# *HEALTH AND ENVIRONMENT COMMITTEE*

**Members present:**
Mr CG Whiting MP—Acting Chair
Mr SSJ Andrew MP
Ms AB King MP
Mr R Molhoek MP
Ms JE Pease MP
Mr ST O'Connor MP

**Staff present:**
Mr K Holden—Committee Secretary
Ms A Groth—Assistant Committee Secretary

# PUBLIC BRIEFING—OVERSIGHT OF THE HEALTH OMBUDSMAN AND HEALTH SERVICE COMPLAINTS MANAGEMENT SYSTEM IN QUEENSLAND

## TRANSCRIPT OF PROCEEDINGS

**FRIDAY, 27 MAY 2022**

**Brisbane**

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**The committee met at 10.46 am.**

**ACTING CHAIR:** Good morning. I declare open this public briefing for the committee's oversight of the Health Ombudsman and health service complaints management system in Queensland. My name is Chris Whiting. I am the member for Bancroft and I am substituting for Aaron Harper, the member for Thuringowa, as chair of the committee today. I would like to respectfully acknowledge the traditional custodians of the land on which we meet today and pay our respects to elders past, present and emerging. 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 share.

With me today are Mr Rob Molhoek, the member for Southport and deputy chair; Mr Stephen Andrew, the member for Mirani; Ms Ali King, the member for Pumicestone; Ms Joan Pease, the member for Lytton; and Mr Sam O'Connor, the member for Bonney. This briefing is a proceeding of the Queensland parliament and is subject to the parliament's standing rules and orders. Only the committee and invited witnesses may participate in the proceedings. Witnesses are no not required to give evidence under oath or affirmation, but I remind witnesses that intentionally misleading the committee is a serious offence. I also remind members of the public that they may be excluded from the briefing at the discretion of the committee. I remind committee members that officers are here to provide factual or technical information. Any questions seeking an opinion about policy should be directed to the minister or left to debate on the floor of the House.

These proceedings are being recorded and broadcast live on the parliament's website. Media may be present and are subject to the committee's media rules and the chair's direction at all times. You may be filmed or photographed during the proceedings and images may also appear on the parliament's website or social media pages. I ask everyone to turn off their mobile phones or switch them to silent mode.

### BEASLEY, Ms Prue, Director, Office of the Health Ombudsman

### COULSON BARR, Dr Lynne OAM, Health Ombudsman, Office of the Health Ombudsman

### EDWARDS, Ms Heather, Queensland State Manager, Australian Health Practitioner Regulation Agency

### FLETCHER, Mr Martin, Chief Executive Officer, Australian Health Practitioner Regulation Agency (via teleconference)

### HARDY, Mr Matthew, National Director, Notifications, Australian Health Practitioner Regulation Agency (via teleconference)

### HILL, Ms Maree, Acting Executive Director, Assessment and Resolution, Office of the Health Ombudsman

**ACTING CHAIR:** I now welcome representatives from the Office of the Health Ombudsman and the Australian Health Practitioner Regulation Agency who have been invited to brief the committee on the health service complaints management system. Would someone like to make an opening statement?

**Dr Coulson Barr:** I would also like to start by acknowledging the traditional owners of the land on which we meet today and pay my respects to all elders past, present and emerging, particularly today being the first day of National Reconciliation Week.

Thank you for the opportunity to provide my first briefing on the important work of the Office of the Health Ombudsman, which is known as the OHO and I will refer to the office as the OHO. As the committee is aware, I commenced my role as the Health Ombudsman on 15 January this year, so just around four months ago. I feel really privileged to have the opportunity to build on the strong

performance of the office that was established under the leadership of the former health ombudsman, Mr Andrew Brown, and really to have the opportunity to strengthen the way in which the office works to achieve the key objectives of the Health Ombudsman Act 2013. As you know, those include protecting the health and safety of the public, namely health consumers; promoting high standards of health service delivery; and, importantly, maintaining that public confidence in the health service complaints management system.

I am also really pleased to brief the committee together with Ahpra today, as I believe that the co-regulatory model and the strong collaborative relationship that exists between the OHO and Ahpra is really one of the key strengths of Queensland's health service complaints management system, along with the OHO being that single point of entry for all health complaints and notifications. It was one of the features of the system that attracted me to put myself forward for this role.

I thought I would use my opening statement to follow up on the information provided by the former health ombudsman in his last meeting, which was in November last year. In that he provided an overview of the performance of the office over the 2020-21 reporting period. At that stage the annual report had not been published so he went in to more detail about that last reporting period than the current performance. I thought it would be helpful to cover the performance of our office for the first three quarters of this reporting period, which obviously covers some of the period in which I have not been in the role—that is, the period from 1 July 2021 through to 31 March 2022—and compare that to the 2020-21 performance indicators that the former health ombudsman spoke to. I would also like to highlight some key areas that I would like to focus on in future briefings.

Where relevant, I will provide some current figures to provide the committee with further insights into our current performance, particularly given that the performance reports for quarter 2 and quarter 3 have only recently been able to be finalised and provided to the committee. I apologise for the delay in that. It was due to unexpected issues in our data reporting systems, which have required significant remediation and some priority attention. This is post the process of the joint consideration of technical solutions. I can speak to that if the committee is interested in those issues we have had to address.

I would appreciate it if the committee might allow me a bit more time than normally allowed so I can cover these areas in my first briefing. Is that permissible? It will be around 10 minutes.

