HEALTH AND ENVIRONMENT COMMITTEE

Members present:
Mr AD Harper MP—Chair
Mr R Molhoek MP
Mr SSJ Andrew MP (virtual)
Ms AB King MP (virtual)
Mr JR Martin MP
Mr A Powell MP

Staff present:
Ms R Duncan—Assistant Committee Secretary
Ms H Koorockin—Committee Support Officer

PUBLIC BRIEFING—INQUIRY INTO THE HEALTH AND OTHER LEGISLATION AMENDMENT BILL (NO. 2) 2023

TRANSCRIPT OF PROCEEDINGS

Thursday, 14 December 2023

Brisbane

THURSDAY, 14 DECEMBER 2023

The committee met at 10.18 am.

CHAIR: Good morning, everyone. I declare open this public briefing for the Health and Environment Committee's inquiry into the Health and Other Legislation Amendment Bill (No. 2) 2023. I am Aaron Harper, the member for Thuringowa and chair of the committee. I would like to start by respectfully acknowledging the traditional custodians of the land on which we meet today and pay our respects to elders past and present. We are very fortunate to live in a country with two of the oldest continuing cultures in Aboriginal and Torres Strait Islander peoples, whose lands, winds and waters we all now share. With me today are Mr Rob Molhoek, member for Southport and deputy chair; Mr James Martin, member for Stretton; and Mr Andrew Powell, member for Glass House. Via videoconference we have Ms Ali King, member for Pumicestone, and Mr Stephen Andrew, member for Mirani.

On 30 November 2023, the Hon. Shannon Fentiman MP, Minister for Health, Mental Health and Ambulance Services and Minister for Women, introduced into the Queensland parliament the Health and Other Legislation Amendment Bill (No. 2) 2023. The bill was referred to this committee for detailed consideration and report. The purpose of today's briefing is to assist the committee with the examination of the bill.

This briefing is a proceeding of the Queensland parliament and is subject to the parliament's standing rules and orders. Witnesses are not required to give evidence under oath, but potentially misleading the committee is a serious offence. These proceedings are being recorded and broadcast live on the parliament's website. I remind committee members that officers are here to provide factual and technical information. Questions seeking an opinion about policy should be directed to the minister or left to debate on the floor of the House.

LIDDY, Mr James, Manager, Legislative Policy Unit, Strategy Policy and Reform Division, Queensland Health

MILLER, Ms Deborah, Acting Chief Nursing and Midwifery Officer, Clinical Excellence Queensland, Queensland Health

REILLY, Dr John, Acting Executive Director, Mental Health Alcohol and Other Drugs Branch, Clinical Excellence Queensland, Queensland Health

SKETCHER-BAKER, Ms Kirstine, Acting Deputy Director-General, Clinical Excellence Queensland, Queensland Health

CHAIR: Thank you, all, for being here today. We thank you for the briefing paper. We are mindful of the 45 minutes we have. If we can perhaps keep the introduction summarised, then we can move to questions. Thank you very much.

Ms Sketcher-Baker: Chair and committee members, thank you for this opportunity to brief you on the Health and Other Legislation Amendment Bill (No. 2) 2023. I, too, would like to respectfully acknowledge the traditional owners of the lands on which we are meeting today, the Yagara and the Turrbal people, and pay my respects to elders past, present and emerging. I am the Acting Deputy Director-General of Clinical Excellence Queensland in Queensland Health and today I am joined by my Queensland Health colleagues.

The bill amends four acts in the health portfolio: the Termination of Pregnancy Act 2018, the Hospital and Health Boards Act 2011, the Mental Health Act 2016 and the Public Health Act 2005. It facilitates initiatives to enhance access to termination-of-pregnancy care in Queensland, lays the groundwork for implementing midwife-to-patient ratios, promotes quality improvement and patient safety in public facilities in Queensland, and includes technical amendments to improve the operation of health legislation. The bill also makes consequential amendments to the Criminal Code and the Powers of Attorney Act 1998. I will briefly summarise the amendments in the bill and provide the committee with additional information about more substantial amendments.

The bill amends the Termination of Pregnancy Act 2018 and the Criminal Code to allow nurses and midwives to perform medical terminations of pregnancy through the use of termination-of-pregnancy drugs. Other practitioners will be able to be authorised to perform medical terminations in future if prescribed by regulation. It also amends the Termination of Pregnancy Act to ensure all pregnant people can access termination-of-pregnancy care and strengthens legal recognition of transgender and gender-diverse Queenslanders.

