequent to the act being considered by parliament, of course, and a reciprocal change in perhaps the functionality of the HQCC as that occurs.

I think, just from my perspective, this transition planning is going to be very important. The transition plan needs to be well thought through and it will be developed in consultation with both AHPRA, the boards and the HQCC. That will be the document that we will look at to define a whole range of the matters or clarify many of the matters that have been raised here today. In particular, it will identify when the proclamation would be able to be considered.

Mrs MILLER: Finally, Mr Sheehy, you spoke about the administrative arrangements. It is right, of course, that this particular bill, if it becomes an act, particularly given that the AMAQ and the Nurses Union and hardly anyone thinks it is worthy, in relation to the administrative arrangements it will be under the Minister for Health as normal?

Mr Sheehy: That is a matter for the government. We have not heard otherwise.

Dr Cleary: Just in terms of the AMA, subsequent to our last meeting, I think, we had the opportunity to meet with the AMA and with some of the medical defence organisations. At that meeting I think the AMA presented 25 areas—sorry, it was prior to the bill coming to the committee, but just prior to. At that meeting, they presented 25 areas that they thought would be worthy of consideration for the minister. Of those areas, I think the minister's office agreed that about 15 were worthy of consideration and made modifications to the draft that had been provided to the AMA and five others where modifications were made but not to the level proposed by the AMA. From my perspective, I think there has been a very comprehensive level of consultation with key stakeholders such as the AMA and the medical defence organisations.

Mrs MILLER: And they are still unhappy.

Dr Cleary: For them to have received support for that level of change in the draft bill I think is a substantial matter.

Mrs MILLER: And they do not support the bill.

CHAIR: I am going to go to Mr Shuttleworth, please.

Mr SHUTTLEWORTH: Thank you, Chair. Dr Cleary, a lot of the submissions made earlier this morning were around concerns in relation to immediate actions, publication of documentation and so forth. How do you see clinicians or professional bodies being protected to some degree from vexatious claims?

Dr Cleary: In terms of the practicalities of the operation of the bill, the bill provides for the Health Ombudsman to not take on a complaint. The Health Ombudsman may receive a complaint, determine that it is not appropriate to progress with and may discontinue the complaint at that time. In New South Wales, I understand the health ombudsman there would close approximately 25 per cent of their complaints within a week. That is not that they have not taken them on, but they have either referred them to another agency to manage because that is more appropriate, and there are a small number there that the health ombudsman determines would not be appropriate to proceed.

It may also be worthwhile to outline for the committee how that occurs. In New South Wales, the Commissioner—I may have made an error before in referring to the ombudsman, but the Commissioner in New South Wales forms a panel each week around medical complaints and that panel includes a representative from the equivalent of the medical board, which is a council in New South Wales. They consider all of the matters that have been raised that week. They make a determination at that time as to how they should be progressed. That includes identifying any complaints that are considered to be matters that do not need further investigation.

Mr SHUTTLEWORTH: This is more of a statement, I guess: therefore, what we had referred to previously of our understanding that by satisfying those minimum standards and a concern for significant public safety, those particular clauses would significantly address those areas of concern and the Ombudsman may well draw upon all of that and not proceed to that immediate action.

Dr Cleary: That is correct, yes.

CHAIR: We have gone well over time, but we have time for one more line. Dr Douglas, that is up to you.

Dr DOUGLAS: Thank you, Michael, for the detail you have given us here today and previously. My question is typically medical. Earlier, you talked about the efficiency of process. You have raised the two issues which are salient, where you spoke about the Chesterman report and the report about the board. Then you spoke about what the profession was seeking. There are two broad assumptions that I am having trouble reconciling. One broad assumption has to be laid against the fact about the minimum reporting requirements. Statistically, the most recent reports in all the journals state there has been less reporting since the type of changes that we have had recently, so people are being reported less. The second assumption is that under this process the public or the consumer will be making, effectively, more complaints because the medical people are making less. I would have to say that that is a very broad assumption and it may mean that—forget all the transition stuff that was raised very elegantly here today by Professor Herbert and Dr Russell Stitz in excellent presentations—the problem you will be left with is no efficiency of process. The

legislation may actually paralyse us more because the assumptions we are making are very broad. The idea that consumers, in an increasingly complex world, will be able to understand the complaints is a very broad one. Have you thought about that?

Dr Cleary: Yes. I think the change we will see is that, instead of multiple entry points into the system for complaints, there will be this single entry point for complaints, be they complaints from health practitioners, which come forward in the way of notifications, or complaints from patients or consumers about the services that they have received. Having a single entry point with a clear structure around the triage of those complaints, early assessment of the complaints and, from my experience in New South Wales, that usually results in the matters being considered at a very early stage, so in that first week for health matters. If you were to look at the report undertaken by Dr Forester, I think that the way complaints were managed when they went through the medical board often were that they were received, assessed, they went to an assessment panel, they may have gone to an investigation panel. The first that the board may have seen of a complaint was quite some time down the track. One of the things that we have been talking with Dr Flynn about today is how, in the next few months, for example, we bring forward that assessment by the board so that the board can make an assessment of a complaint very early on, rather than waiting for a process to be undertaken for the information to be presented to the board.

I apologise for the long answer, but I think there are two key themes in this. One thing is having a single entry point for all complaints so that they can be managed in the standard process and managed as efficiently as possible. The second is early and active management of matters, rather than having a process that is followed before a decision can be made. It is having a clear and appropriate assessment done, but then having early management of those matters. Both of those types of arrangements, I think, will lead to reduced resource consumption in the complaints management system.

Dr DOUGLAS: As doctors, sometimes problems seem superficial but they are often more complex. Does that inherently mean that problems may well then be treated in a very superficial way, because of this timely almost rushing-it process, as opposed to addressing the issue? Russell raised it very elegantly. Of problems, 90 per cent are systemic. To identify a systemic problem, you have to dig into the problem. You have to really give it time and thought. Are we pushing that envelope so hard that that is possibly what will happen?

Dr Cleary: I don't believe so because, if I use the New South Wales model, the New South Wales model is that if there is a matter relating to a health practitioner the council's representative at that regular meeting has with them the council's records on the health practitioner, so that there can be a comprehensive review of, if you like, the history of the practitioner's practice, as well as consideration given to the matter that is on foot, so whatever the current complaint is. I think as Dr Stitz has indicated before, often it is not just the particular matter that has arisen that gives the indication that there is something more complex going on, but often the history of a particular practitioner's practice. I think again Dr Stitz has published some work or been a co-author of some work recently showing that if there are four complaints about a particular practitioner, then that is when there needs to be some further and more detailed considerations. That is probably just one example, but I would agree with you: I think it is very important to have a very carefully considered review process. The aim would really be to identify those things that need immediate action, those things that can be progressed or referred to other agencies without a more complex review and then there will be a number that do require further review and investigation. They are the ones that I think would then progress through to the assessment and investigation phases.

CHAIR: Thank you, Mr Sheehy and Dr Cleary. The time allocated for hearings has now expired, so I draw these proceedings to an end. Thank you, Hansard, all the witnesses and those attending today for obliging us with an extension of time. On behalf of the committee, I thank all witnesses for their attendance today. We appreciate your assistance. To committee members, I thank you for your attendance. Although the conversation was robust at times, that is democracy in action. Thank you all. I declare these hearings closed.

Committee adjourned at 1.20 pm