

22 August 2016

Ms Deborah Jeffrey
Research Director
Health Communities Disability Services and
Domestic and Family Violence Prevention Committee
Parliament House Queensland
George Street
BRISBANE QLD 4000

By email: hcdfsdfvpc@parliament.qld.gov.au

Dear Ms Jeffrey

Inquiry into the performance of the Queensland Health Ombudsman's functions pursuant to section 179 of the *Health Ombudsman Act 2013*

The Australian Health Practitioner Regulation Agency (AHPRA) and the 14 National Boards are pleased to provide a joint submission to the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee (the Committee) Inquiry into the performance of the Queensland Health Ombudsman's functions pursuant to section 179 of the *Health Ombudsman Act 2013* (the Inquiry).

We would firstly like to thank the Committee for agreeing to an extension to 22 August 2016 for the lodgement of our joint submission.

The Queensland co-regulatory model is an important part of the National Registration and Accreditation Scheme for the regulation of 14 health professional groups. It is important to evaluate any changed model after a period of time post implementation. A review provides an opportunity to improve arrangements, to identify and address any unintended consequences, and to ensure key objectives and guiding principles are being met.

In our joint submission, we recommend changes to the co-regulatory health complaints model in Queensland to improve public protection and accountability through the application of the right expertise to the right matters, at the right time.

The model would include the following features:

- The Office of the Queensland Health Ombudsman (OHO) would continue to be the 'single front door' in Queensland for receiving all health related complaints and for dealing with matters about unregistered practitioners or health service and systems issues
- Through a new joint consideration process between the OHO and AHPRA, based upon the current requirements in all other states and territories, health service complaints would be efficiently streamed to the body most appropriate to deal with them effectively. This should ensure Boards and AHPRA have full visibility of all complaints about registered health practitioners, including those that are less serious but may form a pattern of complaints that Boards can identify as a predictor of a higher risk incident in the future if not addressed.
- The OHO would remain responsible for complaints that are appropriate for conciliation, local resolution or referral to another body with jurisdiction to deal with the matter

- A single track for health, conduct and performance complaints about registered health practitioners would be introduced with AHPRA and the Boards taking carriage of all these matters, including for the most serious allegations that require immediate action and referral to the Queensland Civil and Administrative Tribunal, and
- The OHO would continue to have an oversight role for the performance of AHPRA and the Boards' management of complaints about registered health practitioners, and for assurance reporting.

The recommendation for a changed model is not made lightly. Working with the OHO, AHPRA and the Boards have found ways to improve the operation of the complaints management model in Queensland since 2014 through more streamlined operations and better information sharing. However, there are limits to the improvements that can be made administratively.

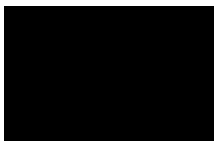
We consider that changes are necessary to ensure the public is better protected through timely and appropriate regulatory action on serious matters, to reduce recurrent and unnecessary duplication and delays, improve efficiency and cost, and to capture consistent data for national performance reporting, evaluation and research to improve regulatory effectiveness.

We would like to assure Committee members that AHPRA and the Boards remain committed to working with the OHO, the Queensland government and the Health Minister to make the health complaints management system in Queensland work as efficiently and effectively as possible to protect the public in Queensland.

Please contact Mr Martin Fletcher, Chief Executive Officer, AHPRA on [REDACTED] or [REDACTED] if committee members would like any further information. We would also be pleased to make arrangements to meet with Committee members in a private meeting or at a public hearing if these are scheduled later this year.

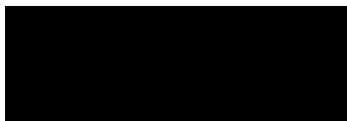
We trust that our joint submission will be of assistance to the Committee in formulating your report on the performance of the OHO's functions. We look forward to the report being available in October 2016.

Yours sincerely



Mr Michael Gorton AM

Chair, Agency Management Committee



Dr Joanna Flynn AM

Chair, Medical Board of Australia



Ms Renee Owen

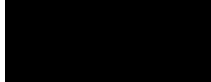
Presiding Member, Aboriginal and Torres Strait Islander Health Practice Board of Australia



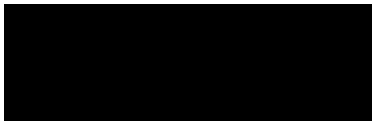
Professor Charlie Xue
Chair, Chinese Medicine Board of Australia



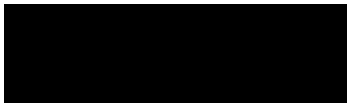
Dr Wayne Minter AM
Chair, Chiropractic Board of Australia



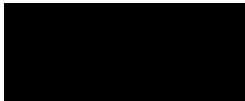
Dr John Lockwood AM
Chair, Dental Board of Australia



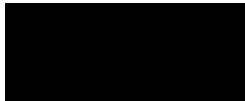
Mr Neil Hicks
Chair, Medical Radiation Practice Board of Australia



Dr Lynette Cusack
Chair, Nursing and Midwifery Board of Australia



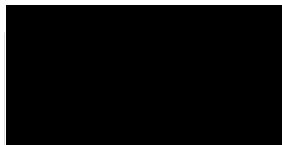
Ms Julie Brayshaw
Chair, Occupational Therapy Board of Australia



Mr Ian Bluntish
Chair, Optometry Board of Australia

Dr Nikole Grbin
Chair, Osteopathy Board of Australia

Mr William Kelly
Chair, Pharmacy Board of Australia



Dr Charles Flynn
Presiding Member, Physiotherapy Board of Australia



Ms Cathy Loughry
Chair, Podiatry Board of Australia

Professor Brin Grenyer
Chair, Psychology Board of Australia

Joint submission to Queensland Parliamentary Committee

August 2016

Inquiry into the performance of the Queensland Health Ombudsman's functions pursuant to section 179 of the *Health Ombudsman Act 2013*

Our recommendations to improve the health service complaints system

- AHPRA and the National Boards recommend changes to the co-regulatory health complaints model in Queensland. These changes are necessary to ensure the public is better protected through timely and appropriate regulatory action on serious matters, to reduce recurrent and unnecessary duplication and delays, improve efficiency and cost, and to capture consistent data for national performance reporting, evaluation and research to improve regulatory effectiveness.
- A changed complaints model would improve public protection and accountability through application of the right expertise to the right matters, at the right time, and have the following features:
 - The Office of the Queensland Health Ombudsman (OHO) would continue to be the 'single front door' in Queensland for receiving all health related complaints and for dealing with matters about unregistered practitioners or health service and systems issues;
 - Through a new joint consideration process between the OHO and AHPRA, based upon the current requirements in all other states and territories, complaints would be efficiently streamed to the body most appropriate to deal with them effectively. This should ensure Boards and AHPRA have full visibility of all complaints about registered health practitioners, including those that are less serious but may form a pattern of complaints that Boards can identify as a predictor of a higher risk incident in the future if not addressed.
 - The OHO would remain responsible for complaints that are appropriate for conciliation, local resolution or referral to another body with jurisdiction to deal with the matter;
 - A single track for health, conduct and performance complaints about registered health practitioners would be introduced with AHPRA and the Boards taking carriage of all these matters, including for the most serious allegations that require immediate action and referral to the Queensland Civil and Administrative Tribunal;
 - OHO would continue to have an oversight role for the performance of AHPRA and the Boards' management of complaints about registered health practitioners, and for assurance reporting.
- The Health Minister and Queensland Parliament would then be assured that our regulatory expertise and the expertise of the OHO as an ombudsman and health complaints authority are applied in the best possible way to protect the Queensland public. Our respective resources would be used more effectively as unnecessary delays and duplication would be addressed.

Why we recommend changes are required

- A constructive relationship has been built with the OHO and the Boards and AHPRA. We have found ways to improve the operation of the complaints management model in Queensland since 2014 through more streamlined operations and better information sharing. However there are limits to the improvements that can be made administratively.
- There remains duplication and a lack of timely action on the most serious complaints that the OHO is required to deal with under this co-regulatory model which leads us to question whether the Queensland public is adequately protected by the current arrangements. The OHO's published performance reports provide demonstrable evidence of unmet statutory timeframes for assessment and substantial delays in referrals and outcomes.
- The current model presents a conflict of interest for the OHO being both a co-regulatory partner and having oversight of AHPRA and Boards' performance. This would be resolved under our proposed model through clear role delineation.
- We recognise that legislative amendment is required to effect the change. The benefit should be better protection of the public under a model that is more cost effective through better allocation of expertise and resources. More resources or an expansion of OHO functions is not supported.
- National Boards and AHPRA support an efficient, effective, transparent and accountable health complaints system in Queensland. The Queensland co-regulatory model is an important part of the National Registration and Accreditation Scheme for the regulation of 14 health professional groups.

Introduction

1. This joint submission is from the Australian Health Practitioner Regulation Agency (AHPRA) and the National Boards with the:
 - a. Queensland Board of the Medical Board of Australia
 - b. Queensland Board of the Nursing and Midwifery Board of Australia
 - c. Queensland Board of the Psychology Board of Australia, and
 - d. Dental Board of Australia's Registration and Notification Committee (Queensland).
2. The National Registration and Accreditation Scheme commenced on 1 July 2010 in all states and territories (except Western Australia, which commenced from 18 October 2010). The *Health Practitioner Regulation National Law* as in force in each state and territory (the National Law) establishes the National Scheme for the regulation of health practitioners and in certain circumstances, students, including in Queensland. The legislation establishing the scheme was first passed in Queensland before each other state and territory.
3. As prescribed by the National Law, a **key objective of the National Scheme** is to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practice in a competent and ethical manner are registered. Our guiding principles are for the National Scheme to operate in a way that is transparent, accountable, efficient, effective and fair. Fees required to be paid by practitioners are to be reasonable having regard to the efficient and effective operation of the scheme. Any restrictions on the practice of a health profession are to be imposed only if it is necessary to ensure health services are provided safely and are of an appropriate quality.
4. National oversight of the scheme is provided collectively by the Australian Health Workforce Ministerial Council which comprises the Health Ministers from each state and territory and the Commonwealth. Health Ministers also individually have oversight of local issues and matters involving registered health practitioners practising in their jurisdiction.
5. Of the 652,000 registered health practitioners in Australia across the 14 health professional groups, more than 125,000 have a principal place of practice in Queensland. Overall, **Queensland has the third highest** registrant base (following New South Wales and Victoria)¹. Nursing and midwifery, medical, and psychology are the three professional groups with the most registrants based in Queensland, and this is also the case nationally.
6. Relevant background to the introduction of the new complaints management system in Queensland and previous advice provided to the Queensland Parliamentary Committee is summarised in **Appendix B**.

