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Health Legislation (Waiting List Integrity) Amendment Bill 2015

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Health and Ambulance Services Committee

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Health and Ambulance Services Committee

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ABBREVIATIONS

AIHW	Australian Institute of Health and Welfare
Bill	Health Legislation (Waiting List Integrity) Amendment Bill 2015
CARU	Clinical Access and Redesign Unit
COAG	Council of Australian Governments
Committee	Health and Ambulance Services Committee
The Department	The Department of Health
ED	Emergency department
HHS	Hospital and Health Service
Minister	Minister for Health and Minister for Ambulance Services
NEST	National Elective Surgery Target
NHPA	National Health Performance Authority
NPHED	National public hospital establishments database
OHO	Office of the Health Ombudsman
QAO	Queensland Audit Office

Chair's foreword

This Report presents a summary of the Health and Ambulance Services Committee's examination of the Health Legislation (Waiting List Integrity) Amendment Bill 2015, a Private Members' Bill.

The main objectives of the Bill as set out by the explanatory note are to:

- Establish the Health Ombudsman as the independent reviewer of clinical waiting times for Queensland patients in the public health system;
- Ensure the Health Ombudsman manages auditing of wait time matters in a transparent, accountable and public way; and
- Provide certainty in clinical waiting times for Queensland Public Hospital patients.

The Committee's task was to consider the policy outcomes to be achieved by the legislation, as well as the application of fundamental legislative principles.

The Committee sought written submissions on the Bill and held a public hearing. A total of four submissions were received.

This report sets out a summary of the evidence provided to the Committee and a number of recommendations where further clarification on issues such as the scope of the audit, duplication of roles and timeframes, are needed. The Committee was however unable to reach agreement on whether the Bill should be passed and as such, the views of both government and non-government Members have been represented separately in parts.

The importance of sound wait time policy and transparency and accountability in wait time data reporting is not in dispute.

What is in dispute is whether the Bill, as drafted, achieves its stated objectives and is based on sound policy. Furthermore, the Health Ombudsman was not consulted on the potential new function during the development stage of the Bill, and raised concerns with the compatibility of such an auditing function with the existing functions of his office. These are significant issues for consideration by the Parliament during the second reading debate.

Regardless of our divergent views, I would like to thank my fellow Committee Members for their genuine willingness to find common ground where possible and constructive debate on issues before the Committee.

On behalf of the Committee, I thank those individuals and organisations who lodged written submissions on the Bill. I also thank the Department of Health and the Health Ombudsman for the advice they have provided to the Committee during its inquiry.

Finally, I would like to acknowledge the Committee Secretariat's ongoing assistance and support.

Leanne Linard MP

Chair

Recommendations

No recommendation could be reached on whether the Bill should be passed.

Recommendation 1 **22**

The Committee recommends the Member for Caloundra clarify the intended scope of the audit during the second reading debate of the Bill.

Recommendation 2 **23**

The Committee recommends the Member for Caloundra clarify the issues relating to duplication of resources by CARU and the new independent audit function of the Health Ombudsman during the second reading debate of the Bill.

Recommendation 3 **29**

The Committee recommends the timeframes set out in the Bill, for both the conduct of the audit and preparation and publishing of the report on the audit, be reviewed.

The review of the timeframes should be undertaken in consultation with the auditor and the 16 Hospital and Health Services and the Member for Caloundra should address the review of timeframes during the second reading debate of the Bill.

1. Introduction

1.1 Role of the Committee

The Health and Ambulance Services Committee (the Committee) is a portfolio committee of the Legislative Assembly which commenced on 27 March 2015 under the *Parliament of Queensland Act 2001* and the Standing Rules and Orders of the Legislative Assembly.[1]

The Committee's primary areas of responsibility include health and ambulance services.

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

- the policy to be given effect by the legislation;
- the application of fundamental legislative principles; and
- for subordinate legislation – its lawfulness.

1.2 Referral

The Member for Caloundra, Mr Mark McArdle MP, introduced the Health Legislation (Waiting List Integrity) Amendment Bill 2015 as a Private Members' Bill into the Queensland Parliament on 19 May 2015.

In accordance with Standing Order 131 of the Standing Rules and Orders of the Legislative Assembly, the Bill was referred to the Health and Ambulance Services Committee for detailed consideration and report back on 19 November 2015.

On 2 June 2015, by a motion supported by the Legislative Assembly, the report date for the Committee was changed to 14 September 2015.

1.3 Inquiry process

The Committee wrote to stakeholders and subscribers on 5 June 2015 seeking written submissions on the Bill and received at total of four submissions.

As the Bill was a Private Members' Bill, the Committee wrote to the Member for Caloundra on 11 June 2015 inviting him to provide any additional information that could inform the Committee's consideration of the policies issues relating to the Bill. No further information was received.

A public hearing was held on 15 July 2015 to elicit further evidence for consideration by the Committee. The transcript of the hearing is available on the Committee's website.

Following the Public Hearing, the Committee wrote to the Member for Caloundra to seek clarification on a number of issues that arose during the Committee's examination of the Bill. The Member for Caloundra provided a response.

[1] *Parliament of Queensland Act 2001*, section 88 and Standing Order 194.

1.4 Policy objectives of the Health Legislation (Waiting List Integrity) Amendment Bill 2015

The objectives of the Bill, as set out in the explanatory note, are as follows:

- Establish the Health Ombudsman as the independent reviewer of the clinical waiting times for Queensland patients in the public health system;
- To ensure the Health Ombudsman manages auditing of wait time matters in a transparent, accountable and public way. This is the legislative outcome of the previous Queensland Government's announcement of its intention to create a new independent body following the announcement of the wait time guarantee; and
- To provide certainty in clinical waiting times for Queensland Public Hospital patients and allay concerns as a result of being on a waiting list longer than necessary.[2]

1.5 Consultation on the Bill

No consultation was undertaken prior to the Bill being introduced.

1.6 Should the Bill be passed?

Standing Order 132(1) requires the Committee to examine the Bill and determine whether or not to recommend the Bill be passed.

The Committee considered whether it should make a recommendation for the Bill to be passed and a vote on a motion to that effect was tied (3 Ayes/3 Noes) and, therefore, in accordance with section 91C(7) of the Parliament of Queensland Act 2001, the question on the motion failed.

A motion before the Committee to recommend the Bill not be passed, also resulted with a tie in the votes and similarly failed.

Consequently, no recommendation could be reached on whether the Bill should be passed or not.

While the Committee supports sound wait time policy and transparency and accountability in wait time data reporting, a number of issues were identified with the Bill, in its current form, that led the Government members to query whether the Bill would meet its stated objectives.

Non-Government members considered the Bill should proceed, and that it would be possible for minor amendments to be made in the consideration in detail stage to rectify any defects.

[2] Explanatory Note, page 1.

