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19 September 2019

Committee Secretary
Health, Communities, Disability Services and
Domestic and Family Violence Prevention Committee
Parliament House
George Street
Brisbane Qld 4000

By email: ***health@parliament.qld.gov.au***

Thank you for providing AMA Queensland with the opportunity to provide a submission to the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee's (HCDSDFVPC) regarding the Health Transparency Bill 2019.

AMA Queensland is the state's peak medical advocacy group, representing over 6000 medical practitioners across Queensland and throughout all levels of the health system and are strong advocates for improved quality of care and appropriate levels of staffing in hospital and health care settings and in residential aged care facilities.

AMA Queensland supports the amendments contained within the Health Transparency Bill 2019 and the objectives of the Bill, that:

i. Establishes a legislative framework for collecting and publishing information about public and private hospitals and residential aged cared facilities (RACFs),
ii. Amends 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, and
iii. Amends the *Health Ombudsman Act 2013* to implement recommendations of the committee's Inquiry into the performance of the Health Ombudsman's functions pursuant to section 179 of the *Health Ombudsman Act 2013*.

AMA Queensland wishes to address each of these objectives separately.

Objective 1 Establish a legislative framework for collecting and publishing information about public and private hospitals and residential aged cared facilities (RACFs)

AMA Queensland 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 residential aged cared facilities (RACFs). The Queensland health system provides a level of care and safety in hospitals and other health care facilities which is amongst

the best in Australia, despite recent pressures at accident and emergency departments as witnessed recently at Logan, Cairns and Townsville Hospitals, where AMAQ's interventions and representations were warranted.

Queensland's communities rightfully expect to receive a high quality of care in all publically owned health facilities, irrespective of their geographical location and on the whole, place enormous trust and understanding in the doctors, nurses and others staff who deliver quality care every day. However, recent adverse media coverage of Queensland hospitals including "ramping" at Logan Hospital, code yellow at PAH due to troubles with the autoclave machines and the abrupt closure of the Earle Haven Retirement Village at the Gold Coast has the public questioning the perceived variation in care between public and private facilities.

The proposed interactive website associated with this Bill, which will display patient data and elective surgery data (including activity information and patient outcome information) from all public and private hospitals and residential aged cared facilities (RACFs) will not only provide some reassurance about quality of care, but allow the public to "choose" a facility which best meets their expectations. Of course the public's ability to choose is not guaranteed in an emergency situation or when hospitals are on bypass, but this is uncommon.

For health providers, this proposed website increases accountability to health consumers, governments and stakeholders and places the providers who are not performing as highly as other facilities "on notice".

AMA Queensland fully supports the collection and publishing of relevant patient data and elective surgery data (including activity information and patient outcome information) from public and private hospitals and residential aged cared facilities (RACFs) on the understanding that the provisions within the Hospital and Health Boards Act and the Private Health Facilities Act to protect the confidentiality of information acquired by individuals in performing their duties are upheld; and for private facilities, that information must not be disclosed if the disclosure of information would be likely to damage the commercial activities of a facility.

Objective 2 Amends 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.

AMA Queensland has been advocating for some time on the establishment of minimum registered nurse and support worker skill mix ratios to improve resident care hours in RACFs and we recognise Minister Miles' recent announcement on this very issue. AMA Queensland has previously raised the issue of staff ratios in our submission to the Inquiry into aged care, end of life and palliative and voluntary assisted dying where we stated the following:

> *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[1]. This decrease, which also confirmed by Leading Aged Services Australia (LASA)[2] 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 situations and in the provision of palliative care.

Clinical handover - Nurses are crucial when it comes to clinical handover between the General Practitioner, nurses and other staff in the facility. This exchange of information is critical and vital to the continuity of care of the patient. Without an appropriate trained nurse, tests may not be followed up or not carried out at all and clinical handover may not occur as this forms the foundation of good clinical care.

When a General Practitioner prescribes medication - Having access to a nurse is also important when a General Practitioner prescribes medication for patients in residential aged care facilities. The General Practitioner needs the facility to action the script as soon as possible, so in the situation that a nurse is not present, then the pharmacist should pick up the script at the next available opportunity or the General Practitioner would fax it off to the pharmacist for action. Without a nurse present there is the possibility of a delay in the script being acted upon.

Managing an emergency event -The importance of having trained nurses is also important, in the event of an emergency event, where an ambulance may have to be called. In the event a nursing supervisor is not available, and a personal care attendant is required to call an ambulance, then the patient would typically be transferred to an emergency department.

Provision of palliative care - AMA Queensland believes the opportunity to access palliative care should be no less in a residential aged care facility as it should be to any other older Australian. AMA Queensland would suggest the lack of an appropriately trained nurses, particularly in overnights shifts, is also limiting access to appropriate palliative care.