The National Scheme's interface with the Queensland complaints system

7. **Protection of the public** through effective practitioner regulation is the core business of AHPRA and the National Boards. The **new paramount guiding principle** in the *Health Ombudsman Act 2013* (the Act), mirrored in the National Law as applied in Queensland, makes it clear that the health and safety of the public are paramount and is the main consideration for the Queensland Health Ombudsman (OHO), AHPRA and the National Boards when dealing with complaints and notifications in Queensland. In Queensland, as a co-regulatory jurisdiction, we have a shared responsibility with the OHO for managing complaints about registered health practitioners and upholding the paramount guiding principle of protecting the health and safety of the public.
8. The Act establishes the OHO. The Health Ombudsman may be seen as having the contemporary powers of a health complaints commissioner, traditional oversight and reporting functions of an ombudsman, while being a co-regulator for complaints about registered health practitioners in Queensland. The OHO is responsible for:
 - receiving health service complaints and deciding on the relevant action to deal with them
 - identifying and dealing with health service issues by taking relevant action, such as undertaking investigations or inquiries

¹ AHPRA Quarterly Performance Report – Queensland – January-March 2016 <http://www.ahpra.gov.au/About-AHPRA/What-We-Do/Statistics.aspx>

- identifying and reporting on systemic issues in the way health services are provided, including their quality
 - monitoring the performance of AHPRA and the national health practitioner boards in their functions relating to the health, conduct and performance of registered health practitioners in Queensland
 - identifying and communicating ways of providing health services that minimises and assists in resolving health service complaints
 - reporting publicly on the performance of the health complaints management system in Queensland.
9. The Act also
- a. Charges the Queensland Health Minister with clearer oversight of the complaints management system. The Minister oversees system administration, the performance of the Health Ombudsman and the performance of the national boards and AHPRA in relation to the management of health conduct and performance matters in Queensland. The Minister may also direct the Health Ombudsman to publish regular performance reports on the health complaints management system, including on the performance of the national boards and AHPRA.
 - b. Provides the Committee with the authority to monitor the operation of the health complaints management system, and the performance of the functions of the Health Ombudsman. This Inquiry has been initiated by the Committee in accordance with section 179 of the Act.
10. From 1 July 2014, the OHO received all new health complaints in Queensland. The OHO also assumed responsibility for some specific complaints-handling functions that were previously undertaken by AHPRA in partnership with National Boards about registered health practitioners in Queensland. The Health Ombudsman has a mandate for managing the most serious of matters – those where professional misconduct is suspected, or where the behaviour of a practitioner may lead to suspension or cancellation of registration. The OHO is able to refer all other complaints about registrants to AHPRA and the Boards for regulatory action. The Act and the National Law as applied in Queensland are intended to be complementary. Therefore, the OHO and AHPRA and National Boards work together to apply our respective expertise and resources to protect the public when concerns are raised about the registered health practitioners in Queensland.
11. Nationally, AHPRA and the Boards work in partnership to manage the registration, complaints (notifications) and compliance functions of the National Scheme. The AHPRA office in Queensland administers the day-to-day work of registration, notifications and compliance monitoring with the Boards, to help ensure our work meets local needs within a national framework.
12. All Boards have established committee structures for dealing with complaints (notifications). The nature and structure of the committees varies across each of the National Boards depending on the volume and complexity of their work. In Queensland, the Medical Board of Australia (the MBA), the Nursing and Midwifery Board of Australia (NMBA) and the Psychology Board of Australia (PsyBA) have established Queensland Boards. Their practitioner and community members are appointed by the Queensland Health Minister. Their functions are to deal with registration and notification (complaint) matters. The Dental Board of Australia has established a dedicated registration and notification committee (RNC) in Queensland with practitioner and community members from Queensland.

Response to the Inquiry terms of reference

Term of reference (a): The operation of the health service complaints management system

Strengths of the current co-regulatory model

13. **Single front door in Queensland.** Having the OHO as the single point of entry for all health complaints in Queensland is an important function under the co-regulatory model. AHPRA and the Boards recognise that complaints about registered health practitioners are multi-faceted issues that involve consumers, the OHO (in its shared role as regulator for serious matters), employers, educators, individual practitioners and their patients. Given the different roles and responsibilities of organisations working to protect public safety in Queensland, it can be understandably challenging for people to access and navigate the systems in place to deal with or respond to concerns, and for systemic issues to be detected.

The explanatory notes to the Health Ombudsman Bill 2013 clearly indicate the intent to remove role confusion between complaints entities by requiring all health service complaints to be made to the Health Ombudsman, rather than being split between the Health Quality and Complaints Commission (HQCC) and the National Boards, as was the case at that time.² What is important now is that people know that in Queensland there is one door – that of the OHO. Having one body receive all health complaints should enable the OHO to build a complete picture of the health system across Queensland and supports a core role of the OHO – to identify and report on systemic issues.

14. **Conciliation, local resolution, and identifying/reporting on systemic issues within the health system.** The OHO deals with health complaints that are most appropriate for conciliation or local resolution and this can better meet the expectations and needs of people who make a complaint. The OHO's ability to investigate systemic issues within the health system is strongly supported as a critical function of a health complaints entity. Having the OHO as the body in Queensland that can make recommendations for change and prevent the same systemic issues recurring is an essential component of a modern health complaints management system.
15. **Unregistered health practitioners.** The OHO manages complaints about unregistered health practitioners and has contemporary powers to issue an interim prohibition order if a practitioner's health, conduct or performance poses a serious risk to people and immediate action is necessary to protect public health and safety. For transparency, orders are published online, and anyone can check to see if a practitioner's name is on this register. The *Queensland code of conduct for health care workers* has been an important public safety initiative that complements existing arrangements for public protection in this state. AHPRA notes that over the next twelve months, state and territory health complaints entities will implement the nationally consistent elements of the code-regulation regime as agreed by Australian Health Ministers in April 2015. This project should further strengthen the regulation of health care workers in Queensland.
16. **OHO performance reporting and oversight.** OHO has oversight of performance of the health complaints system in Queensland, including reporting on our performance in managing health, conduct and performance complaints about registered health practitioners. The publication by the OHO of online performance reports promotes transparency and is an accountability mechanism to the Queensland public. Monitoring and reporting on performance can encourage better performance. As the Committee may be aware, AHPRA is also now publishing online quarterly performance reports for each state and territory and nationally. AHPRA built a tailored reporting infrastructure, which has been applied more widely across other states and territories in the interests of national consistency, to enable us to identify national trends and reduce duplication and potential costs to practitioners. During its development, AHPRA consulted the OHO to ensure that the reports would meet the requirements of the OHO and enable an analysis to be conducted.
17. **Management of complaints (notifications) by the Boards and AHPRA.** AHPRA and the National Boards have implemented a consistent, responsive and risk-based approach to regulation and managing notifications and complaints to protect the public. The Boards (and national committees) make all regulatory decisions about practitioners in Queensland, under delegation from the relevant National Board, in accordance with the National Law and national standards, as informed by the national regulatory principles for decision-making under the scheme.³ Board and committee members have a deep understanding of professional issues and community expectations and the Queensland health context. The knowledge and experience of board members is central to our ability to assess matters, make consistent and informed decisions, and take appropriate action to protect the public. AHPRA has a dedicated team of trained assessors and investigators that provide detailed reports to the Board to inform decision-making. This approach helps to manage the complexity and volume of matters about registered health practitioners, and ensures local expertise is applied while working within our national framework. The OHO does not have the same access to professional and community expertise and has to establish ad hoc panels to provide clinical input – an approach that provides limited opportunity for the development of knowledge and can impact on consistency of decision-making.

² Explanatory notes for the Health Ombudsman Bill, Queensland Parliament, page 2
<https://www.legislation.qld.gov.au/Bills/54PDF/2013/HealthOmbudsmanB13E.pdf>

³ The regulatory principles are published online: <http://www.ahpra.gov.au/About-AHPRA/Regulatory-principles.aspx>

Areas requiring attention under the current model

18. There are aspects of the current co-regulatory model for dealing with complaints about registered health practitioners that have led to unintended consequences and inefficiencies, resulting in duplication of effort and unnecessary delays, including delays in taking action to protect the public.
 - a. **Protection of the public – OHO management of serious matters.** The OHO's published performance reports provide demonstrable evidence of unmet statutory timeframes required of the OHO to protect the public. Decisions by the OHO that immediate registration action is needed on serious matters to protect the public are far fewer than expected, including in comparison with actions taken by the Boards before Queensland became a co-regulatory jurisdiction. The Boards have also expressed concerns about the lack of referral of serious matters to the Queensland Civil and Administrative Tribunal (QCAT). In the last two years, we understand that 1 matter has been referred by the OHO. Our response to **term of reference (b)** identifies our concerns and why we recommend a change to the co-regulatory model in Queensland to better protect the public.
 - b. **There are also concerns about public protection when complaints are closed without referral to the Boards and AHPRA, and when limited information is provided about complaints that are not accepted by the OHO.** There is no statutory obligation to share any information about complaints received by the OHO, that are not referred to AHPRA and the Boards under section 91 of the Act. AHPRA does not receive contextual information about matters that are not accepted by the OHO, or marked as 'no further action' by the OHO after the complaint has been received. The OHO reports on the number of matters but this does not include a breakdown of whether the complaints involved registered or unregistered health practitioners and no detail is given about the context of the complaint and why it was not accepted or no further action taken. While it is likely that these complaints are about minor matters, it is appropriate for Boards to have full visibility to determine if regulatory action is needed. Complaints about the same registered practitioner may also be made under our national notifications system as practitioners can practice in another state or territory. When Boards have all information about complaints, including 'minor' matters, a pattern of complaints about a practitioner's conduct or behaviour can be detected, and early intervention can be taken before a more serious event occurs that may place the public at serious risk of harm. Not having access to these details causes an unintended fragmentation in relevant information being available to the Boards and AHPRA. This type of information would have been available under the previous model when AHPRA and the Boards had receipt and carriage of complaints. **Appendix A to this submission provides more information.**
 - c. **The thresholds for regulatory action and decision-making by the OHO remain unclear leading to unnecessary duplication, delays and referral loops.** The triage approach introduced by the OHO has not addressed known inefficiencies of multiple consultations on the same matter. The legislation envisages that the threshold for seriousness and our respective responsibilities would be clear and duplication would be minimal. The Health Ombudsman has a mandate for the most serious matters – ie those where professional misconduct is suspected or where the behaviour of a practitioner may lead to suspension or cancellation of registration. The OHO is able to refer all other complaints about registered health practitioners to AHPRA and the Boards for regulatory action. However, in practice, this has not been our experience. On occasion, complaints are referred that are considered by the Boards to meet the threshold for retention and investigation by the OHO because they are serious matters about registered health practitioners in Queensland. When this occurs, the Boards are required by law to advise the OHO of the assessment and the OHO can take the matter back or direct the Board to continue with the matter. The result is significant duplication, delays and at times multiple referrals of the same matter between the two systems that operate in Queensland. **Appendix A to this submission provides more information.**
 - d. **Splitting the management of health and conduct matters** can create a risk to protection of the public. For example where a complaint raising an impairment concern is referred to AHPRA and the Boards and the performance/conduct issues raised in the same complaint about the same practitioner are retained by the OHO. When health and conduct elements are separated, and all relevant information is not shared, concerns may not reach the necessary threshold for action (including for taking immediate action or placing conditions on a practitioner's registration). If the complaint were kept intact and all relevant information shared, it is often clearer to see the actual risk of harm to the public and the need to take action and remediate the practitioner (where possible).

This is also an unintended consequence of this model. **Appendix A to this submission provides more information.**

- e. **Experience of notifiers and practitioners.** Splitting matters, referral loops, duplication and delays cause frustration which is ultimately unsatisfactory for the people who make complaints and the practitioners who are the subject of a complaint. Understandably, there is confusion about who is dealing with the matter, and doubts about the efficiency and integrity of the complaints management system when matters are handled by, or referred between, more than one body. As stated in our *Annual report 2014/15*,⁴ a significant investment has been made to improve the experiences of notifiers and practitioners in their contacts with us. The overall goal is to improve our customer service, be clear about what people can expect and make it easier for people to interact with us. We will continue to pursue improvements in this area and respond to concerns from complainants and practitioners in Queensland who are dissatisfied with the current arrangements.
 - f. **Data continues to be misaligned with the national dataset and approach** which has a negative impact on national reporting and analysis of notifications data to help improve risk based regulation, including in Queensland. Having a bespoke system for Queensland adds unnecessary cost and complexity to the regulatory environment which is further articulated in **term of reference (e)** in this submission.
 - g. **There continues to be pressure to increase registrant fees for Queensland practitioners due to the costs of the current co-regulatory model in Queensland.** The National Scheme is self funded through the fees paid by registrants in each profession. AHPRA and the National Boards' concerns about costs of the co-regulatory arrangements in this state and the impact on practitioners and the government have been advised to the Health Minister. Concerns about the impact of data misalignment and costs of the co-regulatory model in Queensland **are raised against term of reference (e)** in this submission.
19. **Appendix C1** to this submission provides a diagram to demonstrate the complexity and flow of information between the OHO and AHPRA and the Boards for complaints about registered health practitioners under the current co-regulatory model.
 20. **Appendix C2** illustrates how the complexity which causes delays, duplication of effort, and multiple consultations would be addressed by our proposed change to the co-regulatory model described below.