2. Wait times and wait time data

2.1 The current position

There has been much debate over a number of years on how wait times for health care services should be calculated, published and used. When the Bill was introduced, the Member for Caloundra advised the Parliament that independent auditing and publishing of wait times for healthcare services was required to 'provide peace of mind for patients and to improve patient satisfaction'. He stated:

> *To this day waiting lists and waiting to be seen have been the ultimate problem for overall patient satisfaction within the Queensland healthcare system. Waiting times for treatment continue to be a major concern. Not only does delay for treatment negatively impact upon the dignity, sense of wellbeing and frustration levels for patients, in some instances it contributes to the decreased health outcomes of those who wait longer than clinically recommended.*
>
> *The greatest problem is that patients often require further outpatient care as a result of being stuck on the waiting list and that ends up costing more than the actual procedure would. This does not take into account the emotional turmoil suffered by the patient and their family.*[3]

The Member for Caloundra acknowledged that appointing the Health Ombudsman, as an independent office, to audit and publish wait time data would remove the allegation as to the 'accuracy and otherwise' of wait time data which is currently published by Queensland Health.[4]

Waiting lists and waiting time data are a live issue, which policy makers across all jurisdictions continuously monitor and strive to improve for all stakeholders in the healthcare system. In April 2015, here in Queensland, the Minister for Health and Minister for Ambulance Services (the Minister) announced a review (the Hunter Review) to examine the *'… governance, organisational structure and capability gaps within the Department of Health'*.[5]

One of the key themes identified during the review, and identified by all stakeholder groups, was inefficiencies created by poor data quality and inequitable access to data. It was reported that these issues impact relationships between the Department and the Health and Hospital Services (HHSs) and the ability of staff to carry out their functions.[6]

At the Committee's public hearing, the Department officials advised:

> *The Hunter review identified that information is critical to the running of the department and understanding where opportunities for improvement are necessary in investment et cetera. The Hunter review recommended that we set up an improved*

[3] Queensland Parliament, Record of Proceeding, 19 May 2015, page 617.
[4] Member for Caloundra, correspondence, 13 September 2015, page 2.
[5] Minister for Health and Ambulance Services, media statement, 2 April 2015. <site accessed August 2015>
[6] The Hunter Review, Final Report, June 2015, page 13. <site accessed August 2015>

> *governance structure within the department. At the moment there is [the] … Office of Data Integrity and Patient Safety … Their primary purpose is to ensure there is an appropriate governance structure around information, standards, the way it is collected and the storage of that information and how it can be accessed in the broader departmental aspects.*[7]

The Department advised it was currently implementing the recommendations contained in the Hunter Review, Final Report and that '*this implementation will further define and strengthen the role of the Department as the independent system manager, and provide for clearer lines of accountability between HHSs and the Department of Health. The review provides new directions to improve the Department's role in assessing the performance of the HHSs, and I see the use of wait time information as central to this task'.*[8]

2.2 Wait time data sources

Before turning to what the Bill proposes, the Committee considered what wait time data is currently available, how it is collected and how this data is used.

Queensland Health

Wait time data is published online by Queensland Health for HHSs, reporting hospitals, dental clinics[9] and the whole state.[10] It is also published in HHS Annual Reports. Wait lists are primarily used by HSSs to *'… operationally deliver clinical services …'* and function as a register *'… for hospitals to know which patients require treatment and when to schedule their care.'*[11]

Data collection and analysis is managed by the Department of Health's Clinical Access and Redesign Unit (CARU).[12] The Queensland Health website notes the unit *'… plays a major role in improving the flow of patients through the health system by removing bottlenecks and providing clinical redesign support and advice.'*[13]

According to the Queensland Health website, in partnership with HHSs, CARU improves:

- *levels of service efficiency;*
- *access to services for patients; and*
- *patient experience within our hospitals*[14]

[7] Department of Health, public hearing transcript, 15 July 2015, page 3.
[8] Department of Health, submission 4, page 2.
[9] See for example, http://www.performance.health.qld.gov.au/hospitalperformance/oh-main.aspx?clinic=88.
[10] Queensland Health https://www.health.qld.gov.au/system-governance/performance/default.asp
[11] Department of Health, public hearing transcript, 15 July 2015, page 2.
[12] Department of Health, submission 4, page 1.
[13] Queensland Health https://www.health.qld.gov.au/caru/about-us.asp <site accessed August 2015>
[14] Queensland Health https://www.health.qld.gov.au/caru/about-us.asp <site accessed August 2015>

The Department confirmed that current data collection and reporting is completed independently of HHSs, '… *as they are their own statutory authorities.'*[15] In the Department's submission, it noted CARU manages key statewide data collections, including elective surgery and specialist outpatients, to enable meaningful analysis to inform effective decision making.

The Department advised collections had been developed and maintained to ensure that appropriate data was captured to fulfil the business needs of both the HHSs and the Department.[16]

Hospital performance

Data is published on the Queensland Health website on a monthly basis for the 61 hospitals operated by the HHSs. Some data is published quarterly, such as median waiting time to treatment. The Committee found that data could be accessed by navigating a number of linked webpages, rather than via a single report, and included more than a thousand different measures.

Data was categorised according to elective surgery, emergency department, specialist outpatient, hospital activity and patient experience.

Hospital and Health Service performance

Queensland Health publishes data for each of the 16 HHSs on its website. The following data is published quarterly:

- Percentage of patients whose length of stay in EDs was within four hours;
- Total number of patients (including those not ready for care) who waited longer than clinically recommended for surgery;
- Percentage of patients who received surgery within clinically recommended time frames;
- Number of people who waited two years and over on the general dental care waiting list;
- Percentage of category three specialist outpatients waiting less than 12 months for their first appointment;
- Number of families who received an in home visit at two or four weeks after birth, or both;
- Incidence of hospital acquired infections; and
- Value for money (benchmark cost target).[17]

HHS Annual Reports also include wait time data for hospitals and HHSs. The type of data provided varies between HHSs. Examples of what data is included, is as follows:

[15] Department of Health, public hearing transcript, 15 July 2015, page 2.
[16] Department of Health, submission 4, page 1.
[17] Queensland Health https://www.health.qld.gov.au/performance/

- Metro South HHS – outpatient waiting time (not by specialist), number of patients waiting more than two years for oral health services, National Emergency Access Target (NEAT) and National Elective Surgery Target (NEST).[18]
- Cairns and Hinterland HHS – emergency department (ED) patients seen within recommended timeframes (category 1-5), ED patients who depart within four hours, percentage of elective surgery patients treated within clinically recommended timeframes (category 1-3) and specialist outpatients waiting within clinically recommended timeframes (not by specialty). [19]
- Townsville HHS – number of patients waiting longer than two years for dental services, percentage of patients treated within recommended time for elective surgery (category 1-3), NEAT and number of people waiting longer than the clinically recommended timeframe for specialist outpatient appointments.[20]

HHSs also have their own webpages on the Queensland Health main website, however most of the performance data for HHSs directs users back to the Queensland Health performance website for individual hospitals. The Gold Coast HHS provides additional data, such as a monthly snapshot (chart) of the current waiting list times for clinics offered by Gold Coast Health and a chart of elective surgery waiting list by category and months waited.[21]

Dental clinic performance

Data is published on the Queensland Health website about waiting times for public dental services. Examples of data include:

- number of patients waiting for general care and number starting treatment, in less than 12 months, 12-24 months, 24-36 months, 36-48 months, 48-60 months and over 60 months. Also, the percentage seen within recommended waiting time;
- number of patients waiting for clinical assessment, in less than one month, one to two months, two to three months, three to four months, four to five months and over five months. Also, the percentage seen within recommended waiting time; and
- number of patients waiting for dental treatment according to priority level (category one to three) and number of months. Also, the percentage seen within recommended waiting time.[22]

MyHospitals (National)

The performance of individual public and private hospitals is summarised by the National Health Performance Authority (NHPA) on the Commonwealth Government's MyHospitals website.