**ACTING CHAIR:** Yes.

**Dr Coulson Barr:** In terms of overall performance to date, I am really pleased to report that the OHO has maintained its strong operational performance into this reporting period. As at 31 March 2022 we have received 7,387 complaints—that is, since 1 July. That is a three per cent increase on the same period in 2021 when, for the first time, there had been a decrease in numbers of complaints. Despite this increase, the OHO has performed very strongly against the majority of its legislative time frames and the SDS measures. I want to say that that is a real credit to the commitment, dedication and hard work of the OHO staff and also the systems that have been put in place to support the work during the pandemic. It is a real credit to the office in terms of how it has been able to continue its strong performance in those circumstances.

I will start first with the performance measures for intake assessment and resolution of complaints. There was actually an increase in performance against the legislative time frames in intake decisions. That is that tight statutory time frame of seven days to make a decision. Ninety-eight per cent of decisions were made within that time frame, which compares to 91 per cent in the 2020-21 reporting period. Both of those measures are above the SDS target of 90 per cent. This is a significant indicator of timely and agile decision-making and it enables prompt attention to the risks identified in complaints and notifications. It also ensures that matters are dealt with in the most appropriate process in terms of the decision-making that happens in that seven days but also by the most appropriate agency. I will speak in a moment about the joint consideration process with Ahpra that commenced on 6 December 2021, during that period.

In addition, 93 per cent of the matters referred to the OHO's assessment processes in those first three quarters were completed within the legislative time frames, and that is 22 business days or 44 days if there is an extension. That compares to 91 per cent in the 2020-21 period. Both of those are above the SDS target again. Again, this is significant given the complexity of matters that are referred to assessment. They are most commonly the ones that deal with serious risk and need further examination.

The rate of resolution matters being finalised within the legislative time frames—again, that is 22 business days or 44 days with extension—has been slightly down in the first three quarters, at 90 per cent. That compares to 94 per cent in the 2020-21 period and it compares to the SDS measure

of 100 per cent. This appears to be due to a range of factors, I think primarily associated with the COVID-19 pandemic in terms of the availability of practitioners and services to participate in those resolution processes, which has sometimes taken a bit longer to accommodate. Despite these challenges, there have been really positive outcomes from those processes that I think have been particularly important during the pandemic where consumers, practitioners and services are all experiencing unique stresses and challenges. Some of them play out in terms of issues around communication and access to treatments. They are really important matters to be able to resolve, particularly for the consumers' ability to access health services going forward.

One of the areas that I would like to cover in future briefings to the committee is some of those qualitative measures of the OHO's performance, particularly some of the examples of the work that is performed across the functions such as assessment resolution and conciliation, as well as the referral processes when we are referring matters back to health services and reviewing the actions they have taken. All of those processes can lead to improved outcomes for consumers as well as service and practice improvements. In addition, they can give us some key insights into some of the emerging quality and safety issues in the health system. I think giving attention to all of those processes, and not just the numbers but the types of outcomes, is really important for the OHO's function in terms of maintaining that public confidence in the health service complaints system. We really want the community to have high visibility of the types of outcomes that can be achieved through making complaints and the types of actions that can be taken to address quality and safety issues.

As I indicated earlier, a significant development for both the OHO and Ahpra over recent months has been the successful implementation of the joint consideration process that commenced on 6 December. I have to say that it is a real credit to the work undertaken by the staff of both offices that this joint consideration process and the associated IT solution worked successfully from day one. The technical solution that was developed really enables the real-time electronic sharing of information between the case management systems of the two agencies, which are different. It has required a technical solution so they can speak to each other.

In addition, the technical solution supports the process of the OHO and Ahpra jointly considering the health practitioner complaints and notifications and determining which agency should deal with a matter. It is important to note that all matters have been determined by agreement, which means that the OHO and Ahpra have agreed which organisation should be dealing with the matter. I think that really reflects the strong consultative processes that were already in place between the two agencies. As well, it speaks to the shared understanding of the regulatory risk and our respective roles.

To give you a sense of the quantum of the matters, around 1,400 matters have been jointly considered since the commencement in December through to the end of April. As a ballpark, approximately 50 per cent have been referred to Ahpra, 15 per cent have been retained by the OHO and 35 per cent of the matters have resulted in decisions of no further action. That is now occurring in a timelier manner because it is being made at that point in time.

I will now turn to investigations. In his last briefing, the former health ombudsman spoke about some of the challenges in meeting the SDS measure of 75 per cent of investigations being completed within 12 months. He also spoke of some of the progress made in addressing aged matters. I am pleased to say that that progress has continued. At the current time the performance measure is sitting at around 59 per cent, similar to that of 2021. The progress continues to be with a dedicated focus on reducing and completing those aged matters. I think it is important to note that when we do not include the number of paused investigations—and I believe there have been discussions around those with the committee. Those are the matters pending court proceedings, ones where the office cannot take any action; they are currently 59 out of the 166 open investigation matters. When you take those matters out, the percentage of investigations completed within 12 months is sitting at around 73 per cent, so close to that 75 per cent SDS measure.

It is also important to note that the number of investigations commenced so far in this reporting period has increased, whereas last year they were decreasing. Since 1 July 2021 we have commenced 161 investigations—they are the parent investigations—compared to 150 in the same period. It is unlikely in this reporting period that we will be able to close more investigation matters than were opened. That had been a strategy to reduce the backlog in previous years. The workload associated with the increase in investigations, however, has really been carefully managed. We have a range of strategies in place to do that, including tailoring our investigation approach; a complexity rating; and incorporating both clinical and legal advice in the early planning stages of investigations. That helps to inform the scope and approach to the investigation. I have to say that the investigation teams are incredibly skilled and targeted in their approach, so I am very confident we will not be accumulating a backlog, which has been a feature of previous years.

