Parliamentary Committees



Health Transparency Bill 2019

Report No. 27, 56th Parliament
Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee
October 2019

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

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Acknowledgements

The committee acknowledges the assistance provided by Queensland Health and the Office of the Health Ombudsman.

[1] On 9 October 2019, the Member for Logan, Linus Power, attended as a substitute member of the committee for the Member for Rockhampton, Barry O'Rourke MP, for the committee's public hearing and briefing relating to the Bill.

Contents

Abbreviations

AHPRA	Australian Health Practitioners Regulation Agency
ACQSC	Aged Care Quality and Safety Commission
AMA	Australian Medical Association
Bill	Health Transparency Bill 2019
committee	Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee
Explanatory notes	Health Transparency Bill 2019, Explanatory Notes
HCQ	Health Consumers Queensland
HHS	Hospital and Health Service
LASA	Leading Age Services Australia
LSA	*Legislative Standards Act 1992*
MIGA	Medical Insurance Group Australia
Minister	Minister for Health and Minister for Ambulance Services
OHO	Office of the Health Ombudsman
PSA	Pharmaceutical Society of Australia
QCAT	Queensland Civil and Administrative Tribunal
QLS	Queensland Law Society
QNMU	Queensland Nurses and Midwives' Union
RACFs	Residential aged care facilities

Chair's foreword

This report presents the committee's findings from its consideration of the Health Transparency Bill 2019.

The benefits of transparency in public health care information are widely reported. During this inquiry, the committee was left in little doubt as to the widespread support for the introduction of measures that would shine a light on public and private health and aged-care facilities in this state.

This Bill deals with the welfare of elderly Queenslanders and one of the most important ingredients for safe, dignified and professional care of our elderly in nursing homes – its staff.

For residents living in nursing homes, staff are like family and are often the only people they have close daily contact with, and the amount of contact time they have with staff is critical to their welfare.

When operators short-staff their facilities or don't employ staff with the right skill set, it impacts on the health and welfare of both the residents and the staff. The committee has seen this first-hand during our Inquiry into Aged Care, End-of Life and Palliative Care and Voluntary Assisted Dying and in our investigation into the recently closed Earle Haven aged care facility at Nerang.

The Health Transparency Bill provides for the first time a system to set minimum contact hours for residents and skill mix ratios in nursing homes operated by the Queensland Government. It also provides the opportunity for privately run facilities to make staffing information accessible to everyone. These important reforms will help to ensure operators in Queensland are accountable for the staffing decisions they make. It will also help to ensure residents receive the one-on-one time with staff they need and are entitled to.

The benefits of greater transparency in this space are self-evident. I therefore take exception to comments by the Commonwealth Department of Health, that the Bill and draft regulations:[2]

> *… create a reporting burden on providers, with no clear benefits to consumers.*

I encourage all Honourable Members to read the Commonwealth department's letter.

This Bill also takes steps to improve the operation and efficiency of Queensland's health complaints system. The committee welcomes the implementation of the proposed amendments to the Health Ombudsman Act.

On behalf of the committee, I thank those individuals and organisations who made written submissions on the Bill and who gave evidence at the committee's public hearing.

[2] Australian Government Department of Health, 2019, Correspondence to Queensland Health, 9 August 2019, Tabled Papers Database ref. 5619T1303.

I also thank my committee colleagues, departmental officials, and parliamentary service staff for their professional support throughout.

I commend this report to the House.

Mr Aaron Harper MP

Chair

Recommendations

1 Introduction

1.1 Role of the committee

The Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee (committee) is a portfolio committee of the Legislative Assembly which commenced on 15 February 2018 under the *Parliament of Queensland Act 2001* and the Standing Rules and Orders of the Legislative Assembly.[3]

The committee's primary areas of responsibility include:

- Health and Ambulance Services
- Communities, Women, Youth and Child Safety
- Domestic and Family Violence Prevention, and
- Disability Services and Seniors.

Section 93(1) of the *Parliament of Queensland Act 2001* provides that a portfolio committee is responsible for examining each bill and item of subordinate legislation in its portfolio areas to consider:

- the policy to be given effect by the legislation
- the application of fundamental legislative principles.[4]

Further information about the committee can be found on the committee's website.[5]

1.2 Bill referral

The Health Transparency Bill 2019 (Bill) was introduced into the Legislative Assembly and referred to the committee on 4 September 2019. The committee was to report to the Legislative Assembly by 18 October 2019.

1.3 Inquiry process

On 6 September 2019, the committee issued a call for written submissions on the Bill. Submissions closed on 19 September 2019. A total of 19 submissions were received. A list of public submissions is provided at **Appendix A**.

Queensland Health provided the committee with a written response to the key issues identified within the submissions. The correspondence is available on the inquiry webpage.

The committee received a public briefing about the Bill from Queensland Health and the Office of the Health Ombudsman on 16 September 2019. A second public briefing took place with Queensland Health on 9 October 2019. A list of officials attending the briefings is provided at **Appendix B**.

The committee conducted a public hearing in Brisbane on 9 October 2019. A list of witnesses who appeared at this hearing is provided at **Appendix C.**

All inquiry related documents including: submissions, correspondence, transcripts of briefings and the public hearing, tabled papers, questions on notice, are available on the inquiry webpage.

At the time of reporting, the committee was also conducting an inquiry into aged care, end-of-life and palliative care and voluntary assisted dying. This report deals with information related to the Health Transparency Bill only.

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3 *Parliament of Queensland Act 2001*, section 88 and Standing Order 194.

4 Schedule 6, Standing Rules and Orders of the Legislative Assembly.

5 See: https://www.parliament.qld.gov.au/work-of-committees/committees/HCDSDFVPC

1.4 Policy objectives of the Bill

The main purpose of the Bill is to improve transparency in public and private health facilities, and in residential aged-care facilities (RACFs), and to amend the *Health Ombudsman Act 2013* in order to improve the operation and the efficiency of the complaints health system.

The Bill sets out three key objectives:

- establish a legislative framework for collecting and publishing information about public and private hospitals and RACFs
- amend the *Hospital and Health Boards Act 2011* to introduce a minimum nurse and support worker skill mix ratio and minimum average daily resident care hours in public RACFs
- amend the *Health Ombudsman Act 2013* to implement recommendations of the Health, Communities, Disability Services and Domestic and Family Violence Committee's Inquiry into the performance of the Health Ombudsman's functions pursuant to section 179 of the Health Ombudsman Act 2013.[6]

1.5 Government consultation on the Bill

Government consultation undertaken for each component of the Bill is discussed below.

1.5.1 Reporting by public and private health facilities

As set out in the explanatory notes, consultation on the establishment of a reporting framework took place with a range of external stakeholders:

> *… operators of private RACFs, private health facilities, Private Hospitals Association, Leading Aged Services Australia (Queensland), Aged and Community Services Australia, Council on the Ageing, Carers Queensland, Health Consumers Queensland, Queensland Nurses and Midwives' Union (QNMU), Australian Medical Association (AMA) Queensland, Aged Care Quality and Safety Commission, the Heart Foundation, and Primary Health Networks were consulted on the proposed reporting framework.*[7]

The explanatory notes advise that 'many stakeholders were supportive of improving transparency of health care quality through public reporting'.[8]

However, it was acknowledged that some stakeholders suggested that further consultation was required on the specific information to be reported, that the proposal will impose an additional administrative burden on clinicians and hospitals, and that reporting certain information may lead to the identification of clinicians and patients.[9]

The explanatory notes acknowledged that private hospital stakeholders were concerned about the publication of commercially sensitive information, and that some stakeholders had sought clarification on how information would be reported in the framework.[10]

1.5.2 Reporting residential care information

In regards to reporting residential care information, the explanatory notes state that while some stakeholders, such as Health Consumers Queensland (HCQ) and the Queensland Nurses and Midwives'

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6 Queensland Health, Public briefing transcript, Brisbane, 16 September 2019, p 1.

7 Explanatory notes, p 19.

8 Explanatory notes, p 19.

9 Explanatory notes, pp 19 - 20.

10 Explanatory notes, pp 19 - 20.

Union (QNMU) were supportive, 'RACFs and aged care stakeholders were generally not supportive' of the proposals.[11]

The explanatory notes acknowledged the following stakeholder issues:

- *aged care was a Commonwealth responsibility and reporting requirements would pose an additional burden on RACFs*
- *reporting arrangements would duplicate existing Commonwealth requirements or overlap with potential recommendations from the Royal Commission into Aged Care Quality and Safety*
- *multiple factors, including patient acuity and models of care influence the delivery of care in RACFs and the reporting of 'average daily resident care hours' would not provide consumers with a clear understanding of a RACF's service delivery*
- *the Act should require RACFs to report more information to provide consumers with a comprehensive view of residential aged care services in Queensland.*[12]

1.5.3 Amendment of the Hospital and Health Boards Act to introduce minimum aged care ratios

The explanatory notes advised that Hospital and Health Services (HHSs) and the QNMU were consulted on the proposed amendments to the *Hospital and Health Boards Act 2011*. The notes also state that the QNMU supported the legislative framework for aged care ratios generally and provided general comments about the definitions in the legislation.[13] The explanatory notes do not provide information on feedback received from the HHSs.

1.5.4 Amendments to the Health Ombudsman Act and Health Practitioner Regulation National Law

The explanatory notes state that, the Australian Health Practitioners Regulation Agency (AHPRA) and the Office of the Health Ombudsman (OHO) were consulted during the development of the reforms relating to the consideration of joint matters and reducing the splitting of matters. Queensland Health worked closely with the Health Ombudsman to develop other reforms in the Bill.[14]

The explanatory notes advise that draft amendments were circulated to 'a wide range' of stakeholders in June 2019. This included peak bodies representing health practitioners, indemnity insurance providers, Queensland Civil and Administrative Tribunal (QCAT), HCQ, and relevant unions. The explanatory notes state that stakeholder expressed 'general support' for the proposed reforms.[15]

The explanatory notes acknowledged that QNMU did not support amendments that enable the Health Ombudsman to make prohibition orders for unregistered practitioners, and the reform to remove the requirement that QCAT be constituted by a judicial member for certain matters.[16]

1.5.5 Feedback from Australian Government Department of Health

The Government also sought feedback from the Australian Government's Department of Health on the Health Transparency Bill 2019 and related subordinate legislation. The response was tabled by the Minister for Health and Minister for Ambulance Services in the Legislative Assembly on 21 August 2019.

Feedback outlined within the response included:

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11 Explanatory notes, p 20.

12 Explanatory notes, p 20.

13 Explanatory notes, p 21.

14 Explanatory notes, p 21.

15 Explanatory notes, p 21.

16 Explanatory notes, p 21.

> *This Bill appears to create a reporting burden on providers, with no clear benefits to consumers, and no relationship to regulatory functions.*[17]

In relation to staffing ratios, the letter stated:

> *On 13 September 2018, the then Minister for Senior Australians and Aged Care, the Hon Ken Wyatt, AM, MP, released the Aged Care Workforce Strategy (the Strategy), developed by an industry-led Taskforce (2017-18). While not supporting mandatory staff ratios in aged care, the Strategy recommends changes to workforce planning and oversight to ensure that care is delivered in accordance with individual care plans. The Strategy also recommends "organisations publish the model of care and hours of care across elements of the holistic care plan to better support their consumers and inform the family, carers and the local community".*[18]

The Department of Health acknowledged that as a result of the Royal Commission, there will be a number of recommendations in relation to the structure and performance of the existing aged care sector, and that the Australian government will consider any recommendations that are included in the Royal Commission's final report. [19]

1.6 Should the Bill be passed?

Standing Order 132(1) requires the committee to determine whether or not to recommend that the Bill be passed.

After examination of the Bill, including consideration of the policy objectives to be implemented, stakeholders' views and information provided by Queensland Health, the committee recommends that the Bill be passed.

Recommendation 1

The committee recommends the Health Transparency Bill 2019 be passed.

[17] Letter, dated 9 August 2019, from State Manager – Queensland and the Northern Territory, Australian Government Department of Health, Ms Nicole Jarvis, to the Deputy Director-General, Clinical Excellence Queensland, Queensland Health, Dr John Wakefield PSM, regarding feedback on the draft Health Transparency Bill 2009 and Health Transparency Regulation 2019, tabled paper reference 1303, p 5.

[18] *Ibid*, p 3.

[19] *Ibid,* p 3.

2 Examination of the Bill

This section discusses issues raised during the committee's examination of the Bill.

2.1 Establishing a transparent reporting framework

2.1.1 What does the Bill propose?

The Bill proposes to 'establish a legislative framework to compel public and private health facilities and RACFs to provide certain information, and to enable that information to be published'.[20] It is intended that information will be reported on a new website.[21]

2.1.1.1 Benefits of the Bill

Dr John Wakefield, Director-General, Queensland Health summarised the policy rationale for the Bill as follows:

> *International research indicates that transparency of health service information leads to better quality of care and outcomes. Queenslanders currently do not have easy access to information about public and private health services or aged-care facilities. This bill will enable consumers to make informed choices through being able to easily access and compare different providers. It will encourage providers to improve and will ultimately lead to a better health system for Queenslanders.*[22]

The explanatory notes also outlined the following benefits of public reporting:

- *Improve healthcare outcomes and reduce unwanted variation in care due to the competitive nature of providers;*
- *Inform system learning and improvement through better understanding of variation;*
- *Increase accountability of providers to health consumers, governments and stakeholders;*
- *Help foster a spirit of openness and trust with the public;*
- *Increase health literacy of the public;*
- *Reassure the public about the quality of care received at health facilities; and*
- *Improve efficiency, reduce waste and drive better value care.*[23]

2.1.1.2 What information does the Bill deal with?

The Bill deals with three types of information:

- General information - this information is administrative in nature and includes information such as contact details, services provided by a facility, visitor information.
- Quality and safety information - this includes a broad range of clinical information and patient data, including performance against the National Safety and Quality Health Service Standards, percentage of patients treated within clinically recommended timeframes, number of admitted patients and information about patient outcomes.
- Residential care information - this includes information about the nursing care and personal care provided to residents of RACFs, including staffing provided for the care.[24]

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20 Explanatory notes, p 9.