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[18] Queensland Health http://metrosouth.health.qld.gov.au/about-us/publications/annual-report

[19] Queensland Health https://www.health.qld.gov.au/cairns_hinterland/docs/chhhs-annual-report-section1.pdf page 23.

[20] Queensland Health https://www.health.qld.gov.au/townsville/About/annual-report.asp

[21] Queensland Health https://www.health.qld.gov.au/goldcoasthealth/

[22] Queensland Health http://www.performance.health.qld.gov.au/hospitalperformance/oh-clinics.aspx?id=80

This is reported to be the *'… most up-to-date nationally consistent data available at the hospital level.'*[23] The NHPA is required to report on indicators agreed by the Council of Australian Governments (COAG) in December 2011.

Stakeholders can search for hospitals, specific services provided by hospitals, performance results over time, compare results against other hospitals and review hospital performance against indicators such as:

> *… waiting times in emergency departments or for some types of surgery, rates of bloodstream infections acquired in hospital, the length of time patients spend in hospital after being admitted for various conditions or procedures ...*[24]

Data from the '… *National Public Hospitals Establishments Database (NPHED), supplemented by additional information provided by states and territories'* is used to inform the MyHospitals website.[25]

Australian Institute of Health and Welfare

The Australian Institute of Health and Welfare (AIHW) is a national agency that collects and reports statistics and information on a wide range of health and welfare topics.[26] The NPHED is managed by the AIHW and holds data from 1993-94 onwards. It collects data on, for example, revenue, staffing levels and expenditure, and is used to inform reports prepared by the AIHW. Reports are prepared mainly at the national level. There is limited data analysis completed and reported on for individual state and territories. The NPHED:

> *… is based on the National Minimum Data Set (NMDS) for Public hospital establishments. It holds establishment-level data for each public hospital in Australia, including public acute hospitals, psychiatric hospitals, drug and alcohol hospitals and dental hospitals in all states and territories.*
>
> *The NPHED is compiled from data supplied by the state and territory health authorities. It is a collection of electronic records for public hospitals within Australia. All records are based on information collected for financial years.*[27]

The AIHW published annual reports on Australian hospitals using *'… the majority of the data elements …'* of the NPHED.[28]

[23] National Health Performance Authority, MyHospitals, *About the data*. <site accessed June 2015>
[24] National Health Performance Authority, MyHospitals, About MyHospitals, http://www.myhospitals.gov.au/about-myhospitals/overview <site accessed 29 June 2015>
[25] National Health Performance Authority, MyHospitals, http://www.myhospitals.gov.au/about-the-data/elective-surgery-waiting-times <site accessed 29 June 2015>
[26] Australian Institute of Health and Welfare, http://www.aihw.gov.au/about/ <site accessed 7 July 2015>
[27] Australian Institute of Health and Welfare, http://www.aihw.gov.au/hospitals-data/national-public-hospital-establishments/ <site accessed 29 June 2015>
[28] Australian Institute of Health and Welfare, Australian Hospital Statistics, http://www.aihw.gov.au/hospitals/australian-hospital-statistics/ <site accessed 29 June 2015>

This includes, for example:

- Australian hospital statistics 2013–14: emergency department care - Median waiting time and proportion seen on time, state and territory;
- Australian hospital statistics 2013–14: elective surgery waiting times - National Elective Surgery Target (NEST); and
- Australia's hospitals 2013–14: at a glance - Percentage of patients seen within recommended time for triage category, and percentage completed within four hours.

As the Bill would require the auditing of wait list data, the Committee considered whether data was audited or reviewed at the national level. The NHPA reported:

> *States and territories are primarily responsible for the quality of data they provide. Routine data quality checks are conducted by the states and territories prior to submission to data custodians such as AIHW. Data are checked for valid values, and for internal and historical consistency. Data received by the Performance Authority will then be subject to our own quality assurance processes for publication of performance information and analysis. If data are incomplete or not correct, the Performance Authority will contact the respective data supplier to query and correct errors.*[29]

[29] National Health Performance Authority, MyHospitals, About the data, http://www.myhospitals.gov.au/about-the-data <site accessed 29 June 2015>

3. Examination of the Bill

At a basic level, the Bill proposes that (a) wait time data is to be provided to the Office of the Health Ombudsman and (b) the Health Ombudsman audits the data, and prepares and publishes a report on the audit. The Bill proposed to make these changes through amending the *Health Ombudsman Act 2013* and the *Hospital and Health Boards Act 2011*.

The data itself is also required to be published by the Health Ombudsman.[30] Although a significant amount of wait list data is currently published, the quarterly auditing and reporting on the data would be a key change introduced by the Bill.

The Bill does not amend any current wait list policies, nor does it address wait list performance issues or require that any new wait list data be collected and as such, these issues are not considered in this report.

3.1 Wait time data and its provision to the Health Ombudsman

The Bill proposes that the 16 Hospital and Health Services (HHSs) provide quarterly '*wait time data'* to the Health Ombudsman within 14 days of the end of each quarter.

Wait time data is defined in the Bill to mean:

- data on the number of patients of a HHS waiting longer than a clinically appropriate period for surgery, by type of surgery;
- data on the number of patients of a HHS waiting longer than two years for general dental care, by type of dental care;
- data on the time an outpatient of a HHS waits for an initial consultation with a specialist health practitioner by type of specialist health practitioner; and
- other data, prescribed by regulation, about waiting times for a HHS.[31]

In his introductory speech, the Member for Caloundra stated:

> *General practitioners would also benefit from accessing the data. This information will better enable local doctors and patients to make informed decisions on healthcare options. Properly informed, they may choose to refer patients to an appropriate hospital service with a shorter wait or consider a referral to private specialists or alternative providers in the community.*[32]

As stated above, the wait time data is currently published online by Queensland Health for each of the 61 reporting hospitals.[33]

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[30] Clause 4 of the Health Legislation (Waiting List Integrity) Amendment Bill 2015 – proposed section 244C(3)(a).

[31] Clause 4 of the Health Legislation (Waiting List Integrity) Amendment Bill 2015– proposed section 244A, definition of wait time data.

[32] Hansard, 19 May 2015, page 617.

[33] Queensland Health, Hospital Performance, http://www.performance.health.qld.gov.au/hospitalperformance/ <site accessed 28 July 2015>

The wait time data is published in part for HHSs, however, relevant individual hospital data can be collated to provide a value for HHSs. The Department advised the Committee:

> *… data is captured from an appropriate selection of hospitals, health services and information systems, and capturing sufficient data elements to monitor and evaluate services with relevant frequency. These data are collated and stored centrally in a supported and secure technical environment with efficient architecture, indexing and reference data, and is translated into information and knowledge that is relevant to a range of stakeholders.*[34]

The following table identifies the wait list data referred to in the Bill, and to what extent it is currently published by Queensland Health and HHSs.