Term of reference (b): Ways in which the health service complaints management system might be improved

Changes to co-regulatory arrangements in Queensland are recommended to improve the system

21. The Boards and AHPRA acknowledge that a constructive relationship has been built with the OHO over the last two years. This has been based on a shared aim of ensuring complaints about registered health practitioners are managed in a way that protects the Queensland public. There has been goodwill and interagency cooperation to make improvements to the implementation of the model through administrative means, and working within the current parameters of our respective and complementary legislation.
22. However, the Boards and AHPRA consider that the improvements required cannot be achieved through administrative improvements alone. Therefore a change to the co-regulatory model in Queensland is needed to ensure the Queensland public is adequately protected from registered health practitioners who pose a risk of harm due to their conduct, performance or health.
23. The **proposed change to the model** is outlined below:

AHPRA and the Boards recommend the introduction of a single track for all health, conduct and performance matters involving registered health practitioners in Queensland. Responsibility for assessing, investigating, and taking regulatory actions **should rest with AHPRA and the Boards**. This should include for serious matters where it is necessary to take immediate action to protect the public, and apply both professional and community expertise to consideration of matters, and to bring these

⁴ AHPRA annual report 2014/15: <http://www.ahpra.gov.au/annualreport/2015/downloads.html>

most serious of matters to the QCAT.

While management of complaints would be the responsibility of AHPRA and the Boards, the OHO could retain an oversight role through a new **joint consideration process** consistent with the framework agreed with health complaints entities for the national system of managing notifications. The national joint consideration framework for complaints about registered health practitioners supports clarity and flexibility and helps ensure that the right entity deals with the right matters at the right time.

The OHO would **continue to have a public protection role** by remaining responsible for complaints that are more appropriate for conciliation or local resolution, or where the matter requires referral to another body, for dealing with matters about unregistered practitioners, and identifying health service and systems issues.

The OHO would also continue to have **reporting and oversight** for the performance of our management of complaints about registered health practitioners.

If the Boards and AHPRA dealt with these complaints, **the OHO could better direct expertise and available resources** to monitoring the performance of AHPRA and the National Boards for health, conduct and performance of registered health practitioners in Queensland and further embed public reporting on the performance of the health complaints management system in Queensland.

Other expected benefits include:

- The OHO being better able to **protect the Queensland public** as the 'single front door' in Queensland for receiving all health related complaints and communicating this important service
- Resolving the current conflict of interest for the OHO being both a co-regulatory partner and having oversight and reporting on the performance of AHPRA and the Boards' management of complaints through clear role delineation.
- A model that is more cost effective through better allocation of expertise and resources and substantial reduction in duplication of resources and delays.
- An improved experience for notifiers (complainants) and practitioners as it would not be necessary for two agencies to manage or refer complaints based on seriousness, or to split matters. There would be one agency – AHPRA – as the contact point once a complaint is accepted.
- Ensures that AHPRA and the Boards as regulators of the 14 groups of health professions have carriage of registration and notification matters, and responsibility for monitoring and compliance activities.

The recommended change to the model is not a return to the past and Queensland may remain a co-regulatory jurisdiction. The changes are for the future protection of the Queensland public. AHPRA has matured in its operations and is better positioned to support the Boards who are in turn better able to make consistent and timely decision making about complaints against registered health practitioners.

24. An amendment to the Health Ombudsman Act to effect this change would be needed. By recommending this change, we seek better protection of the Queensland public through a model that applies our regulatory expertise and the expertise of the OHO in the best possible way and directs our respective resources more effectively. We propose *better* allocation of expertise and resources – not allocation of more resources and/or an expansion of OHO functions.

Term of reference (c): The performance by the health ombudsman of the health ombudsman's functions under the *Health Ombudsman Act 2013*

25. All complaints about Queensland health practitioners are received by the OHO. The OHO retains serious matters. Boards must receive a referral from the OHO under section 91 of the Act to have jurisdiction to act or to subsequently take a registered practitioner's conduct into account under section 35(2) of the National Law.
26. Importantly, the Health Ombudsman must report on the performance of AHPRA and the National Boards in dealing with health conduct and performance matters that are referred by the OHO.

27. The model results in the OHO being both co-regulator and having oversight of our performance for dealing with complaints.
28. When our performance is impacted because complaints are not referred, or there are delays and duplication of resources from the model, or a lack of timely action on serious matters, this presents a conflict of interest for the OHO and a risk that the public is not being adequately protected. These concerns can be resolved by our recommended change to the co-regulatory model.

Protection of the public – lower than expected immediate registration actions

29. The implementation of the co-regulatory model in Queensland and the establishment of the OHO was partly in response to what was regarded as a light-handed touch in the regulation of medical practitioners by the (former) Queensland Board of the MBA. To strengthen the way serious allegations against registered health practitioners are managed in Queensland, the OHO was given the legislative responsibility to manage all such complaints. Serious matters are where a health practitioner may have engaged in professional misconduct (as defined in the National Law), or where another ground may exist for the suspension or cancellation of a health practitioner's registration.
30. The explanatory notes for the Health Ombudsman Bill emphasises this focus:

To strengthen the way that serious allegations against registered health practitioners are managed in Queensland, the Health Ombudsman will assume the role of managing all such complaints. Serious matters are:

 - *where a health practitioner may have engaged in professional misconduct (as defined in the Health Practitioner Regulation National Law (called the 'National Law'), or*
 - *where another ground may exist for the suspension or cancellation of a health practitioner's registration.*

One of the key functions of the Health Ombudsman is to deal with serious matters raised in health service complaints, and identified in other ways, by undertaking investigations or referring matters to the Director of Proceedings for taking proceedings before QCAT. This focus on serious matters is reflected in clause 91(1) of the Bill which states that the Health Ombudsman must not refer serious matters, as defined in that clause, to the National Agency. A mirror provision in the National Law (section 193) requires a national board to advise the Health Ombudsman of serious matters for referral to the Health Ombudsman.
31. As committee members know, the Act provides that **either** the OHO or the National Boards may exercise powers to restrict a practitioner's registration in circumstances where their behaviour poses a serious risk to persons. Immediate registration action by the OHO or immediate action by the Boards is taken for the most serious of matters. It was the clear intent of the Queensland Parliament for the OHO to have the power to take immediate action to suspend or place conditions on a health practitioner's registration where there is a serious risk to the public.
32. In AHPRA's July 2015 response to the Health and Ambulance Services Committee, we advised that AHPRA had on several occasions raised concerns about the apparent lack of immediate registration actions taken by the OHO – especially in comparison with immediate actions taken by the Boards in the same time period and prior to the establishment of the OHO.
33. One of the clearest demonstrators of protecting the public is that regulators take timely and necessary action in response to examples of serious risk to the public.
34. It is difficult to reconcile that even though the OHO has a mandate for the most serious matters and a responsibility to protect the health and safety of the public by ensuring that appropriate regulatory action is taken for serious matters:
 - In 2014/15 the OHO took immediate registration action five times in relation to medical practitioners⁵. However, no immediate registration actions were taken against registered medical practitioners⁶ by the OHO between July 2015 and May 2016. By contrast, the Queensland Board of the MBA took

⁵ Office of the Health Ombudsman Annual Report 2014–15, appendix 1, page 100, <http://www.oho.qld.gov.au/wp-content/uploads/2015/10/OHO-Annual-Report-2014-15.pdf>

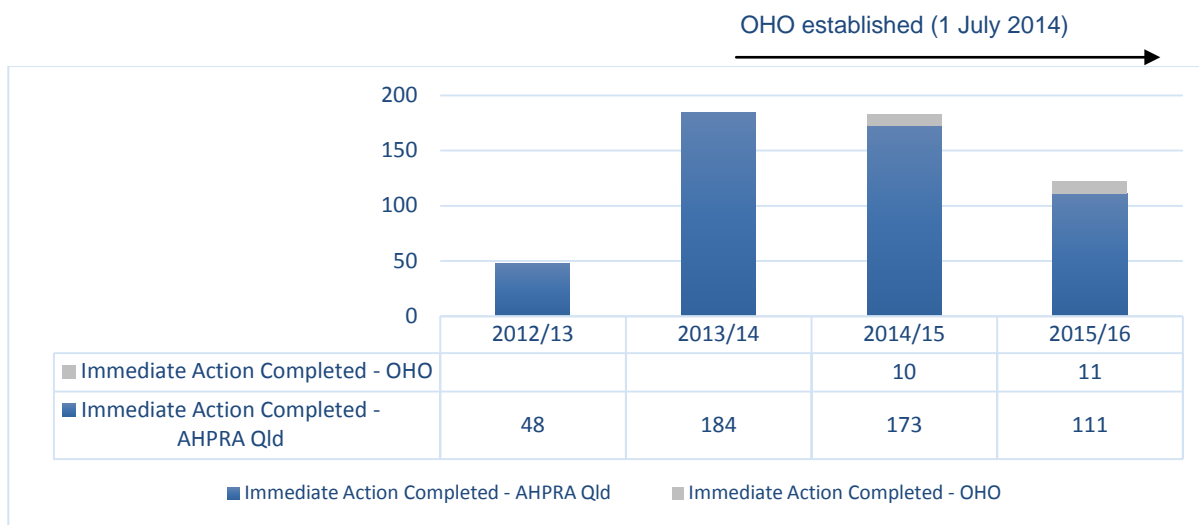
⁶ Medical practitioners consistently attract the highest number of notifications nationally with 53% of all notifications being made about the profession. AHPRA and National Boards Annual Report 2014/15, page 35: <http://www.ahpra.gov.au/annualreport/2015/downloads.html>

immediate action against 21 medical practitioners during the same period. The first time that the OHO took immediate registration action, in 2015/16, against one medical practitioner was in June 2016 as reported in the OHO's most recent performance report.⁷ The other immediate registration actions taken by the OHO during 2015/16 involved registered health practitioners from other professions.

- As at 1 July 2016, we understand that one matter (about a registered nurse) has been referred to QCAT since the commencement of the OHO in July 2014. AHPRA is not aware of any other referrals since this date.
35. Significant concerns are raised about whether appropriate and sufficient steps have been taken by the OHO to protect the health and safety of the Queensland public. This is illustrated by the data in Table 1 below.

Table 1: Number of immediate registration actions completed

The rate of immediate registration action to protect the public increased from 48 in 2012/13 to a peak of 184 in 2013/14. Since the establishment of the OHO the number of immediate registration actions completed reduced marginally to 183 (of which the OHO completed 10). In 2015/16 the number of immediate registration actions against registered health practitioners has substantially reduced to 122 (of which the OHO completed 11).



36. In particular, AHPRA and representatives of the Queensland Board of the MBA have had regular contact with the OHO to raise these issues and concerns about regulation of practitioners in Queensland – particularly to seek clarity about the OHO's threshold for taking immediate action and referring matters about medical practitioners to the QCAT.
37. To date, the Board has been advised by the OHO that the threshold for taking regulatory action is considered appropriate despite our highlighting the substantial lack of regulatory outcomes or sanctions on the most serious complaints about medical practitioners in Queensland. For the current arrangements to work better, it would be beneficial for the OHO threshold for considering matters as serious to be more clearly and transparently stated.
38. If, as is recommended, a single track for complaints about registered health practitioners was introduced, the Boards and AHPRA would be responsible for these matters, and our decisions for taking immediate action will be clearly guided not only by our authority under the National Law, but also by our Regulatory Principles and with the practitioner and community expertise of board members. All of these elements are applied when the seriousness of the matter and the implications for public safety are being considered.

⁷ Office of the Health Ombudsman Performance report June 2016, page 19: <http://www.oho.qld.gov.au/wp-content/uploads/2016/07/OHO-monthly-performance-report-June-2016.pdf>

39. Concerns about lower than expected numbers of immediate registration actions are not confined to matters involving medical practitioners and are shared by the other Boards. The **de-identified case study** below demonstrates the value of a Board's professional and community expertise being applied to a matter involving a registered nurse. The Board was able to identify its seriousness and took immediate action under the National Law to manage the risk to the public, after the OHO had formed a view that immediate registration action under the Act was not needed.

In 2015 a registered nurse working in a public hospital applied for renewal of registration and disclosed (as is required under the National Law) that during the previous registration period their criminal history status had changed.