21 Explanatory notes, p 9.

22 Public briefing transcript, Brisbane, 16 September 2019, p 1.

23 Explanatory notes, p 1.

24 Explanatory notes, p 10.

Definitions as provided in the Bill are set out in the table below.

Table 1: Information to which the Bill applies

Type of information	Description
General information	Clause 8 defines *general information* about a public sector health service facility, private health facility, State aged care facility or private residential aged care facility to be: • Information that identifies the facility including, for example, the name, address, phone number and website of the facility; and • Details of the health services provided at or by the facility including, for example, the types of clinical specialities or maternity models of care a facility provides; and • Information about other services available at or near the facility that may help people who are admitted at the facility, attending an appointment at the facility or visiting the facility including, for example, car parking and public transport information or the availability of interpreter services at the facility.
Quality and safety information	Clause 9 defines *quality and safety information,* about a public sector health service facility or private health facility, as information about the facility's accreditation and performance against the National Safety and Quality Health Service Standards. *Quality and safety information* can also be any of the following information prescribed by regulation: • Access to care information o which means information about the time frames in which health services are provided to patients at or by the facility, including for example – (a) the percentage of patients treated within clinically recommended times at the facility (b) the number of patients waiting for a health service at the facility. • Activity information o which means (a) information about patients admitted to a facility, including, for example – (i) the number of patients admitted to and discharged from the facility; and (ii) the reason for admission (iii) the length of time spent in the facility; or (b) information about patients who are not admitted to a facility, but who receive a service at the facility, including for example, the number of patients receiving care as an outpatient at the facility. • Patient outcome information o Which means information about (a) the impact on patients of a health service provided at or by the facility, including for example, the change in the health of a person, group of people or population that is wholly or partly attributable to the service; or (b) the effectiveness of a health service provided at or by the facility, including for example, the extent to which a health service provided to a person at the facility achieved the best possible outcome for the person's health. • Process of care information o Which means information about processes that are in place to support quality and safety of health services at the facility, including, for example, infection management processes at the facility. • Other information relating to the quality and safety of health services provided at the facility.
Residential care information	Clause 10 defines *residential care information,* about a State aged care facility or private residential aged care facility as information which is (a) prescribed by regulation about – (i) the personal care or nursing care provided to residents at the facility; or (ii) the staffing for the personal care and nursing care provided to residents at the facility (b) information that explains, and helps in understanding the information mentioned in (a) above.

Source: Explanatory notes, pp 24 – 26; Health Transparency Bill 2019, clauses 8, 9 and 10.

The explanatory notes state that specific types of quality and safety information and residential care information, to be sought from health facilities and RACFs will be set out in subordinate legislation.[25]

The Minister for Health and Minister for Ambulance Services tabled draft subordinate legislation titled Draft Health Transparency Regulation 2019 alongside the Bill so that the proposed legislative framework could be considered holistically.[26]

The draft Health Transparency Regulation 2019 set out the following information requirements:

- for each private health facility, the number of cases of staphylococcus aureus bacteraemia at the facility in a particular period is prescribed
- the average daily resident care hours at each state aged care facility or private residential aged care facility for a particular period.[27]

Dr Wakefield, Director-General, Queensland Health, explained that this approach provided flexibility to expand the information to be made available on the website over time.[28]

2.1.1.3 Who does the Bill apply to?

The reporting framework will apply to public and private health facilities (including licensed private hospitals and licensed day hospitals) as well as public and private RACFs.[29]

Regarding public and private health facilities, the Bill will empower the Chief Executive of Queensland Health to request *general information and quality and safety information.*[30]

Regarding public and private RACFs, the Bill will empower the chief executive to collect and publish *general information* and *residential care information.* The chief executive may also request information which aids in the understanding of this information.[31]

The Bill provides an opt-out mechanism for providers of private aged-care facilities**.** Approved providers will have 15 days to respond to a notice for information. If a facility chooses not to provide information, it must indicate in writing to Queensland Health its decision to opt-out and this will be published on the website.[32] The Bill proposes a maximum penalty of 100 penalty units if the approved provider of a private RACF does not provide a response to the notice.[33]

2.1.1.4 How will the information be published

It is intended that information will be published on a new interactive website.[34] Dr Wakefield, Queensland Health explained:

> *A new Queensland Health website will be developed to improve the transparency of the health and aged-care sectors in Queensland. The website, co-designed with consumers, will be an easy way to access information about health and residential aged-care facilities that is up to date, informative and Queensland focussed. The website will provide a single point of reference for*

25 Explanatory notes, Draft Health Transparency Regulation 2019, p 2.

26 Queensland Parliament, Record of Proceedings, 4 September 2019, p 2641.

27 Draft Health Transparency Regulation 2019, p 2.

28 Public briefing transcript, Brisbane, 16 September 2019, p 2.

29 Explanatory notes, p 9.

30 Explanatory notes, p 10.

31 Explanatory notes, p 10.

32 Public briefing transcript, Brisbane, 16 September 2019, p 4.

33 Explanatory notes, p 11.

34 Explanatory notes, p 9.

consumers to view and compare information about public and private hospitals, health facilities and residential aged-care facilities.[35]

Dr Wakefield confirmed that production and development of the website is to be funded through existing resources.[36]

2.1.2 Supporting evidence

The committee sought information on the evidence supporting the introduction of transparent reporting. Dr Wakefield tabled four studies which are available on the inquiry webpage.[37]

Dr Wakefield summarised the findings of these studies, explaining that clinical care and patient outcome indicators improved as a result of the public reporting of information:

In summary, these studies show that indicator rates fall significantly with the transparency of health information in the public domain, particularly around clinical care – both what we call process indicators of care, such as accreditation status, hand hygiene rates and so on, and outcomes in terms of how well people do after care in our hospital facilities such as mortality and survival rates, as well as other types of outcome indicators such as infection rates etc, are improved as a consequence of putting this information in the public domain.[38]

Dr Wakefield further explained that the reason for this improvement was that the publication of indicators motivated clinicians and served to address variations in performance and outcomes against other service providers:

The reason for that is hypothesised to be down to clinicians, particularly, and services not wanting to be bottom of the performance list and in that way that motivates clinicians and service providers to address issues of variation in their performance and outcomes. That is deemed to be the likely reason why putting information in the public domain leads to better outcomes.[39]

2.1.3 Stakeholder views on reporting by public and private health facilities

This section discusses stakeholder views on the reporting of information by public and private health facilities and the corresponding responses from Queensland Health.

2.1.3.1 *Support for the introduction of transparent reporting by health facilities*

There was widespread support for the introduction of measures to enhance transparency of public and private health facilities through public reporting.[40]

The Australian Medical Association Queensland (AMA Queensland), the state's peak medical representative body, outlined its strong support, stating that not only will the proposal provide reassurance to patients about quality of care, but it will allow the public to choose a facility which best meets their needs:

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35 Pubic briefing transcript, Brisbane, 16 September 2019, p 1

36 Pubic briefing transcript, Brisbane, 16 September 2019, p 9.

37 Studies included: UNSW Australia, Australian Institute of Health Innovation, *Final Report: Performance indicators used internationally to report publicly on healthcare organisations and local health systems,* October 2013; Bureau of Health Information, Jack Chen MCCS PhD MBA, *Public reporting improves healthcare,* October 2010; Health Quality & Safety Commission New Zealand, *Evidence Review and Appendices, Position paper on the transparency of information relating to health care interventions,* 2016; Campenella et al, *The impact of Public Reporting on clinical outcomes: a systematic review and meta-analysis,* 2016.

38 Public briefing transcript, Brisbane, 16 September 2019, pp 2-3.

39 Public briefing transcript, Brisbane, 16 September 2019, pp 2-3.

40 See, for example, submission nos. 13, 18, 3, 5, 10, 11, 9, 14, 15.

> *AMA supports the collection and publishing of patient data and elective surgery data (including activity information and patient outcome information) from public and private hospitals and RACFs.*[41] *… Queensland's communities rightfully expect to receive a high quality of care in all publicly owned health facilities irrespective of their geographical location and on the whole, place enormous trust and understanding in Doctors, nurses and others staff who deliver care every day. … The proposed interactive website associated with this Bill … will not only provide some reassurance about quality of care, but allow the public to 'choose' a facility which best meets their expectations.*[42]

AMA Queensland also acknowledged that for health providers, the website increases accountability to health consumers, governments and stakeholders.[43]

QNMU expressed similar support, noting benefits including greater consumer empowerment, and improvements in clinical outcomes:

> *We believe a regulatory approach that holds the public interest above all other considerations should be the basis for any safety and quality reporting regime. The benefits of public reporting are multi-fold and include greater consumer empowerment as well as strengthening quality improvements and clinical outcomes.*[44]

HCQ, a peak organisation representing the interests of health consumers and carers in the state, expressed similar support:

> *We know that information and transparency drives improvement in the health system and that making informed decisions is a crucial cornerstone of a consumer centred health system. HCQ has long advocated for improved public reporting of safety and quality data. … In 2018 we surveyed our consumer network and asked them how important a number of issues were to them. Out of a list of 20 they ranked No. 1 consumer and carer engagement, which would be of no surprise, but No. 2 was the public reporting of safety and quality data. We are thrilled to be at this juncture in Queensland of increasing our transparency and accessibility to meaningful information to help us make decisions about our care. This is about what consumers want.*[45]

Other organisations including Cancer Council Queensland, National Heart Foundation of Australia, Dementia Australia and Queensland Alliance for Mental Health, also supported the proposals.[46]

2.1.3.2 Health facility information to be reported on the website

A significant focus of many submissions was the specific information identified for reporting, with some organisations calling for the inclusion of additional reporting requirements**.**

For example, Cancer Council Queensland called for the inclusion of oncology as a clinical specialisation as soon as was practicable. It also suggested that information relating to emergency department performance be included and the list of errors and hospital acquired complications identified for reporting be expanded to include broader indicators such as in-hospital mortality.[47]

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41 AMA Queensland, Submission 13, p 1.

42 AMA Queensland, Submission 13, p 2.

43 AMA Queensland, Submission 13, p 2.

44 QMNU, Submission 9, p 4.

45 HCQ, Public hearing transcript, 9 October 2019, p 22.

46 Cancer Council Queensland, Submission 3, p 1; National Heart Foundation of Australia, Submission 5, p 1; Dementia Australia, Submission 10, p 3; Queensland Alliance for Mental Health, Submission 11, p 1.

47 Cancer Council Queensland, Submission 3, p 3.

Similarly, the National Heart Foundation of Australia called for the publication of information relating to cardiac services.[48] The organisation suggested that data could be used from the Heart Foundation's Heart Maps, and that information on cardiac complications under hospital-acquired complications data, could be reported.[49]

Dementia Australia advocated for the inclusion of information relating to whether a hospital is equipped to support people with dementia, that data should be collected on the level of dementia training amongst staff, and that dementia friendly hospitals should be noted within the quality and safety information published on all hospitals.[50]

QNMU also suggested that additional indicators be prescribed within the legislation. Ms Beth Mohle, Secretary, QNMU stated:

> *The undoubted benefit to stakeholders in creating a website for public reporting is transparency. We see this website evolving to include other measures and topics that provide consumers with information to make informed decisions about where to go for their health care and aged care. Our submission provides a number of other indicators that we believe should be published, such as bed numbers; licence to operate; costings on the average prices for common hospital procedures, out-of-pocket expenses and the type of arrangement the hospital will have with each health fund; the top 10 Australian refined diagnosis related groups—AR-DRGs—for each facility; the average length of stay; readmission rates; post-surgical mortality rates; presentations to emergency departments; nurse or midwife-sensitive outcomes; and patient experience surveys for all facilities.*[51]

Some stakeholders expressed reservations about the publication of certain information identified within the Bill.

The Royal Australasian College of Surgeons (RACS) expressed concern that the publication of performance outcomes has been confined to surgical and procedural specialities and maternity outcomes. RACS also stated that there had been no direct consultation on the reasons or methodology used in selecting the procedures to be reported.[52] The Queensland Health Surgical Advisory Committee, an expert multidisciplinary group comprising representatives from various specialities, expressed a similar view.[53]

At the public hearing, Adjunct Professor, Deborah Bailey, Chair, Queensland State Committee, RACS, expressed the following concerns:

> *Our submission is about the far-reaching powers given within the Health Transparency Bill to change at any time in the future the patient outcome information able to be requested and published by health executives. The process so far has failed to reassure the royal college that this information would not result in harmful effects on surgeons, surgical departments and patient expectations and other expensive and unintended consequences.*
>
> *The stakes are high. Performance measurement done well is broadly productive for those concerned. Done badly, it is very costly and not merely ineffective but harmful and indeed destructive. The college is gravely concerned that undifferentiated future outcome data will be released that will affect patient confidence in public health surgical care and their surgeons.*[54]

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48 Heart Foundation, Submission 5, p 2.

49 Heart Foundation, Submission 5, p 2.

50 Dementia Australia, Submission 10, p 5.

51 Public hearing transcript, Brisbane, 9 October 2019, p 1.

52 Royal Australian College of Surgeons (RACS), Submission 7, p 1.

53 Surgical Advisory Committee, Submission 16, p 2.

54 Public hearing transcript, 9 October 2019, p 26.

Response from Queensland Health

In its response to issues raised in submissions, Queensland Health advised that input on the nature of information to be reported on the website, was sought during a consultation process.[55]

Ms Sketcher-Baker, Executive Director, Patient Safety and Quality Improvement Service, Queensland Health provided the following information:

> *We undertook quite a rigorous consultation process. The first part was, in late 2017, to go out to consumers and clinicians and understand whether or not they wanted public reporting in the first instance. The second part was really about then establishing from consumers and clinicians what information they actually wanted to see on the website.*
>
> *In terms of feedback we received from consumers, they were interested in basic hospital information. Furthermore, they were really interested in comparisons between hospitals around a range of measures. When looking at length of stay, they were interested in knowing particularly how long they would be expecting to go into hospital for. In terms of knowing how long they had to wait, they were very interested to compare hospital against hospital. In terms of maternity patients or women who were pregnant, they were also really interested to know comparisons around caesarean section rates, inductions of labour, perineal tears. They were probably more informed in their decision-making than some of the other consumer cohorts we talked to.*[56]

Queensland Health advised that the proposed indicators were refined following further consultation on an exposure draft of the Bill in August and September 2019. Stakeholders consulted included consumers, clinicians, and hospital administrators from public and private sectors, unions, clinical colleges, Primary Health Networks and the Private Hospitals Association of Australia.[57]

Queensland Health also advised that many of the indicators were selected for initial publication as they were part of existing data collections, which would minimise the impact on hospitals and health facilities.[58]

Dr Wakefield, Director-General, Queensland Health, acknowledged that there had been many calls for the inclusion of additional information:

> *Our focus on clinical outcomes initially commences with maternity services. There are many calls, I think, to broaden that out to other areas such as stroke, heart attacks, cancer et cetera. I think we will be keen to explore that with stakeholders going forward and make sure we do that in a consultative way.*[59]

Queensland Health also advised on its intentions to establish an Advisory Committee comprised of representatives from public and private health facilities and RACFs to guide the development of future indicators.[60]

2.1.3.3 Committee comment

The committee has noted the calls for additional information to be published on the website. The committee agrees that there is significant opportunity in this regard and welcomes the intention of Queensland Health to establish an Advisory Committee to inform future discussions on what information on public and private health facilities, as well as residential aged care facilities, may be published in the future.