Table 1 - Comparison of wait list data required by the Bill with that currently published

Wait list data required by Bill	Is this data currently published?	
	Hospital	HHS
Number of patients waiting longer than a clinically appropriate time for surgery, by surgery type	Yes. QH publishes # patients waiting longer than the clinically recommended time for care on a monthly basis, by 11 surgical specialties.	In part. QH publishes this data quarterly by HHS but not by surgery type. Hospital data can be tallied to provide total for HHS.
Number of patients waiting longer than two years for general dental care, by type of dental care	Yes. Data is published for each dental clinic on patients waiting for general dental care.	In part. QH publishes this data quarterly by HHS but not by type of dental care. Hospital data can be tallied to provide total for HHS.
Time an outpatient waits for an initial consultation with a specialist health practitioner, by type of specialist practitioner	Yes. Data is published by health specialist and urgency category.[35]	No. Hospital data can be tallied to provide total for HHS.
Other data prescribed by regulation about waiting times for a HHS	N/A	N/A

[34] Department of Health, submission 4, page 1.

[35] Category 1 - Patients should be seen within 30 days of being added to the waiting list.
Category 2 - Patients should be seen within 90 days of being added to the waiting list.
Category 3 - Patients should be seen within 365 days of being added to the waiting list.

Issues identified by Stakeholders

Submitters had differing views on whether wait time data, as defined in the Bill, should be published. Directors of Physiotherapy Services Queensland supported the Bill, in particular the requirement for the*'…transparent collection of data by the Health Ombudsman on the time outpatients of Hospital and Health Services wait for initial consultation with specialist health practitioners, including physiotherapy'.*[36]

In contrast, the Queensland Nurses' Union (QNU), did not support the Bill, stating concerns that it would enable the *'…reporting on just one function of the public health system when there are so many other indicators of performance that fail to be published'.*[37]

At the public hearing, Together Queensland told the Committee the critical issue was the 'anterior wait list', which referred to the number of people who require a health service. Together Queensland raised concerns that this issue would not be addressed by the Bill.[38]

Wait list policy was also acknowledged by the QNU, which noted in its submission *'...emerging best practice includes measuring the waiting time of patients and the total patient journey beginning in primary care'.*[39]

The Department also expressed concern at the lack of specificity in the Bill, including the format of the data, how the data should be provided and the scope of data provided. This included the lack of guidance on what 'other data' meant.[40]

The Member for Caloundra considered the definition of *'wait time data'* was clear in the Bill and the terminology used in the definition had been used for many years in reporting data and is clearly identifiable by common usage and past publications. With regard to the inclusion of 'other data' used in subsection (d) of the definition, the Member for Caloundra considered defining the myriad of wait time data available would be imprudent as it may restrict future interpretation. [41]

The Member for Caloundra provided the following examples of data sets that have been published in the past and could inform what 'other data' could include in the future:

- people treated in emergency departments;
- emergency admissions;
- on admissions to Queensland public acute hospitals by month;
- elective surgery by surgical specialty;
- surgical specialty long waits;
- radiation treatment; and

[36] Directors of Physiotherapy Services Queensland, submission 3, page 1.

[37] Queensland Nurses' Union, submission 1, page 5.

[38] Together Queensland, public hearing transcript, 15 July 2015, page 11.

[39] Queensland Nurses' Union, submission 1, page 4.

[40] Department of Health, submission 4, page 2.

[41] Member for Caloundra, correspondence, 13 September 2015, page 1.

- national performance reported.[42]

The Member for Caloundra considered there needed to be discretion to add 'other data' based on historical fact and there needed to be an ability to provide the people of Queensland with significant health information alerting them to the status of their own HHS, as and when it was determined appropriate.[43]

Committee comment

The definition of wait time data is fundamental to the achievement of the policy objectives of the Bill. Members of the Committee had differing views as to the whether the definition of wait time data was sufficient.

The non-government members were satisfied with the explanation provided by the Member for Caloundra and considered the definition of 'wait time data' was appropriate in its current form. Non-government members considered it was consistent with common usage and past publications. Further, published wait time data would enable patients to get a detailed understanding of the scope of waitlists across the State and would provide certainty for patients that they were not on a waiting list longer than necessary. With the data published in the form provided under the Bill, doctors would be properly informed as to current waiting lists and would be provided with options to refer patients to an appropriate hospital service with a shorter wait list or consider a referral to private specialists or alternative providers in the community.

Government members were not persuaded by the advice from the Member for Caloundra and considered the three wait time measures defined in the Bill only provided a limited overview of waiting time performance. As identified by stakeholders, government members considered there were many indicators of the performance of the health system, which they considered would provide a more complete picture of wait time experience, including for example, emergency department data.

Members were split on whether the definition allowing for 'other data' was appropriate. Government members considered it was preferable for the definition of wait time data to be comprehensive in the primary legislation and not be left for subordinate legislation at a later date. This would give the body conducting the audit a better understanding as to what the audit would entail and assist with resourcing and allocation of tasks. Government members considered the scope of the audit would be better understood if the definition was complete in the primary Act.

The non-government members considered there was nothing adverse with the definition as provided and it simply allowed flexibility for additional data to be set out in regulation at a later date on what was to be audited.

Government members also considered that for a more complete measure, wait time data should be collected from the date a GP refers a patient to a health specialist. Consequently, government members considered the definition of 'wait time data' should be amended to include a comprehensive list of wait time indicators; and measure patients' actual wait time from referral from a general practitioner through to receiving the health service.

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[42] Member for Caloundra, correspondence, 13 September 2015, page 1.

[43] Member for Caloundra, correspondence, 13 September 2015, page 2.

3.2 Auditing, reporting and publishing the data

The Bill proposes that the Health Ombudsman must conduct an audit of the wait time data provided by the HHSs, and must prepare and publish a report on the audit. The basis for the audit, as set out in the Bill, is to 'examine the accuracy of the data'.[44]

The Health Ombudsman has 30 days from the end of each quarter in which to complete the audit,[45] and within 14 days after the audit is conducted, the Health Ombudsman must then prepare and publish a report on the audit.[46]

The Health Ombudsman's report must include the findings in relation to the accuracy of the data,[47] and must also include a copy of the wait time data for each HHS and each hospital operated by the HHS.[48] The Health Ombudsman may include other information considered appropriate. This could include, for example, recommendations and observations.[49]

The report must not include adverse comments about an identifiable HHS unless the HHS has been given a copy of the comment and at least seven days to make a submission about it. The Health Ombudsman must consider the submission before finalising the report and cannot include the comment in the report, unless it includes the HSS's submission (or a fair summary of the submission).[50]

The Health Ombudsman must also consult with any HHSs if a specific recommendation about that HHS is propsed to be made, before finalising the report.[51]

Issues identified by Stakeholders

A number of issues were raised by stakeholders in relation to the auditing function proposed to be given to the Health Ombudsman. These are dealt with below under separate sub-headings.

Scope and need for the audit

The Health Ombudsman and the Department of Health expressed concern about the lack of specificity in the Bill regarding the tasks involved in the audit. At the public hearing, the Health Ombudsman raised uncertainty with the language used in the Bill.