The bill amends the Hospital and Health Boards Act 2011 to clarify that for nurse-to-patient and midwife-to-patient ratios a newborn baby is counted as a separate patient when the birthing parent is on a maternity ward. The bill also makes changes to the clinical incident management framework in the Hospital and Health Boards Act 2011 to improve information sharing to improve patient safety. The bill amends the Mental Health Act 2016 to clarify and extend provisions for the use of Mental Health Court expert reports and transcripts for certain purposes. Finally, the bill amends the Public Health Act 2005 to avoid duplicative reporting obligations for prescribed medical practitioners in Queensland if they have made a notification to the National Occupational Respiratory Disease Registry. I will now give the committee details about some of the more substantial amendments in the bill.

Regarding medical termination of pregnancy, the bill amends the Termination of Pregnancy Act and the Criminal Code to support improved access to safe termination-of-pregnancy care in Queensland. Medical terminations of pregnancy up to nine weeks gestation are performed using the termination-of-pregnancy drug MS-2 Step. Currently in Queensland, MS-2 Step can only be prescribed by a trained medical practitioner. A medical termination using MS-2 Step must be performed in the early stages of pregnancy up to 63 days gestation, or nine weeks. This results in a limited window of opportunity to access the option. Pregnant people unable to access medical termination of pregnancy using MS-2 Step must go to a hospital or a clinic for a medical induction or a surgical termination of pregnancy. This option can be exacerbated for those living in regional and remote areas where additional social, financial and travel burdens may inhibit them accessing termination-of-pregnancy care.

On 1 August 2023, changes to the arrangements for the prescribing and dispensing of MS-2 Step took effect. The changes were made by the Therapeutic Goods Administration, commonly referred to as the TGA, to allow MS-2 Step to be prescribed by any health practitioner with appropriate qualifications and training if authorised by the relevant state or territory. The bill implements new arrangements for Queensland as a result of the changes by the TGA.

The bill will authorise additional types of health practitioners to perform medical terminations of pregnancy through the use of termination-of-pregnancy drugs such as MS-2 Step. The additional registered health practitioners authorised to perform medical terminations of pregnancy under the bill will be nurse practitioners, registered nurses, endorsed midwives and midwives. The bill also includes a regulation-making power to allow additional types of registered health practitioners to be prescribed to perform medical terminations of pregnancy in future. This step would only be taken after careful consideration and ensuring the additional cohort to be prescribed has the appropriate qualifications and training.

After consultation with stakeholders, it was decided not to include a gestational limit for the use of termination-of-pregnancy drugs in the bill. Gestational limits for the use of these drugs are decided by the TGA, and this advice can be updated and changed over time in accordance with clinical evidence and research. The approach taken in the bill not to include the gestational limit helps to futureproof the legislation by ensuring it is responsive to changes in health advice or if new termination-of-pregnancy drugs with different gestational limits are approved in Australia by the TGA.

If the bill is passed, a range of implementation steps will need to be taken including updates to the extended practice authorities for registered nurses and midwives under the medicine and poisons framework. The extended practice authorities will be updated to include a requirement that registered termination-of-pregnancy drugs must be given in accordance with approved medicine information from the TGA.

Nurse practitioners and endorsed midwives will be authorised to prescribe MS-2 Step as a schedule 4 medicine, while registered nurses and midwives will be authorised to administer or give a treatment dose of the drug under their extended practice authority. Medical practitioners will continue to be the only health workers authorised to perform surgical terminations of pregnancy. The bill amends related provisions of the Criminal Code to align with the changes to the Termination of Pregnancy Act. This ensures nurses and midwifes who are authorised to perform medical terminations of pregnancy do not commit a criminal offence.

The bill also replaces reference to 'woman' with 'person' in the Termination of Pregnancy Act and related provisions of the Criminal Code and Powers of Attorney Act. The change ensures legal access to termination-of-pregnancy care by all pregnant people including gender-diverse Queenslanders.

In relation to the midwife-to-patient ratios, the bill makes an important change to the Hospital and Health Boards Act to clarify that a baby is counted as a separate patient when they are staying in a room on a maternity ward with their birthing parent. This change lays the groundwork for the midwife-to-patient ratios to be rolled out to Queensland hospitals, helping midwives to provide safer, more comprehensive care to families.