For AMA Queensland, it was not a surprise that some of the leading providers in aged care who presented to the Aged Care Royal Commission (Commonwealth Department of Health and Aged and Community Care Australia[3]) disagreed with the idea of staff ratios arguing that staff ratios does not allow providers the flexibility they need to address changes in the levels of patients with complex conditions, which does not remain stable. Let's fast forward to recent examples of poor quality care at Earle Haven Retirement Village and BUPA nursing homes (where 50% of BUPA's facilities failed their quality tests) to see what can happen when mix of staff in different settings does correspond with the care needs of residents.

AMA Queensland is concerned with the opt-out provisions for private RACF in Queensland (as contained within the Bill) associated with a minimum nurse and support worker skill mix

[1] Aged Care Royal Commission, Australian College of Nursing quoting data from Flinders University 13 February 2019
[2] Aged Care Royal Commission, Leading Aged Services Australia 19 February 2019
[3] Aged Care Royal Commission, Aged and Community Care Australia 19 February 2019

ratio and average daily resident care hours. What better way to reassure the public about the level and the quality of care being provided in private RACF, recently tarnished through information presented to the Aged Care Royal Commission, than by voluntarily getting on board with these sensible and necessary changes.

AMA Queensland would also strongly encourage an increase in the cooperation between residential aged care providers and service providers that deliver medical care, allied health care (e.g. physiotherapists, nutritionists, audiologists, occupational therapists and psychologists), and non-GP Specialists like psychiatrists and geriatricians. This includes increased cooperation between RACF and the health system to ensure greater collaboration and continuity of care for older Australians.

Objective 3 Amends the *Health Ombudsman Act 2013* to implement recommendations of the committee's Inquiry into the performance of the Health Ombudsman's functions pursuant to section 179 of the *Health Ombudsman Act 2013*.

AMA Queensland supports the amendments. In July 2019, AMA Queensland provided feedback to Queensland Health about proposed changes to the *Health Ombudsman Act 2013* (***attachment 1***) and we are pleased that the proposed amendments contained within this Bill largely address our concerns.

Firstly, that complaints will now be a joint consideration between OHO and AHPRA and national boards. AMA Queensland agrees joint consideration will reduce duplication of work, decrease delays in complaints being addressed and lead to more informed and consistent decision making.

Secondly, AMA Queensland agrees with the provision that serious matters involving a health issue may be split between OHO, who retains the overall matter while referring to AHPRA and national boards.

Finally, AMA Queensland supports the provision within the Bill that OHO has the discretion to not accept a complaint if the complainant has not first attempted to resolve the matter with the health service provider or if the complaint is better addressed by another entity. AMA Queensland has previously called for the development of a transparent and fair process for both the complainant and the health service provider and these provisions go some way towards addressing this, including the development of new materials (by the OHO) for complainants and health service providers about making and resolving complaints under section 35A.

Yours sincerely

Dr Dilip Dhupelia
President
Australian Medical Association Queensland

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16 July 2019

Mr Leif Ettrup
A/Manager
Legislative Policy Unit
Strategic Policy and Legislation Branch
Queensland Health
By email: ***legislation@health.qld.gov.au***

Dear Mr Ettrup

Thank you for the opportunity for AMA Queensland to provide feedback about the proposed amendments to the *Health Ombudsman Act 2013* and the Queensland-specific provisions of the *Health Practitioner Regulation National Law Act 2009*.

AMA Queensland sought feedback from our members regarding these changes.

AMA Queensland members who had been investigated by AHPRA (after being referred by OHO) found the that process questions the integrity and honesty of doctors and assumes the doctors have committed a serious criminal offence. AMA Queensland members found the process led to stress, anxiety and unnecessary worry.

AMA Queensland's recommends the following actions be considered by OHO (based on the responses from our members):

1. OHO should develop and implement a framework to assess whether the complaint is legitimate/important rather than automatically referring the complaint on to AHPRA. For instance, cases against doctors should initially be reviewed by a clinician (engaged by OHO), including communication with the GP against whom the complaint has been made, and a recommendation made to either refer to AHPRA or not to refer, prior to referral.

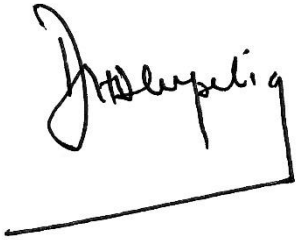
2. AMA Queensland recommends serious penalties be applied for people making false allegations, i.e. when the allegations are unfounded.

3. AMA Queensland recommends that the legislation embeds a transparent and fair process for both the public and the practitioner. The medical literature documents the importance of reducing medico-legal stress experienced by health practitioners during assessments and investigations and we want to ensure this is one of the outcomes of the changes to this legislation.

4. AMA Queensland wishes to emphasise the importance of ensuring changes to this legislation will not impact upon health access for doctors.

5. AMA Queensland strongly recommends that timeframes for assessing complaints be reduced – universally our members found investigations by AHPRA too lengthy, with little transparency regarding the timeframe for assessing complaints.

Yours sincerely,



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