HEALTH AND ENVIRONMENT COMMITTEE

Members present:

Mr AD Harper MP—Chair
Mr SSJ Andrew MP
Ms AB King MP
Mr R Molhoek MP
Ms JE Pease MP
Dr MA Robinson MP

Staff present:

Dr J Dewar—Committee Secretary
Ms A Groth—Assistant Committee Secretary

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

TRANSCRIPT OF PROCEEDINGS

MONDAY, 22 FEBRUARY 2021

Brisbane

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The committee met at 10.04 am.

CHAIR: Good morning everyone. I now declare open this public briefing of the Health and Environment Committee. I acknowledge the traditional owners of the land on which we are meeting today and pay my respects to elders past, present and emerging. I will introduce the members of the committee. I am Aaron Harper, the member for Thuringowa and chair of the committee. Mr Rob Molhoek, the member for Southport, is our deputy chair. Other committee members are Mr Stephen Andrew, the member for Mirani; Ms Ali King, the member for Pumicestone; Ms Joan Pease, the member for Lytton; and Dr Mark Robinson, the member for Oodgeroo.

The purpose of today's briefing with the Office of the Health Ombudsman and the Australian Health Practitioner Regulation Agency is to assist the committee with discharging our responsibilities on behalf of the parliament for its oversight of the Health Ombudsman and the health service complaints management system. The committee appreciates the regular correspondence and reports provided by the OHO. The committee finds those very helpful. The briefing today is a formal proceeding of the parliament and is subject to the Legislative Assembly's standing rules and orders. Please ensure that your mobile phones are switched off or are on silent. Hansard will be recording the proceedings and you will be provided with a copy of the transcript.

BROWN, Mr Andrew, Health Ombudsman, Office of the Health Ombudsman

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

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

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

WELLARD, Ms Jess, Executive Director Assessment and Resolution, Office of the Health Ombudsman

CHAIR: I welcome representatives from the Office of the Health Ombudsman and Australian Health Practitioner Regulation Agency. We have had this co-regulatory model for a number of years now to manage health complaints. We very much value the information and data that was sent in the last reports. I will ask the OHO to make the first opening statement and then we will turn to Ahpra. Then the committee members will ask questions.

Mr Brown: Thank you, Chair, for the opportunity to address the committee this morning about the important work of the OHO and about our achievements and performance during 2019-20. I start by acknowledging the staff of the OHO who, through hard work, have delivered another very strong year of operational performance during, I must add, difficult times. Most importantly, beyond the performance data, because of their work the OHO continues to be well positioned to discharge its very important functions.

2019-20 saw the continued growth in contacts and complaints being received, and that has been a consistent theme each year since the OHO commenced. In fact, it is worth pointing out that now, six years after the OHO commenced, complaint numbers have more than doubled, to a record 9,703 complaints received. We saw a 13 per cent increase in complaints received from 2018-19 to 2019-20. Despite this significant growth in 2019-20, the OHO has been able to maintain its strong performance against the majority of its legislative KPIs. I will take you through some of those performance highlights now.

One of the critical functions of the OHO is that it is a single point of contact for all health service complaints in Queensland, so being able to quickly review a complaint and get it to the correct place in a timely manner is essential for the system. The OHO has seven days to decide whether or not to accept a complaint and make an initial decision. In 2019-20, despite an increase in the number of

contacts and complaints, we achieved a rate of 95 per cent of intake decisions made within seven days. That is comfortably above the 90 per cent SDS target and up from 89 per cent the previous year. When you look at the first six months of this financial year, that rate of 95 per cent in seven days has been maintained and, in fact, in January this year the team hit 99 per cent, which is a remarkable achievement.

Turning to the assessment function, where the OHO decides that a more detailed assessment of a complaint or notification is necessary, it has 30 to 60 days to undertake it. In 2019-20 we achieved a rate of 92 per cent of matters assessed in time. That was above the SDS target of 90 per cent but down slightly from 98 per cent achieved in 2018-19. I would argue that 92 per cent is still a strong result, but part of the reason for the drop was the impact of COVID-19. The pandemic did not actually impact on the OHO's ability to do its job. We were able to quickly transition to a remote working arrangement, we maintained all our services during the relevant lockdown periods and our productivity remained high. However, we did make a conscious decision to temporarily pause the progression of some assessment matters. We did not want to impact on the ability of health services to respond to the pandemic during critical times by having to respond to non-urgent complaints.

