Queensland Nurses & Midwives' Union

Submission to

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

Health Transparency Bill 2019 and

Health Transparency Regulation 2019

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submission

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Introduction

The Queensland Nurses and Midwives' Union (QNMU) thanks the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee (the Committee) for the invitation to comment on the *Health Transparency Bill* (the Bill) and the *Health Transparency Regulation 2019* (the Regulation).

Nursing and midwifery is the largest occupational group in Queensland Health (QH) and one of the largest across the Queensland government. The QNMU is the principal health union in Queensland covering all classifications of workers that make up the nursing workforce including registered nurses (RN), registered midwives (RM), nurse practitioners (NP), enrolled nurses (EN) and assistants in nursing (AIN) who are employed in the public, private and not-for-profit health sectors including aged care.

Our more than 60,000 members work across a variety of settings from single person operations to large health and non-health institutions, and in a full range of classifications from entry level trainees to senior management. The vast majority of nurses and midwives in Queensland are members of the QNMU. Our members not only provide midwifery, health and aged care services, they are also informed consumers.

The QNMU has shown a longstanding commitment to public reporting. 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. To this end the QNMU supports the Bill and Regulation.

The Bill will create a standalone legislative framework to collect and publish information about hospitals and aged care and the associated quality and safety information about these services. This information will be displayed on the website and will allow consumers to compare meaningful information about the health and residential aged care systems. We see this initiative as putting safety and transparency at the forefront of healthcare and aged care in this state and commend the Queensland Government for this undertaking.

The Bill also makes amendments to the *Health Ombudsman Act 2013* and the *Hospital and Health Boards Ac 2011* to establish nurse-to-resident ratios in State aged care facilities.

We thank the Queensland government for seeking the opinion of Queensland's nurses and midwives during the consultations for the bill. These are significant changes that will enable transparency in reporting of health data and improved quality of care in State provided aged care facilities. Our submission reiterates some of the general comments we made during this process and we provide suggested amendments to the Bill and associated Regulations.

Recommendations

The QNMU recommends the parliament pass the Bill and associated Regulation with the following suggested amendments.

Health Transparency Bill 2019

In Part 1 (3) **Purposes of Act** we suggest the addition of higher objectives based on KPMG's six dimensions of transparency in healthcare discussed on page 6.

Amendments to the Health Ombudsman Act 2013

- Clause 32 - Insertion of new s. 35A – Non-acceptance of complaint – be deleted.
- Clause 40 - Insertion of new part 8A – be deleted.
- Clause 44 - Amendment of s. 97 (Constitution of QCAT) - be deleted.

Amendment of Hospital and Health Boards Act 2011 in relation to the following:

- Residential aged care
- State aged care facility workload management information
- Clearly indicating in section 138H - Prescription of minimum nurse and registered nurse percentages that Team Leaders are not counted in calculations of hours of care per resident per day.

Health Transparency Regulation 2019

Insertion of the following definition of 'midwife' to distinguish this profession from nursing and align with the *Hospital and Health Board Act 2011*.

> *midwife* means a person registered under the Health Practitioner Regulation National Law to practise in the midwifery profession, other than as a student

Hospital and Health Boards (State Aged Care Facilities) Amendment Regulation 2019

The definition of 'residential care' be further clarified to refer to personal care or nursing care, or both personal care and nursing care provided to a person, i.e. it is not referring to delivering meals or cleaning furnishings, furniture and equipment as also identified in the *Aged Care Act 1997* (Cwlth), ss 41-3.

The term 'state aged care facility workload management information' be reworded to 'state aged care facility nursing and support worker workload management information' to ensure only those staff undertaking nursing or support worker roles in the delivery of nursing and/or personal care are included in workload calculations.

The average minimum of 3.65 hours of care per resident per 24 hours should be clearly identified as the minimum with actual hours of care as calculated via the Business Planning Framework and documented in facility/ward/unit Service Profiles.