CHAIR: Ms Sketcher-Baker, I am mindful of the time. We have half an hour for questions, so can you wrap up in a minute or two?

Ms Sketcher-Baker: No problems at all.

CHAIR: It is a very detailed report. We are pretty happy with where things are and we are happy to move on if you are. I know there are some questions from members. I did want to point out that, with regard to nurse-to-patient ratios—or, in this case, midwife-to-patient ratios in maternity wards—this committee has a proud history in previous iterations of nurse-to-patient ratios in both acute wards and aged care. We are pleased to see that babies are counted. Of note, I wanted to point out that having clarifying amendments that a newborn baby includes a baby not born alive, and accordingly a stillborn baby will be counted as a patient while the baby remains in the room with the birthing parent, is so important from both my personal and clinical experience and background. Thank you very much for your opening statement. I am going to move to questions.

Mr MOLHOEK: Thanks for being here today and the very comprehensive briefing. It provides a very good overview of the main issues. I have a question with regard to the issue of termination of pregnancy. Could these changes have been dealt with under regulation? Why do we need legislation to enact those changes or the broadening out of who can administer the MS-2 Step drug?

Mr Liddy: The Termination of Pregnancy Act is the framework that authorises termination of pregnancy to occur in Queensland. At the moment, the act provides that only a medical practitioner can perform a termination of pregnancy. Amendments are required to that legislation to change it from a medical practitioner to authorise these other types of practitioners. Importantly, one of the things that the bill does is draw a distinction between what is referred to as a surgical termination and what is referred to as a medical termination. A medical termination is the use of a drug to terminate a pregnancy; a surgical termination involves a surgery or procedure.

As Kirstine mentioned in her opening statement, medical practitioners will continue to be the only practitioners who are able to perform a surgical termination. What the bill does is actually set up a framework for additional practitioners to undertake medical terminations. That is where nurses and midwives will be authorised.

Mr MOLHOEK: In terms of the number of people available to administer this prescription, what does that mean in terms of numbers? At the moment, how many registered medical practitioners do we have available to provide that service and then how many extra? Is it just midwives and nurse practitioners; or is it midwives, nurse practitioners and all nurses; or is it only nurses of a certain grade? I would just like to understand a bit more who is included in 'registered health practitioners'. I assume it does not include optometrists, if they are registered health practitioners. What does the definition provide for?

Mr Liddy: As Kirstine mentioned in her opening statement, all nurse practitioners and all endorsed midwives, as I understand it, will be able to use this drug, although it will depend on the setting in which that person is working. All practitioners are bound by their scope of practice, by their training, the facility they work in. There are guidelines and clinical oversights to make sure they are not stepping outside of their area of expertise. Registered nurses and midwives will be able to give this drug under the extended practice authority. Again, that will occur in particular settings. I think Deborah has some additional information about some of the settings where they might occur—around sexual health clinics and those types of things.

Ms Miller: The settings where nurse practitioners and endorsed midwives may be working are not limited to but would include: private practice, such as privately practising midwives or women's health nurse practitioners; a non-government organisation such as True, which was previously known as Family Planning; community controlled Aboriginal health organisations; Queensland Health in a variety of settings such as sexual and reproductive health clinics; a women's health service; a rural and isolated practice area; or an emergency department. For midwives, it is predominantly in perinatal settings.

Mr MOLHOEK: Would that also include community nurses who work in those centres and help people who have had babies with follow-up?

Ms Miller: Registered nurses working within a primary healthcare clinic would be required to work under the extended practice authority, and they would also be required to have specific training and education in relation to being able to undertake those duties.

Mr MOLHOEK: It might be helpful if we could have a little bit more information, perhaps even the information you have been reading from there, just so we are clear as to whom, how, how many and what the training is, just so we are clear about that moving forward.

CHAIR: If you want to take that on notice?

Ms Miller: Certainly.

Mr MOLHOEK: Excuse my ignorance, but I thought people could go to a pharmacy and get a prescription drug within certain time frames as well, so how is that different to this whole process?