The OHO also provides a resolution service seeking to resolve disputes between consumers and providers. This is known as local resolution. The performance against statutory time frames in local resolution continues to be very strong, with 94 per cent of local resolutions completed in time during 2019-20. When you look at the front-end processes in the office—intake, assessment, local resolution—you see that the office has maintained a very strong performance over the last couple of years in the face of increased growth of complaints. Ms Jess Wellard represents that division this morning.

Turning to investigations, one of the key functions of the OHO is to investigate the most serious complaints against registered and unregistered practitioners. For the benefit of new members of the committee, a number of years ago—and this is prior to 2017-18—the OHO had accumulated a significant backlog of investigation matters. At its worst, there were 394 open investigations in the office at the beginning of 2017. A lot of the heavy lifting in relation to addressing the backlog of investigations occurred in the 2017-18 financial year, when the number of open matters was reduced to 152 by the end of the financial year. The challenge then has been staying on top of the new matters coming in and stopping the open matters climbing back up.

Over the last two financial years we have successfully been able to achieve that goal by maintaining a 100 per cent or greater clearance rate, and that is where you finalise more matters than you receive. In 2019-20 we finalised 10 per cent more matters than we received and finished the year with only 135 open investigations, which was an excellent result. While we benefited from a reduction in the number of new investigations commenced—we commenced 199 compared to 234 the previous year—we were also faced with the challenge of processing a small number of very complex and resource intensive practitioner investigations during the year which impacted on the resources that were available for other matters.

Finally, I turn to the performance of the legal division and the Director of Proceedings, which has been another success story in 2019-20. Again for the benefit of new members, one of the roles of the OHO's Director of Proceedings, or DoP, is to receive finalised investigations, determine whether a disciplinary matter should be filed in QCAT and then prosecute the practitioner through QCAT. Addressing the backlog of matters in investigations pushed a significant number of practitioner matters to the DoP, and at its worst in 2018-19 the DoP had 170 open matters to consider. During 2018-19 and then 2019-20, the OHO largely addressed that backlog at the same time as progressing new matters. By the start of 2019-20 those 178 matters were reduced to 88 and then by the end of the financial year, on 30 June 2020, it had been reduced to only 42. The number of open cases with the DoP now fluctuates between about 40 and 50, which is a much more manageable business-as-usual workload.

The increase in productivity with the DoP pushed the backlog of matters into QCAT, and that is the final destination of those matters. A really encouraging development in 2019-20 was that QCAT increased substantially the number of OHO matters it finalised. In 2019-20 QCAT finalised 78 OHO matters, which was up from 18 the year before and four the year before that. It is possible that a similar number of cases will be finalised this year as well. In these circumstances I am optimistic of the ability of the OHO and QCAT to get through that volume of practitioner matters in the system over the next 12 to 18 months and then reach a very sustainable business-as-usual position going forward.

2019-20 saw the introduction of some key amendments to the Health Ombudsman Act that came into operation on 1 March 2020. These included provisions that allow the OHO to not accept a complaint if the complainant has not first sought a resolution of the complaint with the health provider

and it is reasonable in the circumstances so to do. Another amendment empowered me as the Health Ombudsman to issue permanent prohibition orders against unregistered practitioners without having to bring proceedings in QCAT. Another key amendment included provisions that allow the OHO to send some professional misconduct matters to Ahpra and the boards to manage, including avoiding splitting health, impairment and conduct matters between the agencies. I am happy to talk more about those amendments if you wish.

Finally, I want to make a few comments about the operation of the co-regulatory model. The OHO shares a regulatory space in relation to registered practitioners with Ahpra and the national boards. As I said earlier, the OHO is the single point of contact for all complaints and we retain the most serious matters. The majority of complaints and notifications, however, are referred to Ahpra and the national boards to manage and matters can move both ways. The success of the system relies upon effective working relationships between the agencies, and 2019-20 saw another successful year of partnering between OHO and Ahpra. The agencies worked well together not only at operational officer levels but also importantly at strategic and leadership levels to assure the best outcomes.

One example of that strategic partnering is the development of a joint consideration model of decision-making for complaints and notifications. A recommendation of this former committee that has now been passed by amendments to the governing legislation will give Ahpra and the boards input into the decisions that OHO makes about how to respond to complaints and notifications about each registered practitioner. The legislative provisions in relation to joint consideration will come into operation in early December this year, unless they are proclaimed earlier, and both agencies are currently dedicating significant resources to developing IT systems and business processes that will make this important initiative work. Thank you.

CHAIR: Thank you very much, Mr Brown. A lot of work has certainly gone into your office and it would be remiss of us if we did not commend the work that the OHO has done, particularly during COVID. You have just found a way. We will continue to see some of those changes from our former committee being implemented and we look forward to that, particularly in that joint consideration area.

