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

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20th April 2017

Dear Director

**Re Public Health (Infection Control) Amendment Bill 2017 - Call for Submissions**

Thank you for the invitation to make a submission in relation to the proposed Bill.

The Queensland Branch of the Australian Dental Association has some reservations about the effect of the Bill on our membership if it were to be enacted as proposed.

These concerns are set out in the attached document.

Yours faithfully

[redacted]

Dr Gary Smith - President

Australian Dental Association (Queensland)

[redacted]

Professor Ian Meyers - CEO

Australian Dental Association (Queensland)

**ADAQ**

**Public Health (Infection Control) Amendment Bill 2017 – Submissions**

1. In relation to the **Achievement of policy objectives**, at bullet point 1, mandatory training, competency and infection control standards are to be prescribed by regulation. It will remain to be seen what these provisions are, but ADAQ is concerned about the resourcing of the appropriately qualified persons for these tasks.

2. Under the heading **Alternative ways of achieving policy objectives**, it might be argued that a legislative response may be the only feasible option, but legislative response, through modifications of the Queensland *Health Practitioner Regulation National Law* and/or the *Health Ombudsman Act*, might be more appropriate and not result in an expansion and duplication of regulations.

3. The proposed changes would amount to conflicting regulations between AHPRA and its Queensland Notifications Boards, the OHO, and now Queensland Health.

4. ADAQ submits that changes to the *Health Ombudsman Act* 2013 and *Health Practitioner Regulation National Law 2009* would be more practical and effective.

5. In relation to the **Costs of implementation**, it is said that this will not involve additional costs outside those already funded through existing budget allocations. It may be there will clearly need to be increased staffing, and most importantly expertise in relation to how these regulations are enforced. There has been a tendency for both Queensland Health and the Ombudsman to rely on internal staff who do not have the relevant scientific background and specialist skills to perform these duties.

**Queensland Health Decisions and Review Generally**

6. An issue needs to be addressed is that if there is going to be a power exercised by a senior person in Queensland Health, then there needs to be a right of appeal to have that decision reviewed because of the catastrophic effect of a directions notice which can result in the closure of a practice.

7. The Chief Executive's power to issue such a notice, if it is based on poor advice is of little comfort to the affected practitioner involved.

8. Presently, the *Public Health Act* does not have any right of review, beyond Application to the Supreme Court, which is expensive for affected registrants and can be time consuming.

9. For those reasons, if these provisions are to be implemented as in this Bill, then it is important that the rights of practitioners for appeal, review or stay are identified within the Bill.

10. ADAQ respectfully submits that a right of review to the QCAT ought to be established in the Bill for each decision of the Chief Executive and his delegates.

**Entry without Notice**

11. ADAQ has concerns that where an authorised person is to enter Dental premises without any notice whatsoever then the effects on the practice can be extreme on staff and patients and reputation.
12. Of course public safety is paramount but ADAQ submits that a balancing of this paramountcy with some safeguards for affected registrants is critical and reasonable.
13. For those reasons ADAQ submits that some higher level of diligence by an appropriate person with relevant expertise is required so that the decision to enter without notice is justified in all of the circumstances.
14. Perhaps when the regulations are provided and if these are available for comment ADAQ will be invited to make a comment in relation to the practical effect of this clause

**Effect on Non Registrants**

15. Section 151 as proposed could have the effect of making any person involved in the provision of a declared health service liable.

16. The examples include, on page 5, a registered nurse who is presumably not an owner or operator, but it could include a dental assistant and registrants or non-registrants who are working in the declared health service.

17. On its face, this could mean a dental assistant involved in the provision of declared health service, for example working assisting implant surgery must take reasonable precautions and care to minimise the infection of this to other persons. That seems simple enough, but if they were for some reason to breach the terms of the ICMP, then as a non-registrant they could be penalised 1000 penalty units.

18. It does say by way of an example, that if such a person complies with the ICMP then they are preventing and controlling the spread of infectious diseases, presumably with an approved and appropriate ICMP.

19. This broad use of the term “involved in” is of concern as it appears to impose duties on employees and removes the vicarious liability protection.