In terms of outcomes, to date this year around 70 per cent of the completed investigations have resulted in either referral to the director of proceedings to consider whether to file a disciplinary matter in QCAT—there have been 77 to date in this reporting period—or to commence a show cause process for a prohibition order. That is in the case of unregistered practitioners. There have been 30 to date in this reporting period. Eleven of those prohibition orders have already been issued in the first three quarters. That was actually the same number for the 2020-21 total, so the numbers seem to be steadily increasing.

In addition to the investigations undertaken, the monitoring and compliance team actively monitors the conditions imposed on practitioners as a result of immediate action and prohibition orders. Together with the work performed by our immediate action team, this is really a critical safeguarding and protective function performed by the OHO. The numbers are steadily increasing in both of these areas of work and it is the area that I want to give attention to. I would be pleased to have a further opportunity in future briefings to talk more about the nature of that work.

Finally, I will cover the work of the director of proceedings and the progression of matters through to QCAT. This was the focus of a briefing of a former health ombudsman. There continues to be strong performance in this area, with a progressive reduction in the age of matters awaiting action by the director of proceedings. That number is currently sitting at 39 matters. The average age for a matter now is six months. The aim is to have no matters older than six months by the end of this reporting period—or close to, depending on the progress of some current matters.

In the first three quarters of this year 23 referrals for disciplinary matters were filed in QCAT compared to 30 in the same period in 2020-21, but this reflects steady progress in reducing the backlog of matters that had built up in that area. The number of matters in QCAT also continues to drop. The year-to-date figure is 78 compared to 104 at the end of the last reporting period. As at 26 May the tribunal has heard 60 matters in the reporting period compared to 2020-21, where they finalised 66 matters.

The director of proceedings and I have met with the president and deputy president of QCAT and had a really productive meeting. We have identified a range of processes that will further support the timely progress of matters filed in QCAT. That is really looking at the way in which we file our matters and the nature in which the evidence is presented. On a final note, to date the SDS measure of QCAT deciding that there is a case to answer when we file a disciplinary matter by the director of proceedings has also been achieved. That is been the case for 100 per cent of the matters to date.

There is a lot more that I could share with the committee on the work of the OHO and the key areas of focus that I have identified for the work going forward. I hope I can cover some of that in the questions or in future meetings.

**ACTING CHAIR:** Thank you for that comprehensive outline. I had a couple of questions that you have already answered. Ms Edwards, Mr Hardy and Mr Fletcher, is there anything you would like to add?

**Mr Fletcher:** Thank you very much, Chair. I am happy to make some very brief opening comments. I would also like to acknowledge the traditional owners of the lands from which I am joining you today and their continuing association to land, their community and culture. Thank you for this opportunity to brief you on the work the Ahpra and the national board as part of the health complaints management system in Queensland.

I am really pleased to say that our relationship with the Office of the Health Ombudsman is really positive, and we are continuing to build on that strong partnership with Dr Coulson Barr. As she has highlighted, both agencies worked closely together to ensure the successful implementation of joint consideration, which is progressing really smoothly, and of course this helps ensure that complainants get to the right place quickly for their concerns. I note also that the contribution of Queensland complaints data to national reporting has been of great interest to the committee. I am also pleased to advise that the OHO has been able to provide more datasets with 14 tables in our last annual report, including Queensland data.

More widely, as of 30 June last year there were just over 168,000 registered health practitioners in Queensland across the 16 regulated professions. That is about 20.4 per cent of the total 825,000 registered health practitioners in Australia. Of course, COVID-19 has really underlined how much we rely on these health workers to keep us safe, and registered health practitioners continue to do exceptional work in very challenging times. I am really pleased to let you know that we have just completed our largest and most successful new graduate registration campaign, which has seen over 6,300 new graduate health practitioners available to work in Queensland. We continue to refine our temporary pandemic subregister. There are 4,300 Queensland practitioners on that subregister who are potentially available to help in terms of the wider COVID response.

In terms of complaints, in 2020-21 OHO and Ahpra managed 4,838 complaints about 3,453 registered health practitioners in Queensland. That is an increase of nearly 15 per cent on the year before. In fact, the national increase was under one per cent, so it is quite a significant difference compared to the national picture. We dealt with just over 2,600 of those complaints, and clinical care provided to patients remains the most common type of complaint. As we have previously briefed the committee, Queensland practitioners have been subject to more complaints per capita of practitioner population compared to other jurisdictions, so about 2.1 per cent of all Queensland registered practitioners are subject to a complaint. The national average is about 1.6. That has been consistent with previous years, and we think those differences are probably likely to indicate a stronger reporting culture within Queensland and greater community awareness of the avenues to raise concerns.

I know that the committee has also been really interested previously in the Medical Training Survey, which is our national survey of all doctors in training in Australia. We have just completed the third year of data collection. Approximately 21,000 doctors in training across Australia, about 55 per cent, responded to the survey and over 4,350 of those were from Queensland. Results are pretty consistent with previous years, and the results from Queensland are largely consistent with the national response. On the whole, trainees rate the quality of their training highly, but concerns persist about the culture of medicine. Just to give you one piece of data, 21 per cent of Queensland trainees have experienced, and 30 per cent have witnessed, bullying, harassment and/or discrimination including racism in the workplace. Again, this is consistent with the national picture, but of particular concern to us is that Aboriginal and Torres Strait Islander doctors in training are much more likely to experience these issues. We published the results. They have been disseminated widely. I am in fact in a meeting today with a number of medical colleges to talk about what we all need to do together to address that and build that culture of respect medicine.

Finally, we know that the Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2022 has been referred to the committee for scrutiny and that there will be a separate process around that. We will certainly make a written submission. We would also be pleased to attend a public hearing. We would like to propose that the committee might find it helpful, if you are having a public hearing with us, for Ahpra and the OHO to appear jointly given that Queensland is a co-regulatory jurisdiction and both agencies will undertake implementation activities to support the reforms. Thank you again for the opportunity to provide an overview. I am very happy to take any questions.