General comment on the Bill

The development of the website and associated legislation will have an impact on the different stakeholders who are part of Queensland's health and aged care sectors including:

- Consumers, patients and residents of health and aged care services. Reporting by itself is a limited activity but with the establishment of the website comes many opportunities for consumers and patients to compare like-for-like across a range of indicators. The information on the website must be meaningful and enable consumers, patients and residents to make informed decisions. It gives the consumer power to be a 'prosumer' and take responsibility for their health and aged care preferences and requirements. With the unprecedented access to information for consumers and an increasing push by consumers for health and aged care services to be accountable, the website is timely;
- Our members, the nurses and midwives of Queensland. We believe the website will show the vital contribution nurses and midwives make and shed light on the workloads of our members who practice in these areas and the consequential effect on patient safety. Further, increasing the knowledge of healthcare workers of their own performance can foster and inform their quality improvement activities and motivation to provide better care (Bureau of Health Information, 2010);

- Facilities and organisations who deliver the health service or operate residential aged care facilities. It will increase their accountability and transparency of the service and care they provide and safety and quality indicators. It will enable them to look at their care delivery and compare to other services and facilities;
- Regulatory and governance bodies which will have an opportunity to identify trends and issues in the health and residential aged care sectors and respond in a timely manner. It will also be an opportunity to use the health data to provide the evidence that informs health policy decision-making.

The undoubted benefit to stakeholders of creating a website for public reporting is transparency. The principles that underpin transparency were researched by Klynveld Peat Marwick Goerdeler (KPMG) an accounting and consultancy firm who undertook a study to establish what health systems need to do to make transparency into a powerful, positive change agent. Based on literature, the KPMG study established six dimensions of transparency in healthcare, those being:

1. **Quality of healthcare**: health provider performance measures, particularly quality of outcomes and processes.
2. **Patient experience**: patient perceptions of their experiences and outcomes.
3. **Finance**: transparency in price and payment and the public nature of accounts for healthcare services.
4. **Governance**: open decision-making, rights and responsibilities, resource allocation, quality assurance processes and accountability frameworks.
5. **Personal healthcare data**: access, ownership, and guaranteeing patients' individual health-related data.
6. **Communication of healthcare data**: the extent to which all the points above are made accessible, reliable and useful to all relevant stakeholders (KPMG, 2017).

In consideration of these dimensions, KPMG defines a transparent health system as one that provides accessible, reliable, useful and up-to-date information to all interested stakeholders, so they can acquire meaningful understanding of the quality, patient experience, finance, governance, and individual health data associated with healthcare systems, and make judgement on its fairness (KPMG, 2017). We ask the Committee to consider these dimensions to use as a foundation for the website.

The QNMU also asks the Committee to consider the establishment of a Health Performance Commission. We first recommended this in our submission to QH on public reporting in 2017. A Health Performance Commission would be an overarching, independent body to gather, analyse and report on data that enables value-based healthcare. This body should be under the aegis of a Health Performance Commissioner who has responsibility for designing, collecting and reporting on cost-utility of health data. Quality and safety indicators must inform this process.

The establishment of a Health Performance Commission, a specialist health data analytics and performance reporting body independent from QH, could be responsible for the proposed website. Its functions could include:

- Mapping and co-ordinating the collection, analysis and publication of health data across the public, private and aged care sectors to enable value-based healthcare;
- Managing end-to-end data, working from collection to publication;
- Linking hospital, aged care and health data with other economic and social data as an evidence base for value-based healthcare and new health programs;
- Developing the quality of clinical performance indicators for value-based healthcare and aged care;
- Undertaking further research to develop standardised, national nurse/midwife sensitive outcomes as important mechanisms for evaluating patient safety. As a minimum these must include:
    - Nurse/midwife staffing numbers;[1]
    - Nurse/midwife to patient ratios;
    - Nurse/midwife skill mix levels;
    - Nursing/midwifery process;
    - Nurse/midwife models of care;
    - Patient/resident health outcomes;
    - Nursing/midwifery workload concerns;
    - Patient/resident/staff satisfaction.
- Improving access to clinical data by clinicians, boards, departmental and Hospital and Health Services (HHS) staff;

[1] Public reporting of staffing numbers is to be inclusive of employment types such as permanent, temporary, casual, agency and full-time or part-time status as well as nursing/midwifery classification percentages.