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55 Queensland Health, correspondence dated 26 September 2019, p 5.

56 Public briefing transcript, Brisbane, 16 September 2019, pp 5-6.

57 Queensland Health, correspondence dated 26 September 2019, p 5.

58 Queensland Health, correspondence dated 26 September 2019, p 5.

59 Public hearing transcript, Brisbane, 16 September 2019, p 11.

60 Queensland Health, correspondence dated 26 September 2019, p 6.

The committee considers that an Advisory Committee will be an important consultation mechanism and any proposals regarding information to be reported should be informed by the expertise and considerations of that group. As such, the committee considers that the Advisory Committee should comprise internal and external stakeholders, and have broad representation from relevant sectors. Its membership, mandate and deliberations should be transparent.

Recommendation 2

The committee recommends that Queensland Health establish an Advisory Committee of external and internal stakeholders to provide feedback on existing reporting data and any proposed changes to the data to be published on the website.

2.1.3.4 Accuracy of information

A number of submitters expressed views relating to the accuracy of information to be published on the website.

RACS recommended that adequate timeframes be provided to institutions in the Bill to enable the review of reports prior to publishing to verify accuracy in content.[61]

The Surgical Advisory Committee recommended the same, stating that there was concern about the accuracy of data sources.[62] Dr Robert Franz, Chair of the committee, stated:

> *In principle, we have no great problems with public reporting. What we do have concern with is data. Queensland Health, as any health service, collects a huge amount of data and unfortunately it is not always accurate and once published it is hard to retract even though it is false. Experiences overseas with cardiac surgery in New York and in the NHS have shown huge troubles when data was published erroneously. … There needs to be a very close balance and checks before things become in the public domain.*[63]

Response from Queensland Health

In response, Queensland Health advised that stakeholders will have the opportunity to verify their data and flag any inaccuracies before it is published on the website. Policy and guidance documents are also being developed to educate facilities on the processes for reporting, reviewing and publishing information.[64] Facilities will be provided with a reasonable period of time to undertake this review.[65]

Queensland Health explained that the Bill does not specify the timeframes and verification process as these procedures are administrative in nature and may change over time as website functionality changes. Queensland Health also contended that flexibility was required to manage these processes as the time needed to review the data will be dependent on the volume of data that requires verification.[66]

2.1.3.5 Protecting confidential information

Some stakeholders emphasised the need for the protection of confidential or potentially identifying information.

For example, Queensland Law Society (QLS) expressed concerns that 'the patients to which some activity information, patient outcome information, or residential care information relates could be identifiable where the facility in question generates only a small pool of data'. QLS suggested that

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61 RACS, Submission 7, p 2.

62 Surgical Advisory Committee, Submission 16, p 16.

63 Public hearing transcript, 9 October 2019, p 27.

64 Queensland Health, correspondence dated 26 September 2019, p 3.

65 Queensland Health, correspondence dated 26 September 2019, p 6.

66 Queensland Health, correspondence dated 26 September 2019, pp 6-7.

exemptions to publishing such information, or measures which enable the aggregation of data could alleviate privacy concerns.[67]

Similarly, AMA Queensland stated that it fully supports the collection and publishing of relevant patient data and elective surgery data on the understanding that the provisions within relevant legislation to protect the confidentiality of information acquired by individuals in performing their duties are upheld. Furthermore, and in relation to private facilities, information must not be disclosed if that disclosure would likely damage the commercial activities of that facility.[68]

The RACS stated 'it does not support the release of reports on individual surgeon performance'. The submission stated that information on institutions with too few procedures to accurately characterise performance by statistical analysis or cases where there is an individual who can thus be identified should not be included in any public reporting. RACS suggested that an appropriate statement for these institutions would be that an inadequate number of procedures do not allow a meaningful analysis and in no way reflects on the performance of the institution.[69] The Surgical Advisory Committee expressed a similar view.[70]

Response from Queensland Health

In response to issues around confidentiality and the release of identifying information, Queensland Health confirmed 'it does not intend to publish identifying information on the proposed website. All information will be reported at a facility level and not at a clinician level'.[71]

Furthermore, the Bill provides 'that personal information must not be used or disclosed except in stated circumstances' and that Queensland Health and its staff are required to adhere to relevant privacy legislation and principles when handling confidential information.[72]

In relation to instances where the amount of data is low enough to potentially identify individual patients, Queensland Health advised that 'this information would not be published'.

However, in cases where one surgeon was conducting procedures, and there was a sufficient volume of procedures so as to not identify individual patients, that data would be published. The reason outlined for this was that the outcome for the patient is reflective of the care provided by all staff at the facility, as well as other facility related factors such as resourcing.[73]

2.1.3.6 Risk adjustment of information

Risk adjustment is a statistical process where existing patient characteristics are considered when assessing the likelihood that an outcome will occur. Some stakeholders suggested that information to be published should be risk adjusted.

RACS called for information to be risk adjusted to provide for accuracy:

> *The RACS supports the release of surgical reports at the Hospital level to the public that are valid, reliable and transparent with rigorous statistical analysis to avoid misrepresentation of the quality performance of institutions. In particular, there should be a risk adjustment methodology, to ensure accuracy for patients who are at higher risk of complications and poor outcomes such*

67 Queensland Law Society, Submission 17, p 2.

68 AMA Queensland, Submission 13, p 2.

69 RACS, Submission 7, p 1.

70 Surgical Advisory Committee, Submission 16, p 3.

71 Queensland Health, correspondence dated 26 September 2019, p 3.

72 Queensland Health, correspondence dated 26 September 2019, p 4.

73 Queensland Health, correspondence dated 26 September 2019, p 4.

as those who have significant patient comorbidities or lower health resources available in their communities.[74]

The Surgical Advisory Committee agreed, adding that:

… when considering the health systems, the most urgent cases and those most in need or requiring the most intensive support are usually dealt with in the public sector. These patients may not be comparable with the population group operated on in the private sector or low acuity institutions. Similarly those populations from both remote and regional areas and quaternary/tertiary facilities should not be compared with low acuity institutions.[75]

Response from Queensland Health

Queensland Health advised that 'it will risk adjust relevant indicators such as hospital acquired complications data and maternity outcome data'. Furthermore, health facilities will have the option to add annotations and explanatory information to data to help consumers interpret the published information.[76]

In the public briefing of 9 October 2019 Queensland Health provided further information on how it intended to risk adjust the data.

For all our outcome indicators, we will certainly be looking to risk-adjust. For the hospital acquired complications of surgery, there already exists a risk adjustment methodology and approach that has been nationally defined with clinicians and statisticians. We will be adopting that process. The reason for adopting that process is that, where possible, stakeholders have said, 'We need to adopt national indicators so that we avoid any confusion between yet again producing a different definition to something that already exists nationally.' That is what we intend to do for the hospital acquired complications. For our maternity indicators, we will be seeking some expert opinion around the maternity risk adjustment comorbidities and sex, age and things like that as well.[77]

2.1.3.7 Consideration of unintended consequences

RACS and the Surgical Advisory Committee outlined the potential for the publication of certain information to have 'unintended consequences in public expectation and demand'. RACS stated that 'the selection of this proposed list of procedures without further in-depth consultation, is particularly concerning in the environment of providing high value beneficial care and re-evaluating interventions offered in the public sector'.[78]

74 RACS, Submission 7, p 1.

75 Surgical Advisory Committee, Submission 16, p 2.

76 Queensland Health, correspondence dated 26 September 2019, p 3.

77 Ms Kirstine Sketcher-Baker, Executive Director, Patient Safety and Quality Improvement Service, Public briefing transcript, 9 October 2019, p 6.

78 RACS, Submission 7, p 2.

The Surgical Advisory Committee provided the following example to illustrate the issue:

> *… The experience we have taken is from overseas. For example, in cardiac surgery in New York they did exactly that. They did not risk-adjust and they published results of individual surgeons. The outcome was not patient improvement; it was that all of the surgeons said, 'We're not going to do high-risk cases,' because it was not worth their while. It disadvantaged patients more than advantaged them.*[79]

2.1.3.8 Timeframes associated with requests for information

QLS stated that the Bill does not provide any limits on the time periods to which requested information may relate, noting that it would be 'unfair and overly burdensome to expect facilities to collate retrospective data where information may not have previously been collected in a manner that corresponds to the data prescribed by regulation'.[80]

Response from Queensland Health

In response, Queensland Health advised that the Bill 'deliberately does not limit the time period to which requested information may relate'.[81] Most of the information to be published will be drawn from existing sources. By not limiting the time periods to which the information can relate, Queensland Health will be able to use the information that has already been collected to report on historical data trends.[82]

2.1.3.9 Definitions contained in Bill

QLS identified 'potential difficulties with the way various types of information are described for the purpose of the Bill' and suggested that further consideration be given to the drafting of these definitions:

> *In the view of the QLS, the definition of patient outcome information is vague and will be difficult to apply. It is not clear what is meant by the 'impact of patients of a health service' nor is it clear how a health facility is to determine and provide data on whether the 'facility achieved the best possible outcome for the person's health'. These definitions do not provide a sufficiently clear framework to appropriately limit any future regulations and QLD urges that the definitions be given further consideration'.*[83]

Queensland Health did not provide a response on this issue.

2.1.3.10 Committee comment

The benefits resulting from increased transparency are widely acknowledged. It is also clear to the committee that there is widespread support for public reporting as a means to drive improvement in health care provision, and enable consumers to make more informed choices about the health services that they need.

The committee supports the introduction of a legislative framework as prescribed within the Bill for collecting and publishing information about public and private hospitals.

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79 Public hearing, Brisbane, 9 October 2019, p 28.

80 Queensland Law Society, Submission 17, p 2.

81 Queensland Health, correspondence dated 26 September 2019, p 12.

82 Queensland Health, correspondence dated 26 September 2019, p 12.

83 Queensland Law Society, Submission 17, p 2.

2.1.4 Stakeholder views on reporting residential care information

This section discusses stakeholder views on the reporting of information by public and private residential aged care facilities and corresponding responses from Queensland Health.

2.1.4.1 Support and calls for more information to be published

Many inquiry participants outlined their support for the transparent reporting of residential aged care information, with some calling for information additional to that prescribed in the Bill to be published.

AMA Queensland outlined its strong support for the proposals:

> *AMA Queensland wishes to state from the outset that we are extremely supportive of the amendments contained within the Health Transparency Bill 2019. We congratulate the government for these changes—in particular, the move to publish the level of care, safety and health outcomes in hospitals and aged-care facilities and the introduction of minimum nurse and support worker skill mix ratios in public residential aged-care facilities. These changes are needed because of the appalling state of affairs regarding the quality of care being provided in aged-care facilities in Queensland and the rest of Australia. Recent examples of poor care being provided in aged-care facilities presented to the aged-care royal commission and, closer to home, the abrupt closure of the Earle Haven Retirement Village at the Gold Coast tell us we are failing those who need our help the most.*[84]

Dementia Australia stated:

> *… reporting aged care staff-resident ratios would increase transparency around aged care services and potentially drive improvements in quality. Furthermore, evidence from our advocates indicates that the lack of transparency on providers is a key barrier to accessing supports. Consequently, people with dementia often struggle to find an aged care facility that is equipped to support their needs and matches their preferences.*[85]

The Public Advocate Ms Mary Burgess agreed, stating that the legislation had the potential to significantly impact people's lives:

> *This legislation, which will improve the transparency of the quality and safety of health services provided in Queensland and help members of the community to make better-informed decisions in relation to their health and aged care. Legislation such as this has the potential to significantly impact people's lives, providing access to necessary information to make, what often can be, very difficult decisions, particularly in relation to selecting an aged care facility for themselves or a family member.*[86]

Ms Burgess recommended that RACFs be required to report not only care hours provided to residents, but also the skill mix of staff available at the facility (ideally for weekdays, nights and weekends) and divided between registered nurses, enrolled nurses and support workers.[87] Ms Burgess provided the following rationale:

> *The additional information will enable a more meaningful and direct comparison of residential aged care facilities, with decisions made on the basis of both the number of staff, their experience and qualifications, as well as the care needs of residents, rather than just the total hours of care/contact per day per resident.*[88] *This approach may also potentially encourage aged care providers to aspire to higher levels and quality of care as a point of differentiation, rather than*

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84 Public hearing transcript, Brisbane, 9 October 2019, p 10.