**Ms PEASE:** Thank you to both organisations for appearing and for the great work you have done. Mr Fletcher answered one of my questions, which was with regard to the increasing number of referrals. You mentioned that it was to do with the fact that Queenslanders might be more inclined to make reports and complaints. Do you think there might also be more awareness of access to this complaints process?

**Mr Fletcher:** From my perspective, I think it is both of those things. We have a stronger reporting culture in Queensland, and I think we would say that we see greater awareness among consumers about the avenues to raise a concern.

**Ms PEASE:** Would you agree with that, Dr Coulson Barr?

**Dr Coulson Barr:** Yes. I would add that I think the single point of entry, for OHO being the first front door for health consumers to raise their issues, is a really strong feature of this system. I think that does explain some of the high numbers in this jurisdiction. I would be cautious, though, in terms of whether we are hearing from all sectors of the community. That is one of the areas that I have identified as a priority area of focus. I know that the numbers have increased and Queensland has a strong reporting culture and higher numbers of complaints, but I am cautious that we need to be mindful of whether we are hearing from all sections of the community, particularly our Aboriginal and Torres Strait Islander communities—all sections of the community, including rural and remote areas.

Younger people are a concern for me in terms of whether our processes are tailored for young people, who tend to raise issues in different ways than the mainstream. I have already commenced discussions with the commissioner for children and young people in terms of how we can test that in terms of our younger population, also people with disabilities and mental health consumers. There are a range of communities that can find it harder to raise an issue, so I think we cannot be complacent that we have strong complaint numbers and that we are hearing all the concerns. I think it is something we have to pay dedicated attention to, and that is something I am going to be looking at during my term.

**Ms PEASE:** I do not have any further questions, but I would just like to make a comment. I have been on the health committee for some time now and we have heard in the past about all of the work you have had to do with regard to your QCAT engagements, prosecutions and working together, so

congratulations on how successful it has been. The integration of your IT and technology is really great, so congratulations. I know that has been a big step. I acknowledge all of the great work you have done. Thank you for the great work and commitment you have shown in all of those areas you have spoken about. It has been a bit of a journey for you all, I know, and I appreciate the commitment you have made and the great outcomes you are displaying.

**Mr MOLHOEK:** I echo the member for Lytton's comments. I think it has been a pretty rapid entry into the role for you, Dr Coulson Barr. It is comforting to see that there has been no drop-off in trend or noticeable decline in service levels or responsiveness. That is very encouraging.

Martin, you touched briefly on the number of doctors who are in training. Given the demands we are seeing in the health system currently, do we have enough in training? What would be an optimal number to have coming through the system? I know it is a little bit of a sidebar from your report, and I will get to the report, but I was curious.

**Mr Fletcher:** There is no doubt that there is huge pressure on both health and aged-care systems around Australia at the moment. I think it is a question of attracting not only more people into the professions—and I am probably seeing medicine and nursing as the two standout ones—but I think a range of allied health professions as well. It is also the question of retaining people. I would have to say that, from our point of view, we are seeing more registered health practitioners in every profession every year. I think we have a really good graduate pipeline coming through. We are continuing to be very attentive to the question of overseas trained doctors being able to come into Australia, particularly given that we rely on those doctors often to go to areas of need where there are under-served communities. It continues to be a huge focus for us to play our part fully from the registration point of view, to make sure that works as smoothly as possible and, as I say, we have the health workforce we need at a very exceptional time.

**Mr MOLHOEK:** This question is to the OHO and Ahpra. There has been some public concern about the North Queensland full scope of practice pilot, with some public reporting of adverse patient outcomes as a result of the pilot. Are there any cases that you are aware of or that have been raised with you which stem from that pilot program?

**ACTING CHAIR:** I cannot remember seeing that in the annual report. Whereabouts can we find that?

**Mr MOLHOEK:** It is a broader question about matters and complaints that come to—

**ACTING CHAIR:** It is, but I would like to know more about it. I am asking where that may be in the annual report.

**Mr O'CONNOR:** It is a Queensland Health trial that allows pharmacists to diagnose and prescribe drugs for conditions including diabetes, middle ear infections and urinary tract infections. There have been some claims that cases have come from this—it is described as a turf war between pharmacists and doctors.

**ACTING CHAIR:** I am not sure how this is going to impact on the examination of the annual report.

**Mr O'CONNOR:** That is what the annual report is about.

**ACTING CHAIR:** I know it is there, but there is information that I would have liked to have considered as well. I do not know if you have any information, bearing in mind the context in which we are asking is an examination of the performance that we are currently discussing.

**Dr Coulson Barr:** I have just been informed we have had one inquiry so far, not a complaint, around those matters. There is not much more I can add at this stage. It is something that has just been brought to our attention but only as an inquiry.

**Mr MOLHOEK:** What about Ahpra?

**Mr Fletcher:** I have nothing to add at this stage, either.

**Ms KING:** Dr Coulson Barr—and I think we have canvassed these issues previously when you have attended—I am interested in your comments around the sections of the community that are not necessarily being represented in the complaints statistics. Of course, we all look forward to a scenario where complaints increase even further because we are hearing from people who are not perhaps currently having their say. I know we have discussed this matter previously. I wonder if you can point to how your concerns are grounded. What gives you the sense that we are not hearing from people? Last time we discussed it we did not necessarily have data to pull on, but you clearly have concerns about it, as I do myself. I am wondering if you have encountered further evidence since embarking further on your role that strengthens your views around that.