- Consulting with consumers and interest groups on the format, content, context and accessibility of publication of healthcare data;
- Evaluating new technologies, treatments and drugs, e.g. the effective use of prostheses;
- Making research findings and raw data available to researchers where this has ethical approval and is in the public interest;
- Liaising with other States, Territories and the Commonwealth to compare and share data, produce economies of scale and ease the ongoing disagreements over funding; and
- Ensuring compliance with mandatory, public reporting requirements in the public, private and aged care sectors.

The QNMU also sees the website as an opportunity to develop specifically designed data sets and information systems for planning the nursing and midwifery workforce and delivering value-based care. Data sets provide information about the structure, process and quality outcomes specific to nursing and midwifery care. In consultation with nurses and midwives the development of these minimum data sets would provide the framework for nursing and midwifery care and recognize the valuable contribution nurses and midwives make to the health and aged care sectors.

The QNMU has a strong industrial, professional and social focus, and is committed to improving the safety and quality of care in hospitals and aged care facilities for all Queenslanders. The six dimensions of transparency in healthcare and the establishment of a Health Performance Commission we see as improving the care Queenslanders receive in private and public health facilities and public and private residential aged care facilities.

Information to which the bill applies

We wrote in a previous submission on Queensland Health's Governance Framework earlier this year about the need for targeted transparency - the disclosure of standardised information about each HHS regarding their performance to serve a regulatory purpose. HHSs provide performance data in their annual reports, but it is not standard across the board and the QNMU has experienced extreme difficulty in accessing meaningful workforce data. This makes any form of meaningful comparison virtually impossible.

Given the HHSs provide annual reports, targeted transparency could provide greater enforcement leverage in the public health space. Certainly, we see the creation of the website as a method to ensure standard quality and safety information is provided by all HHSs, hospitals and residential aged care facilities as requested by the proposed Health Performance Commission or QH.

Existing information

Information already captured by health and aged care services through existing data sources should be used to ensure staff and organisations are not burdened by duplication for the new website and should thus be covered under the new Bill.

General information

We suggest the following information should also be included as general information on the website:

- Bed numbers (capacity);
- License to operate;
- Costings:
    - the average prices for common hospital procedures;
    - out-of-pocket expenses; and
    - the type of arrangement the hospitals have with each health fund and whether the health funds will fully or partially cover costs relating to the hospital fees.

Quality and safety information

The QNMU asks that consumers using the website continue to be involved and consulted within the development of the website and patient-reported outcome measures. We also offer further suggestions of specific quality and safety information that can be prescribed by regulation to have content made available on the website:

- top ten Australian Refined Diagnosis Related Groups (AR-DRGs) for each facility;
- average length of stay;
- readmission rates;
- post-surgical mortality rates;
- presentations to emergency departments;
- reporting nurse/midwife sensitive outcomes; and
- patient experience surveys for all facilities.

Residential care information

The QNMU has long campaigned for staff ratios in aged care. Subsequently 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 residential aged care facilities.

The QNMU supports the Bill in the publication of ratios of aged care recipients to staff members in residential aged care, with the aim to create greater public transparency in the provision of residential aged care services. We believe the public reporting for this sector on the website should include:

- average hours of care per resident per day;
- percentage of RNs, ENs, AINs/ Personal Care workers (PCWs) to residents;
- pressure injuries – Stage 1, 2, 3, 4 as well as unstageable and suspected deep tissue injury;
- falls and falls-related fractures;
- use of physical restraint – intention to restrain, use of physical restraint devices;
- use of chemical restraint with psychotropic medications;
- resident and carer surveys;
- use of nine or more medicines; and
- unplanned weight loss, consecutive weight loss and significant weight loss.