85 Dementia Australia, Submission 10, p 3.

86 The Public Advocate, Submission 8, p 1.

87 The Public Advocate, Submission 8, p 3.

88 The Public Advocate, Submission 8, p 3.

focussing on meeting minimum standards that might be benchmarked or set by the industry with the requirement for the reporting of average daily resident care hours alone.[89]

Dr Wynne, Policy Analyst for Aged Care Crisis expressed a similar opinion:

… we are delighted to see Queensland leading the way in this important reform in the face of federal government criticism and inaction. We welcome and strongly support the submissions made by ADA Australia and the Public Advocate, including the additional transparencies they advocate for aged care. To be useful, we do need information about skills as well as acuity of residents, as is reflected in the funding. As with staffing ratios, transparency like this is a necessary condition for improving standards but is not really a sufficient condition. It is the beginning and much more is needed.[90]

Dementia Australia recommended that details on the model of care underpinning aged care services should be reported as contextual information.[91] QLS agreed, adding that the skill mix of staff providing the care was also important:

While QLS can see the value in being able to compare facilities, it does not appear that the comparison will be meaningful where there is no contextual information around the model of care provided at the facility or the care needs of the residents and no information about the qualifications, skill mix of staff providing the care.[92]

The Council on the Ageing (COTA) also emphasised the importance of reporting information on the model of care used by a facility:

A relatively high number of care hours may appear attractive to consumers, however, the overall model of care used by the provider may have a strong clinical focus but lack other key elements of a person and relationship-centred model of care.[93]

The committee also sought information on whether complaints about state-run aged care facilities would be reported. Dr Wakefield confirmed that at this stage there is no plan to publish information about specific complaints on the website, as it was a matter for the Commonwealth Government to determine what complaint information is published as regulator.[94]

The Pharmaceutical Society of Australia suggested that the direct care provided by other registered health practitioners be considered in ratios and reported, noting that this would provide elderly Queenslanders and their families with more comprehensive information about quality of care when making comparisons and informed decisions for selecting an aged-care provider.[95]

Response from Queensland Health

In its response to issues raised in submissions, Queensland Health advised that 'the average daily resident care hours indicator is a starting point to improve transparency in RACFs. RACFs are currently not required to report this information to the Commonwealth Department of Health'.[96]

89 The Public Advocate, Submission 8, p 3.

90 Public hearing transcript, Brisbane, 9 October 2019, p 11.

91 Dementia Australia, Submission 10, p 6.

92 Queensland Law Society, Submission 17, p 3.

93 Council on the Ageing (COTA), Submission 6, p 1.

94 Public briefing transcript, Brisbane, 16 September 2019, p 5.

95 Pharmaceutical Society of Australia, Submission 14, p 2.

96 Queensland Health, correspondence received 26 September 2019, p 18.

Queensland Health also acknowledged that the Bill provides scope to expand reporting requirements by regulation and that RACFs may be requested to report further residential care information such as skill mix in the future.[97]

2.1.4.2 Committee comment

The committee supports the introduction of a legislative framework as outlined within the Bill for collecting and publishing information about Queensland's residential aged care facilities.

The committee acknowledges the calls from stakeholders for additional information on residential aged care to be reported on the website. The committee agrees that there is opportunity in this regard and that additional information will assist people in making informed choices about aged care. In particular, the committee believes there is merit in the publication of information on models of care, specialty care, and the skill mix of staff within aged care facilities.

Recommendation 3

The committee recommends that Queensland Health provide opportunity for facilities to publish contextual information on care facilities that will assist consumers understand the information reported on the website.

Recommendation 4

The committee recommends that Queensland Health, in consultation with a representative Advisory Committee, consider expanding residential aged care information to be reported to include skill mix data for aged care facilities in Queensland.

2.1.4.3 Concerns

While Leading Age Services Australia (LASA), the national association for providers of age services, expressed its 'support' for the goal of providing consumers with better information to support their choice of residential care services', it outlined a number of concerns with the Bill.[98]

To support its position, LASA submitted results of a survey of 24 residential care services drawn from its Queensland membership. Findings included:

- *Over **95 per cent** of survey respondents reported that they do not support the proposed Bill and regulation*
- *Over **90 per cent** of survey respondents reported not seeing any benefit in providing residential care information to Queensland Health*
- *Although, over **70 per cent** of survey respondents indicated their concern with the possibility of being named and shamed through the making available of public information consistent with the draft Bill and Regulation, nearly **80 per cent** of respondents indicated that they would not be willing to provide the data or information requested*
- *Nearly **80 per cent** of survey respondents did not support providing general information to Queensland Health as outlined in Clause 8*
- *Over **95 per cent** of survey respondents did not support providing residential care information to Queensland Health as outlined in Clause 10*
- *Over **95 per cent** of survey respondents did not support Clause 16, whereby the Chief Executive of Queensland Health may publish information about response to notice.*[99]

97 Queensland Health, correspondence received 26 September 2019, p 18.

98 Leading Aged Services Australia (LASA), Submission 4, p 2.

99 LASA, Submission 4, pp 3-4.

2.1.4.4 *Commonwealth Government responsibility for aged care and potential duplication of requirements*

One of the primary issues raised by LASA, was that requirements to provide general and residential care information would be duplicative of the Commonwealth regulatory processes.[100]

LASA noted that information is currently collected by the Commonwealth Government, including accreditation and compliance reports, and that this information was publicly available.[101] LASA noted the National Quality Indicator Program, a mandatory program for all residential aged care services, collects data on Pressure injuries, physical restraint and unplanned weight loss, with the intent to add falls/fracture and medication issues in July 2020. This data is to be reported quarterly, with the first report due by 21 October 2019.[102]

Southern Cross Care (Qld) expressed a similar view, noting that the introduction of state specific reporting could result in confusion and duplication.[103]

Furthermore, LASA and Southern Cross Care noted that the proposed amendments may pre-empt recommendations from the Royal Commission into Aged Care Quality and Safety and that is will likely further address regulatory changes after significant consultation across Australia.[104]

Response from Queensland Health

In response to this issue Queensland Health advised that the intention of the Bill was not to regulate the sector, but rather improve transparency and help consumers make informed choices:

> *… the proposed amendments are not designed to regulate the aged care sector. Instead, the amendments are intended to improve the transparency of residential care and staffing in residential aged care facilities in Queensland and help consumers and their families use information to make informed choices about their aged care needs.*[105]

Queensland Health acknowledged the Commonwealth reporting requirements, however advised that information published on the My Aged Care website focussed on general information such as the acuity level of patients catered to, specialisations of a facility, costs involved with receiving care at a facility and any sanctions recorded against a facility. It 'generally does not include information covered by the Bill such as hours of care provided'.[106]

Queensland Health also acknowledged that RACFs have also not adopted the option of reporting staffing information on the My Aged Care website.[107]

Queensland Health confirmed that the power to request information from RACFs under the Bill is discretionary. Therefore, should the Commonwealth Government legislate to require providers to publish staffing information or information about the hours of care, the Chief Executive of Queensland Health can elect not to request the information.[108]

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100 LASA, Submission 4, p 2.

101 LASA, Submission 4, p 5.

102 LASA, Submission 4, p 5.

103 Southern Cross Care, Submission 19, p 2.

104 LASA, Submission 4, p 5; Southern Cross Care, Submission 19, p 2.

105 Queensland Health, correspondence received 26 September 2019, p 15.

106 Queensland Health, correspondence received 26 September 2019, p 14.

107 Queensland Health, correspondence received 26 September 2019, p 14.

108 Queensland Health, correspondence received 26 September 2019, p 14.

The committee questioned Queensland Health as to whether it had satisfied itself that that there was no inconsistency between state and commonwealth jurisdictions. Queensland Health provided the following answer:

> *In developing this legislation, the department satisfied itself that the requirements in the bill do not replicate or are not inconsistent with those of any currently existing Commonwealth laws. For that reason, if this bill is enacted Queensland could successfully require private facilities to provide information to the department.*[109]

2.1.4.5 Appropriateness of existing indicators

Some inquiry stakeholders questioned whether reporting average daily resident hours would be of benefit to consumers.

LASA stated that staffing information would not give consumers a meaningful indication of the level of care that is available as an overall staffing ratio will not indicate whether the appropriate skill mix of staff are available at the appropriate time, and does not take into account key drivers such as the staffing needs of residents:

> … the ratio does *not take into account resident acuity, building layout, staff experience, mix or qualifications.. All of these result in making the data non-specific, unreliable and difficult to interpret. Staffing levels are also based on the accumulative demand for responding to care needs of a facility's resident population not simply the number of residents. Higher care needs/acuity across a facility's resident population demand more targeted health staff expertise hours overall to attend to clinical care.*[110]

Southern Cross Care (Qld) expressed a similar view noting that the interpretation of staffing levels is not straight forward:

> *There is no conclusive evidence that personal care and nursing staffing inputs are a reliable indicator of quality of care and quality of life experienced by residents in aged care services. Many other staffing related factors influence quality outcomes – including the skills, qualifications and experience of staff, the quality of their training, the culture of the organisation, the appropriateness of the skills to the care needs of the resident profile in each service, the quality of leadership, management and clinical governance, and the effectiveness of the interfaces with the wider health service.*[111]

2.1.4.6 Administrative impact

Some inquiry stakeholders reported that the proposals would result in an additional administrative burden on aged care providers.

LASA stated that 'the draft Bill and Regulation will impose increasing regulatory and administrative burden upon residential care providers in their having to provide the required information to Queensland Health and maintain its integrity with account for the dynamic and fluid nature of care provision relative to changing care needs'.[112] LASA also reported that the proposed changes have been introduced at a time when residential care sector is experiencing increasing financial strain.[113] LASA outlined a series of potential impacts on current and future residents and families as a result of implementation of the proposals:

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109 Public briefing transcript, Brisbane, 16 September 2019, p 6.

110 LASA, Submission 4, pp 5-6.

111 Southern Cross Care, Submission 19, p 1.

112 LASA, Submission 4, p 5.

113 LASA, Submission 4, p 5.

- *Potential decrease in customer focussed care and continuous improvement within residential care services that will result from providers having to allocate resources towards regulatory and administrative requirements of Bill*
- *Increased staff engagement with residents and families in responding to negative public perceptions and views relating to publication of indicator of staffing levels.*[114]

Response from Queensland Health

In response, Queensland Health advised that the Bill allows for private RACFs to opt-out of providing 'residential care information' and that if a facility 'is unable or unwilling to report this information due to financial or administrative considerations, it can choose not to report the requested information. Private RACFs can also elect to opt out of reporting indefinitely or for a defined period.[115]

Private RACFs that elect to report 'residential care information' will be requested to report on one indicator quarterly. Queensland Health advised that this is not expected to create a significant administrative or financial burden. Further, 'General information' will only need to be provided once as changes to this type of information are expected to be minimal. RACFs will be able to update their 'general information' if changes occur.[116]

2.1.4.7 Committee comment

The committee notes comments from Queensland Health that the purpose of this legislation is to improve the transparency of the aged care sector in Queensland, rather than to regulate it.

The committee acknowledges the comments of providers of aged care that Queensland's reporting requirements could potentially duplicate Commonwealth requirements. The committee recommends that Queensland Health give consideration to avoiding the duplication of reporting requirements where possible, by aligning the format of reported information, with requirements of other reporting regimes.

The committee also acknowledges the important work of the Royal Commission into Aged Care Quality and Safety and the potential for recommendations to lead to change in Commonwealth legislation and regulation. The committee recommends that the Minister for Health and Minister for Ambulance Services, in his second reading speech, indicate how Queensland reporting requirements will align with possible future Commonwealth requirements, to minimise potential overlap in reporting obligations for facilities.

Recommendation 5

The committee recommends that Queensland Health give consideration to avoiding duplication of reporting burdens where possible, by aligning the format of reported information with the requirements of other reporting regimes.

Recommendation 6

The committee recommends that the Minister for Health and Minister for Ambulance Services, in the second reading speech, indicate how Queensland reporting requirements will align with possible future Commonwealth requirements, to minimise potential overlap in reporting obligations for facilities.

114 LASA, Submission 4, pp 6-7.

115 Queensland Health, correspondence received 26 September 2019, p 16.

116 Queensland Health, correspondence received 26 September 2019, p 16.

2.1.4.8 Opt-out mechanism

LASA suggested that 'it would be more straight forward to allow residential care services not to respond to the request for information rather than requiring them to respond, but allowing them to refuse to provide the information'.[117]

Response from Queensland Health

In response, Queensland Health stated that it 'requires a private RACF to confirm it is opting out of reporting information to enable this fact to be published on the website with certainty'. However, to limit any potential administrative burden on an RACF to respond to a request for information, Queensland Health would implement a process whereby the facility could opt-out of reporting for a defined period, or indefinitely.[118]

2.1.4.9 Accessibility of website

A number of inquiry stakeholders emphasised the importance of ensuring that the website and the information contained on it, was accessible for all.

By way of example, QNMU stated that 'the website must be in a format that is consistent, meaningful and easily accessible and understood by consumers and other stakeholders. It should be compatible with a range of technologies, and comply with international standards on best practice on accessibility'.[119] The Queensland Alliance for Mental Health expressed a similar view.[120]

Dementia Australia submitted that the accessibility was one of the most 'critical components' of the legislation:

> *… most critical to implementing this legislation, is the need to ensure published information is accessible and easy to navigate so that people can compare providers and services. Ultimately, information on providers needs to be written in plain English, easy to compare between providers and there needs to be consideration to people from special needs groups, such as people from culturally and linguistically diverse communities. Consideration of the needs of people in rural and remote locations who may not have immediate or convenient access to online information, is also required.*[121]

At the public hearing Mr Rowe from Aged and Disability Advocacy Australia (ADA) reiterated the need for education for the community and for health professionals to support the launch of the website.

> *A website by itself will get those who are motivated to go and look. Education is incredibly important—that is, broader education of the community. There are a range of strategies to do that. Ultimately, if the key people—the health practitioners, the hospital system, social workers et cetera—are aware of where to go, when people are faced with a crisis they can at least point them in a direction.*[122]

2.1.4.10 Committee comment

The committee acknowledges the importance of ensuring that information contained on the website is accessible for all.

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117 LASA, Submission 4, p 3.