**Dr Coulson Barr:** My starting point is that there are known barriers for certain population groups and they are known nationally and internationally. For instance, there are known challenges for mental health consumers to raise issues, for Aboriginal and Torres Strait Islander communities to raise issues et cetera. That is a known barrier that needs a dedicated attention for any organisation to be addressing. My caution in commenting on our capabilities to date is that I do not think our data really can tell the story in terms of our demographic data and comparing that to the populations of health consumers across Queensland.

One of my priorities is to build our data capabilities so we can do that comparative analysis of who are we hearing from and who are we not and how that compares in terms of share of populations. Then that will inform our strategies. My starting point is that there are known barriers for raising complaints and we need to be assured that we are taking all appropriate steps to ensure we are truly accessible, responsive and supportive of all sections of the community. That is my starting point.

That being said, OHO has undertaken significant initiatives in this area so that we have strong foundations to build upon, particularly for Aboriginal and Torres Strait Islander communities where there was a targeted outreach program pre the COVID pandemic. We are just in the process of reinvigorating that outreach campaign and visiting communities again. That reaped rewards in terms of engagement with those communities. However, any program like that needs to be sustained and needs to be embedded in our day-to-day practice, so there is still work for us to do in that area.

In terms of mental health consumers and consumers who may otherwise experience other vulnerabilities or challenges in raising complaints, we do have an initiative called the Complaints Navigator program where we have a dedicated officer who provides additional support and a consistent point of reference for consumers as they engage through our different processes. One of the challenges is that the matters we are dealing with are highly personal; they are often deeply traumatic. It involves consumers coming forward at a point in time when they feel comfortable to raise their complaint. That may change in the course of our dealing with them in terms of them not having the capacity to revisit those traumatic events. We have designed a program to enable an officer who can provide that support and that one consistent reference to support someone through the process, through assessment and maybe resolution or investigation. That is a pilot and we are evaluating that. I believe we also need to look at how we embed those processes throughout all of our dealings with people so that people feel supported.

There are some particular initiatives that we have undertaken, together with our dedicated prisoner phone line. That deals with quite sensitive management of prisoners' health concerns, and having that accessible process is a really strong feature of our work. We can also build on that as one of our models. I might pause there, but it is an area that we need to really have a deeper understanding of in terms of how we address our work.

**Ms KING:** At intake of complaint, does the OHO collect data about people's specific vulnerabilities? I recognise that there might be challenges and people could even feel like they were being stereotyped based on the answers to those questions. Are we deeply engaging with people and finding what their personal vulnerabilities or circumstances might be at that point?

**Ms Hill:** You are absolutely right. We take 60 per cent of our complaints via the phone, so we have that very personal encounter initially. We will talk about sensitive matters. We have a triage process. If we know someone is vulnerable, we might escalate a matter. We have good training processes for our officers, who can recognise when someone has been through a traumatic issue or event.

We do obtain details around demographics. Sometimes people are not comfortable to let us know about that. We have a dedicated complaint form, as you would know. We ask for demographic information, but it is not mandatory because we are very conscious about people's privacy. I can guarantee that taking complaints via the phone is a very sensitive process. We will spend as much time as we need to in talking to people, and we have good staff wellbeing processes and escalation processes to deal with people who are vulnerable.

**Mr ANDREW:** I have a quick question on the impact of training and also on your complaints side of things. Have the vaccine mandates had any impact on your complaints system and also on the training of doctors going forward here in Queensland?

**ACTING CHAIR:** Member for Mirani, can you expand on what you think—

**Mr ANDREW:** A lot of people in my electorate have come to me and said they have either finished their training because of the vaccine mandate or cannot continue on because of it and obviously they have lost their job due to that. I want to see how that has impacted the OHO and also the Ahpra training side of things.

**ACTING CHAIR:** Just to clarify, would that be a basis of complaint to the OHO about—

**Mr MOLHOEK:** It is probably more Ahpra.

**Dr Coulson Barr:** I was going to defer to Ahpra to respond.

**ACTING CHAIR:** I am not sure what you can expand on, but it is a question obviously about—I do not know whether a person could complain about that. I am not sure.

**Mr ANDREW:** Even training numbers. Have people pulled out because of it?

**Mr Fletcher:** In the Medical Training Survey I referred to, this year we did ask about COVID related pressures and how they had impacted on the training experience. I have to say, it was not really significant. Obviously there was the question of increased pressure and at times people having to work more flexibly, but on the whole people were not reporting significant impacts, although that did vary a little bit by state and territory. Overall, it seems if there had been an impact it was probably more marked in those states that had higher rates of COVID. There was a sense that it had had an impact but people still rated their training experience overall as being positive.

**ACTING CHAIR:** We have the quarter 2, quarter 1 and quarter 3 performance reports. One of the things we are interested in hearing about—and I know we touched on this earlier—is the difficulty in collating and presenting those reports. Can you expand on the difficulties you may have had?

**Dr Coulson Barr:** One of the unexpected impacts of the technical solution for the joint consideration was impacts on our data reporting capability. It changed some of the fields and the way in which the counting rules were applied in our system. We then discovered the reports that were generated had significant errors in them. It is useful because we have a very close working relationship with Ahpra and we were reconciling our figures and found quite a number of discrepancies. We have had to go through a remediation process. We are currently going through an assessment process of how we address those unintended impacts of the technical changes that were made primarily through the joint consideration process. There were also some changes made, subject to legislative amendments, that changed some of the time frames for making decisions. That had unintended consequences, and we also had a changeover of staff in our IT team.