Public reporting of adverse incidents such as assault, abuse, poor care, mistreatment or neglect must occur in all Queensland and Australian aged care facilities. We suggest the process for complaints should be evaluated to ensure the reporting pathway is accessible, visible and easily understood. These reported incidents should then be made available on the website.

Publishing information

To allow the public access to this information, 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 browsers and devices and assistive technologies. The website must also comply with international standards and best practice such as the Web Content Accessibility Guidelines (WCAG) 2.1 (World Wide Web Consortium (W3), 2018).

Collecting information

The QNMU supports the collection of information from existing sources to reduce double-handling and workload for organisations. The more information that is linked to or provided on the website, the greater informed consumers and patients. We suggest these information sources should be included and/or linked to:

- Aged Care Quality and Safety Commission (Australian Government);
- Coronial recommendations (Queensland Government);

- My Aged Care (Australian Government);
- Office of the Public Guardian (Queensland Government);
- Annual reports of for each public and private health facility and public and private residential aged care facilities.

Amendment of the *Health Ombudsman Act 2013*

Clause 32 - Insertion of new s. 35A Non-acceptance of complaint.

We accept clause 31 - Amendment of s. 35 (Deciding how to proceed) - however we do not accept the premise of clause 32 - Insertion of new s. 35A and part 3, divisions 2A and 2B - relating to acceptance of complaints.

Proposed s. 35A – Non-acceptance of complaint - states –

The health ombudsman may decide not to accept a complaint if the health ombudsman is satisfied—

(a) the complaint would be more appropriately dealt with by an entity other than the health ombudsman or an entity to whom the health ombudsman may refer the complaint under this Act; or

(b) the complainant has not sought a resolution of the complaint with the relevant health service provider and it is reasonable in the circumstances for the complainant to first seek the resolution.

Although there are other entities that may deal with investigations – for example the Aged Care Quality and Safety Commission (ACQSC) – the ACQSC investigates aged care, not health care, we contend OHO and AHPRA should accept the complaint under s. 35A(a) as OHO and AHPRA have knowledge of health service standards that apply in aged care.

The caveat to seek resolution of the complaint with the relevant health service provider under proposed s. 35A (b) may be difficult and inequitable in circumstances where there is a power imbalance or personal differences between the parties.

The QNMU recommends Clause 32 – insertion of new s. 35A Non-acceptance of complaint – be deleted.

Final prohibition orders for unregistered health practitioners to be made by Health Ombudsman

Clause 40 – insertion of a new part 8A

The proposed Part 8A would, if passed, empower the HO to make final prohibition orders for unregistered health practitioners.

We have concerns about this proposal, and do not support it.

Prohibition orders can be very broad in scope and application. Prohibition orders can prohibit a person from providing 'any health service'. 'Health service' is defined very broadly, as 'a service that is, or purports to be, a service for maintaining, improving, restoring or managing people's health and wellbeing', and includes 'a support service' for a health service (see s. 7).

Prohibition orders can be imposed with permanent effect. A prohibition order can render a person unemployable in any area even remotely connected with their work history and expertise. 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.

The HO's ability to make permanent prohibition orders themselves would arguably be akin to allowing the Police Commissioner themselves to permanently disqualify a person from driving.

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.

The QNMU recommends Clause 40 – Insertion of new part 8A – be deleted.

Composition of QCAT for certain matters

Clause 44 – amendment of s. 97 – Constitution of QCAT

The QNMU does not support the proposal to remove the requirement for the Queensland Civil and Administrative Appeals Tribunal (QCAT) to be constituted by a judicial member for certain matters. In our view, the current arrangements best serve the public interest by maintaining the independence and authority of the judicial member.

We reject the claim that constituting QCAT with judicial members causes increased cost and delays. No evidence has been provided to support this claim.