118 Queensland Health, correspondence dated 26 September 2019, p 17.

119 QNMU, Submission 9, p 11.

120 Queensland Alliance for Mental Health, Submission 11, p 1.

121 Dementia Australia, Submission 10, p 8.

122 Public hearing transcript, 9 October 2019, Brisbane, p 11.

2.1.4.11 Evaluation

The committee sought information on how the reform would be evaluated going forward to ensure that it was achieving intended benefits. Dr Wakefield advised that Queensland Health would be working closely with consumers to ensure that the information was assisting consumers:

> *We are very keen to make sure that the No. 1 priority is that this helps consumers make decisions and provides them with the information that they want and need in a format that helps them and their families make decisions about health care. We will be working very closely with them to evaluate that and make changes as needed going forward. As I said, that will be overseen by an advisory committee going forward.*[123]

2.1.4.12 Health Performance Commission

The QNMU advocated for the establishment of a Health Performance Commission which would be an overarching, independent body to gather, analyse and report data to enable value-based healthcare.[124]

Response from Queensland Health

In response to the proposal, Queensland Health advised that a Health Performance Commission is not proposed at this time and that 'health facilities are actively monitored through various regulatory and legislative bodies and activities'.[125]

2.2 Amendments to *Hospital and Health Boards Act 2011* – Legislating minimum standards

2.2.1 What does the Bill propose?

Queensland Health currently operates 16 residential aged-care facilities across seven hospital and health services. These publicly run facilities account for 16 of a total of 461 RACFs in Queensland.[126] These facilities are generally located in areas poorly served by private or non-government providers or provide specialised care to those with particularly high needs that are generally not catered for in the private and non-government sector.[127]

The Bill will amend the *Hospital and Health Boards Act 2011* to create a legislative framework for aged care ratios in the 16 public RACFs. This includes provisions which will enable a minimum nurse and support worker skill mix ratio; and a minimum average daily resident care hour requirement, to be prescribed in regulation.[128]

The Minister for Health and Minister for Ambulance Services tabled the *Draft Hospital and Health Boards (State Aged Care Facilities) Amendment Regulation 2019* alongside the Bill, which prescribed intended minimum nurse workforce for public RACFs:

- *a minimum nurse percentage, that is, registered nurses and enrolled nurses of 50 per cent of the workforce, with a minimum of 30 per cent required to be registered nurses during a 24 hour period*
- *a minimum average daily resident care requirement of 3.65 hours.*[129]

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123 Public transcript briefing, Brisbane, p 11.

124 QNMU, Submission 9, pp 8-9.

125 Correspondence from Director-General, received 26 September 2019, Attachment 1a, p 5.

126 Public briefing transcript, Brisbane, 16 September 2019, Brisbane, p 3.

127 Public briefing transcript, Brisbane, 16 September 2019, Brisbane, p 2.

128 Explanatory notes, p 11.

129 Explanatory notes, Draft Health Transparency Regulation 2019, p 2.

2.2.1.1 Supporting Evidence

The explanatory notes refer to a number studies to support the proposal:

> *International research indicates that the number of nurses to the number of patients and the work environment for nurses has a clear impact on patient outcomes. Furthermore, a higher proportion of nurses to patients can lower patient mortality and benefit persons receiving care and treatment with improved patient safety and quality of care. In turn this provides greater patient satisfaction and improved patient outcomes, such as reduced patient falls and reduced facility-related pressure injuries.*[130]

The explanatory notes also state that 'higher nurse-to-patient ratios can also provide safer workloads for the front-line public sector nursing workforce, improving recruitment and retention and staff satisfaction, and may lead to greater workforce sustainability'.[131]

In relation to the skill mix of staff, the explanatory notes state that a 2016 study conducted by the Australian Nursing and Midwifery Federation, Flinders University and the University of South Australia identified that the absence of an effective staffing methodology had resulted in decreasing staffing levels and skill mix in residential aged care services across Australia. The National Aged Care Staffing and Skills Mix Project Report 2016 recommended a minimum care requirement for residents in aged care facilities including a skill mix requirement.[132]

The explanatory notes also explain that the proposal will align residential aged care with the framework for mandated nurse and midwife-to-patient ratios in prescribed public-sector health service facilities, such as in-scope acute adult medical and surgical wards in public hospitals, as well as acute adult medical mental wards in Princess Alexandra Hospital and the Royal Brisbane and Women's Hospital.[133]

The explanatory notes state that the effects of legislated nurse ratios on nursing, patient and organisational outcomes in Queensland is currently being assessed through an independent research and evaluation process led by the University of Pennsylvania in collaboration with the Queensland University of Technology.[134]

2.2.1.2 How are staffing levels currently determined?

Staffing and average daily resident care hours in public RACFs are determined using the *Queensland Health Business Planning Framework: A tool for nursing and midwifery workload management,* 5th edition (Business Planning Framework). This is an industrially mandated tool designed to support business planning for managing nursing and midwifery resources and workload management in public sector health facilities.[135]

The explanatory notes state:

> *… workforce skill mix differences are dependent on the types of patients and their nursing care needs in each sector. Nursing care for residents in public RACFS is provided by a skill mix of registered nurses, enrolled nurses and support workers such as personal care workers or assistants in nursing. It is for this reason, that a minimum nurse and support worker skill mix*

130 Explanatory notes, p 3.

131 Explanatory notes, p 3.

132 Explanatory notes, p 3.

133 Explanatory notes, p 3.

134 Explanatory notes, p 3

135 Explanatory notes, p 3.

ratio, as opposed to a minimum nurse-to-resident ratio, is appropriate for public RACFs and has been adopted in the Bill.[136]

Queensland Health advised that as part of the preparation for these reforms, it undertook to understand nurse-to-resident and staff-to-resident ratios, across all public residential aged care facilities. Dr Wakefield explained:

The average hours of care provided to residents daily across residential aged care facilities operated by Queensland Health ranges from 2.8 hours to 5.2 hours. The average hours of care provided to residents at each facility is determined by resident acuity and care needs.[137]

2.2.1.3 Resourcing required to implement proposal

Dr Wakefield advised that the estimated cost of resourcing the implementation of the nurse and support worker skill mix ratio and minimum average daily resident care hours in public RACFs is approximately $10 million annually.[138]

The committee sought information on whether the current supply of nurses in the state was taken into account in setting the ratios.

Dr Wakefield explained that supply had been considered, and that was why the Bill provided for a two year introduction period:

… the bill provides for a two-year introduction period whereby they [facilities] *work towards the changes both in terms of the uplift in hours and the recruitment that goes along with that and also the skill mix changes in accord with government policy around job security and so on.*[139]

Ms Miller, Queensland Health provided the following information on the current supply of nurses:

Currently the supply in nurses is early career—that is, graduates and early career nurses. There is a significant supply there. The department is looking to build the image of nursing in the aged-care sector to encourage more nurses into that area. We also have some transitional support programs for nurses wanting to move into the aged-care setting. We are also currently working on some strength with immersion programs as well to rapidly build early career nurses up so that they are competent to work in those aged-care settings.[140]

Queensland Health further advised that the total full time equivalent (FTE) number of additional registered and enrolled nurses required to meet the minimum nurse skill mix percentages, across residential aged care facilities (RACFs) operated by Queensland Health is estimated to be 75 registered nurses FTE and 18 enrolled nurses FTE.[141]

2.2.1.4 How was the daily care requirement determined?

The committee sought information on how the minimum average daily resident care requirement of 3.65 hours was determined.

Dr Wakefield stated that there were two primary inputs:

- the National Aged Care Staffing and Skills Mix Project Report by the Australian Nursing & Midwifery Federation, Flinders University, and the University of South Australia (discussed above)

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136 Explanatory note, p 4.

137 Correspondence, Queensland Health 15 September 2019, attachment 1c.

138 Public Briefing, Queensland Health, 16 September 2019, p 3; Explanatory notes, p 15.

139 Public Briefing, Queensland Health, 16 September 2019, p 3.

140 Public briefing transcript, Brisbane, 16 September 2019, p 10.

141 Queensland Health, correspondence dated 16 September 2019, p 31.

- the existing range in daily care hours experienced across the existing services.

Dr Wakefield explained:

> *There was the ANMF study* [Australian Nursing & Midwifery Federation] *which deemed 4.3 hours to be what I would regard as an optimum. There was the existing range, which is what we knew to be the case across our services, noting that the various services had different levels of acuity. Those data inputs were used to determine what we would recommend.*
>
> *I think it is fair to say that, because we were focusing on a minimum rather than an optimum, we felt that it was appropriate—at some level there was an arbitrariness to determining what that was. We used both of those data inputs to make that decision, noting that more research was needed to make a determination about the link and the relationship between staffing and resident outcomes and that there was a commitment by government to put a minimum in place.*[142]

Dr Wakefield acknowledged that there was limited evidence to define with accuracy exactly what the minimal level of care hours should be within a residential aged care setting. Therefore one of the outcomes of this proposal would be to seek to research and evaluate the impact of setting minimum standards of care.[143] At the public briefing on 9 October 2019 Dr Wakefield added Queensland Health was in the process of requesting quotes from the market for this work to be completed.[144]

The committee sought information on why the figure of 4.3 hours, as recommended within the ANMF-Flinders study was not prescribed, Dr Wakefield explained:

> *Whilst we were very keen to examine in detail the ANMF-Flinders study, we felt that that was insufficient on its own to make assertive decisions to go with 4.3 hours.*
>
> *In addition, we were really clear that we already have a BPF* [Business Planning Framework]*. We already had a mechanism for working out staffing. The question about the BPF is: is that right? As we have said, patients are getting more complex and, as the population ages, does that tool adequately recognise the staffing that is required and that it produces? Obviously, we considered a number of options, including 4.3 hours.*
>
> *The decision of the minister and cabinet was to go for a middle ground in terms of an average of what our current staffing was because that was real for us. We knew that that was the staffing that we had. … The decision was made by cabinet to make a start and to choose the average, 3.65 hours, as the minimum in full knowledge that further work was required to determine whether that was well pitched or whether it needed to be expanded or increased, also in full knowledge that the royal commission and the considerations of this committee are in play. I think the decision was to make a start and make it very clear that staffing mattered.*[145]

2.2.1.5 Committee comment

The committee welcomes the intention of Queensland Health to evaluate the impact of the introduction of minimum average care hours in public residential aged care facilities. The committee considers this to be an important piece of research and recommends that the results of this evaluation be made publicly available.

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142 Public briefing transcript, Brisbane, 16 September 2019, pp 9-10.

143 Public briefing transcript, Brisbane, 16 September 2019, p 7.

144 Public briefing transcript, Brisbane, 9 October 2019, p 7.

145 Public briefing transcript, Brisbane, 16 September 2019, pp 11-12.

Recommendation 7

The committee recommends that the results of the research project as acknowledged by the Director-General, Queensland Health, on page 7 of the transcript of the public briefing of 9 October 2019, be made publicly available upon completion.

2.2.2 Stakeholder views

Stakeholders expressed a range of views regarding the introduction of mandated minimum standards of care in residential aged care facilities.

2.2.2.1 Support

QNMU outlined its strong support for the introduction of minimum nurse-to-patient ratios:

> *We applaud the Queensland Government for introducing minimum nurse-to-resident ratios in state-owned residential aged care facilities. We continue to call on the federal government to establish staffing ratios for private aged care facilities.*[146]

Ms Beth Mohle, Secretary, QNMU stated:

> *For many years the QNMU has been lobbying to improve quality and safety in aged care. We therefore strongly support the introduction of nurse-to-resident ratios in state aged-care facilities. We believe that ratios will lead to better care for residents and more manageable workloads for our members and that they should be introduced in all aged-care facilities.*
>
> *Among other recommendations, we have suggested that the average minimum 3.65 hours per resident per 24 hours be clearly identified as the minimum, with actual hours of care calculated by the business planning framework and documented in the facility, ward or unit service profiles.*[147]

AMA Queensland expressed similar support. In support of its position, AMA Queensland noted the following in relation to the aged care workforce:

> *AMA Queensland is concerned with reduction in access and number of trained nurses reducing as a proportion of total staff involved in the facilities as this may lead to a lesser standard of care being provided to older Australians in these facilities.*
>
> *The latest data on the number of registered nurses in RACF had gone down from 21% in 2003 to 14.9% now. This decrease, which also confirmed by Leading Age Services Australia (LASA) during the Aged Care Royal Commission, corresponded with an increase in the number of personal care workers who have significantly less training and background than trained nurses.*
>
> *Registered nurses should be involved in all stages of care for patients including clinical handover, ensuring prescriptions are actioned, managing emergency situation and in the provision of palliative care.*[148]

HCQ also expressed strong support for proposal, noting feedback received from consumers during a consultation process undertaken for Queensland Health:

> *Many commented that residential aged care facilities are severely understaffed. Some commented that the staff on the floor are doing their best and the staffing and care issues are with the management. Others felt that there is no quality of care in care homes.*

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146 QNMU, Submission 9, p 10.

147 Public hearing transcript, Brisbane, 9 October 2019, p 1.

148 AMA Queensland, Submission 13, p 3.

Better and more qualified nursing and care staff is wanted. Family members commented that staffing ratios are not adequate with a comment that in one home an enrolled nurse is the lead nurse. They want improved staff ratios and improved education and training for staff.[149]

The Public Advocate also suggested that there should be some absolute minimums:

I would make one point about the ratio issue. I know that people keep walking out one statement in the Productivity Commission report that staff-to-patient ratios are a very blunt instrument for assessing quality and levels of care, and on the face of it is. However, there is a tipping point beyond which the staff-to-patient ratio is just too low to be acceptable and there probably should be some absolute minimums. I actually reviewed evidence that was given to the Productivity Commission's review into the workforce in aged care and I heard stories from staff where some nurses were on at night—the lone nurse—with 150-plus patients.[150]

2.2.2.2 Opposition to proposal

While many inquiry stakeholders supported the proposal, a number of issues were identified.

LASA stated that over 90 per cent of survey respondents did not agree with the requirements listed under Clause 3 to have the daily resident care hours prescribed.[151] LASA also reported that the requirement for minimum staffing ratios could result in resourcing issues that could impact adversely on the quality of care received by residents:

Fixed staffing ratios will create issues for the redeployment of skilled staff to undertake duties outside their scope of practice of these staff may be underutilised contributing to inefficiencies that adversely impact on quality of care for the resident population. [152]

Southern Cross Care stated that the Bill's focus on personal care and nursing inputs also assumes a medical model of care in aged care homes, and does not adequately recognise the contribution of allied health, social, lifestyle and pastoral roles and the roles of volunteers. The contribution of these roles is critical for quality of care and quality of life in long term environments'.[153]

Dementia Australia contended that the minimum time spent with residents should be flexible, and adjusted according to a resident's level of care needs.[154]

Queensland Health

In response, Queensland Health advised that the proposed 3.65 hours of care is a minimum, and will serve as a starting point for RACFs operated by Queensland Health.[155] Queensland Health also explained:

RACFs operated by Queensland Health will continue to use the Business Planning Framework: A Tool for nursing and midwifery workload management (BPF) to determine the appropriate staffing for facilities, the skill mix of staff required to care for residents and the average hours of care required by individual residents. Facilities will continue to use the BPF as the standardised and required methodology for determining staffing profiles and care requirements for residents.