Mr Brown: Thank you.

CHAIR: I will come back to you to look at trends in complaints after we hear from Ahpra. Mr Fletcher, would you like to make an opening statement?

Mr Fletcher: Thank you for the opportunity to brief the committee today. I am very sorry that I am unable to be there in person but, due to the fact that I am in Melbourne, I am unable to travel to Brisbane so I very much appreciate this opportunity to join you via teleconference. I will give some brief background on us for the benefit of newer committee members. Ahpra works in partnership with 15 national health practitioner boards to ensure that over 801,000 registered health practitioners in Australia across 16 professions are safe and qualified to practise. We do this by setting registration standards, registering and renewing practitioners, maintaining an online national register, managing complaints about registered practitioners in Queensland where these are referred by the Health Ombudsman, prosecuting offences such as fake practitioners, and accrediting programs of study that lead to qualification in a registered profession.

Our work is grounded in a national law that is enacted in each state and territory, with Queensland as the host jurisdiction. Together health ministers from each state and territory and the Commonwealth oversee our work. We are a self-funded regulatory scheme from the registration fees paid by health practitioners each year. This includes an amount determined by the Queensland health minister annually for the costs of the OHO in relation to his work with registered health practitioners. In 2019-20 we expect to provide around $5.45 million from health practitioner fees towards the costs of the OHO in Queensland. Over the coming year we will be working closely with the OHO and the Department of Health to review the methodology for calculating this funding.

Let me now highlight some outcomes and achievements in our work in Queensland in 2019-20. As at 30 June 2019, there were 161,813 registered health practitioners in Queensland across the 16 regulated professions. This represents around 20.2 per cent of total registered health practitioners in Australia. This included 7,000 Queensland retired or non-practising health practitioners who in April 2020 joined a temporary pandemic subregister for a surge workforce. During the year we dealt with 2,644 complaints referred to us by the ombudsman. We closed 2,475 complaints, so slightly less than the number we received during the year, and as at 30 June 2019 we had 1,443 open complaints on our book which is an increase on the previous year. However, I am pleased to say that for Queensland practitioners the average time taken to complete complaints reduced by 16 per cent over the past year and we completed around 63 per cent of matters within six months.

In 2019-20 in total the OHO and Ahpra managed 4,216 complaints about 3,522 registered health practitioners in Queensland. This was up just over five per cent on 2018-19, which is just over half the national increase of 9.6 per cent. Nearly half the complaints we dealt with were a wide range of concerns about the clinical care provided to a patient, and this pattern has been consistent over a number of years. Overall, around 70 per cent of complaints end with a board decision to take no further regulatory action. Sometimes we do not need to act because the practitioner or their employer has recognised a problem in their practice and already taken steps to address the concern and safe, professional responses by practitioners and their workplaces help us to keep future patients safe.

Some 2.2 per cent of all Queensland registered health practitioners were the subject of a notification during the year, slightly above the national average of 1.6 per cent and consistent with previous years. While there is variability in this rate across different professions, we can see no systemic difference in the risk profile of matters we deal with in Queensland compared to other states and territories. We have redoubled our focus, particularly in light of some of the impacts of COVID-19 on our working, to reduce the length of time it takes us to assess and investigate complaints. This work aims to more quickly identify both low-risk and higher risk patient safety concerns through comprehensive risk screening. There is clinical input at every stage and Ahpra has employed professional doctors and other health professionals to provide that input.

As Mr Brown said in his comments, our relationship with him and his office continues to be a very strong, collaborative and productive relationship. For example, again as he mentioned, we have worked closely to implement the legislative amendments which mean that a practitioner with both performance and health concerns no longer needs to be subject to parallel investigations managed by both our agencies. This is good for practitioners, removes duplication and serves the Queensland community better. Mr Brown also mentioned that we are looking forward to the implementation of joint consideration through which OHO and Ahpra will work together to consider notifications about registered practitioners to address any delays in getting complaints quickly to the right place and further improve time frames.