Delays in reviews under Part 7 of the *Health Practitioner Regulation National Law Act 2009* (the National Law) can be caused by many factors which vary in each case. Parties' preparedness for trial, the compulsory conferencing process and convening the health panel can all impact on the time a matter takes to proceed to a hearing.

Reviews under Part 7 of the National Law include reviews of decisions about applications for general registration, renewal of registration or endorsement. The powers of the Board which are subject to review include refusing to grant these applications and granting registration subject to conditions. 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.

Under s. 142 of the *Queensland Civil and Administrative Tribunal Act 2009* (QCAT Act), QCAT matters heard by a non-judicial member may be appealed to the QCAT Appeals Tribunal and therein lies a right of appeal from the QCAT Appeals Tribunal to the Court of Appeal (s. 150 of the QCAT Act). The proposed change will enliven these further appeal avenues and cause more time, cost and uncertainty for all parties.

Review of interim prohibition orders and final prohibition orders by the HO

The consequences of any kind of prohibition order are serious and the matters are usually complex. They require judicial consideration.

In any event, only a very small number of matters heard by QCAT relate to interim and final prohibition orders, so the proposed change will not have any material effect on the alleged delays and costs. Our searches have revealed only five QCAT decisions that deal with interim prohibition orders or prohibition orders since the Act commenced (one of these related to the HO seeking a prohibition order, and the other four related to appeals of the HO's decision to impose interim prohibition orders).

The QNMU recommends clause 44 - Amendment of s. 97 (Constitution of QCAT) - be deleted.

Amendment of the *Hospital and Health Boards Act 2011*

138G Definitions for Division

We propose rewording the following definitions.

Residential care

While the definition of residential care is accepted as having the meaning given by the *Aged Care Act 1997* (Cwlth), ss 41-3, we recommend the definition be further clarified to refer to personal care or nursing care, or both personal care and nursing care provided to a person,

i.e. it is not referring to delivering meals or cleaning furnishings, furniture and equipment as also identified in the *Aged Care Act 1997* (Cwlth), ss 41-3.

If modifying this definition is not possible in the Bill, the QNMU recommends this be clarified specifically in the Regulation.

State aged care facility workload management information

As the Bill relates specifically to nurses and support workers in the context of aged care ratios, it is recommended this term be reworded to *State aged care facility nursing and support worker workload management information.* This specificity will ensure only those staff undertaking nursing or support worker roles in the delivery of nursing and/or personal care are included in workload calculations.

The QNMU also suggests appropriate support resources be developed, e.g. educational packages and a Principles Document which will provide explicit guidance regarding collection and calculation of workload management information.

138H Prescription of minimum nurse and registered nurse percentages

Team leaders

While sub-section (3) states ".. a nurse or support worker is taken to be providing residential care at a State aged care facility only if the nurse or support worker is directly involved in providing residential car at the facility", it is the position of the QNMU that Team Leaders, however titled, and other staff such as Nurse Unit Managers should not be included in any ratios calculations.

Amendment of the *Hospital and Health Boards (State Aged Care Facilities) Amendment Regulation 2019*

30E Minimum average daily resident care hours – Act s. 138I

We recommend the average minimum of 3.65 hours of care per resident per 24 hours be clearly identified as the minimum with actual hours of care calculated via the Business Planning Framework and documented in facility/ward/unit Service Profiles. This must be clearly identified in the Bill and Regulation and be added to the *Nursing and Midwifery Workload Management Standard* developed under section 138L.

Conclusion

The proposed website and the legislative framework that aims to improve the transparency of the quality and safety of health services and aged care services provided in Queensland, is the first step in building a transparent health and aged care sector. We see this website evolving to include other measures and topics that provides consumers with information to make informed decisions about where to go for their healthcare and aged care. Implementing nurse-to-resident ratios in State aged care facilities and a reporting regime that focuses public attention on the level of safety and quality of care is a step forward in achieving an accountable and transparent health and aged care industry and a more informed consumer.

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