AHPRA conducted a criminal history check that confirmed the practitioner had been charged with multiple drug-related offences and possession of stolen property.

The criminal matters were the subject of complaints being managed separately by the OHO. It was alleged that prescription drugs had been found in the nurse's home for which the practitioner did not have a prescription, and that the nurse had allegedly stated to the police they may have obtained the drugs from the workplace.

AHPRA contacted the OHO and was advised that they did not consider it necessary to take immediate registration action at that time as the nurse had been suspended by their employer and therefore was not a risk to the public.

The Queensland Board of the NMBA formed a different view that immediate action was necessary to protect the public as the nurse was otherwise not restricted from practice and could attempt to obtain work elsewhere (eg as a locum) where they could have access to restricted medicines/dangerous drugs.

The Board decided to place conditions on the nurse's registration restricting access to medication and requiring the practitioner to practice while supervised. The Board also required the practitioner to undertake a health assessment, which resulted in a finding that the practitioner had a health impairment that would detrimentally affect their capacity to practise the profession. As a result of the health assessment the Board has restricted the practitioner from practising as a nurse.

***Under our recommended changed model**, the Boards and AHPRA would have carriage of the original complaint and could take timely regulatory action to protect the public informed by professional expertise and community expectations. We would not be required to enter into a consultation with the OHO about whether immediate registration action was needed.*

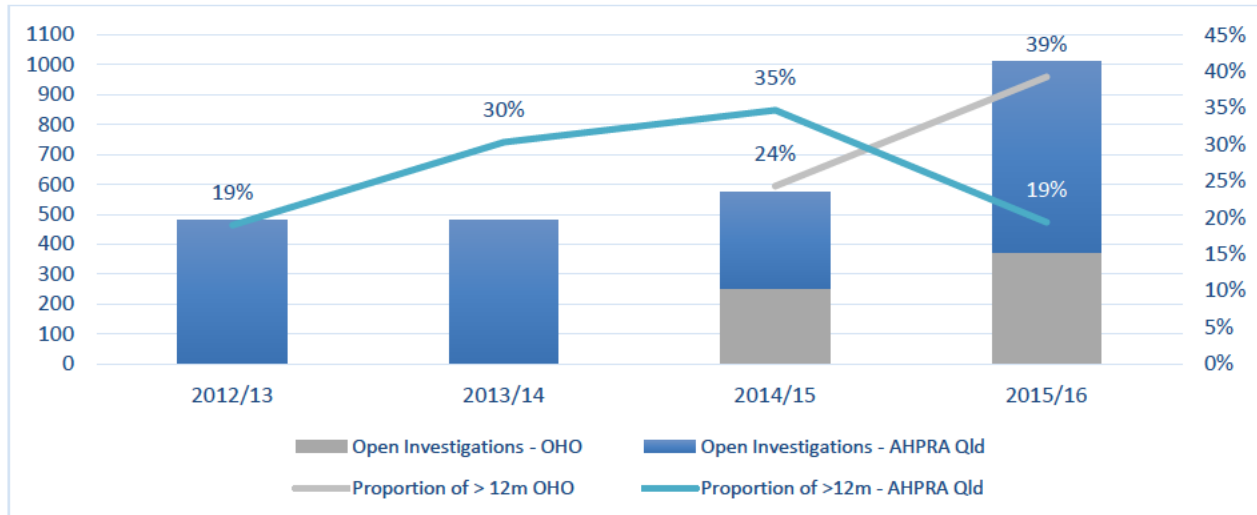
Timeliness of investigations by the OHO

40. In the published OHO June 2016 performance report, the percentage of investigations that have been open for more than 12 months is **39.25%** (or 146) of all investigations.⁸ Further, the number of investigations that have taken more than 12 months to close is **63.34%** (19 matters). AHPRA and the Boards are aware of matters that were required to be transferred to the OHO after the office was established in July 2014 that have not yet been resolved.
41. All investigations that have been open for more than 12 months are published on the investigations register on the OHO website. This transparency is commendable and is a direct result of the implementation of the complaints system in Queensland and the direction that there be greater transparency and accountability for conducting investigations.
42. However, these data also demonstrate that the percentage of investigations that are greater than 12 months is the highest proportion on record over the last 4 years.
43. Further, there were a number of serious matters that were 'on foot' as at 1 July 2014, that were required to be transferred to the OHO by the Boards and AHPRA. Investigations have not yet been concluded some two years later.

⁸ Office of the Health Ombudsman report, page 18 <http://www.oho.qld.gov.au/wp-content/uploads/2016/07/OHO-monthly-performance-report-June-2016.pdf>

Table 2: Number of investigations greater than 12 months, and the proportion of investigations greater than 12 months from all investigations open

The number of investigations in Queensland has remained between 400 and 600 from 2012/13 through 2014/15 with a large spike in 2015/16 to over 1000. The proportion of AHPRA investigations greater than 12 months peaked in 2014/15 at 35% of all open investigations, however this reduced dramatically in 2015/16 to be only 19% of all open investigations. The proportion of OHO investigations has increased from 24% in 2014/15 to 39% in 2015/16. This is the highest proportion of investigations greater than 12 months on record over the last 4 years.



44. The **de-identified case study** below is about a matter that was 'on foot' at the time that the OHO was established, and was required to be transferred to the OHO for management in October 2014. AHPRA and the Board await advice from the OHO about any action taken.

The Queensland Board of the MBA investigated a general surgeon after receiving notifications, prior to the establishment of the OHO, about cancer surgery the surgeon performed on multiple patients. The patients had experienced complications following surgery. In one case the patient died from the complications.

On receiving the first notification, the Board took immediate action to restrict the surgeon's practice and requiring that he only perform certain types of surgical procedures and only under supervision. The Board subsequently amended these conditions following receipt of additional notifications.

After considering the investigation report, medical records and expert opinion obtained during the investigation, the Board formed the reasonable belief that the practitioner's conduct and performance in relation to several of the patients constituted professional misconduct as the treatment provided by the practitioner was below the standard reasonably expected of the practitioner in his performance as a registered specialist general surgeon; and the knowledge, skill and clinical judgment possessed and care exercised by the practitioner as a registered specialist general surgeon included significant departures from accepted practice.

By this time, the OHO had been established. The Board was required to inform the OHO of the outcome of the investigation and the Board's reasonable belief that this was a serious matter that had grounds for referral to the Tribunal.

The OHO decided to take carriage of the matter in October 2014 and the Board complied with the request to transfer all information to the OHO. The matter has remained open since that time.

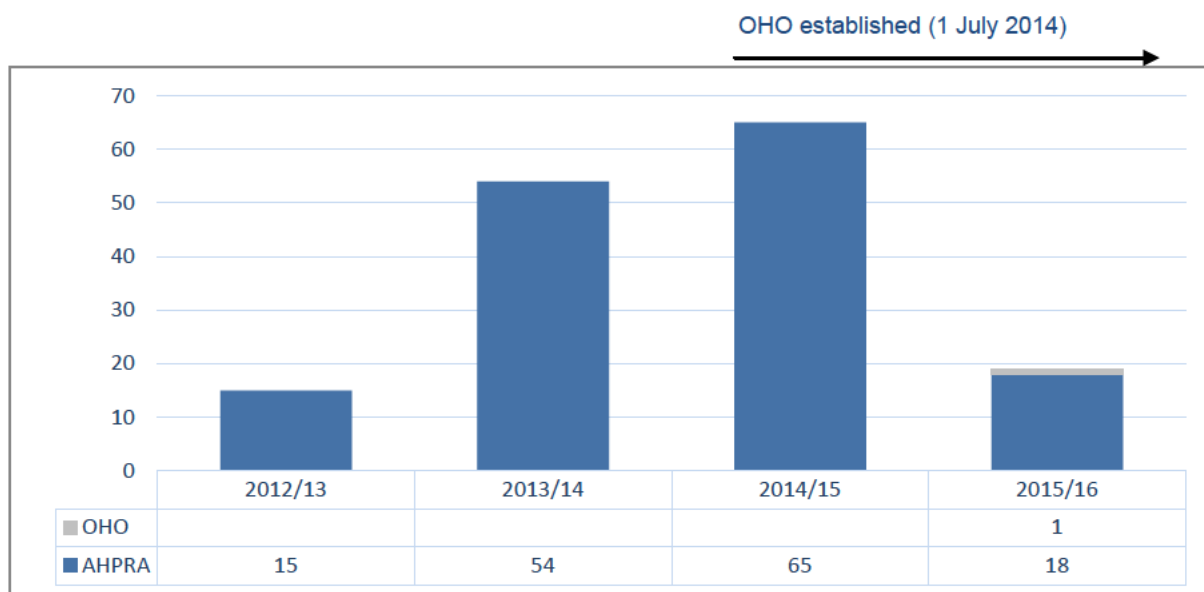
The practice restrictions imposed on the surgeon by the Board remain in place to protect the public.

If the Board had been able to retain responsibility for this serious matter, the practitioner's performance would have been referred to the Tribunal because the board formed a reasonable belief that this was professional misconduct and would have been required under the National Law to refer the matter to QCAT in 2014. Tribunal action has a deterrent effect and enables the Board to uphold professional standards and maintain public confidence in the regulated health professions.

Lack of referral of serious matters to the Queensland Civil and Administration Tribunal (QCAT)

45. As demonstrated by the published OHO performance data for June 2016, the number of referrals to QCAT is also significantly lower than would be reasonably expected for serious matters involving registered health practitioners. These apparent inconsistencies also make it difficult to compare regulatory actions and decisions across the scheme, which contributes to national fragmentation.
46. The OHO is clearly empowered under the Act to take serious matters about health practitioners to QCAT⁹. There is a dedicated position of Director of Proceedings who must be provided with all relevant information by the Health Ombudsman to enable a decision to be made about taking a matter forward to QCAT. Again, the OHO is charged with dealing with the most serious of matters and these are more likely to require intervention to protect the public.
47. Since the establishment of the OHO only one matter has been filed by the OHO with QCAT and this was in late 2015.

Table 3: number of matters referred to a tribunal



48. The reduction in the number of matters referred to tribunal by the Boards since 2014/15 can be attributed to the OHO's:
 - responsibility to retain these matters and not refer to AHPRA;
 - decisions in the majority of cases (when notified of these matters by the Boards) for the matters to be referred to the OHO instead of allowing the Boards to continue to deal with the matter. AHPRA understands that there are more than 30 serious matters referred by the Boards and AHPRA, that remain open with the OHO.
49. Prior to the implementation of the OHO, the Boards were obliged to refer to the tribunal, all matters in which a reasonable belief was formed that the behaviour of a practitioner constitutes professional misconduct or that there was another ground for suspension or cancellation of registration. The OHO now has the responsibility to retain matters which fall into this category. Further, if the Boards form a reasonable belief that the behaviour in a referred matter constitutes professional misconduct or that there is another ground for suspension or cancellation of registration, the Boards must notify the OHO. The OHO then has the option to ask the Boards to refer the matter to the OHO or ask the Boards to continue to deal with the matter.

⁹ Explanatory notes for the Health Ombudsman Bill, Queensland Parliament, page 2:
<https://www.legislation.qld.gov.au/Bills/54PDF/2013/HealthOmbudsmanB13E.pdf>

50. The **de-identified case study below** illustrates a matter that the Queensland Board of the MBA would have been required to refer to the QCAT under the National Law as in force immediately prior to the enactment of the Health Ombudsman Act. Based on previous experience and similar matters that the Board has managed, this matter was expected to be referred to QCAT in late 2014. To date, we understand that it remains open with the OHO, but with no outcome.

AHPRA received an anonymous complaint in May 2014 (before the commencement of the OHO) alleging that a medical practitioner had been charged and convicted of two counts of assault and battery and two counts of contravening an abuse prevention order in another country, and that the practitioner had voluntarily agreed to cease practicing medicine in that jurisdiction pending the resolution of professional regulation proceedings.

The practitioner had failed to disclose these overseas criminal convictions to the Medical Board of Australia (MBA) when making an application to renew his registration.