149 HCQ, Submission 18, p 4.

150 Public hearing transcript, Brisbane, 9 October 2019, p 38.

151 LASA, Submission 4, pp 3-4.

152 LASA, Submission 4, p 7.

153 Southern Cross Care, Submission 19, p 1.

154 Dementia Australia, Submission 10, p 8.

155 Queensland Health, correspondence dated 26 September 2019, p 22.

This is in line with the existing legislated minimum nurse-to-patient ratios and related workload management standard under Division 4 of the Hospital and Health Boards Act 2011 for acute adult medical, surgical and mental health wards.[156]

2.2.2.3 Committee comment

The committee supports the introduction of nurse and support worker skill mix ratios and minimum average daily resident care hours in public residential aged care facilities.

2.3 Amendments to the *Health Ombudsman Act 2013*

2.3.1 What does the Bill propose?

The main objects of the *Health Ombudsman Act 2013* are to

- protect the health and safety of the public
- promote professional, safe and competent practice by health practitioners and high standards of service delivery by health service organisations
- maintain public confidence in the management of complaints and other matters relating to the provision of health services.[157]

The Act achieves its objects by the establishment of a health complaints system.

Under the *Health Ombudsman Act 2013* the Office of the Health Ombudsman (OHO) is the single point of entry for health complaints in Queensland. The OHO manages complaints about unregistered health practitioners. However, responsibility for dealing with complaints about registered health practitioners is shared with the Australian Health Practitioner Regulation Agency (AHPRA) and the National Boards.[158] The Act also provides statutory timeframes for key decisions in the complaints process.

In December 2016, the former Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee tabled its report on the performance of the Health Ombudsman's functions pursuant to section 179 of the *Health Ombudsman Act 2013*. The committee made four recommendations aimed at improving the performance of the health complaints system.[159] The Bill implements the committee's recommendations 1, 2 and 4. No legislative amendments were needed to address recommendation 3.[160]

The amendments include:

2.3.1.1 Joint consideration of matters between OHO and AHPRA and the National Boards (Recommendation 1 of the former committee)

The OHO deals with the most serious complaints and notifications while those of a less serious nature are referred to APHRA and the National Boards. At the public briefing the Health Ombudsman explained that the proposed changes to the *Health Ombudsman Act 2013* that cover joint consideration would improve both consistency and efficiency in the decision making process in the management of complaints about registered practitioners. The Health Ombudsman provided the following example:

What happens at the moment and what has been happening since the office started in July 2014 is that the OHO on their own would make a decision when a complaint or notification came in,

156 Queensland Health, correspondence dated 26 September 2019, p 22.

157 S3 *Health Ombudsman Act 2013*

158 Explanatory notes, p 4.

159 The performance of the Health Ombudsman's functions pursuant to section 179 of the *Health Ombudsman Act 2013*.

160 Explanatory notes, p 4.

in relation to what to do with it. For a lot of those matters the decision is to refer them to AHPRA to manage because they do not meet the seriousness threshold for us to deal with it. That matter then goes to AHPRA. With a lot of those matters, no further action will ultimately be taken on them, quite appropriately. This process, from a complainant perspective, will ensure that some of those 'no further action' decisions that might ultimately be made by AHPRA on matters we refer to them will be made at the front door so that a complainant will not see their complaint be sent from one organisation to another just for it to be closed. Also, for practitioners, it is a better outcome because, if no further action is going to be taken, again it is better to do that early at the front door than send them through that process.[161]

2.3.1.2 Reducing the splitting of matters between OHO and AHPRA (Recommendation 2 of the former committee)

A split matter occurs where a health impairment matter is associated with a misconduct matter. The proposed amendments to the *Health Ombudsman Act 2013* enable these matters to be dealt with together rather than splitting them between the Health Ombudsman for matters relating to conduct matters and AHPRA for matters relating to an impairment. Dealing with these matters together prevents inefficiencies that arise when complainants and practitioners need to deal with multiple regulatory bodies.[162]

2.3.1.3 Amendments recommended by the Health Ombudsman (Recommendation 4 of the former committee) to improve the operational, administrative and legislative processes for dealing with health service complaints

The sections below detail the amendments proposed under Recommendation 4 which were recommended by the Health Ombudsman to make the OHO operate more efficiently in the face of increasing complaint numbers.[163]

2.3.1.4 Deciding how to proceed with a complaint

According to the explanatory notes, if passed, the new S35A, of the *Health Ombudsman Act 2013* will give the Health Ombudsman the discretion not to accept a complaint in cases where the complainant has not attempted to resolve the complaint with the health service provider or where the complaint is better handled by another entity. The Health Ombudsman may accept complaints where direct resolution may not be appropriate, such as if the complaint involves an allegation of physical or sexual misconduct and the complainant may be uncomfortable in contacting the health service provider directly. However, these amendments do not authorise legitimate complaints to be refused. Rather, these changes will ensure that the appropriate entity is dealing with a complaint and that a complainant has first attempted a direct resolution with the practitioner or service, where possible and appropriate.[164] According to the explanatory notes, these measures will assist in ensuring resources are allocated efficiently and directed to more complex and serious complaints; and that resources are only directed to low-risk matters if attempts by the complainant to resolve the matter are unsuccessful or if it is unsuitable for the parties to resolve the matter without OHO's involvement.[165]

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161 Public briefing transcript, Brisbane, 16 September p 13.

162 Explanatory notes, p 6.

163 Public briefing transcript, Brisbane, 16 September p 13.

164 Explanatory notes, p 13.

165 Explanatory notes, p 13.

2.3.1.5 Practitioner monitoring

There is no specific power in the *Health Ombudsman Act 2013* to monitor compliance with conditions, prohibitions or other action that may be taken by the Health Ombudsman.[166] Clause 54 of the Bill inserts a new subsection (c) to S186 which clarifies that function of authorised persons is to investigate or monitor the activities of a person the subject of immediate registration action, or an interim prohibition order.[167]

2.3.1.6 Final prohibition orders for unregistered practitioners

Under the current system the Health Ombudsman can only make interim prohibition orders, while final prohibition orders can only be made by QCAT under section 113 on referral from the Director of Proceedings.[168]

The Bill proposes that the Health Ombudsman also makes final prohibition orders for unregistered health practitioners, with QCAT becoming responsible for reviewing these decisions upon application.[169]

At the public briefing on 16 September, 2019 the Health Ombudsman explained that this change would align Queensland with other jurisdictions including Victoria, New South Wales and South Australia. He noted that 10 to 12 percent of the OHO workload (both investigations and Director of Proceedings matters) relate to unregistered practitioners. If those matters would no longer need to go to QCAT or the Director of Proceedings in the first instance but could go there on review. That would lead to a reduction in the quantity of work going to QCAT.[170]

2.3.1.7 Obtaining additional information after referral to the Director of Proceedings

The Director of Proceedings is a staff member of the OHO and is responsible for lodging proceedings about health practitioners with QCAT. Where required, the Director of Proceedings is able to refer matters back for to the OHO for further investigation. However, some of the referrals to the Health Ombudsman for further investigation were matters requiring further evidence or information, rather than requiring the Health Ombudsman to further investigate the complaint. The proposal to amend the Health Ombudsman Act aims to streamline the process so that rather than referring the matter back to the Health Ombudsman for further investigation, the Director may refer a matter to the Health Ombudsman to obtain additional information.[171]

At the public briefing the Director of Proceedings provided an example of a situation in which this new proposal would create efficiencies in the health complaints process.

> *I had one matter where the sole piece of information that I required before being able to make a decision was medical records. In order to do that, the matter had to go back to the Health Ombudsman. The Health Ombudsman had to make a decision to refer it to investigations. Investigations then were required to send out notices saying that there is an investigation undertaken. It took a week. They then had to send out a notice again to say that the matter had been referred back to the Health Ombudsman, and then the Health Ombudsman had to refer it back to the DOP. Really, the only thing practically was that the DOP required some medical records. Practically the only distinction is the amount of work involved.*[172]

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166 Explanatory Notes, p7.

167 Explanatory Notes, p39.

168 Part 7, division 2 of the *Health Ombudsman Act 2013*.

169 Explanatory Notes, p14.

170 Public briefing transcript, Brisbane, 16 September p15.

171 Explanatory Notes, p9.

172 Public briefing transcript, Brisbane, 16 September p16.

2.3.1.8 Changing the constitution of QCAT for certain matters

According to the explanatory notes Queensland is currently the only state that requires a judicial officer to hear disciplinary proceedings involving unregistered health practitioners. The Health Ombudsman Act requires that, for a disciplinary proceeding, QCAT must be constituted by one judicial member.[173] The Bill proposes to amend the Health Ombudsman Act and the Queensland-specific provisions of the National Law to give greater discretion to the president of QCAT to decide which members should constitute QCAT for certain matters.[174]

2.3.1.9 Altering timeframes in the Act by changing calendar days to business days.

To ensure consistent timeframes, the Bill proposes that timeframes in the Health Ombudsman Act will be changed from 'days' to 'business days' for actions under the Act.[175]

2.3.2 Stakeholder views

Of the submissions received on the Bill, the Cancer Council of Queensland, the National Heart Foundation and AMA Queensland noted general support for the proposed changes to the *Health Ombudsman's Act 2013.*[176] In addition, QNMU, HCQ, QLS and the Medical Insurance Group Australia (MIGA) provided commentary on the proposed changes.[177]

2.3.2.1 Joint consideration of matters between OHO and AHPRA and the National Boards (Recommendation 1 of the former committee)

AMA Queensland[178] and QNMU[179] expressed support for the proposed amendment. HCQ indicated that they would like to see a comparison in time taken to resolve complaints under both the old and new systems.[180] The Medical Insurance Group of Australia (MIGA) also supported the expanded use of the joint consideration process but thought that the changes should go further to include joint consideration in the post-assessment and investigation stages.[181] The MIGA submission asserted that an expanded consideration process has worked well in New South Wales and provides more flexibility in dealing with a complaint in later stages of the process in circumstances where more information about a particular case emerges warranting a different course of action.[182] MIGA also expressed the view that the OHO should be informed by clinical input during the joint consideration process.[183]

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173 A 'disciplinary proceeding' is defined in schedule 1 of the Health Ombudsman Act and includes a wide range of QCAT proceedings, including proceedings to review a decision by the Health Ombudsman to take immediate registration action or issue an interim prohibition order, and to hear matters referred to QCAT by the Director of Proceedings and by a National Board.

174 Explanatory Notes, p 8.

175 Explanatory Notes, p 9. See also Schedule 1 of the Acts Interpretation Act 1954 which defines commonly used words and expressions in Queensland legislation, including 'business day', which is defined as a day that is not a weekend, public holiday, special holiday or bank holiday.

176 Cancer Council Queensland, Submission 3, p1., National Heart Foundation of Australia, Submission 5, p1., AMA Queensland, Submission 13, p1.

177 QNMU, Submission 9, p12, AMA Queensland, Submission 13, p4, HCQ, Submission 18, p5., Queensland Law Society, Submission 17, p1.

178 AMA Queensland, Submission 13, p 4.

179 QNMU, Submission 9, p 5.

180 HCQ, Submission 18, p 5.

181 Medical Insurance Group Australia (MIGA), Submission 2, p 1.

182 MIGA, Submission 2, pp 2-3.

183 MIGA, Submission 2, p 4.

QLS expressed concern about the proposed Division 2B because it enables AHPRA to require a referral after the OHO has decided to take no further action. This could subject a practitioner to a possible second investigation.[184]

Response from Queensland Health

In its response to the public submissions, Queensland Health stated that it did not consider it necessary for OHO to be routinely informed by clinical input during the joint consideration process.

> *A significant proportion of potential professional misconduct matters retained by the OHO are not clinical performance matters but rather non-clinical conduct issues. OHO seeks clinical input into decision-making when needed.*[185]

Queensland Health advised that although the OHO must provide a copy of the complaint and other relevant information to AHPRA where it proposes to take no further action, AHPRA will only deal with the matter if it considers that further action is required.[186]

2.3.2.2 Reducing the splitting of matters between OHO and AHPRA (Recommendation 2)

Stakeholders supported reducing the splitting of matters between OHO and AHPRA with AMA Queensland[187] and HCQ backing the change.

> *…we support the amendments aimed at maximising joint consideration of serious professional misconduct matters to be able to be dealt with as a whole (conduct, performance and health/impairment), rather than being split between the Health Ombudsman (conduct) and AHPRA (impairment).*[188]

MIGA was also supportive of the proposed amendments, but would like to see the development of policies around handling split serious impairment matters.[189]

Response from Queensland Health

Queensland Health did not comment on the MIGA suggestion.

2.3.2.3 Deciding how to deal with a complaint (Recommendation 4)

Most of the stakeholders that commented on the changes to the *Health Ombudsman's Act 2013* were supportive of the insertion of the new S35A relating to the acceptance of complaints.[190] However QNMU recommended that the new section 35A be deleted and provided the following reasons:

- AHPRA and OHO should accept complaints rather than referring them to other entities such as the Aged Care Quality and Safety Commission (ACQSC). That is because ACQSC investigates aged care and not health care whereas AHPRA and the OHO have knowledge of health service standards.[191]
- Expecting a complainant to seek resolution with a service provider in the first instance may be difficult in circumstances where there is a power imbalance.[192]

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184 Queensland Law Society (QLS), Submission 17, p 4.

185 Correspondence, Queensland Health, 26 September 2019, p 23.

186 Correspondence, Queensland Health, 26 September 2019, pp 23-24.

187 AMA Queensland, Submission 13, p 4

188 HCQ, Submission 18, p5.

189 MIGA, Submission 2, p 1.

190 MIGA, Submission 2, p 1; Cancer Council Queensland, Submission 3, p 1; National Heart Foundation of Australia, Submission 5, p 1; AMA Queensland, Submission 13, p 1.