I am confident we are going to address those. I have an IT consultant who is an expert in this area to give us an assessment of the remediation work that we need to do. More broadly, in terms of how we need to address our data capabilities, this is a priority area of attention for me in terms of how we can produce more meaningful reports that have forecasting and trend analysis. I am conscious that the reports are in a table format and they do not give you a clear picture of emerging issues. As we were saying earlier, there is not a comparative analysis of what the complaints are looking like per share of consumers or regional/rural focus. There is a whole range of areas that we need to address so that this is really meaningful for both the committee and the public more broadly.

Another priority of mine is: I have the view that complaints and notifications are a vital window in terms of what is working and what is not working in the health system. We really have an obligation to draw on the insights of that data in terms of what it tells us about quality and safety issues and also how we share that data with others within the system—with Ahpra, with Queensland Health, with the boards and others as well as services—so that we have a combined picture of what this is telling us. It seems to me it can feel quite fractured and we are not all seeing the same picture. I have had some very productive and promising conversations with Queensland Health and with services about a desire to look at how we can share our data and what emerging issues we are seeing.

Back to your original question about some of the challenges we have had in terms of producing reports, I was of the view that we cannot produce a report when we are not confident of its accuracy. These have been checked and checked again. There is much more granular detail about the joint consideration processes in terms of the time frames in those processes and the nature of matters. We have had to not include those in these quarterly reports, but we will do so by the fourth quarter when we can reliably report on those matters. I apologise again. It was an unanticipated aspect that we have had to address.

**ACTING CHAIR:** Thank you. Obviously we look forward to getting the next quarterly report. You are confident that you have solved those problems with the IT, joint resolution process and different legislative expectations?

**Dr Coulson Barr:** We have identified what the problems are and we are getting advice in terms of how we are going to address it going forward. We have more or less done a manual remediation process at this point. That is not viable going forward, but we are confident it is going to be addressed.

**ACTING CHAIR:** Thank you.

**Mr MOLHOEK:** My question is to the OHO. There have been a few recent cases of alleged clinical malpractice in Queensland public hospitals within the last year, the latest one being Bundaberg and the other two at Mackay and Caboolture. Are you able to provide us with an update as to whether there has been any OHO involvement in these cases in terms of investigation or complaints received?

**ACTING CHAIR:** Is it appropriate to comment on individual cases? We are looking at the system itself. I agree that how those complaints are dealt with deals with the system, but I would certainly advise caution on reviewing or analysing certain cases, because this committee does not want to be seen as a method of alternative dispute resolution for any of these cases.

**Mr MOLHOEK:** The question is: has anyone—

**ACTING CHAIR:** No, I have not finished yet. Can we have that answer in light of the general system that we are assessing at the moment?

**Dr Coulson Barr:** Thank you, Acting Chair and Deputy Chair. I guess I would reiterate that I am not in the position to talk about individual matters, but in terms of our OHO's approach what I would want to give the committee confidence on is that whenever there are matters that are reported in the media or elsewhere—and I have to say that I have been really impressed by the feature of the work of the OHO in this respect—there is a very agile and rapid response in terms of identifying whether it is an issue that has already been brought to our attention, whether we are already dealing with it, whether there is information in the public arena that we are not aware of that we should be or whether it is a matter that should have been notified. We have very agile working relationships, for instance, with QPS, Queensland Health and others and Ahpra where we can check that information and proactively look at whether it is something that we should be dealing with. I want to give the committee that confidence that whenever anything is reported in the public arena we are assessing whether it is something we are already dealing with or should be dealing with and taking steps to address that, but I would be happy to take questions on notice or to deal with this in a private session.

**Mr MOLHOEK:** Perhaps I can put that as a question on notice and it could come back to the committee open or closed. The question really is: are these matters of concern that have been raised with the OHO and is the OHO in the process of any current investigation around some of those allegations?

**ACTING CHAIR:** Hang on a tick. You are wanting to get details of particular cases that may be before the OHO; is that correct?

**Mr MOLHOEK:** The OHO reports to us on many cases, Acting Chair, individually through the committee system. We get updates all the time.

**Ms KING:** The extremely aged cases are the only ones we receive specific details of and they are in private.

**Mr MOLHOEK:** I do not think it is that controversial a question. It just says—

**ACTING CHAIR:** Hang on a tick. I do have concerns that we are fishing for certain cases. I do not want us to be pulling cases out of the work that they do. I think the question—

**Mr MOLHOEK:** And I am not asking for detail, Acting Chair.

**ACTING CHAIR:** Good, so the question you are asking is about specifically—

**Mr MOLHOEK:** Have these matters been raised with the OHO and is the OHO looking at them?

**Mr O'CONNOR:** And an update on their involvement. It is not—

**Ms PEASE:** Excuse me, Acting Chair—

**ACTING CHAIR:** I am not real comfortable with that.

**Ms PEASE:** Acting Chair, the Health Ombudsman answered the question herself, saying that she is not able to comment on specific cases.

**ACTING CHAIR:** Yes, exactly. We cannot say, 'Have you got these complaints and what happened to them?'

**Mr MOLHOEK:** I think the Acting Chair may have led us to that place.

**ACTING CHAIR:** Well—

**Ms KING:** That is a breach of people's confidentiality.

**ACTING CHAIR:** Okay; hang on a tick.

**Mr MOLHOEK:** If I could move on, I will—

**ACTING CHAIR:** We can discuss this later, because if we go any further into discussions amongst us here we will need to go into private for that. You might want to refine and come back to us, because we are not chasing individual cases down rabbit holes. You can look at systemic issues. If you can put it in that light, we will go from there.