The practitioner subsequently admitted the convictions to AHPRA, advising that he had served a custodial sentence, and failed to declare the charges and convictions in his application for renewal of his Australian registration as a medical practitioner.

In August 2014 (one month after the commencement of the OHO), the Queensland Board of the MBA formed a reasonable belief that the practitioner had engaged in professional misconduct. Behaviour that may constitute professional misconduct meets the threshold of being a serious matter and is the type of conduct matter that the Board would refer to the tribunal.

As required by the National Law as it currently operates in Queensland, the Board informed the OHO of the assessment.

The OHO required that the notification be referred for further management under the Health Ombudsman Act.

The Board complied with the decision of the OHO and since this time, the matter remains on foot.

Under our recommended changed model, the Boards and AHPRA would be responsible for managing serious complaints about registered health practitioners enabling professional and community expertise to be applied at the initial stage of assessment, including serious allegations. Matters, such as this one, would likely be referred to the tribunal in a timely way based on similar matters that the Board has brought to Tribunal. Tribunal action has a deterrent effect and enables the Board to uphold professional standards and maintain public confidence in the regulated health professions.

Assurance activities – monitoring the performance of AHPRA and the National Boards

51. In August 2015, the OHO published its first *Annual assurance plan 2015-16 – monitoring the performance of AHPRA and the National Boards*.¹⁰ The Assurance Plan identified four quality assurance reviews to be completed in 2015/16. The OHO described the first two assurance activities as follows:

Assurance activity 1: Management of registered health practitioners with a health impairment

Health impairments, such as alcohol and drug or mental health problems, are common causes of notifications about health practitioners to AHPRA and the National Boards, accounting for more than one-quarter of all notifications that AHPRA received in 2013-14. The purpose of this activity is to determine if AHPRA's and the National Boards' processes for monitoring practitioners with a health impairment adequately protect the health and safety of Queenslanders. The activity will provide feedback and identify opportunities for improvement. The scheduled activity was to be conducted between October-December 2015 with the findings reported January-March 2016. The timing was subsequently revised.

Assurance activity 2: End-to-end complaint case management

Best-practice complaints handling involves a comprehensive end-to-end approach to effectively manage all parts of the process in a timely and responsive manner. This activity will review AHPRA's and the National Boards' case management processes, in the context of the co-regulatory system in Queensland, to provide a full view of the case management process and activities within and across organisations. The scheduled activity was to start April to June 2016 for report publication for the quarter July to September 2016.

52. To date, none of these reviews have been completed. AHPRA understands that this has been due to a lack of resources being available to undertake this critical task. In June 2016, the OHO advised that while the Assurance Activity 1 continues to be progressed, plans for 2016–17 assurance activities have

¹⁰ Annual assurance plan 2015–16 <http://www.oho.qld.gov.au/wp-content/uploads/2015/08/Health-Ombudsman-annual-assurance-plan-2015.pdf>

commenced. The Health Ombudsman has cited changes in staffing levels and competing priorities as being key barriers to the successful start and completion of this work.

53. AHPRA and the National Boards consider that there is significant value in the OHO completing these assurance activities. We agree with the OHO that reporting should encourage transparency and accountability in the performance of our functions relating to the health, conduct and performance of registered health practitioners in Queensland. Any recommendations about how our performance could be improved would be welcomed and may also have the potential to be applied nationally for the benefit of the scheme as a whole.
54. If a change were made to the co-regulatory model as proposed in our joint submission, an expected benefit would be that the OHO could better use their expertise, time and resources to undertake these critical assurance activities and provide timely reporting. Health practitioner regulation is dynamic and the need for continuous improvements is constant. These reports will provide the most value if they are developed in a timely fashion and evaluate current and not obsolete processes and practices that underpin performance.

Term of reference (d): Review of the National Boards' and National Agency's performance of their functions relating to the health, conduct and performance of registered health practitioners who provide health services in Queensland

55. **AHPRA and the National Boards welcome the opportunity to respond to this term of reference. Since the decision was made by the former Health Minister to implement a new health complaints system in Queensland, our performance, systems and processes have improved considerably.**
56. The reasons for introducing the new complaints management system in Queensland resonate today. By the time the Bill was introduced into Queensland Parliament in 2013, AHPRA had already implemented a program for continuous improvement and Board support, which was making in-roads into improving complaints management in Queensland.
57. Six years since the start of the National Scheme, this program has led to more robust and mature systems being in place for complaints management and better support for all Boards to make informed and consistent regulatory decisions. The Annual Reports published on the AHPRA website track the improvements that have been made.
58. Ours is a learning organisation. AHPRA and the National Boards, with our Queensland boards and committees, welcome feedback on how to improve our regulatory work and the exercise of our functions under the National Law and within Queensland as a co-regulatory jurisdiction. In particular, we have a continuous focus on improving our management of notifications (complaints) and have committed to further developing our risk assessment framework and implementing strategies to better manage high risk investigation matters.
59. Key areas of improvement are highlighted below.

Embedding the regulatory principles for the National Scheme

60. Regulatory decision making is complex and contextual, requiring judgment, experience and common sense. Decision-making in the National Scheme is guided by the national Regulatory Principles as endorsed by all National Boards and the AHPRA Agency Management Committee. The regulatory principles were introduced in July 2014 for a 12 month pilot phase. An evaluation was done to assess whether introduction of these principles achieved what they set out to do – ie, support a responsive, risk-based approach to regulation across all professions within the National Scheme and redress concerns (including those raised in Queensland) about inconsistent decision-making and a 'light touch' to regulation. The principles have now been embedded into the National Scheme and support decision making which is consistent and balanced.

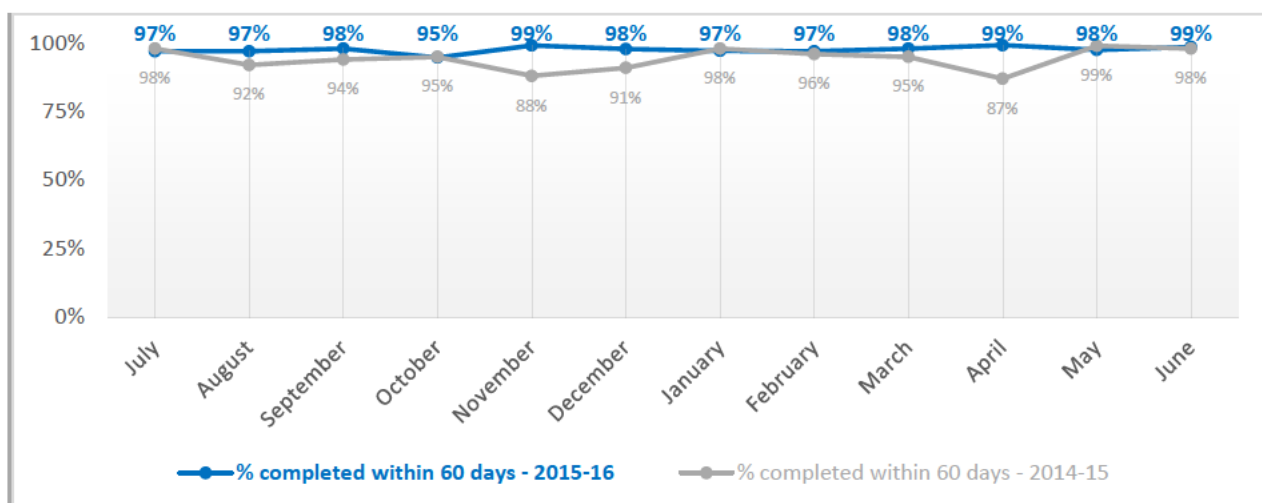
Performance reporting

61. Our performance reporting is significantly more comprehensive than existed under previous state and territory arrangements, when there was wide variation in performance reporting across jurisdictions and professions. Reporting was largely limited to notifications volumes and outcomes with almost no reporting on measures of notifications handling. AHPRA and the National Boards understand the importance of

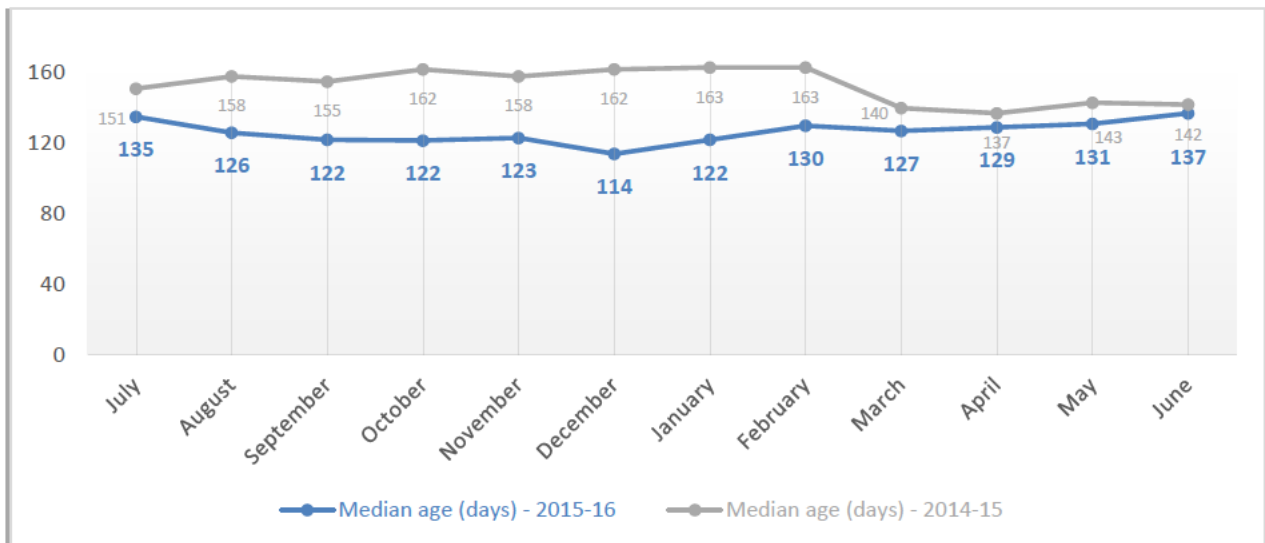
public reporting of our data and that reporting ensures greater accountability and transparency on matters of public importance. This is one of the mechanisms to encourage us, as an organisation, to continuously improve our performance.

62. From April 2016, in addition to our annual report and the state, territory and professional summaries, **quarterly performance reports are published on our website:** <http://www.ahpra.gov.au/About-AHPRA/What-We-Do/Statistics.aspx> The reports contain data on each state or territory over a three month period and cover our main areas of activity – managing registration, managing notifications and offences against the National Law, and monitoring registered health practitioners and students with restrictions on their registration.
63. The Boards and AHPRA acknowledge the criticism of us and regulatory bodies that existed prior to the National Scheme by the Chesterman and Forrester reports – particularly about the length of time being taken to conduct investigations and the consequential impact on both the practitioner who is the subject of the investigation, and the notifier. We acknowledge that historical problems with responding to complaints warranted additional oversight.
64. Under the National Scheme’s notifications process AHPRA has implemented a system that has the target for completion of an investigation being under six months. Sometimes gathering the information needed to complete the investigation is complex, and the investigation takes longer. All investigations are therefore reviewed at six, nine and 12 months to make sure that the information we are gathering is necessary to complete the investigation and where necessary any concerns about progress are escalated with oversight being provided by members of the Boards.
65. Our most recent internal reporting shows 99% of preliminary assessments are completed within 60 days. The median age for open investigations is 137 days, which is lower than for the same period in 2014/15.