Ms Miller: A nurse practitioner or endorsed midwife can prescribe a dose, and they can write out a script as well for the patient or the client then to take to a pharmacy and get filled. If it is a registered nurse or a midwife, they would be under an extended practice authority, and as such they supply under protocol. That is the term we use. There is a protocol outlined where they can supply and administer.

Ms KING: Just briefly, Chair, could I ask a clarifying question for the benefit of the member?

CHAIR: Absolutely. I was going to go to you, member for Pumicestone.

Ms KING: I was just going to ask Kirstine to clarify under what authority medical abortions or terminations of pregnancy occur now. My understanding is that a doctor must currently write the script for somebody to get filled.

Ms Miller: Correct.

Ms KING: Then there are other steps. I think that might be what the deputy chair wishes to understand. Forgive me, member.

Mr MOLHOEK: Thanks, member for Pumicestone; that is exactly what I was trying to understand.

Ms Sketcher-Baker: That is correct. Essentially, at the moment it only enables medical officers to undertake medical or surgical terminations and no other profession.

Mr MOLHOEK: Currently, the only people who can write a script are registered health practitioners?

Ms Sketcher-Baker: No. Currently it is only a medical practitioner.

Mr MOLHOEK: This bill will allow other people to provide a script for that or provide the medication in certain settings?

Ms Sketcher-Baker: Correct.

Ms Miller: If the bill is passed it will allow better access, particularly in some of our regional, rural and remote areas where there are limited medical practitioners to provide this service in a much more timely way.

CHAIR: Member for Pumicestone, do you want to continue with some questions?

Ms KING: I could ask questions about this all day, as you probably know. I might ask the department to indicate for the benefit of members what happens now to somebody who is seeking a termination of pregnancy, perhaps in a regional setting where there is not an available medical practitioner who has done the training to prescribe MS-2 Step. What is the pathway to care for that person at this point in time, and does it involve travel?

Ms Miller: The short answer is yes, it would if there is no medical practitioner in that community, given that currently medical practitioners are the only health practitioners who can prescribe.

Ms KING: It is the case, is it not, that not every medical practitioner must do or have done additional training for MS-2 Step, or was that additional requirement recently removed?

Ms Miller: If the bill is passed, yes, there will be a number of activities that need to be undertaken. Training and education will be one of those. There will also be an update of the termination-of-pregnancy clinical guidelines—the establishment of a clinical pathway that will clearly prescribe what is required by the professional who will be prescribing or administering.

Mr Liddy: It may be helpful just to add that the genesis of this bill and this process really was the federal Senate committee inquiry into access to termination of pregnancy. They wrote a report which found that, really, access to termination-of-pregnancy care is a 'postcode lottery'. That is the terminology they used. As we know, in Queensland that is a particular issue because we have such a decentralised state that people were having trouble accessing this type of care. This bill will extend care into other types of settings and to other types of practitioners.

Another thing that is worth noting, I think, is that a medical termination, as Kirstine mentioned in her opening statement, has to happen within a particular time frame. If the person who is seeking care or a termination of pregnancy is unable to access a medical practitioner currently within the time frame, it can then mean that they need to be admitted to a hospital or a clinic, which can mean additional costs of travel. That is particularly difficult in situations for vulnerable people, people who may be subject to domestic and family violence or other forms of vulnerability, in those rural and regional areas who may find it difficult to actually leave their local community.

Ms KING: I just have one more follow-on question, Chair, if that is okay. I recognise that other members have questions. Do we have any estimate of the number of women who are currently likely to be in a termination-of-pregnancy 'desert', effectively, who cannot seek this care in their own community with ease?

Ms Miller: We would have to take that question on notice. We do not have that information available.

Ms KING: Could you, please?

Ms Miller: Certainly.

Mr ANDREW: AMA Queensland said that this bill ignores the recent federal report on reproductive health and poses a risk to patient safety. They said that this cannot be justified, lacks evidence and must not be further progressed. I am trying to understand where they are coming from. They are saying that they only had a week for public consultation on this bill. They are not thoroughly going along with it. Can you tell me why this is a risk to patient safety, and why does it pose a threat to reproductive health and patient safety?

Ms Miller: With regard to safety, in order to safely prescribe or administer medication, all nurses and midwives undertake the following: assess the patient including medication history, understand the legal requirements associated with the medicine and the clinical situation, have pharmacological knowledge of the medication, and have skills and knowledge related to safe medication administration. From a safety perspective, I would have to disagree.