**What is an ICMP**

Section 155 as it presently stands provides as follows:

***155 What an ICMP must contain***

*(1) An ICMP for a health care facility must state—*

*a) the infection risks associated with the provision of declared health services provided at the facility; and*

*b) the measures to be taken to prevent or minimise the infection risks for declared health services; and*

*c) how the operator is to monitor and review the implementation and effectiveness of the measures; and*

*d) details about the provision of training in relation to the ICMP for persons employed or otherwise engaged at the facility; and*

*e) how often the ICMP is to be reviewed; and*

*f) if a person other than the operator of the facility is also responsible for providing advice about, and monitoring the effectiveness of, the ICMP— the name of that person.*

*(2) A regulation may prescribe matters to be included in an ICMP, including the measures under subsection (1)(b) that are to be included in an ICMP.*

*(3) The ICMP must be written in a way likely to be easily understood by persons employed or otherwise engaged at the facility.*

*(4) The operator of the facility must—*

*a) sign and date the ICMP; and*

*b) sign and date the ICMP each time it is reviewed.*

*(5) The operator must keep a copy of the ICMP at a place at the facility that is readily accessible to persons employed or otherwise engaged at the facility.*

*(6) If, after developing an ICMP for a health care facility, the operator of the facility intends to provide a declared health service not identified in the ICMP, the operator must, before providing the service, review and amend the ICMP to address the infection risks associated with the service.*

20. Section 155 lists 1 to 5 what an ICMP must contain, and that has not been varied; there are no available templates or examples of what an ICMP might be. It now provides where an operator does not keep a copy at the place that is readily accessible, then this is breached.

21. It would be useful if the legislation discusses the acceptability of an electronic copy rather than a printed copy because this has been problematic for our members.

**Timeliness**

22. The new part 3A of Chapter 4 relates to improvement notices and directions and where there is a compliance with an improvement notice at section 156D(1) and (2) some time restraints on the authorised person would be appropriate.

23. There is a potential problem in that the owner or operator of a health facility may believe they have complied with a notice and have informed the authorised person of that belief, presumably by way of documentation, but there is no provision as to how long it might be before the authorised person will indeed record the date of compliance and give a copy of the dated notice.

24. In relation to section 156E, the directions notice is perhaps better explained in the Bill than in the covering notes but the Chief Executive can give a thirty (30) day directions notice, which will obviously contemplate the inability of the facility to operate and then can extend a basis for another thirty (30) days.

25. This amounts to 60 days without a right of review or appeal by an affected registrant.

26. This is with respect unacceptable and offends natural justice.

**Review of Directions Notice**

27. Section 156G is about Court direction and that such an order for an extension of a directions order is clearly appellable from the Magistrates Court to the District Court, but there is still an issue in that there is no means of appealing or staying a decision of the Chief Executive Officer to impose a directions notice for a period of up to sixty (60) days.

28. It is important that a mechanism for appeal or stay in the first instance is introduced because the basis on which the Chief Executive Officer makes their decision may not be evidenced by an appropriate source.

29. ADAQ submits that there should be a means for an affected registrant to have the decision to issue a directions notice stayed on application to the QCAT or at the least be reviewed at the QCAT.

**Administrative Delay**

30. Section 156I is problematic in that there could be circumstances in which an operator informs the Chief Executive of the belief that they have complied with the notice and directions notice stops having effect on the date of the compliance.

31. There is the potential for a long period to run from the time of the operator's belief and compliance, the Chief Executive's recording the date of compliance and therefore triggering the ending of the directions notice. The affected practitioner may well be unable to earn an income in this time.

32. A period of time needs to be provided for the Chief Executives decision process, so that an affected registrant can be assured that a decision will be made in a time period that is definable. ADAQ suggests a period of not more than 14 days.

33. Delegations about directions notices can only be given to certain people and those delegations may well be appropriate if the resources and appropriately qualified persons are there to provide appropriate advice as to the suitability of the issuing of directions notices.

## Conclusion

The concerns with the Public Health (Infection Control) Amendment Bill 2017 as far as our membership is concerned include:

1. The replication of regulatory frameworks.
2. No demonstrable increase of resources in an effectively new body regulating health practice.
3. A demonstrated lack of knowledge and resources in dealing with dental practice and an imposition of Queensland Health policies across private dental practices.
4. A lack of administrative timeliness in the responses to affected practitioners.
5. A lack of recourse for review by effected practitioners.
6. A lack of any particularity in relation to the ICMP requirements.

Australian Dental Association (Queensland)
20th April 2017