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Completed in ≤ 60 days	1,477	1,675	1,705	2,244
Completed in > 60 days	37	47	49	34



	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Median age of open notifications	122	114	127	137



National Restrictions Library

66. At the start of the National Scheme, former state and territory regulatory schemes had developed a number of different kinds of conditions and undertakings to manage similar issues, which made it difficult for compliance teams to monitor. AHPRA and National Boards have progressively reviewed conditions imposed on practitioners' registration based on our national experience in monitoring and compliance. It is critical that any restrictions imposed on a practitioner's registration are able to be monitored, and that the types of conditions imposed are nationally consistent. Restrictions only protect the public effectively if registrants can comply with them and if compliance with the restrictions can be measured through evidence and be monitored on an ongoing basis.
67. For this reason, from March 2016, AHPRA launched the National Restrictions Library (NRL), to be used by decision makers nationally, including being available to tribunals. The NRL has been shared with the OHO and has also been provided to QCAT to support the application of consistent principles to matters for which Tribunal orders are being sought. Monitoring a practitioner's restrictions requires expert resources. Having AHPRA as the single agency responsible for monitoring all registered health practitioners enables expertise to be developed, and promotes a consistent approach to the monitoring task, regardless of how the restrictions were placed on the practitioner's registration.

Term of reference (e): Any other matter about the health service complaints management system

68. **There continues to be a risk of increasing costs for the government and registered health practitioners in Queensland in operating this co-regulatory model and considerable challenges in collecting and comparing complaints (notification) data from Queensland; a state with the third highest registrant base nationally. This contributes to national fragmentation and lost opportunities to use data to report to state and federal Parliaments, and to inform our work as regulators protecting the public both locally and nationally.**

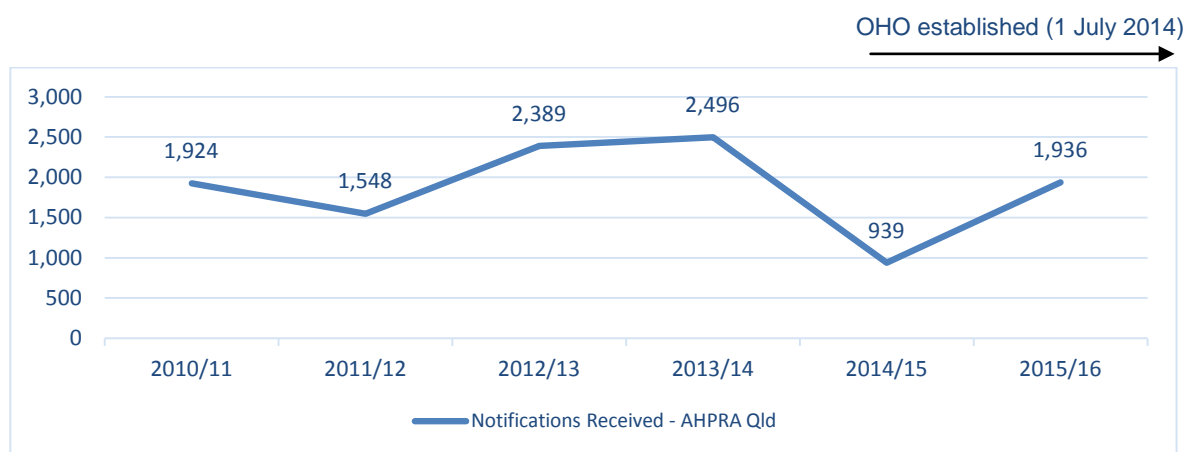
Determination of funding to be paid by the National Scheme to the OHO – increasing costs

69. AHPRA and the National Boards have voiced our concerns about the cost of the current co-regulatory arrangements in Queensland, and the consequent impact on governments and registered health practitioners based in Queensland.

70. The funding of the OHO is derived from two sources: the Queensland government and from the National Scheme based on fees collected from registrants in Queensland that would otherwise have been used to manage notifications in the scheme. Under the Health Ombudsman Act, provision is made for the transfer of a proportion of fees payable by health practitioners based in Queensland to the Health Ombudsman to reflect the reasonable cost of the ombudsman performing functions related to the health, performance and conduct of registered health practitioners that would otherwise have been performed under the National Law by the National Boards and AHPRA. That is, for dealing with the most serious complaints about registered health practitioners, while the National Boards deal with the others (the 'required functions').
71. It was the intention of Parliament that the passing of the Health Ombudsman Bill would be cost neutral for government.¹¹ AHPRA and the National Boards contend that, on the contrary, this has become a higher cost model for Queensland – particularly due to the unnecessary duplication of resources as demonstrated in this joint submission.
72. Two transfers of funds have been made from the national scheme to the OHO:
- For 2014-15, \$4.5M was transferred. Based on our detailed analysis, we have submitted a joint response to the Health Minister that the OHO's reconciliation overstates the value of work performed by the OHO that would otherwise have been performed by AHPRA and National Boards.
 - For 2015-16, the Queensland Health Minister formally determined that \$4.2M be transferred to the OHO. This determination is required to be published on the AHPRA website:
<http://www.ahpra.gov.au/About-AHPRA/Ministerial-Directives-and-Communiques.aspx>
73. AHPRA and the National Boards continue to be responsible for managing a large volume of work under the state's co-regulatory arrangements. As demonstrated in table 4 below, the rates of referral in 2015-16 have more than doubled from the previous year. At the same time, the OHO proposed an increase to the share of registrant fees that should be transferred to the OHO from the National Scheme to enable the OHO to manage complaints about registered health practitioners. As the rates of referral in 2015-16 have increased considerably, this places additional pressure on fees collected to fund the regulation of health practitioners.

Table 4: Notifications received in Queensland by AHPRA and National Boards

The rate of notifications received in Queensland by AHPRA reached a peak of 2,496 in 2013/14 prior to the establishment of the OHO. In 2014/15, AHPRA received 939 notifications referred by the OHO. In 2015/16, 1,936 complaints were referred by the OHO to AHPRA – more than double the number of complaints from the previous reporting period.



74. AHPRA and the National Boards provided a comprehensive joint response to the Health Minister's Consultation paper on fees to be paid to the Office of the Health Ombudsman for 2015-16. We clearly articulated our concern that the methodology used by the OHO for counting complaints and volume of work and calculating the reasonable costs of the required functions for 2014-15 is flawed. As a result the

¹¹ Office of the Health Ombudsman Performance report June 2016, page 4: <http://www.oho.qld.gov.au/wp-content/uploads/2016/07/OHO-monthly-performance-report-June-2016.pdf>

methodology produces significantly overstated amounts and incorrect distribution of costs to each of the National Boards.

75. In response to our joint submission, the Health Minister has directed his department to commission an independent financial analysis to confirm the most appropriate methodology upon which to base future decisions about the transfer of funding from the National Scheme to the OHO. A report will be provided to the Health Minister in time to inform arrangements for 2016-17 and will be retrospectively applied to the 2014-15 and 2015-2016 determinations.
76. We commend the Health Minister for taking this action. AHPRA is fully committed to participating in this independent review and providing information or data that will assist the reviewer. We look forward to the resulting report later this year.
77. AHPRA and the National Boards are monitoring the costs associated with this model. If the cost of the model in Queensland continues to impact on the National Scheme in other jurisdictions across the country, we will need to consider whether there may be a case to increase fees payable by health practitioners based in Queensland. We acknowledge the Health Minister remains committed to the concept of a single national fee for registration and renewal across Australia and to the principle that registrants should not contribute to the costs of running schemes in other jurisdictions. The National Boards and AHPRA welcome this commitment.

Data collection and incompatible methodologies

78. **The introduction of the co-regulatory complaints management model in Queensland has added complexity, in both the availability and comparability of data nationally. Queensland-specific variations in data make national analysis for reporting purposes challenging and compromise the national dataset used for risk analyses.**
79. In the joint submission from AHPRA and National Boards to the Queensland Parliament's Health and Community Services Committee on the Health Ombudsman Bill 2013 (24 June 2013)¹², we identified that joint arrangements would be needed to ensure alignment between our national IT systems and that developed to support the work of the OHO. We indicated this would be important to support combined reporting and provide transparency and comparability of data at a national level, including for mandatory notifications/complaints. Further, we submitted that there could be substantial risks in this area, unless adequate time and resources were provided to scope requirements and make any necessary systems changes.
80. Since the start of the National Scheme, AHPRA, the National Boards, the NSW Health Professional Councils Authority (HPCA) and the NSW Health Care Complaints Commission have used a standard, objective methodology for counting and recording notifications made about regulated health practitioners. This methodology is consistent with the counting methodology used by boards prior to the commencement of the National Scheme.
81. Each time a notifier (complainant) makes a notification (complaint) about a health practitioner, be that a mandatory or voluntary notification, a count of one notification is made and recorded against that practitioner's record in AHPRA's 'Pivotal' database. Each notification (complaint) might have a number of issues that need to be considered as part of the management of that individual notification (complaint).
82. As outlined in our comprehensive joint response to the Health Minister's Consultation paper on fees to be paid to the Office of the Health Ombudsman for 2015-16 when the OHO began operations on 1 July 2014, a different counting methodology from the one used by AHPRA for the national scheme notifications was adopted to record and report complaints about health practitioners made to that office.
83. AHPRA reports on individual notifications received and tracks each notification through its life until closure. We understand this is the same approach the Health Professional Councils Authority in New South Wales adopts. Data provided on the OHO website indicates this approach is not adopted in Queensland.

¹² Submission accessible from Qld Parliament's website: <http://www.parliament.qld.gov.au/work-of-committees/former-committees/H CSC/inquiries/past-inquiries/HealthOmbudsmanBill>

84. The OHO's counting methodology is reflected in the OHO's *Annual Report 2014-15*.¹³ On Page 90 of this report is a table titled 'Number and type of complaints by health practitioner' with footnotes indicating that the data in this table is "Based on complaints that completed the assessment process during the year" and "There can be multiple issues identified within a single complaint". There are 2,150 'complaints' about health practitioners identified, and of these, 2,031 are about registered health practitioners. This figure of 2,031 is the same number referred to as 'matters' in the OHO's 2014-15 funding reconciliation.¹⁴ The 2,031 complaints recorded in the OHO Annual Report 2014-15 are actually the number of issues that have been identified in those complaints that were taken through all three stages of the OHO's assessment process.
85. In the counting methodology used by the OHO, not all complaints are included in the total count of complaints/matters reported. Similarly, the OHO may report a complaint more than once if more than one issue is identified in a complaint that is counted. Therefore there is no correlation between the number of complaints/matters reported by the OHO, the total number of complaints/notifications about health practitioners referred to AHPRA, or the number of notifications recorded by AHPRA as advised by the OHO.
86. Queensland has the third largest registrant base in Australia. Having incompatible methodologies presents considerable challenges to a consistent notification management perspective across the country, and for the data to be used both for reporting evaluation and research purposes. AHPRA is able to include data collected by the HPCA in quarterly performance reports provided to National Boards. Completed reports are provided back to the HPCA to provide a perspective on the 'whole of national scheme' trends. There are a number of new initiatives underway between AHPRA and the HPCA to evolve this exchange of data and to make the exchange more automated and timely. In comparison, there is no current dialogue with the OHO about data exchange.
87. AHPRA continues to liaise with the OHO to find a way to align some of the Queensland datasets to the rest of the country.

Data for research and regulatory evaluation purposes

88. **A nationally consistent dataset is of vital importance to making evidence-informed local, regional and national policies relating to patient safety and health workforce issues. Having data of sufficient quality that supports the research and evaluation activities that AHPRA is doing in risk based regulation and the development of a competent and flexible health workforce is essential.**
89. AHPRA's Risk Based Regulation Unit was established in 2014 to help reduce harm to the public and facilitate safe workforce reform. The unit does this by increasing the use of regulatory data and research to inform policy and regulatory decision-making. The unit has a particular focus on identifying risk associated with the practice of registered health professions. The unit includes qualified statisticians who undertake internal quantitative and qualitative analyses to identify key themes and risk factors to inform 'right-touch' regulatory decision-making by National Boards, consistent with the NRAS Regulatory Principles. These analyses aim to identify potential 'hotspots' of risk, which may include high-risk practitioners, at-risk patient sub-populations, or particular high-risk health settings.
90. In AHPRA's July 2015 response to the (former) Health and Ambulance Services Committee, we advised that AHPRA would be pleased to work with the OHO, as we do with the HPCA in NSW, to ensure a national data set on notifications is available as a resource to inform risk-based regulatory decisions. The potential lack of availability of compatible data from Queensland for the period from July 2014 may restrict the unit's ability to do this important analysis – particularly as Queensland has the third largest registrant base.
91. There have been limited opportunities to date to explore this further with the OHO and to look at ways to improve the current arrangements.