Ms Sketcher-Baker: The other thing to add is that we are placing a safety framework around this. At the moment we are developing some education and training resources for health practitioners providing some early medical termination of pregnancy using MS-2 Step to provide clinicians with education about contemporary termination-of-pregnancy practices and the knowledge and the skills required to deliver care within the scope of practice. We also have some clinical guidance pathways and frameworks that are under development which will help in terms of directing the clinician as to what pathways to follow. There will also be a safety and quality monitoring framework that will be placed around this.

Ms Miller: In addition, there are national and state regulatory processes for health practitioners which protect the public by setting standards and policies. Regulation ensures that only registered health practitioners who are suitably trained and qualified to practise are registered and able to provide that care. Appropriate Queensland regulatory mechanisms will be updated to reflect these legislative changes if they go through.

Mr ANDREW: If we are still in the process of constructing the framework and we have only taken one week to go out for consultation with the public, should we have not constructed that framework so we could actually critique that as well as this bill to ensure what we are putting in place is fit for purpose, as per the AMA's questions about the bill?

Mr Liddy: It is quite common practice for implementation activities to occur after a bill given that the bill needs to be considered by this committee and by parliament, debated and passed. Whilst things are certainly in train, we would not want to pre-empt the parliament in assuming that the bill would pass. The implementation activities naturally have to occur after the bill has passed.

Mr MARTIN: I have a follow-up question. It goes back to the part of the bill that provides regulation-making power to allow additional types of registered health practitioners to be prescribed to perform medical terminations. Could you give us some examples of other types of health practitioners? Are they always going to be nurses, effectively?

Mr Liddy: We also have Aboriginal and Torres Strait Islander health practitioners and pharmacists. For example, they are authorised under the current arrangements to assist in a termination of pregnancy. They cannot act of their own accord but they can assist. Depending on the training, the qualifications and the arrangements that might apply in future, thought could be given to perhaps extending, if there was appropriate training and qualifications, to some of those groups.

Mr MARTIN: So pharmacists and—

Mr Liddy: Aboriginal and Torres Strait Islander health practitioners.

CHAIR: Coming from regional Queensland and having been in these remote places where there are no GPs, I think this makes sense to use the broader health network to access care. Are there any other jurisdictions that you are aware of that have expanded—and this can be taken on notice—access to this treatment in Australia?

Mr Liddy: We do have that information. Western Australia passed a bill, the Abortion Legislation Reform Bill, on 21 September. It will allow nurse practitioners and endorsed midwives to perform medical terminations. It is expected that those reforms are going to commence in March or April next year. Western Australia is quite similar, as you know, to Queensland in terms of its decentralised nature.

Ms Miller: South Australia?

Mr Liddy: South Australia allows registered medical practitioners and certain other registered health practitioners to perform medical terminations in limited circumstances. New South Wales has not made any changes to its legislation at this stage. Under their Abortion Law Reform Act they need to do a review within five years, and that review is coming up; it is due to happen in 2024. It is expected that New South Wales will make changes as part of that process.

Mr MOLHOEK: I notice there is an Abortion Online service that provides telehealth. Is that currently a common practice? How does this legislation deal with that—a medical practitioner and presumably the extension of that definition? Would that provide for people to do it via telehealth, whereby the substance is prescribed and then perhaps mailed or picked up from a pharmacy? When you talk about performing the medical procedure versus prescribing, do people just pick up the product from the pharmacy and then go home and take it, or do they do it in a supervised environment? I just want to understand how all of that works.

Ms Miller: We would need to take the question on notice in relation to telehealth. As previously mentioned, nurse practitioners and endorsed midwives can prescribe and provide the treatment through consultation.

Mr MOLHOEK: When you say 'provide the treatment', does that mean that the substance is taken in a supervised environment, or do they provide the product and the advice and then the person goes home and takes it in the privacy of their own home? How does it work?

Ms Miller: Generally, the first treatment dose would be taken whilst they were in clinic and then the subsequent doses would be supplied.

Mr MOLHOEK: Is that why it is called 'two step'?

Mr Liddy: That is exactly right. It is a two-step process.

Mr MOLHOEK: Perhaps we could have, as a question on notice, some further advice around telehealth.

Mr POWELL: Just so you are clear, it does appear through a simple Google search. That is a service that is already available. So the question is—

Mr MOLHOEK:—with Medicare available.