In relation to what 'conducting an audit of wait time data' meant, the Ombudsman queried:

> *Does it mean that it is a check on CARU's figures or does it actually mean that I have to go in to the 32 sites at which surgery is conducted, the 103 sites at which dental services are conducted and, for example, in the Gold Coast university hospital, the 32 sites where outpatient services are provided to check that the patient record matches what*

[44] Clause 4 of the Health Legislation (Waiting List Integrity) Amendment Bill 2015– proposed section 244B(1).
[45] Clause 4 of the Health Legislation (Waiting List Integrity) Amendment Bill 2015– proposed section 244B(2).
[46] Clause 4 of the Health Legislation (Waiting List Integrity) Amendment Bill 2015– proposed section 244C(1).
[47] Clause 4 of the Health Legislation (Waiting List Integrity) Amendment Bill 2015– proposed section 244C(3)(b).
[48] Clause 4 of the Health Legislation (Waiting List Integrity) Amendment Bill 2015– proposed section 244C(3)(a).
[49] Clause 4 of the Health Legislation (Waiting List Integrity) Amendment Bill 2015– proposed section 244C(4).
[50] Clause 4 of the Health Legislation (Waiting List Integrity) Amendment Bill 2015– proposed section 244C(5)-(6).
[51] Clause 4 of the Health Legislation (Waiting List Integrity) Amendment Bill 2015– proposed section 244C(7).

> *was input for that patient into the system—that that is accurate and, therefore, the data that has been collected is, in fact, reflective of the data in the patient record?*[52]

The Department also noted the *'… lack of specificity in the Bill, including apparent power for examination in the accuracy of the data without details of the mechanisms and powers by which could deliver this objective'.*[53]

It was the Health Ombudsman's view that the Bill likely required onsite sampling audits:

> *You might say that you could do quarterly samples by way of assurance on CARU, but, to me, this is actually about auditing the data from each of those sites for accuracy, which is a much bigger task on the face of it than an assurance audit of CARU might be.*[54]

Wait list data collected by CARU is currently subject to a number of quality control mechanisms, including intermittent independent audits,[55] and that wait list data has been audited by the Queensland Audit Office (QAO) in the past.[56] Department representatives from CARU advised the Committee:

> *… we have our own internal checks and balances. Sometimes we have independent audits internally. Our own internal audit office will come and look at what we are doing. For example, Leanne was talking about the new structure that is emerging in Queensland Health. The office of data integrity came and looked at our processes. I mentioned in here in the last bit that in recent history we have just finished rebadging all the data definitions, processes and everything that we go through so that if someone does come along, like the QAO or in fact anyone from the department or nationally, we can go, 'Okay, that is what we do,' and you can have a very close scrutiny of that process.*
>
> *… We report nationally. The national body also has a whole swag of rules, I guess we call them. There are data edits and rules that we have to pass for our data to be accepted federally ... We are also monitored in one respect by the HHSs, because for any information that leaves our section and becomes public knowledge they have the cut-off time that I talked about. The health and hospital services have five working days to question any of the data that we would be putting out. They actually have that process, too, to come back and check that anything that we put out is validated by them as being as close to the truth as we all know.*[57]

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[52] Health Ombudsman, public hearing transcript, 15 July 2015, page 15.
[53] Department of Health, submission 4, page 2.
[54] Health Ombudsman, public hearing transcript, 15 July 2015, page 15.
[55] Department of Health, public hearing transcript, 15 July 2015, page 4.
[56] Department of Health, public hearing transcript, 15 July 2015, page 2.
[57] Department of Health, public hearing transcript, 15 July 2015, page 4.

With regard to the quality of current wait time data, the Committee was advised that CARU and HHSs have developed a mutual framework to ensure the quality of wait time data published:

> *One of the elements in this assurance framework is the availability of a number of reports for health and hospital services staff to use to monitor waiting list performance and identify potential data anomalies. So we feed back to them certain pieces of information that they can have a close look at. Another mechanism to assure quality is the collaboration of staff across health and hospital services through various networks in order to promote best practice through the sharing of and improvement of ideas.*[1]

The Committee understands implementation standards have also been developed for data collections, which are *'the definitive type of working document for people out in the field to go through and answer questions they may have in terms of ensuring they put accurate information into the system pertaining to a patient's details'.*[58]

Further, coordinators in each HHS apply the implementation standards and meet with CARU bimonthly to receive training and relevant information. CARU staff also work with business practice improvement officers, health service providers such as surgeons and nurse unit managers at health facilities, who '*… have significant input into the development of standards, definitions, how things are collected. They are extremely focused on things around … urgency categorisation and the like.*'[59]

In relation to whether the audit by the Health Ombudsman was needed at all, the Department identified the Bill may result in duplication of tasks between the Department and the Health Ombudsman, *'[i]n particular, the duplication results from the Department of Health operating as a system manager and the proposal for the Health Ombudsman to also monitor waiting time data.'* As a result, the Department considers that costs may be increased while efficiency decreases '*… without necessarily improving the quality, integrity or transparency of the data.'*[60]

At the public hearing, the Health Ombudsman commented on the potential for duplication, noting:

> *…CARU requires the information not just for validation purposes but also for clinical assessment and workforce planning purposes. As I understand from the evidence this morning, they would still be collecting that information regardless. From my point of view, the information would be collected by them. As I read the bill, the requirement is for the hospital and health services to provide the information to me. Presumably, if they are able to provide it to CARU then they are able to provide it to me, so there would be two sets of information: one to CARU and one to me. That, in a sense, is duplication.*[61]

[58] Department of Health, public hearing transcript, 15 July 2015, page 5.

[59] Department of Health, public hearing transcript, 15 July 2015, page 5.

[60] Department of Health, submission 4, page 2.

[61] Health Ombudsman, Public Hearing Transcript, 15 July 2015, page 14.

Together Queensland also considered the Bill would result in duplication between the Department and the Health Ombudsman, and questioned the rationale for the Bill:

> *The private members bill either proposes a reallocation of functions from the Department of Health to the Ombudsman, or creates a duplication where the Ombudsman will undertake work already completed by CARU. It is Together's view that for such a change to be brought by legislation, there should be a significant rationale. However, in this case, there is no obvious need for this change.*[62]

Together Queensland similarly noted the existing role of CARU in working with HHSs on waiting lists and patient flow, and identified CARU would need the data and would be collecting the data anyway.[63]

The Member for Caloundra advised the Committee that it was the intention of the Bill for the Office of the Health Ombudsman to be the centrepoint of collection and publication of wait time data. The Health Ombudsman would become the lead agency in regard to publishing of wait time data.[64]

Committee comment

The Committee noted the concerns of stakeholders relating to the scope of the audit function and considered the Member for Caloundra should clarify the intended scope of the audit during the second reading debate of the Bill.

Recommendation 1

The Committee recommends the Member for Caloundra clarify the intended scope of the audit during the second reading debate of the Bill.

The Committee also noted at the public hearing, a number of stakeholders raised issues in relation to duplication of roles, primarily between the work of CARU and the proposed new function to be undertaken by the Office of the Health Ombudsman.