¹³ Office of the Health Ombudsman annual report: <http://www.oho.qld.gov.au/news-updates/our-reporting/annual-reports/>

¹⁴ Office of the Health Ombudsman, Reconciliation of funding from AHPRA: <http://www.oho.qld.gov.au/wp-content/uploads/2015/12/Reconciliation-of-funding-from-AHPRA-final.pdf>

92. A strong partnership between AHPRA and the OHO in Queensland for data collection and sharing is expected to lead to a tighter intersection between the national notifications process and the health complaints system in Queensland. At the core of such a partnership, should be a robust and coherent agreement on the roles and expectations of both parties for the sharing of data. A shared and cooperative approach to the data that is collected at first point of entry, would provide both a consistent, coherent and complete picture, as well as minimize respondent burden. This would allow both AHPRA and the OHO to leverage AHPRA's experiences and expertise in health standards and classification that are being further enhanced through recent developments in its public interface. It would allow AHPRA to benefit more from the OHO's expertise in the collection of more consumer-focused information. This shared data approach, would also allow for a more streamlined process for those cases that are relevant to both AHPRA and the OHO.
93. A partnership between AHPRA and the OHO to develop data sets that can accurately reflect regional and national issues is essential to both agencies. The OHO could leverage the experience, reputation and size of AHPRA, while AHPRA could benefit by having a closer relationship with an agency that specializes and focuses on aspects related to the notifiers and their expectations and experiences. The value of a nationally consistent data set, as Dr Marie Bismark has said, "...has tremendous potential to strengthen research into health practitioner regulation, health care quality and workforce planning."¹⁵ A tight integration of data systems, processes, and policies between the two agencies would allow a more transparent approach to the development of agreed business and counting rules, as well as data quality assurance and control measures to assist both agencies when publishing official statistics.

Conclusion

94. While there are strengths to be found in the current co-regulatory model as implemented in Queensland, there are significant areas that require attention and improvement that cannot be achieved through administrative means alone.
95. This joint submission from AHPRA and National Boards has highlighted our ongoing and considerable concerns that the current model is not achieving Queensland Parliament's intent for a better system for health complaints management – one with more transparency and accountability and improved timeliness, and with an emphasis on the protection of the public being the paramount concern in any decision-making involving complaints about health practitioners and health service delivery.
96. Key concerns are that:
- Serious matters that pose a risk to the public are not being dealt with in a timely or appropriate way
 - Matters that are considered minor by the OHO are closed or not accepted without any consideration by or referral to the Boards and AHPRA. This contributes to information fragmentation and greater risk to the public
 - The current model and its implementation is costing more, using more resources, and is likely to result in increased registration fees for Queensland based registered health practitioners.
97. AHPRA and the Boards submit that a change needs to be made to the co-regulatory model in Queensland to better manage risks to the public from the health, conduct or performance of some registered health practitioners in this state and address costly duplication and delays. A changed co-regulatory model would apply the regulatory expertise of the Boards and AHPRA and the expertise of the OHO as an ombudsman and health complaints authority in the best possible way, and direct our respective resources more effectively.
98. We would be pleased to meet with the Committee to clarify any aspect of this submission and attend public hearings when these are scheduled.

¹⁵ Bismark M, Fletcher, M, Spittal M, Studdert D, Australian Health Review, 2015, 39, 483–485

Appendix A

Areas requiring attention under the current co-regulatory model in Queensland

Concerns about public protection as raised by the Boards and AHPRA – additional information for submission paragraphs 18 (b), (c) and (d)

Non-referral of complaints / contextual information not being shared about registered health practitioners

The *Health Ombudsman Act 2013* (the Act) and the *Health Practitioner Regulation National Law* (the National Law) are complementary pieces of legislation with a shared paramount guiding principle, and together form a framework to protect the public.

The framework is to enhance public protection – and not restrict either the OHO or the Boards and AHPRA from exercising functions and taking action when needed.

A primary focus for the Queensland Health Ombudsman (OHO) is the timely handling and resolution of complaints about practitioners and identifying serious and system issues. Under the National Scheme, the Boards and AHPRA have a clear responsibility to regulate the health professions to ensure that only suitably qualified and competent practitioners gain and retain registration.

Sections 36 and 91 of the Act ensure that the OHO has the mandate in Queensland to decide whether or not to accept a complaint and if accepted, what action needs to be taken.

The OHO is not compelled to refer all 'non-serious' matters to AHPRA and the Boards – only those that the OHO decides warrant referral.

Therefore a complaint about a registered health practitioner can be accepted by the OHO, and a decision made to take no further action, with no referral or consultation with AHPRA and the Boards.

Conduct that may be considered by the OHO and staff to be minor and not needing any further action (eg alleged 'minor' breaches of ethical or practice standards) may still give rise to concerns when considered from the perspective of the Boards who have a responsibility to ensure that regulated professions are meeting national standards for conduct and practice including their ethical obligations.

When the OHO decides not to accept a complaint or decides after receipt to take no further action, no contextual information is provided to the Boards and AHPRA. Consequently, the Board cannot contemplate whether regulatory action needs to be taken because the registered health practitioner's health, conduct or performance fails to meet expected standards and warrants steps be taken for the protection of the public.

If complaints about unsatisfactory conduct or performance are not able to be considered at an early stage, by a Board with both clinical expertise and an understanding of community expectations, the practitioner's behaviour can go unchecked and lead to more serious concerns at a later stage and consequently pose an increased risk to the public.

Our recommended changed model of co-regulation would help mitigate this risk. Through a new joint consideration process between the OHO and AHPRA, based upon the current requirements in all other states and territories, complaints would be efficiently streamed to the body most appropriate to deal with them effectively. This should ensure Boards and AHPRA have full visibility of all complaints about registered health practitioners, including those that are less serious but may form a pattern of complaints that Boards can identify as a predictor of a higher risk incident in the future if not addressed.

Referral of matters by the OHO – use of triage system and unclear thresholds

The triage process to support referral of matters by the OHO continues to cause unnecessary delays, duplication of resources and potential for inadequate protection of the public.

Multiple consultation points causing duplication and delays and ‘referral loops’

The OHO uses a triage process to determine which complaints are referred to AHPRA and the Boards.

The legislation envisages that the **threshold for seriousness** and our respective responsibilities would be clear and duplication would be minimal. The Health Ombudsman has a mandate for the most serious of matters – ie those where professional misconduct is suspected or where the behaviour of a practitioner may lead to suspension or cancellation of registration. The OHO refers all other complaints about registered health practitioners to AHPRA and the Boards for regulatory action.

However, in practice, this has not been our experience. The result is significant duplication, delays and at times multiple referrals of the same matter between the two systems that operate in Queensland.

- 1st consultation point. Triage by the OHO. AHPRA can express a view that a complaint should or should not be referred depending on the matter but cannot refuse a referral – even if there are indications that the complaint will be assessed by the Boards and AHPRA as being serious, for example a complaint that is an apparent breach of ethical or practice standards.
- 2nd consultation point (if immediate action is taken by Board). AHPRA and the Boards assess the referred complaint. If the complaint is serious and there is a risk of harm to the public, the Board may take immediate action under the National Law. The Board must then advise the OHO of its assessment and any action taken to protect the public. The OHO must then determine whether to take the complaint or allow the Board to continue to manage it.
- 3rd consultation point. If the Board forms the view that the behaviour may constitute professional misconduct the Board must advise the OHO. The Board waits to receive advice from the OHO. While the OHO deliberates, the Board can take no further action. If OHO decides AHPRA and the Boards can continue to deal with the matter, the Board may take the complaint to the Tribunal. The OHO may require the matter to be referred to that office to deal with. If this is the decision of the OHO, the Board and AHPRA wait further advice on the outcome.

To clarify, the process is not linear, and is dependent on the nature of the matter and actions that need to be taken under our complementary legislation (being the Health Ombudsman Act and the National Law as applied in Queensland) to manage risk of harm to the public.

Delays may be experienced at any point and can cause substantial frustration and stress for all parties involved, especially the complainant and the practitioner who is the subject of the complaint. These referral ‘loops’ and the associated delays are also expected to be of concern for health service delivery and impact on public confidence in the current co-regulatory arrangements.

By contrast, under the national system of managing notifications Boards and health complaints entities have an agreed framework for joint consideration of matters which supports flexibility and helps ensure that the right entity deals with the right matters at the right time. In Queensland, joint consideration does not operate. In NSW, complaints are dealt with by the Health Quality Complaints Commission or the relevant Council and the HPCA and the outcomes communicated to AHPRA and the Boards.

The **de-identified case study** below demonstrates a complaint assessed by the Queensland Board of the MBA as serious, but has been subject to referral loops and multiple consultation points causing duplication and delays.

A general practitioner was the subject of three notifications over a period of two years. Two of the notifications alleged inappropriate behaviour by the practitioner in his practice, including a physical altercation with a patient. The matters were considered by the Queensland Board of the Medical Board of Australia in 2014.

The practitioner made some admissions about the behaviour. The Board formed a reasonable belief that the practitioner had behaved in a way that constituted professional misconduct by engaging in unprofessional conduct that was substantially below that reasonably expected of a practitioner of an equivalent level of training or experience. This is the type of matter that the Board would likely refer to Tribunal.

Behaviour that may constitute professional misconduct meets the threshold of being a serious matter. The Board is required under the National Law as it currently operates in Queensland to inform the Health

Ombudsman (OHO) of the assessment.

After due consideration, the OHO required that the notifications be referred for further investigation under the Health Ombudsman Act and the Board complied with this decision.

A year later the OHO concluded its investigation and referred the matters back to the Board finding that the practitioner had not behaved in a way that constituted professional misconduct noting that the police had decided not to progress charges for the physical altercation as the instigator of the alleged assault could not be determined.

The Board reconsidered the matters and took into account the advice from the OHO as well as similar cases considered by state Tribunals previously. The Board again formed a reasonable belief that the practitioner had behaved in a way that constituted professional misconduct as defined by the National Law. Again as the serious threshold was met, the Board was obliged to inform the OHO of its further assessment of the matter.

A month after being advised of the Board's further assessment the OHO required that the matters be referred again for further management under the Health Ombudsman Act.

The matters remain under investigation with the OHO. It has been almost two years since the matters were first considered by the Board and first referred to the OHO.

Under our recommended changed model, the Boards and AHPRA would be responsible for managing complaints about registered health practitioners. This would enable professional and community expertise to be applied at the initial stage of assessment, including for serious allegations. This would likely avoid the double-handling and duplicative assessment and investigations that the current model unintentionally creates because of different thresholds for assessing matters as serious and warranting regulatory action. A changed model would better support the Boards to take timely actions to deal with serious conduct matters without unnecessary delay while protecting the public.

The **de-identified case study** below illustrates the impact on efficiently managing and responding to complaints about registered health practitioners when thresholds for action are unclear or are interpreted differently by the OHO – despite the legislative intent that it would be clear when a matter reaches the threshold of being serious. This complaint benefited from the Board's professional and community expertise to identify the seriousness of the matter on referral from the OHO and enabled the Board to take action to manage the risk posed by the practitioner. The movement of matters between the offices creates duplication of work, and increases the potential for risk to be inadequately managed.

In February 2016, a complaint was received by the OHO about the health and conduct of a dentist. The notification was about the dentist's criminal history and further serious criminal charges that were pending. There were also allegations about the dentist's health, including that he had treated patients while under the influence of illicit drugs.

Two months later, the OHO consulted with AHPRA and proposed to refer the matter to the Board. At that time AHPRA advised OHO that the allegations appeared to be serious involving both a potential health impairment as well as criminal charges. However the conduct and health issues were referred to AHPRA to manage.

Shortly after the matter was referred by the OHO, the Board decided to take immediate action and impose conditions on the dentist's registration as the Board considered the dentist posed a serious risk to the public. The dentist is subject to drug and alcohol screening as part of the conditions. The Board also decided to require the dentist to undergo a health assessment and to investigate the allegations.