Mr POWELL:—if that is the case, again, why is the legislation necessary? I understand what is being said—people remotely are not getting access—but if there is a telehealth service then that suggests they possibly could have access.

Mr MOLHOEK: It would be interesting to know how that telehealth sits with those Commonwealth carriage laws, the ones where there have been some issues with VAD.

Ms KING: Is that for suicide specifically? Those carriage laws were for suicide—

Mr MOLHOEK: I was not trying to be dramatic about it. It would just be interesting to know if there are any technical issues around that.

Ms Miller: Certainly, we can provide that.

Mr POWELL: Changing tack, I would like to ask a couple of questions around the nurse-to-patient ratio aspects of this bill. In particular, what happens in the event that a hospital or a unit is unable to meet a nurse-to-patient ratio as prescribed?

Ms Sketcher-Baker: The department will be providing advice to the government about the best way to roll out the midwife-to-patient ratios across Queensland Health facilities. When we have implemented previous ratios it has been done through a staged approach. We need to be very careful to ensure we are minimising workforce disruptions when we are implementing this, given the worldwide shortage around some of our nursing staff.

We expect that a staged approach will also be used for rolling out the midwife-to-patient ratios, and there are important reasons for taking this approach. A staged rollout will enable us to carefully manage workforce impacts for midwives across the whole of the state. We will need to consult with a range of staff, health consumers and unions to make sure ratios are implemented in a way that is sustainable and safe. We will work in partnership with these key stakeholders to ensure we bring them along during the implementation and get the settings right. We know from experience that implementing ratios properly actually takes time.

We will also work with universities and education providers to build an enhanced pipeline of trained midwives and ensure we can recruit and retain staff successfully. The department will work with all of our stakeholders to determine the best approach for implementing minimum midwife-to-patient ratios, and we will draw on our extensive experience in implementing previous ratios to ensure it is done carefully and meticulously.

Mr POWELL: I understand the progressive rollout. Does that include explanation as to how a nurse can escalate a situation where suddenly the number of patients has increased, such as where a couple of kids have been born and the ratio therefore is not being met within a shift? How does that change?

Ms Miller: That is managed operationally within facilities, and facilities have different approaches to that. Some facilities have nurse managers that will move staff where required to meet the demand if a particular clinical unit has increased pressure, as you have described. Staff are moved around.

Mr POWELL: Moving staff is one thing. Do you call in staff on short notice as well? Is that a solution?

Ms Miller: Again, it is dependent on the facilities' local protocols and processes. Yes, staff can be called in and at times staff may be asked to work an extension to their shift and do a couple of hours overtime whilst they find an additional staff member.

Mr POWELL: What are the consequences for not meeting the nurse-to-patient ratio?

Ms Miller: There are currently no consequences as such. We do report. The compliance is reported monthly. Hospital and health services provide us on a monthly basis their compliance against the current ratios. That is provided quarterly and published on our website.

Mr POWELL: You mentioned nurse unit managers. Is there any flow-on impact on increasing the number of nurse unit managers based on the nurse-to-patient ratio? I am imagining that the number of nurses will increase. Does the number of nurse unit managers increase as well?

Ms Miller: I would not expect that.

Mr POWELL: Can I give some feedback? I have had it reported at, say, Caboolture Hospital. Previously there were two nurse unit managers covering the birthing suite, the maternity ward and the specialist care, so one looked after the birthing suite and one looked after the specialist care and maternity ward. That allowed them to do exactly what you have said: move resources as required and deal with escalations as required, particularly in the birthing suite. I am now advised there is only one nurse unit manager overseeing all three elements. My concern is that if we increase the number of nurses we are not going to have in place the nurse unit managers to oversee that. Do you have any comment?

Ms Miller: It is difficult to comment on that given the operational nature, I am sorry.

Mr POWELL: I use it as an example. I am not asking you to comment on Caboolture specifically but more on the concept that if we are increasing the number of nurses, is there a commensurate increase in nurse unit managers?

Ms Miller: I would not expect there would be, but, again, it would be dependent on the facility and the services that they are providing. I note that the facilities do use the business planning framework, which is a framework that is industrially mandated and provides a tool to identify the supply and demand of workforce. That is a tool that would be used to manage the level of staff that would be required.