**Mr MOLHOEK:** I will let you take the question to Ahpra.

**Mr O'CONNOR:** They are at whole hospitals and health services; they are not individual people that we are raising.

**ACTING CHAIR:** It is getting better.

**Mr MOLHOEK:** I will move on, Acting Chair. If I can ask a question of Ahpra, I am curious about the percentage of the registered workforce here in Queensland that is checked each year by the agency to ensure that clinical registration is current and correct. I understand there is a certain number that are physically checked every year. I am just wondering how many of those registrations are actually checked each year in Queensland. I want a percentage.

**Mr Fletcher:** Just to explain the process, people are required to renew their registration on an annual basis and they make declarations in relation to the requirements for registration. If they make an adverse declaration, so they say they are not meeting the requirement, then we would look at those individually. For example, somebody might tell us about an impairment and then we would look at that individually and identify whether that had any implications for their registration going forward. We also have a program of audit in relation to just generally randomly looking at a cross-section of practitioners to make sure they are appropriately meeting the requirements. I would probably have to take on notice the numbers for Queensland for that, but they are our two processes—essentially to check any adverse declarations and then a rolling program of audit.

**Mr MOLHOEK:** Do you have some targets around the number that you seek to check or audit each year and is it uniform across the nation or are there more checks undertaken in Queensland than other states or vice versa? I would just be interested to see the percentage of people whose registrations are proactively checked.

**Mr Fletcher:** Essentially, what we do with the audit program is look for a sample size within a profession and nationally that is considered to be statistically significant so that we can not only check compliance in relation to the practitioners we audit but make some conclusions about the profession as a whole. We do include some information about that in our annual report and I would be happy to follow up with any further information in relation to that question.

**Mr MOLHOEK:** Thank you.

**Ms PEASE:** I am interested, Martin, with regard to the Medical Training Survey that you undertook in 2021, and you may be aware that our committee did an inquiry into GP services and primary healthcare services around Queensland. I am wondering if you had any questions tailored in that training survey with regard to GPs who worked rurally and remotely and if you had any comments back as to why people who might undertake their training in rural or remote areas do not go back to those areas.

**Mr Fletcher:** Looking at the sample in Queensland—and what we could provide to the committee is the Queensland report, which is published—in fact 44 per cent of the trainees were specialist non-GP trainees and 16 per cent were specialist GP trainees. We would be very happy, as I say, to share the Queensland data if you were wanting to drill down into some of those questions of specific interest.

**Ms PEASE:** Acting Chair, is that fine if we can ask for that?

**ACTING CHAIR:** That specific information sounds fine.

**Ms PEASE:** Finally, Martin, you talked in your opening statement around a temporary subregister. What is that, who is on that temporary subregister and why are they on that?

**Mr Fletcher:** Going back to when COVID first arose in early 2020, there was a real concern at that time because of, obviously, the uncertainty we were facing to see whether we could quickly provide a surge workforce in case it was needed across the health system and the aged-care system. Essentially, what we did was put in place an administrative arrangement where people who had recently left registration—so they may have retired, for example, or if people had moved from a practising form of registration to a non-practising form of registration—were placed on a temporary pandemic subregister and then were potentially available to assist in different states and territories with the surge workforce response, and then over time some of that turned into supporting things like

the vaccination rollout. We have maintained that subregister and we regularly provide updated data, for example in Queensland to the Department of Health, about the people on that register. It is professions like the medical profession, nursing, midwifery and psychology for example, and we could certainly again provide data to you about the current make-up of that register nationally and also for Queensland across the professions that are involved.

**Mr ANDREW:** One-third of your training survey sheet is focused on bullying. The member for Lytton just talked about regional health care. Do the regional systems have bullying and is that keeping doctors from going to the regions? If you do have bullying and people in the regional system who are bullies, how do you deal with that so that people can go back and work in those spaces?

**Mr Fletcher:** Again, just to repeat the results for Queensland and also nationally, 21 per cent of Queensland trainees had experienced and 30 per cent had witnessed bullying, harassment and/or discrimination, including racism, in the workplace, and I made the point that that was higher for Aboriginal and Torres Strait Islander doctors in training. Interestingly, when we asked people the source of the bullying it was senior colleagues, with 53 per cent in Queensland and nationally 51 per cent, or a supervisor, with 47 per cent in Queensland and nationally 43 per cent.

What was of most concern again—particularly concerning data—was that 65 per cent of the doctors in training did not report the incident they had either experienced or witnessed. Again, that is consistent with the national picture. What we were also concerned about was that 57 per cent of the trainees who experienced bullying, discrimination and/or harassment actually reported moderate or major adverse impacts on their training. There is no doubt that this sort of behaviour is really adverse in the training of people across the piece and, as I say, we have to work with governments, employers, colleges and educators to build a much stronger culture of respect in medicine.

**Mr ANDREW:** Can it be dealt with by the re-registration situation if it is annual? Can you say, 'You guys have been up to no good. You're going to continue the practice.' Do you know what I mean?

**Mr Fletcher:** At times we may get complaints about individual examples of bullying or harassment, but one of the things that I think we think is really important is to have much better systems at a local level where people feel safe to raise these concerns. Some of the feedback is that people, particularly doctors in training, are worried that if they raise a concern it is somehow going to count against them. Of course, if people raise a concern what we also have to do is make sure something actually happens about that to address that at the local level. We are putting a really big focus on what the medical colleges, from a professional leadership point of view, and employers can do to make sure they are really addressing these concerns when they are raised.

**Mr ANDREW:** Thank you.

**Mr MOLHOEK:** Martin, do you think the increase in bullying could be a reflection of the fact that doctors and nurses have been under a lot more pressure in the last couple of years and perhaps their fuses are a bit shorter and they are not perhaps coping as well as in the past?