In June 2016, the OHO requested that the conduct matter be referred back to the OHO as the charges that had previously been pending had now been laid.

The Board continues to manage the health component of the notification.

Splitting the management of health and conduct matters

A further inefficiency that causes delays and can limit the ability of the Boards and AHPRA to protect the public is the splitting of health, conduct and performance matters. Under section 41 of the Health Ombudsman Act, a matter may be split so the OHO can deal separately with more than one matter arising from the complaint.

There is no provision in the Health Ombudsman Act to enable the OHO to require a registered health practitioner to undergo a health or performance assessment. It was the intention of the Queensland Parliament that health (impairment) matters be dealt with by the Boards who have the expertise and an

ability to take appropriate action to manage the impaired practitioner and protect the public. This enables the OHO focus to be on serious conduct matters.

Health matters (impaired practitioners) are being referred more promptly for the Boards' consideration, better enabling a health assessment to be ordered when required. We commend the OHO for the improvement in this area which is consistent with the intent of Parliament. However, there are cases where it is not beneficial to split the health element from the performance or conduct element. The practitioner's alleged conduct often occurs as a direct consequence of their health impairment. Splitting matters can also be problematic for the complainant (notifier) and the practitioner who are subjected to two processes.

In split matters, the OHO will keep the serious conduct or performance issue and the health issue is referred to the Boards. This is problematic in some instances, as immediate action may not be warranted for the health (impairment) component only. But when both the health and conduct are considered together, the need for immediate action becomes apparent, and urgent action is warranted. The recommended changes to the current co-regulatory model would address these concerns as AHPRA and the Boards would have carriage of matters and could take appropriate regulatory action based on the whole of the matter.

The **de-identified case study** below demonstrates that the OHO and the Boards and AHPRA make attempts to ensure that the public is protected and that there is communication between our offices within the scope of our legislation. However, splitting issues in a complaint and having more than one body dealing with the health, conduct or performance of one practitioner, can limit the ability for either body to consider the risk that the practitioner poses to the public, causing it to be unintentionally compromised.

The OHO received a complaint about a medical practitioner employed at a hospital who admitted to forging scripts for a restricted drug in the name of an intern at the hospital. The practitioner stated that he was using the drug to manage his mood and motivation, as well as dealing with the issues raised by the hospital about his performance.

The notifier (also a medical practitioner) believed the practitioner had the restricted drug dispensed at a number of different pharmacies and reported concerns about the practitioner's mental health and risk to his safety. The notifier also reported that a pharmacy had subsequently provided information that the practitioner had allegedly impersonated an intern to obtain authority for the medication and request that the pharmacy increase the supply quantity above the PBS quantity.

The OHO decided to split the matter by referring the concerns relating to the practitioner's health to AHPRA and the Board, but retaining the conduct issue as it was considered serious and required investigation.

Although the Board was aware that this was a split matter, it could only consider the issue to hand – the alleged impairment. With the impairment concern being isolated from the alleged conduct there was insufficient evidence for the Board to form a reasonable belief that the practitioner posed a risk to the public that warranted immediate action.

The Board noted that the practitioner's employment was suspended pending an internal investigation. However, suspending a practitioner's employment does not prevent a practitioner from gaining work elsewhere, for example as a locum.

The Board advised the OHO that a potential unintended consequence of splitting the matter was that the threshold for taking immediate action was not reached for either the OHO or the Board, even though there appeared to be a risk to the public if the practitioner gained employment to practice elsewhere.

The OHO decided to take immediate registration action to suspend the practitioner's registration to ensure this risk was addressed while it completes its investigation.

Under our recommended changed model, the Boards and AHPRA would be able to consider the conduct and health issues as one matter and assess whether the practitioner poses a serious risk that warrants immediate action. The risks posed by a practitioner (to himself and others) can more effectively be managed when the responsibility for regulatory action is vested in one body.

Appendix B

Relevant background to the introduction of the new complaints management system

The introduction of the new health service complaints management system in Queensland was primarily a response to three reports [Chesterman (2012), Hunter (2013), Forrester (2013)].¹⁶ The Chesterman Inquiry arose from a public interest disclosure about the conduct, regulation, registration and discipline of medical practitioners in Queensland. There was a view that the system did not instil public confidence in the way in which complaints about health services and providers were managed in Queensland between the former Health Quality and Complaints Commission and the National Scheme in Queensland.

Mr Chesterman found no evidence of systemic failure and found the claim that the (then) Queensland board of the MBA had failed to maintain adequate standards of medical practice was not justified. However, Mr Chesterman did raise concerns about the way in which the Queensland board discharged its functions and recommended a review of all cases of misconduct or alleged misconduct by medical practitioners. This resulted in Dr Kim Forrester being appointed to head a panel to review the files and determine whether the Queensland board was achieving the primary objective of protecting the public by ensuring that medical practitioners were competent to practice.¹⁷

In the joint submission of AHPRA and the National Boards to the Queensland Parliament's Health and Community Services Committee on the Health Ombudsman Bill 2013 (24 June 2013), the former Health Minister's resolve to strengthen health complaints management in Queensland to restore community and practitioner confidence in the system was acknowledged.¹⁸

AHPRA, the National Boards, and the Queensland boards and committees acknowledge the key criticisms arising from the Forrester and the Chesterman reviews. Three findings of the Forrester Report continue to resonate today:

- Delays in the timeliness of notifications progressing from receipt through the various assessment and disciplinary processes to a final decision;
- A lack of consistency and predictability of outcomes of the (then) Queensland board of the MBA's decisions across notifications of a similar nature (with a subtext of the board taking a 'light handed' approach to matters);
- Considerable delays and inconsistencies in a significant number of files due to cross-jurisdictional referral, consultation and information sharing obligations imposed under the law as it was in 2013.

In 2013, we respectfully submitted that a more rigorous administrative approach within the current arrangements would have addressed many of the Health Minister's concerns, while maintaining national consistency in complaints and notifications handling under the national scheme. Our informed opinion was that the success of the new model would rely on the cooperation of all parties involved to avoid any unintended increased costs, fragmentation or delays in how complaints are managed in Queensland and to support appropriate national consistency in dealing with issues about the health (impairment) conduct or performance of health practitioners.

In June 2015, the (former) Health and Ambulance Services Committee wrote to AHPRA prior to an oversight meeting with the Committee.

¹⁶ Parliamentary Crime and Misconduct Committee, *A report of the Crime and Misconduct Commission's assessment of a public interest disclosure*, Report no. 87, July 2012 (The Chesterman Report); JR Hunter SC, Report to Queensland Health Minister, 28 February 2013. Review of the files held by the Medical Board of Queensland, the Queensland board of the Medical Board of Australia and AHPRA; K Forrester, E Davies and J Houston, Chesterman Report Recommendation 2 Review Panel (The Forrester Report), 5 April 2013.

¹⁷ Refer to summary of the Queensland Parliament Health and Community Services Committee's report on the Health Ombudsman Bill 2013 (August 2013) <http://www.parliament.qld.gov.au/documents/committees/HCSC/2013/HealthOmbudsmanBill/rpt-027-12Aug2013.pdf>

¹⁸ AHPRA and National Boards joint submission accessible from Qld Parliament's website: <http://www.parliament.qld.gov.au/work-of-committees/former-committees/HCSC/inquiries/past-inquiries/HealthOmbudsmanBill>

AHPRA provided its response in July 2015 which provided an opportunity to raise emerging issues about the co-regulatory model that were presenting challenges to achieving the shared objective of having efficient and effective arrangements that protected the Queensland public.

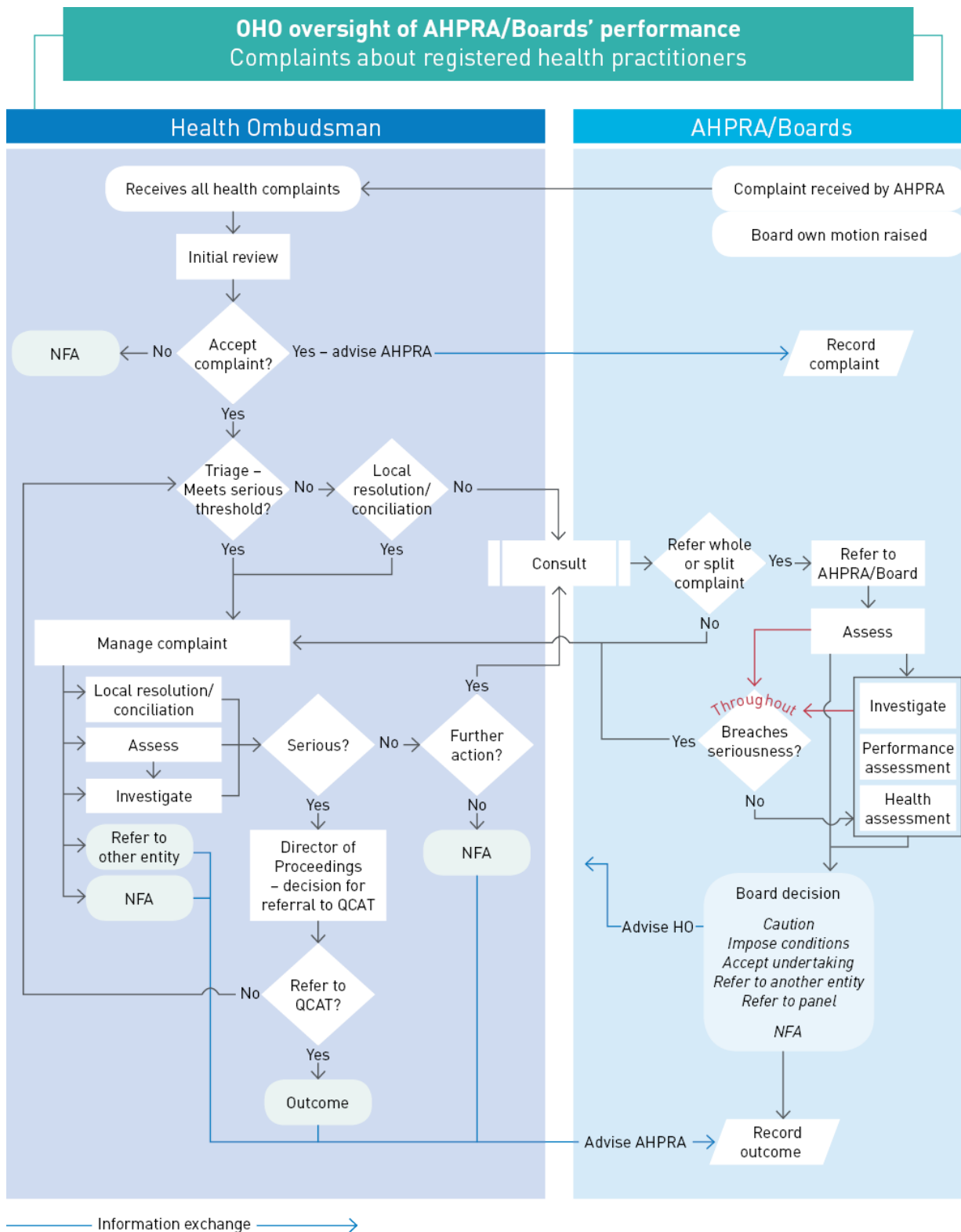
We recommend that new members of the Committee (if they have not already done so) consider this response as being relevant background to this joint submission and our recommendations for making changes to co-regulatory arrangements in Queensland.

The emerging issues identified in that response are, to a large extent, now ongoing concerns. Six focus areas to improve the current co-regulatory arrangements were identified. Achieving improvements in these areas required collaboration with the OHO and other key agencies, and the maturing of our systems and processes. Some improvements have been made, but not to the extent desirable to improve the model and ensure it best protects the Queensland public.

Appendix C 1

Flow diagram – current Queensland model

The diagram below illustrates the complexity of the implemented model and flow of information for complaints about registered health practitioners between the OHO and AHPRA and the Boards.



Appendix C 2

Flow diagram – recommended changed Queensland model

The diagram below illustrates how the complexity of the current implemented model which causes delays, duplication of effort, and multiple consultation points would be addressed by a changed model.