The Member for Caloundra addressed this issue, in part, in his letter to the Committee advising there was no intention for duplication of roles and that the Office of the Health Ombudsman would become the lead agency for publishing wait time data in Queensland. [65]

Despite the advice from the Member for Caloundra, the Committee recognised there was still some uncertainty as to what the ongoing role for CARU would be, should the policy be implemented. The Committee was not satisfied the separation of the roles of CARU and the Health Ombudsman in relation to the proposed new audit function were clear from the Bill and explanatory note and considered further clarification was required from the Member for Caloundra.

[62] Together Queensland, submission 2, page 2.

[63] Together Queensland, public hearing transcript, 15 July 2015, pages 11-12.

[64] Member for Caloundra, correspondence, 13 September 2015, page 1.

[65] Member for Caloundra, correspondence, 13 September 2015, page 1.

Recommendation 2

The Committee recommends the Member for Caloundra clarify the issues relating to duplication of resources by CARU and the new independent audit function of the Health Ombudsman during the second reading debate of the Bill.

Appropriateness of the proposed auditor and achievement of the policy objectives

During his introductory speech, the Member for Caloundra explained the Office of the Health Ombudsman was considered to be appropriate as it was an *'existing independent statutory body …'* and *'reduces the cost and time taken in establishing a new body to provide this information to Queenslanders'.*[66]

The explanatory note provides that through requiring the provision of wait time data and establishing the Health Ombudsman as the independent auditor of this data, the *'… objective of establishing and monitoring the integrity of the patient clinical wait time guarantee'* will be achieved.[67]

Evidence received by the Committee questioned the suitability of the Health Ombudsman as auditor of the wait time data given the compatibility of the audit role with its existing functions; the cost of establishing the new function; perceived absence of demonstrated benefit; likelihood of the objectives of the Bill being met; absence of rationale to justify the new function and given the departmental restructure that is currently taking place.

The current Health Ombudsman, Mr Leon Atkinson-MacEwen was asked at the public hearing whether he considered the proposed new function aligned with his existing functions. He advised the Committee:

> *I do not see it sitting comfortably with the existing functions, because the existing functions are around managing health complaints and, fundamentally, protecting the health and safety of the public. Waiting lists are an important management tool for elective surgery, for specialist services and dental services, for example, but they are a management tool to allow HHSs and the department as well, and others, to look at how best to use the always limited resources they have in the best possible way to deliver the services they need to deliver. That is not my jurisdiction. My jurisdiction is health complaints, particularly around whether or not the service delivered was reasonable and whether or not it puts the public at risk.*[68]

Mr Atkinson-MacEwen also considered there would be a considerable cost associated with the new function, including recruitment of specialist staff, building new information systems and conducting the audits:

> *Currently, this is an audit role that does not sit inside my organisation. I would have to obtain the resources from somewhere to do it. I do not have the resources in-house at this stage to do this work.*[69]

[66] Queensland Parliament, Record of Proceedings, 19 May 2015, page 617.

[67] Health Legislation (Waiting List Integrity) Amendment Bill 2015, Explanatory Notes, page 1.

[68] Health Ombudsman, public hearing transcript, 15 July 2015, page 16

[69] Health Ombudsman, public hearing transcript, 15 July 2015, page 15.

Together Queensland also addressed the issue of resourcing in evidence presented to the Committee:

> *Advice from our members is that approximately 4 FTE [full time equivalent staff] are involved in this [reporting] function within CARU. However, this workload is spread across 11 staff who perform other functions that require a similar skillset. There is no clear manner in which resources could simply be transferred and, in any event, staff in the area may not be willing to transfer to the Ombudsman.*
>
> *It is likely therefore that the Ombudsman's office would need to recruit and train staff (at least 4), as we understand the Ombudsman does not currently have any staff that possess the required skillset. The Ombudsman's current functions in addressing complaint and regulating health practitioners is very different to the technical and specialist role of reporting the wait list, currently performed by CARU.*[70]

Together Queensland considered the Bill *'moves an existing function from an area of substantial expertise with no demonstrated benefit'.*[71] Also, that the objectives of the Bill would not be met through reducing reporting frequency and moving the responsibility to monitor wait time to the Health Ombudsman:

> *Together members value the critical role of the Health Ombudsman in hearing patient complaints and monitoring the service delivery from health care providers and professionals and providing confidence to the public and community around complaints. The Ombudsman's office is well placed to do this work. There is a potential for the Health Ombudsman already to look at complaints from patients regarding service delivery and service access for patients however system-wide patient flow matters are not currently in scope.*[72]

The QNU also questioned whether the Office of the Health Ombudsman was the most appropriate organisation to audit wait time data:

> *While we support greater transparency in the publication of health performance information, we contend that the Health Ombudsman's main objective should be to guarantee safety and quality. We are not convinced it is appropriate to assign an auditing and reporting function to this Office when its main responsibilities are to receive, investigate and act on complaints about health services and providers (Office of the Health Ombudsman, 2015).*[73]

As described in Part 2 of this report, wait list data is currently managed by CARU at the Department of Health. Together Queensland highlighted the Department is currently being restructured as a result of the Hunter Review, with a view to strengthening the Department's role as system manager, and considered it would be appropriate to see the results of this restructure before implementing this or any other legislative change.[74]

[70] Together Queensland, submission 2, page 3.

[71] Together Queensland, public hearing transcript, page 9.

[72] Together Queensland, submission 2, page 1.

[73] Queensland Nurses' Union, submission 1, page 6.

[74] Together Queensland, submission 2, page 3.

Together Queensland also expressed concerns that the Bill specifically targeted CARU and that officers were complicit in manipulation or misleading Queenslanders to the extent special legislation would be required targeting their work area. [75]

Alternative options

The explanatory note states alternative options to establishing the Health Ombudsman as the independent auditor for wait time data were not considered. Alternatives to the Health Ombudsman were, however, considered in evidence received by the Committee.

The Department of Health, Together Queensland and the Health Ombudsman identified the Queensland Audit Office as a possible alternative to audit wait time data. The Department noted *'[t]he Queensland Audit Office (QAO) provides the Parliament with an independent auditing function through reporting on the efficiency and effectiveness of any aspect of public sector finances and administration.'*[76] At the public hearing the Department confirmed audits had been conducted on wait list data by the QAO in the past.[77]

The Health Ombudsman also noted the audit function could be considered a function of the Auditor-General.[78] Together Queensland identified both the QAO and the Queensland Government Statistician as possible alternatives to the Health Ombudsman:

> *… the Auditor-General has extensive experience in auditing data and providing quality assurance. Together also notes that the Queensland Government Statistician is an independent statutory officer with significant expertise in statistical and reporting functions. Parliament could consider resourcing either of these agencies to undertake a broad process of quality assurance of performance reporting by Queensland Government agencies. This could include all Departments, not just the Department of Health.*[79]

The QNU recommended a Bureau of Health Information should be established, with the QAO conducting audits and reports in the interim:

> *Public data reporting provides competitive incentives for healthcare providers to improve their accountability and clinical performance (Henke, Kelsey & Whately, 2011; McKinsey & Company, 2013). To this end, we call on the government to establish a Bureau of Health Information, similar to that which exists in NSW …*
>
> *In the interim, the Queensland Audit Office (QAO) may be a suitable reporting alternative. The QAO conducts financial and performance audits of public sector entities to assess how effectively, efficiently and economically their objectives are being*

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[75] Together Queensland, submission 2, page 2.