**ACTING CHAIR:** That is a broad question.

**Ms KING:** That is an opinion.

**Mr MOLHOEK:** Has there been any research into perhaps why there has been an increase in bullying? That, I guess, is probably the better question.

**Ms KING:** Has there been an increase?

**ACTING CHAIR:** Yes, and has there been an increase?

**Mr MOLHOEK:** There has.

**Mr Fletcher:** We have now done this survey over three years and I have to say that the results we got this year are pretty consistent with what we got in the previous two years. What we are seeing is that it continues to be a significant problem and it was a feature even before the impacts of COVID-19 on the health system started to be realised.

**Ms KING:** My question is to the OHO. Looking at the performance surrounding investigations completed, 59 per cent with an SDS target of 75 per cent, you noted the impact of paused proceedings. Could you just clarify for the committee: when a proceeding is paused, why does that happen and does the OHO have any control over the length of time a proceeding is paused? Those are counted in your statistics, are they not?

**Dr Coulson Barr:** Yes, it is a feature of how the legislation is constructed. In other jurisdictions there can be provisions to stop dealing with a matter when another body is dealing with it, primarily a court or tribunal, and then to recommence. That stops the clock. That is not a feature of the legislation

we operate under. I understand that in the past it has been explained in terms of paused matters. That is not a term that is used in the legislation. Those are matters that are proceeding through the courts where we are waiting for the outcome of the court proceedings, and that will determine what action we take in terms of its implications for a finding of professional misconduct. They are matters that we cannot actively investigate. They are counted in our numbers, but we cannot progress them apart from a process where we track the progress of those matters through the courts and in terms of when they are going to be presented to court and when the matter is likely to be finalised. We are now looking at 11 matters that are more than 12 months old. All but one are before the courts. We have court mention dates and report trial dates for all of those, so we see the end in sight in terms of when those matters are going to be concluded.

**Ms KING:** It is not that those matters are not being progressed; they are just being progressed via different systems the OHO does not control?

**Dr Coulson Barr:** Yes, and they are being actively monitored. We have an excellent relationship with the QPS, which keeps us up to date, and we actively monitor where those matters are up to.

**Mr O'CONNOR:** What trends have you seen in the complaints you have received? Are there particular geographic areas or particular hospitals where you have seen an increase in complaints in the last year or so?

**ACTING CHAIR:** Is that health districts?

**Mr O'CONNOR:** Health and hospital services or geographic areas.

**Dr Coulson Barr:** I would probably have to defer to my colleagues who were here for that period. In terms of my analysis of the data that is available, I cannot ascertain any particular trends over the last year. They are fairly consistent if you look at the data. This brings me back to the need for us to build our data capabilities in terms of how we can actually do some more granular analysis of what are the themes for different types of services and different areas. I think if we are going to have an impact in terms of performing our functions in terms of protecting quality and safety, but also looking at improving quality, we need to be able to track those trends. I might just defer to Maree Hill. Are there any trends that you could comment on?

**Ms Hill:** You are absolutely right, Lynne, that it is difficult to track, and sometimes it does depend on what might you see in the media. We might get an increase in matters but in our prisoner health consumers it is quite consistent. About 25 per cent of our overall complaints are from correctional centres. We manage those very sensitively but that is quite consistent over time. That dataset is more easy to obtain because we know where those complaints are coming from.

**Mr O'CONNOR:** If a matter does come into the public domain as we have heard was raised with Caboolture, Mackay and Bundaberg, does that trigger extra work in terms of proactively looking at their registration? I am just wondering what the process is when something comes up in the public domain. Is there something activated within Ahpra that then looks at that with a bit more scrutiny?

**Mr Fletcher:** I might ask Mr Hardy to comment on that question as our national director of notifications.

**Mr Hardy:** If there is a mention in the media of a particular issue involving a practitioner or a place of practice in Queensland, the usual pathway would be through to the OHO, who would consider that concern first, and then, if a referral is necessary, through to us for management. Where there are cases reported in the media, we routinely screen and identify the service or the individual practitioner and will consider that as virtually an own-motion type concern if we do not receive a notification from the health service or from the patient who was involved in the concern with the practitioner.

**ACTING CHAIR:** I think that goes some way to answering the questions you asked about those particular districts. Can I point out that, from what I have seen here, the committee has held private briefings with the OHO about the progress of individual complaints previously. That has been done previously, but we need a resolution of the committee to do that. Would that be the best way forward?

**Ms PEASE:** I think it is over a period of time that we can get those reviews done.

**ACTING CHAIR:** Can I suggest that it might be something we resolve to write to the OHO about. I will leave that with you.

**Ms KING:** The only time that individual complaints ever come before us—Deputy Chair, correct me if I am wrong—is when we are looking in conjunction with the OHO in private session about those aged complaints.

**Mr MOLHOEK:** We may be able to clear this up now, Acting Chair.

**ACTING CHAIR:** I think we would probably have to go into a private meeting to do that.

**Mr MOLHOEK:** We heard from Ahpra that—I think the words Matthew used were—it is an own motion. I think that was really the nub of my question. Does the OHO function in that way as well when matters come up in the public domain?

**Dr Coulson Barr:** Yes, in a similar fashion.

**ACTING CHAIR:** The time allocated for this public briefing has expired. I do not think we have any questions on notice at this point.

**Ms PEASE:** Ahpra is going to provide the Queensland outcome.

**ACTING CHAIR:** We will liaise with you directly about that. If we could have your response by Friday, 3 June, that would be appreciated. That concludes this briefing. Thank you to all those who participated today. Thank you to our secretariat and Hansard reporters. A transcript of these proceedings will be available on the committee's webpage in due course. I declare this public briefing closed.

**The committee adjourned at 11.52 am.**