191 QNMU, Submission 9, p 12.

192 QNMU, Submission 9, p 12.

HCQ also expressed concern that expecting a complainant to seek resolution with a health service provider may be problematic where for example in remote and rural areas there is often a single provider, therefore raising a complaint results in a perceived or real barrier to not receiving treatment.[193] HCQ also offered the OHO assistance in co-designing decision making pathways and oversight of the system to avoid unintended consequences.[194]

MIGA considered that practitioners should be given notice of the Health Ombudsman's decision not to accept a complaint. [195]

Response from Queensland Health

In its response to submissions Queensland Health provided the following information addressing the concerns of QNMU and HCQ.

> *The Health Ombudsman will develop guidelines for OHO staff about matters that must be accepted and the type of matters that may be appropriate to decline. The guidelines will make it clear that the following aspects need to be considered:*
>
> - *the nature of the complaint (that is, the level of risk/seriousness posed and whether it indicates any systemic concerns);*
> - *the attributes of the complainant (that is, their ability to progress the complaint themselves or whether they are vulnerable or have an impairment); and*
> - *any reasons given by a complainant as to why they do not feel able to progress their complaint themselves.*
>
> *If there is a power imbalance, personal differences or other similar situations between the complainant and practitioner, OHO would not require the complainant to first attempt to resolve the complaint directly.*[196]

Furthermore, Queensland Health agreed to consult with HCQ on the development of the guidelines.[197]

However, Queensland Health advised that requiring practitioners to be notified when a complaint was not accepted would undermine the efficiencies gained by the proposed changes to the *Health Ombudsman's Act 2013.* [198]

2.3.2.4 Practitioner monitoring (Recommendation 4)

There was general support amongst submitters for the proposal about practitioner monitoring.[199] MIGA suggested that a policy should be developed by the Health Ombudsman in consultation with AHPRA and the National Boards bodies, with further input from key stakeholders (including MIGA) on what appropriate monitoring following immediate registration action involves.[200]

Response from Queensland Health

Queensland Health did not comment on this suggestion.

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193 HCQ, Submission 18, p 5.

194 HCQ, Submission 18, p 5.

195 MIGA, Submission 2, p 5.

196 Correspondence, Queensland Health, 26 September 2019, p 25.

197 Correspondence, Queensland Health, 26 September 2019, p 24.

198 Correspondence, Queensland Health, 26 September 2019, p 24.

199 HCQ, Submission 18, p 5, Medical Insurance Group Australia, Submission 2, p 6.

200 MIGA, Submission 2, p 6.

2.3.2.5 Final prohibition orders for unregistered practitioners (Recommendation 4)

Serious consequences of prohibition orders

Although the proposal to enable the Health Ombudsman to make final prohibition orders in relation to unregistered practitioners was supported by stakeholders, QNMU and the QLS were opposed to the changes.

> *Given the extremely serious consequences for a person if a prohibition order is made, it is our view prohibition orders should only be made by an independent body such as QCAT…*
>
> *Prohibition orders, in our view, require independent consideration and the opportunity of a tribunal hearing, rather than a decision made by an involved party akin to a prosecuting authority. We do not consider the availability to appeal the HO's decision in relation to a prohibition order is an adequate measure to ensure independent oversight of a decision with such serious consequences.*[201]

In addition, QLS noted that they would prefer that such a significant power remain with the tribunal, given the impact on individual's rights to practice in their chosen field.[202]

Response from Queensland Health

Queensland Health advised that the legislation includes several safeguards that must apply before the Health Ombudsman can make a final prohibition order.[203] These include:

- the Health Ombudsman must be satisfied that the practitioner poses a serious risk to persons[204]
- the health practitioner may apply for review by QCAT[205]
- the Health Ombudsman is personally required to make the decision to issue a final prohibition order about an unregistered health practitioner[206]
- affording health practitioners natural justice through the show cause process and requiring the Health Ombudsman to have regard to any written submissions made by the practitioner in deciding whether to issue the order[207]
- providing for the Health Ombudsman to vary a prohibition order, either on the Health Ombudsman's own initiative[208]or upon application by the practitioner[209] if there is a material change in relation to the matter giving rise to the issue of the order. A show cause process also applies to the variation of orders.[210]

At the public briefing on 9 October 2019 Dr Wakefield further explained:

> *I think it is really important to note that this reform aligns Queensland with the other jurisdictions including Victoria, New South Wales and South Australia. In these jurisdictions, the relevant*

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201 QNMU, Submission 9, p 13.

202 QLS, Submission 17, p 3.

203 Correspondence, Queensland Health, 26 September 2019, p 25.

204 Clause 40 *Health Transparency Bill 2019*, new section 90C.

205 Clause 40 *Health Transparency Bill 2019*, new section 90N.

206 Clause 62 *Health Transparency Bill 2019*, amendment of section 285.

207 Clause 40 *Health Transparency Bill 2019*, new section 90D.

208 Clause 40 *Health Transparency Bill 2019*, new section 909I.

209 Clause 40 *Health Transparency Bill 2019*, new section 90J.

210 Correspondence, Queensland Health, 26 September 2019, p 25.

health complaints bodies are empowered to issue these types of orders for unregistered practitioners, rather than the tribunal.[211]

Ability for QCAT to stay OHO decision

QLS was of the view that if the power to prohibit the practice of unregistered practitioners is to vest with the Health Ombudsman, with a right to apply to QCAT for review, then it is essential that QCAT is empowered to grant a stay or make an order varying the Health Ombudsman's decision while the application to QCAT is being progressed.[212] However, in the public hearing they qualified this position by stating:

The society is not for a moment suggesting that in the context of an interim prohibition order—in other words, something has to happen urgently—the Health Ombudsman is either prevented from doing that or prevented from going to QCAT or, for that matter, in that context, a stay order should be allowed. The process I spoke about in the bill is the next process. In other words, immediate action has not been taken but an investigation process has taken place and the final outcome is a determination that that unregistered practitioner should not be allowed to remain working in the health space.[213]

Response from Queensland Health

Queensland Health advised that the Clause 45 of the Bill which amends section 100 of the Health Ombudsman Act and provides that QCAT cannot grant a stay of a decision to issue a prohibition order under part 8A is justified because the guiding principle of the Health Ombudsman Act is that the health and safety of the public is paramount.[214] Queensland Health considered that giving QCAT the power to grant a stay of a decision to issue a prohibition order would have the effect of placing the personal interests of the individual practitioner ahead of the interests of the public.[215]

Publication of matters about practitioner health

With respect to proposed section 90Q, QLS was of the view that matters relating to practitioners' health should be excluded from publication.[216]

Response from Queensland Health

Queensland Health explained that the new section 90Q mirrors the existing requirements in section 79 of the Health Ombudsman Act. Furthermore, S90Q(5) requires the Health Ombudsman not to publish information that it considers would be inappropriate to publish. Only the details of a prohibition orders are required to be published.[217] Queensland Health also noted that the OHO has reviewed the prohibition orders currently published and advises that none of those orders contain health information about a practitioner.[218]

Prohibition orders for a limited time period

In its submission, QLS suggested that the Office of the Health Ombudsman should be required to notify the practitioner when a time limited prohibition order is no longer in effect. It also noted there is not

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211 Public briefing transcript, Brisbane, 9 October p 2.

212 QLS, Submission 17, p 3.

213 Public hearing transcript, p 35.

214 Correspondence, Queensland Health, 26 September 2019, p 27.

215 Correspondence, Queensland Health, 26 September 2019, p 27.

216 Queensland Law Society, Submission 17, p 3.

217 S79 *Health Ombudsman Act 2013.*

218 Queensland Health, correspondence dated 26 September 2019, p 28.

a provision for the removal of published information about the expired order from the Office of the Health Ombudsman's website.[219]

Response from Queensland Health

In its response to submissions, Queensland Health noted that if an order is made for a particular period of time, the practitioner will be notified of the length of the order at the time the order is made.[220] Queensland Health again referenced the guiding principle of the Health Ombudsman Act that the health and safety of the public is paramount. So it resolved that it is appropriate for prohibition orders to remain published on OHO's website, even if they are only for a particular period of time.[221]

2.3.2.6 Obtaining additional information after referral to the Director of Proceedings (Recommendation 4)

MIGA was the only submitter that expressed concern about the proposed change regarding referrals back to the OHO from the Director of Proceedings. MIGA contended that further delays would be involved and that practitioners should receive notification about these referrals.[222]

Response from Queensland Health

Queensland Health Advised that the reforms in this area will remove administrative burdens associated with internal processes within the OHO. However, requiring practitioners to be notified if the Director of Proceedings refers a matter back to the Health Ombudsman for the purpose of obtaining additional information would undermine the efficiencies of these changes.[223]

2.3.2.7 Composition of QCAT for certain matters (Recommendation 4)

QNMU and QLS were the only stakeholders that registered an objection to Clause 44, the amendment of s. 97 which provides the president of QCAT with the discretion to decide which members should constitute QCAT in relation to unregistered health practitioners.[224]

QNMU expressed the view that the current arrangements best serve the public interest by maintaining the independence and authority of the judicial member. They also asserted that constituting QCAT with judicial members would lead to delays and went further to state:

> *We cannot see how, given the serious consequences that could flow for practitioners from these decisions these matters are any less deserving of consideration by a judicial member than the matters which would continue to require judicial consideration.*[225]

QLS formed a similar view:

> *QLS does not consider that the appropriate solution to delays in QCAT is to fundamentally change the manner in which matters of great significance to the individuals concerned are dealt with. QLS is of the view that matters relating to the ability of individuals to continue in their profession should continue to be heard by judicial members (or at the very least, senior members) and that QCAT should be adequately resourced to allow that to occur.*[226]

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219 QLS, Submission 17, p 3.

220 Correspondence, Queensland Health, 26 September 2019, p 28.

221 Correspondence, Queensland Health, 26 September 2019, p 28.

222 MIGA, Submission 2, p 6.

223 Correspondence, Queensland Health, 26 September 2019, p 29.

224 QNMU, Submission 9, p14 and Queensland Law Society, Submission 17, p 4.

225 QNMU, Submission 9, p 14.

226 QLS, Submission 17, p 4.

Response from Queensland Health

In its response to submissions Queensland Health reiterated that the amendments do not require QCAT to be constituted by a non-judicial member. Rather, they allow the President of QCAT to decide the composition of the tribunal for each case. Should the President consider the case appropriate to be heard by a non-judicial member then the tribunal be constituted in that way.[227]

2.3.2.8 Timeframes (Recommendation 4)

MIGA was the only stakeholder that expressed a view about changing timeframes from days to business days. It requested more realistic timeframes for practitioner complaint responses and Health Ombudsman assessment timeframes.[228] MIGA went on to suggest that the timeframes used in NSW by the HCCC would be more appropriate.

Response from Queensland Health

Queensland Health did not comment on this suggestion in its response to submissions.

2.3.2.9 Committee comment

The committee supports the proposed amendments to the *Health Ombudsman Act 2013.* The committee considers the changes proposed by the Bill will improve the performance of the health complaints system in Queensland.

[227] Queensland Health, Correspondence dated 26 September 2019, p 29.

[228] MIGA, Submission 2, p 1.

3 Compliance with the *Legislative Standards Act 1992*

3.1 Fundamental legislative principles

Section 4 of the *Legislative Standards Act 1992* (LSA) states that 'fundamental legislative principles' are the 'principles relating to legislation that underlie a parliamentary democracy based on the rule of law'.

The principles include that legislation has sufficient regard to:

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

The committee has examined the application of the fundamental legislative principles to the Bill. The committee brings clauses 9, 15, 20, 21, 22 and 40 to the attention of the Assembly.

3.1.1 Rights and liberties of individuals

Section 4(2)(a) of the *Legislative Standards Act 1992* requires that legislation has sufficient regard to the rights and liberties of individuals.

3.1.1.1 Fairness and reasonableness – Clause 40

Clause 40 introduces section 90C into the *Health Ombudsman Act 2013* (Health Ombudsman Act). Section 90C provides that the health ombudsman may issue a prohibition order to a health practitioner (other than in the person's capacity as a registered health practitioner) if the health ombudsman –

a) has completed an investigation under part 8 relating to the practitioner

b) is satisfied that, because of the practitioner's health, conduct or performance, the practitioner poses a serious risk to persons.

Subsection 90C(2) sets out a non-exhaustive list of matters that may be considered to constitute a serious risk (of harm) posed to a person by a health practitioner.

The provision raises a potential FLP issue in relation to fairness and reasonableness of the treatment of individuals.

Former committees have considered the reasonableness and fairness of treatment of individuals as relevant in deciding whether legislation has sufficient regard to the rights and liberties of individuals.

The imposition of a prohibition order by the health ombudsman on a health practitioner brings with it serious consequences. The effect of a prohibition order is set out in new section 90B (clause 40 of the bill). It states that a prohibition order –

a) prohibits the practitioner, either permanently or for a stated period, from providing any health service; or

b) imposes stated restrictions on the provision of any health service, or a stated health service, by the practitioner.

A health practitioner that is the subject of a prohibition order would be restricted in their normal occupation as a health practitioner or prevented from performing their role as a health practitioner. This is a significant impost on a health practitioner's right to operate in their normal occupation.

However, the health practitioner is provided a show cause notice (section 90D) and can apply to QCAT for a review of the decision (section 90E(b)(ii)).

The explanatory notes do not provide specific justification for these provisions and the potential breach of fundamental legislative principle. The committee sought further information from Queensland Health in relation to this issue.

In its response dated 14 October 2019 and published on the committee's website, Queensland Health stated:

Queensland Health accepts that prohibition orders affect the rights and liberties of individuals, but considers that any potential breach of fundamental legislative principles is justified.[229]

Queensland Health set out the following rationale within its response:

<u>Regulation of health practitioners</u>

Section 4 of the Health Ombudsman Act provides that the main principle for administering the Act is that the health and safety of the public are paramount. Health services are unique as they involve a high level of trust between the patient and practitioner, relate to sensitive and confidential matters and may require interventions such as physical contact, examinations of a person's body or other treatments of a personal nature. People seeking health services are often in a vulnerable position, and there is often a significant power imbalance between a health practitioner and their patient as a result. It is therefore essential that practitioners are held to high standards and that the public can be confident that their health and safety is protected.