[76] Department of Health, submission 4, page 2.

[77] Department of Health, Public Hearing Transcript, 15 July 2015, page 2.

[78] Health Ombudsman, Public Hearing Transcript, page 17.

[79] Together Queensland, submission 2, pages 3-4.

> *met (QAO, 2015). This office is well placed to gather, audit and report on data, independent of the health system.* [80]

The NSW Bureau of Health Information was also highlighted by Together Queensland, however Together considered a similar bureau as unnecessary in Queensland:

> *… this body was created in 2008, and therefore pre-dates the major structural reforms that occurred across Australia that divided health functions into Health and Hospital Services and Department(s) of Health. Therefore, the additional costs of a specific agency would not be warranted in Queensland case at this time. Together also notes that that the NSW BIE was specifically in the context of patient safety incidents as a result of the Garling Report, and aimed to address the availability of this information to clinicians. Together notes that thanks to the diligent work of staff in CARU and the patient safety unit of Queensland Health, Queensland already has sophisticated reporting to hospitals on patient safety. Together considers therefore there is not the same need for a BIE as may have existed in NSW.*[81]

The Member for Caloundra also addressed the issues relating to the appropriateness of the Health Ombudsman as the auditor of wait list data, in his letter to the Committee. He advised the Committee:

> *For many years there has been accusation and counter accusation as to the accuracy and otherwise of wait time data and other data published by Queensland Health. That is not a reflection on the employees of Queensland Health. Appointing the Health Ombudsman, an independent office, removes that allegation. At arm's length to the Government, the office is free from perceived bias. The Ombudsman already is heavily involved in the health system and having significant knowledge within his office as to how the system operates, is best placed on an ongoing basis to provide the expertise and impartiality in auditing and publishing the data.*[82]

As stated earlier, the Member for Caloundra considered the Office of the Health Ombudsman would become the centrepoint of collection and publication of wait time data. [83]

<u>Committee Comment</u>

Despite the assurances from the Member for Caloundra, government members were not satisfied the Health Ombudsman was the most appropriate body to audit wait time data as they had concerns with the compatibility of the new functions with the Health Ombudsman's existing functions.

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[80] Queensland Nurses' Union, submission 1, page 5-6.

[81] Together Queensland, submission 2, page 4.

[82] Letter from Member for Caloundra, dated 13 September 2015.

[83] Letter from Member for Caloundra, dated 13 September 2015.

Evidence received by the Committee, including evidence from the Health Ombudsman, indicated the proposed audit functions did not sit well with the Health Ombudsman and that further, detailed consideration of the selection of an appropriate auditor, needed to occur if this policy was to proceed.

The government members noted no alternatives to the Health Ombudsman were considered prior to the introduction of the Bill and the Health Ombudsman, himself was not consulted on the potential new function during the development stage of the Bill. The government members were of the view that If more detailed consultation with the Health Ombudsman and other stakeholders had occurred during the development stage of the Bill, many of the issues raised with the Committee during its consideration of the Bill, may have been able to be addressed.

Government members considered the detailed examination of the Bill did not clarify why an independent statutory body other than (or in addition to) CARU was required to audit and report on wait time data. Government members considered the alleged problems which the Bill sought to address did not become apparent during the Committee's examination, nor was any information gleaned to justify the introduction of the new function for the Health Ombudsman.

The Member for Caloundra stated there were no concerns with the work being carried out by employees of Queensland Health and therefore it was not clear as to why the same data that they currently publish online was required to be audited and republished by the Health Ombudsman.

Government members were concerned that resourcing and cost estimates relating to the new function were not completed during development of the Bill and that this information was crucial to assessing the feasibility and cost benefit of establishing any new audit role. Without this information, the government members of the Committee questioned both the feasibility and appropriateness of the Health Ombudsman taking on the additional functions as an auditor of wait time data.

Non-Government members were however satisfied that the Health Ombudsman was the appropriate body to conduct the audit of wait time data. As explained by the Member for Caloundra, the Health Ombudsman is intricately involved in the health system and has significant knowledge within his office as to how the health system operates.

Non-Government members considered that as an officer of the Parliament, the Health Ombudsman had the required level of independence from the Executive and was best placed, on an ongoing basis, to provide the expertise and impartiality in auditing and publishing of wait time data.

Non-government members considered that while the Health Ombudsman may need to recruit additional staff to conduct the audit, the Office of the Health Ombudsman would be able to do so and would establish his office as the centrepoint of collection and publication of data. This would provide peace of mind to patients on waiting lists across the State that wait time data from HHSs had been subjected to independent audit and was presented in a logical, clear, and easy to read format and could be trusted to be accurate.

Timeframes

Under the Bill, the Health Ombudsman would have 30 days after the end of a quarter to conduct an audit, of which an HHS has 14 days to provide it with wait time data. The Committee observed that if the HHSs

used the full 14 days in which to provide the data, the time the Health Ombudsman would have to conduct the audit would be restricted to 16 days. Arguably, this renders the timeframe to conduct the audit potentially impossible to meet, depending on the audit's scope.

Further, after the audit has been conducted, the Bill provides the Health Ombudsman has 14 days to prepare a report and publish the findings. In the event that adverse comments about an identifiable HHS are intended to be included in the report, the Health Ombudsman must provide a copy of the comment to the HHS, which then must have at least seven days to make a submission about it.

If the Health Ombudsman proposes to make a recommendation in its report about a particular HHS, it must consult with the HHS about the recommendation before finalising its report. The Health Ombudsman does not have additional time to seek a submission on its recommendations or consult with the HHS about its recommendation as the Bill provides this all must happen with the 14 day period.

In essence, if adverse recommendations are identified by the Health Ombudsman, they must be identified and provided to the HHS within 7 days in order to comply with the timeframes imposed (allowing for 7 days to respond). This severely limits the time the Health Ombudsman has to report and may render the 14 day reporting timeframe unfeasible.

When asked whether the reporting timeframes in the Bill could be met, the Health Ombudsman advised that it would depend on what '*audit wait-time data … to examine the accuracy of the data*' meant:

> *If it is just a check on whether or not CARU has their numbers right then that is not a problem. If it is actually to go into each of those facilities to do a representative sample to determine whether or not the data was accurately input into the system … that is an enormous task if it is actually physically requiring checking of patient records against the data input.*[84]

With regard to reports that are currently provided about wait time data by CARU, the Department advised that monthly and quarterly reports are provided to senior management and HHS executives:

> *… we have live systems and we have real-time information. We have a lot of automated processes. So we are able to generate information on a fairly grand scale very quickly and we happily provide that back to the health and hospital services to help them with their day-to-day operations and their overall management of these various processes and systems.*[85]

Together Queensland advised the Bill would result in less frequent reporting:

> *Officers in the area perform a challenging and technical role to audit and report on waiting lists with a high degree of professionalism, and act in a transparent and accountable manner. Information on wait times is published on websites maintained*

[84] Health Ombudsman, Public Hearing Transcript, 15 July 2015, page 17.
[85] Department of Health, Public Hearing Transcript, 15 July 2015, page 5.