CHAIR: I have a question on that and it is very similar to my last question with regard to other jurisdictions with nurse- or midwife-to-baby ratios. Which other jurisdictions have them in place? Can you advise?

Ms Miller: With regard to what we are discussing here today, midwife-to-patient ratios, Victoria is the only other state that has them currently.

CHAIR: Clearly it is about safety in the ward.

Mr MOLHOEK: I want to move onto the responsibility of the hospital and health boards with regard to complaints, if that is the right term. At what point does the hospital and health service have an obligation to report to Ahpra or the OHO? Is there mandatory disclosure requirements? Do these new provisions present an issue for, say, a hospital and health board where they are now having to make decisions as to whether things are referred? Does it create additional liabilities for their directors that might concern them? Is it at cross-purposes with the intent of Ahpra and OHO and are we simply creating another step?

CHAIR: Is this in relation to clinical reviews?

Ms Sketcher-Baker: This might be in relation to the quality assurance committees.

Mr MOLHOEK: Sorry, I meant to say that at the start.

Ms Sketcher-Baker: That is okay. Quality assurance committees are essentially formed to look at systemic issues across the state. Essentially, at the moment within the legislation, the information is protected. When a member of the quality assurance committee is a registered practitioner and they identify there is a concern with a practitioner that aligns with the public risk notifiable condition, they are to report that through to the Health Ombudsman. The problem we have at the moment is that that information does not go to the hospital and health service where the practitioner the concern is around works. This amendment to the act will allow the quality assurance committee to report that to the hospital and health service chief executive. They will be able to have a look at that and immediately take action if there is some risk to patients. They will still be required, under the legislation, to report to the Health Ombudsman if it constitutes a public risk notifiable contact.

Mr MOLHOEK: It is subject to all of the same provisions that are currently in place?

Ms Sketcher-Baker: That is correct. It is really enabling a health service to be more responsive if there is a safety issue with a practitioner.

Mr MOLHOEK: I guess it is another channel of identifying a potential risk.

Ms Sketcher-Baker: Correct.

Mr MOLHOEK: The current system is essentially complaint-based, whereas these are issues that would emerge from a clinical review or something where perhaps there had not previously been a complaint?

Ms Sketcher-Baker: Typically, these quality assurance committees are set up to have a look at what are the systemic issues that occur across the different clinical domains, but what happens from time to time is that, when they are investigating or looking at these charts, they might identify that there is a concern around a particular practitioner, so it enables them to provide that information to the health service to immediately assess.

CHAIR: I want to get clarification in the clinical review space. I have been part of clinical reviews in a former career where they will look at particular cases on a learning basis. I know that the quality assurance looks at systemic issues, but when we are looking particularly at clinical reviews and a sentinel event occurs, what happens with the department there?

Ms Sketcher-Baker: Essentially, with the clinical review or a health service investigation, that is performed under the Hospital and Health Boards Act. It is either the chief executive of the health service or the director-general that will commission that review. With regard to a clinical review or a health service investigation commissioned by the chief executive of the health service, if there is an issue that arises around a practitioner, again, that information is provided directly to the chief executive and they are able to deal with that issue appropriately. The change in this legislation

enables the director-general, if a clinical review is actually commissioned by the chief executive of the health service and the health service actually provides that report to the director-general, to consider that information. He or she can take disciplinary action against a health service or employee if there is information there to substantiate that. He could make a public statement in relation to the outcomes of the report, or he could provide a copy of the report to the patient's family. At the moment, he is not able to do that.

CHAIR: To clarify, there will be reports to OHO and Ahpra with regard to that as well?

Ms Sketcher-Baker: The chief executive may choose to do that. If they are a registered health practitioner, they must; it is a mandatory requirement. If they are not, they do not have to. However, usually if there is some sort of issue, one of the recommendations in the clinical review report will actually recommend that the person is referred to OHO.

CHAIR: Thank you for the clarification. There being no further questions, I thank you very much. Some questions have been taken on notice. If responses to those could be submitted—sorry to keep your department busy all the way up to Christmas—by next Thursday, 21 December, we would deeply appreciate it. Thank you very much for your attendance today and informing the committee on the various aspects of the bill before us. Please try to have a good and safe Christmas. We will see you again in 2024. Thank you. I now declare this public briefing closed.

The committee adjourned at 11.06 am.