Registered health practitioners are regulated by both the Office of the Health Ombudsman and Australian Health Practitioner Regulation Agency (AHPRA) in Queensland. Registered health practitioners are required to keep AHPRA updated with their employment and address details, meet ongoing educational requirements and disclose their criminal history on an annual basis to maintain their professional registration.

Unregistered health practitioners provide health services but are not required to be registered by AHPRA. They include assistants in nursing, massage therapists, naturopaths, social workers and speech pathologists. As unregistered health practitioners are not required to be registered by AHPRA, it is important that the Health Ombudsman has the ability to regulate them effectively.

Prohibition orders made by Queensland Civil and Administrative Tribunal (QCAT) The power to issue a prohibition order to an unregistered practitioner already exists in the Health Ombudsman Act under part 10, division 4. Currently, QCAT can make these orders on referral from the Director of Proceedings.

Since 1 July 2014, QCAT has issued permanent prohibition orders against three unregistered practitioners preventing them from providing any health service. These practitioners were subject to interim prohibition orders prior to QCAT imposing a permanent prohibition order. In each case, the practitioners were convicted of significant criminal offences against their patients and were found to pose a serious risk to persons by QCAT.

The new division will empower the Health Ombudsman, rather than QCAT, to make prohibition orders. However, an unregistered health practitioner may still apply to QCAT to review a decision by the Health Ombudsman to make a prohibition order.

<u>Least restrictive action</u>

A prohibition order can apply to conduct with varying levels of seriousness. It may not completely prevent a practitioner from performing their occupation. A prohibition order can allow a practitioner to continue practicing but may limit or restrict their practice. For example, it may limit a practitioner to only treating patients of a particular gender or prevent a practitioner from promoting or providing certain remedies or services.

As a statutory decision-maker, when deciding whether to issue a prohibition order, the Health Ombudsman must take the least restrictive action to ensure public protection. The action taken must be proportionate to protect against the conduct of the practitioner in question.

[229] Correspondence, Queensland Health, 14 October 2019, Attachment p 1.

If the conduct is less serious, conditions or restrictions are imposed in the first instance. A decision to issue a prohibition order that prohibits a practitioner from providing any health service is a decision of last resort. It would only be made in the most serious cases where there is a serious risk to patients and a complete prohibition order is the only option that would ensure public protection.[230]

Queensland Health also explained that the ability for a regulatory body to limit or prevent a person from carrying out their occupation is not unique to health practitioners and provided a number of other examples within the legal, teaching and engineering professions.[231]

3.1.1.2 Committee comment

The committee is satisfied with the explanation provided by Queensland Health regarding the justification for the potential breach of FLP.

3.1.1.3 Proportion and relevance - Clauses 15, 20, 21, 22

Summary of provisions

The Bill provides for a number of new penalties. These are summarised in the table below.

Clause	**Penalty**
15	In relation to private residential aged care facilities, a maximum penalty of 100 penalty units is applicable if a person fails to respond to a notice given by the chief executive requesting information.
20	In relation to public sector health service facilities, State aged care facilities and private health care facilities, a maximum penalty of 100 penalty units applies if a person fails to respond to a notice given by the chief executive.
21	A maximum penalty of 100 penalty units applies if a person gives the chief executive false and misleading information
22	This clause provides for a maximum penalty of 50 penalty units if a person involved in the administration of the Act uses or discloses personal information.
40	New section 90P of the Health Ombudsman Act imposes a maximum penalty of 200 penalty units for contravening a prohibition order or corresponding interstate order.

230 Correspondence, Queensland Health, 14 October 2019, Attachment pp 1-2.

231 Correspondence, Queensland Health, 14 October 2019, Attachment pp 3-4.

Potential FLP issues

Proportion and relevance

Consequences imposed by legislation should be proportionate and relevant to the actions to which the consequences are applied by the legislation. The OQPC Notebook states 'the desirable attitude should be to maximise the reasonableness, appropriateness and proportionality of the legislative provisions devised to give effect to policy'.[232]

A penalty should be proportionate to the offence. The OQPC Notebook states, 'Legislation should provide a higher penalty for an offence of greater seriousness than for a lesser offence. Penalties within legislation should be consistent with each other'.[233]

The explanatory notes provide the following justification:

> *The potential breach of FLPs by the inclusion of a penalty provision is necessary to ensure compliance with the provisions regarding the collection of information. The information provided is expected to be used by Queenslanders in making informed decisions about their health care. It is paramount that this information be provided in a timely and accurate way by health facilities and RACFs [residential aged care facilities].*[234]

The explanatory notes also discuss the proportionality of the penalties imposed:

> *The quantum of the penalty is consistent with several similar sections of the Public Health Act that deal with persons providing information. For example, section 424 of the Public Health Act provides a maximum penalty of 100 penalty units for giving an authorised person a false or misleading document. Section 363 provides a maximum penalty of 100 penalty units for providing false or misleading documents to an emergency officer.*[235]

In relation to the maximum 200 penalty unit offence in new section 90P of the Health Ombudsman Act, the explanatory notes provide the following justification:

> *… A significant penalty is considered necessary to deter a person subject to a prohibition order or corresponding interstate order from breaching the order and continuing to practice where they may be a serious risk to persons. The penalty is considered justified because it is consistent with the penalties for similar offences under sections 78 and 115 of the Health Ombudsman Act about contravention of prohibition orders.*[236]

3.1.1.4 Committee comment

The committee is satisfied that the various penalty provisions established under the Bill are appropriate and proportionate to the offending conduct.

3.2 Explanatory notes

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

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232 Office of the Queensland Parliamentary Counsel, Fundamental Legislative Principles: *The OQPC Notebook*, p 120.

233 Office of the Queensland Parliamentary Counsel, Fundamental Legislative Principles: *The OQPC Notebook*, p 120.

234 Explanatory notes, p 16.

235 Explanatory notes, p 17.

236 Explanatory notes, p 19.

3.2.1.1 Committee comment

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

The committee makes one minor comment on the content of the notes, specifically that they did not explicitly discuss all FLP issues (see discussion above regarding Clause 40 in section 3.1.1.1). Queensland Health provided further information on this matter to support the committee's consideration of the Bill.

Appendix A – Submitters

Sub #	Submitter
001	John Carter
002	Medical Insurance Group Australia (MIGA)
003	Cancer Council Queensland
004	Leading Age Services Australia
005	National Heart Foundation of Australia
006	COTA Queensland
007	Royal Australasian College of Surgeons
008	The Public Advocate
009	Queensland Nurses and Midwives' Union
010	Dementia Australia
011	Queensland Alliance for Metal Health
012	Aged Care Crisis Inc
013	Australian Medical Association Queensland (AMA)
014	Pharmaceutical Society of Australia
015	Aged & Disability Advocacy Australia (ADA Australia)
016	Qld Surgical Advisory Committee
017	Queensland Law Society (QLS)
018	Health Consumers Queensland
019	Southern Cross Care (Qld)

Appendix B – Officials at public departmental briefings

16 September 2019

Queensland Health

- Dr John Wakefield, Acting Director-General of Queensland Health
- Ms Kathleen Forrester, Deputy Director-General, Strategy, Policy and Planning Division
- Ms Deborah Miller, Acting Chief Nursing and Midwifery Officer
- Ms Kirstine Sketcher-Baker, Executive Director, Patient Safety and Quality Improvement Service
- Ms Tricia Matthias, Acting Director, Legislative Policy Unit
- Mr James Liddy, Manager, Legislative Policy Unit

Office of the Health Ombudsman

- Mr Andrew Brown, Queensland Health Ombudsman
- Mr Scott McLean, Director of Proceedings

9 October 2019

Queensland Health

- Dr John Wakefield, Director-General, Queensland Health
- Ms Kirstine Sketcher-Baker, Executive Director, Patient Safety and Quality Improvement Service
- Ms Deborah Miller, Acting Chief Nursing and Midwifery Officer
- Mr David Harmer, Senior Director, Strategic Policy and Legislation Branch
- Ms Tricia Matthias, Acting Director, Legislative Policy Unit
- Mr James Liddy, Manager, Legislative Policy Unit

Appendix C – Witnesses at public hearing

Brisbane, 9 October 2019

Queensland Nurses and Midwives' Union

- Elizabeth Mohle, Secretary
- Dr Elizabeth Todhunter, Research and Policy Officer
- Daniel Prentice, Professional Research Officer
- Kalina Pyra, Hall Payne Lawyers

Australian Medical Association Queensland

- Dr Richard Kidd, Chair, Council of General Practice

Aged Care Crisis

- Dr Michael Wynne, Policy Analyst

Council on the Ageing

- John Stalker, Policy Coordinator

Aged and Disability Advocacy Australia

- Geoff Rowe, Chief Executive Officer

Health Consumers Queensland

- Melissa Fox, Chief Executive Officer
- Anne Curtis, Engagement Consultant, Special Projects

Royal Australasian College of Surgeons

- Prof Deborah Bailey, Chair, Queensland State Committee

Queensland Surgical Advisory Committee

- Dr Robert Franz, Chair

Pharmaceutical Society of Australia

- Mark Lock, State Manager, Queensland
- Chris Campbell, Queensland President

The Public Advocate

- Mary Burgess, Public Advocate

Queensland Law Society

- Bill Potts, President
- Rebecca Anderson, Chair - Elder Law Committee
- Andrew Forbes, Deputy Chair - Occupational Discipline Law Committee

Statement of Reservation

Statement of Reservations
By LNP Members of the Committee

With respect to the Health Transparency Bill 2019, Hospital and Health Boards (State Aged Care facilities) Amendment Regulation 2019 and the Health Transparency Regulation 2019.

The LNP Members support the Bill and the recommendations in the Committee report but wish to raise some matters.

No one can't be moved by evidence coming from the hearings of the Royal Commission into Aged Care Quality and Safety and the events at Earle Haven nursing home on the 11th of July 2019 and for the need of an overhaul of the aged care system.

The Earle Haven disgrace was the subject of a hearing before the Royal Commission on the 5th of August 2019 and before this Committee on the 11th, 12th and 20th of September 2019.

The Royal Commission is due to deliver an interim report by the 31st of October 2019 though it is not known if it will contain recommendations.

For the discussion of this Bill it is important to understand the broader context into which the Queensland Government's Health Transparency Bill 2019 falls.

The Queensland Bill was introduced into the House on the 4th of September 2019 together with two regulations dealing with nurse percentages, daily resident care hours and other matters with a reporting date of 18th of October 2019.

EVIDENCE FOR DAILY RESIDENT CARE HOURS BEING SET AT 3.65 HOURS

We will initially look at care hours pursuant to the Hospital and Health Boards (State Aged Care Facilities) Amendment Regulation

> "The minimum average daily resident care hours at a state aged care facility prescribed under section 30c is 3.65 hours."

In relation to how the figure of 3.65 hours was determined the then Acting Director General said (16/9/2019)

> "The evidence base that suggests there is a relationship between staffing and outcomes in residential aged care is that there is very little research underpinning that at this stage."
> "We did a traditional literature search looking at literature that may be international. Given that there is little research, one of the commitments under this policy is that the research occur. On this implementation of minimum hours per resident day in the public sector, we would seek to research and evaluate so that we understood what the impact would be of putting a floor into the hours per patient or resident day."

The question then is - how was the 3.65 hours arrived at?

The Acting Director General (16/9/2019) said

> "I think it is fair to say that, because we were focussing on a minimum rather than an optimum we felt that was appropriate – at some level there was an arbitrariness to determining what that was. We used both of those data inputs to make that decision, noting that more research was needed to make a determination about the link and the relationship between staffing and residential outcomes, and that there was a commitment by government to put a minimum in place. Essentially that is how the figure was arrived at."

We further note the Acting Director General's comment as to when the ratios are to be implemented in the public system (16/9/2019)

> "With reference to the issue of will it take time for this to adjust and to work through these changes in the public system the answer to that is yes. That is why the Bill provides for a two year introduction period whereby they work towards the changes both in terms of the uplift in hours and the recruitment that goes along with that and also the skill mix changes in accord with government policy around job security and so on."

We also refer to the quote by the Director General on page 26 of the Committee's report.

It appears the Government has done "something" – but it can't substantiate the base for it. It is therefore critical as per Recommendation number 7 of the Committee that the work referred by the Director General, in the quote at page 26 of the Committee's report, be made public.

WHICH QUEENSLAND GOVERNMENT AGED CARE RESIDENTS BENEFIT FROM THE RATIO?

The regulation referred to earlier has a section entitled "Minimum average daily resident care hours" which establishes the 3.65 hr benchmark. Yet it only applies to sixteen named Queensland Health State Aged Care Facilities. In addition to those facilities there are 33 Multipurpose Health Services and 11 Transition Health Care Programs, operated by Queensland Health, offering aged care services.

Surprisingly the ratio will not apply to these residents even though significant numbers of Queenslanders access and use these services.

HOW MUCH TIME WILL REGISTERED NURSES SPEND WITH RESIDENTS?

The regulation that sets the hours also:-
"(1) .....prescribes the minimum percentage of nurses or registered nurses providing residential care at a State Aged care facility.....during each 24 hour period.....
(2) At least 50% of the care staff must be nurses
(3) At least 30% of the care staff must be registered nurses"

Does this mean that each resident will receive the 3.65 hours of care by staff in the proportions as outlined in the regulation?

The Director General on the 9th of October was asked

> "When you talk about the regulation, at least one half of care staff must be nurses and 30 per cent of care staff must be RNs. There will not be a calculation as to how much time RNs actually spend with a patient. It will be an average based upon the number of patients, the number of RNs, ENs and AINs. There will be no drilling down as I understand your comment; is that right?"

The Director General responded – "Correct".

Thus it is only an average across the facility and does not guarantee the provision of hours to aged care residents in accordance with the formula of the number of nurses and others.

We will provide further comment during the Second Reading Debate on this and other matters including the collection and publishing of data from private aged care providers.

X

Marty Hunt
Member for Nicklin - Member Queensland P...

X

Mark McArdle MP
Deputy Chair Queensland Parliamentary Hea...