> *by CARU regularly and is available to the Queensland public. CARU receive information on wait times, and other key indicators monthly, not quarterly as proposed in this Bill, and that adds to the integrity of the data and expert reporting they undertake.*[86]

Committee Comment

Based on the evidence provided by stakeholders government members had serious concerns about the timeframes in the Bill in which the Health Ombudsman had to conduct the audit and prepare a report on the findings.

The government members considered that even the most basic of auditing of wait time data of 16 HHSs could not be satisfactorily completed within the time allocated. If the scope of the audit required the Health Ombudsman to go in to the 32 sites at which surgery is conducted, the 103 sites at which dental services are conducted etc., there would be even less chance for the audit to be completed without incurring considerable expense each quarter.

Government members considered the timeframes allocated for the preparation of the report, including consultation or seeking submissions from the HHSs were also unworkable.

Non-Government members were satisfied the timeframes set out in the Bill were potentially achievable and allowed both the Health Ombudsman and the HHSs sufficient time to carry out their respective functions under the Bill without issue. Non-Government members considered that once the issues around the scope of the audit were clarified, the issues regarding timeframes could be addressed with more certainty.

Recommendation 3

The Committee recommends the timeframes set out in the Bill, for both the conduct of the audit and preparation and publishing of the report on the audit, be reviewed.

The review of the timeframes should be undertaken in consultation with the auditor and the 16 Hospital and Health Services and the Member for Caloundra should address the review of timeframes during the second reading debate of the Bill.

[86] Together Queensland, submission 2, page 2.

4. Compliance with the *Legislative Standards Act 1992*

4.1 Fundamental Legislative Principles

Section 4 of the *Legislative Standards Act 1992* states that ‘fundamental legislative principles’ are the ‘principles relating to legislation that underlie a parliamentary democracy based on the rule of law’. The principles include that legislation has sufficient regard to:

- The rights and liberties of individuals, and
- The institution of Parliament.

The Committee has examined the application of the fundamental legislative principles to the Bill and brings the following to the attention of the House.

Rights and liberties of individuals - clear and precise drafting

The Committee was required to consider whether the Bill is unambiguous and drafted in a sufficiently clear and precise way.[87] Plain English is the best approach in drafting legislation, to ensure it is easily understood and achieves desired policy objectives.[88]

As stated earlier in this report, clause 4 of the Bill provides for the auditing of wait time data, and includes definitions and requirements for an audit report. A number of terms used in this clause are ambiguous and not defined, including those used in the definition of wait time data, such as ‘clinically appropriate’, ‘type of surgery’ and ‘general dental care’.

The Bill and explanatory note were silent as to the meaning of these terms and also whether the intention is to use definitions consistent with existing national and state terminology.

Committee comment

This matter was addressed earlier in the report. The Committee notes from an FLP perspective, key terms on which the Bill depends must not be ambiguous as it could likely result in misinterpretation, confusion and inconsistency about what data HHSs are required to provide as part of the audit.

4.2 Explanatory Note

Members are required to circulate an explanatory note for any Bill they introduce into the Legislative Assembly.[89] The requirements for the explanatory note are provided in the *Legislative Standards Act 1992,* which states:

> (1) An explanatory note for a Bill must include the following information about the Bill in clear and precise language—
>
> (a) the Bill’s short title;

[87] *Legislative Standards Act 1992,* section 4(3)(k).

[88] Office of the Queensland Parliamentary Counsel, Fundamental Legislative Principles: *The OQPC Notebook*, pages 87-88.

[89] *Legislative Standards Act 1992,* section 22.

(b) a brief statement of the policy objectives of the Bill and the reasons for them;

(c) a brief statement of the way the policy objectives will be achieved by the Bill and why this way of achieving the objectives is reasonable and appropriate;

(d) if appropriate, a brief statement of any reasonable alternative way of achieving the policy objectives and why the alternative was not adopted;

(e) a brief assessment of the administrative cost to government of implementing the Bill, including staffing and program costs but not the cost of developing the Bill;

(f) a brief assessment of the consistency of the Bill with fundamental legislative principles and, if it is inconsistent with fundamental legislative principles, the reasons for the inconsistency;

(g) a brief statement of the extent to which consultation was carried out in relation to the Bill;

(h) a simple explanation of the purpose and intended operation of each clause of the Bill;

(i) if the Bill is substantially uniform or complementary with legislation of the Commonwealth or another State—

(i) a statement to that effect; and

(ii) a brief explanation of the legislative scheme.

(2) If the explanatory note does not include the information mentioned in subsection (1), it must state the reason for non-inclusion.[90]

Committee Comment

A number of issues identified with the explanatory note are set out below:

The short title of the Bill was incorrectly described.

The explanatory note stated the audit must be conducted within 14 days after the end of the quarter,[91] whereas the Bill provided the timeframe was 30 days.

The explanatory note stated the Health Ombudsman must include a summary of data for the State in its report.[92] There was no provision in the Bill which required that to occur.

The explanatory note included a number of incorrect references and have no reference to new section 244C(4)-(7) which provides what is required to be included in the Health Ombudsman's report. The explanatory note also incorrectly referred to the 'Health Legislation (Wait time Integrity) Bill 2015'.[93] This was not the correct title of the Bill.

In addition, an estimate of cost for government implementation was not supplied in accordance with section 23(1)(e) of the Act. The note stated this could not occur until the Health Ombudsman had been

[90] *Legislative Standards Act 1992,* section 23.

[91] Health Legislation (Waiting List Integrity) Amendment Bill 2015, explanatory note, page 3.

[92] Health Legislation (Waiting List Integrity) Amendment Bill 2015, explanatory note, page 3.

[93] Health Legislation (Waiting List Integrity) Amendment Bill 2015, explanatory note, page 3.

consulted on resources that may be required to execute the activities of the Bill.[94] The explanatory note went on to state in relation to consultation on the Bill, *'[i]t is anticipated that consultation will occur during committee consideration process.'*[95]

Finally, the notes on provisions in the Bill contained numerous other errors, including:

- absence of a number of clause headings;
- absence of reference to clauses 4 and 8 of the Bill;
- clause 5 heading and explanation was omitted;
- proposed new section 244C, subsections 4 to 7 were not addressed;
- reference to 'para 32' on page 3 of the explanatory note appears to refer to 'section 323 – Provision of data about waiting times'; and
- the reference to clause 3 on page 3 of the explanatory note should refer to clause 1.

In summary, there were numerous typographical and grammatical errors throughout the explanatory note which were not acceptable for a document designed to assist legal practitioners and courts in interpreting legislation. Explanatory notes are often used to help the reader of a Bill understand the technical aspects of the Bill in addition to understanding the policy trying to be implemented.

Given the importance of explanatory notes, the Committee considers care must be taken by all Members when preparing material that accompanies a Bill.

The explanatory note, as tabled, did not meet the standard required by the *Legislative Standards Act 1992*.

[94] Health Legislation (Waiting List Integrity) Amendment Bill 2015, explanatory note, page 1.

[95] Health Legislation (Waiting List Integrity) Amendment Bill 2015, explanatory note, page 1.

Appendix A

Submission	Submitter
01	Queensland Nurses Union
02	Together Queensland
03	Director of Physiotherapy Services Queensland
04	Department of Health