Finally, I want to make a brief comment about the medical training survey. The medical training survey is a national annual profession-wide survey of all doctors in training in Australia developed in collaboration with them and others involved in their training. We asked doctors in training about their experience and heard from more than 21,000 nationally, with around 4,300 from Queensland. This is a very strong response rate, with 57 per cent of doctors in training nationally doing the survey. In broad terms, the 2020 results are consistent with the 2019 data and the response from doctors in training in Queensland is largely consistent with the national response. Trainees generally rated the quality of their training highly but concerns persist about the culture of medicine. Some 19 per cent of Queensland doctors in training experienced and 28 per cent witnessed bullying, harassment and/or discrimination, including racism, in the workplace. However, 67 per cent of Queensland doctors in training did not report the incident they experienced and/or witnessed. This is very consistent with the national picture. Clearly, it is important that we all listen to what the thousands of trainees have told us and that we work across the health system to build a culture of respect. With this in mind, the 2020 results were published on Tuesday, 2 February and have been disseminated widely. We would be very happy to take any questions the committee may have on any aspects of the work we are undertaking. Thank you.

CHAIR: Thank you very much, Mr Fletcher. I will echo the comments that I made to Mr Brown in relation to the work that has been done by Ahpra and in particular during this last challenging year, and congratulations on moving forward in that joint consideration area. What does that look like in a practical sense? I think I picked up on some language about some IT sharing of information. Did someone want to comment?

Ms Edwards: We both use different platforms for managing our complaints, so we need to develop a solution so both of the complaint management systems can speak with each other and share the data. There will be so many complaints that we need to consider that it is impossible to do that manually.

CHAIR: Is there some budget allocation for IT systems?

Mr Brown: Not with the OHO. We have had to find funding for that internally to deliver on that project.

Mr Fletcher: It is similar for us also in that we are funding that from internal resources.

CHAIR: You could probably both comment on this after your comments about that survey, Mr Fletcher. In relation to the 9,700—I think that was around the figure you gave—complaints, which is an increase, Mr Brown did a breakdown of professional performance and professional conduct and

I note that 12 per cent related to communication and information. Again, what does that look like in a practical sense? Given that we just heard from Mr Fletcher around the bullying and the culture that exists in some areas, is there a drive from both organisations to address that in a practical sense from a communication point of view? What is happening in that area?

Mr Brown: I would have to say that there is not a lot that has been done to date. Both Heather and I are shortly starting a bit of an engagement process with the Department of Health in relation to practitioner conduct which would include bullying and just looking at, as a whole of system, what can be done to address those issues, and I have done a mapping exercise recently. There are many different agencies and bodies really involved in that space that cut across human rights and industrial relations, so we are interested in embarking on an exercise that tries to bring all of that together as a way to start to think about having a bit of a unified approach. That is in train but I have to say that, short of dealing with complaints when they come in and dealing with them appropriately, there has not been to date any kind of approach like that.

CHAIR: Okay. I was just interested in picking up on Mr Fletcher's comments. Mr Fletcher, do you have any comments around that at all?

Mr Fletcher: I probably have just a couple of things to add to the comments from Mr Brown. One of the key things that we are doing, working very closely with the Medical Board of Australia, is making sure the data from these surveys is widely available. We have set up a special website and people can cut and slice the data in terms of a state or territory, a college or an area of specialist practice, even down to a health service level, providing there are not fewer than 10 respondents in order to keep the confidentiality of the survey. I think we are really encouraging people to use the data. We are doing a lot around raising awareness among key stakeholders. For example, the chair of the Medical Board and I met with presidents of medical colleges last week and highlighted the results from the survey. I think there are some key levers for employers and for colleges and indeed governments. As I say, we are very keen to work with others in terms of the response. We are also working with boards in areas such as codes of conduct to strengthen what the expectations are for registered health practitioners, not only in medicine but in other professions as well, around appropriate conduct.

CHAIR: With regard to systemic investigations, we note in your report that the OHO commenced one systemic investigation, down from 10 in the previous year. Why is that? That is possibly around COVID. What does that systemic investigation look like? I ask you to unpack that.

Mr Brown: Certainly. This in a way relates to your earlier question about funding for joint consideration. As a result of government as a whole having fairly large budget black holes because of the impacts of COVID, this year we have found that there has been a need to tighten belts and look for savings, and that was part of the reason that fed into not being specifically funded for the project. Looking internally, when you have an organisation where 80 per cent of your costs are labour costs, where we settled on that was to wind back, just for this financial year, the systemic work that we are doing. Even though that is a function of ours, there is a little bit of discretion in that space, compared to dealing with 9,700 complaints which just sort of flood in through the door. There is no discretion there. There were some vacancies in that space—staff vacancies—so we just made a conscious decision to run some of those vacancies vacant and redeploy the funds to things like joint consideration and then look at ramping up the systemic function next financial year. That was the background to that winding back.

Mr ANDREW: This might be out of your remit, but in terms of obligations, for instance, to do statutory checks within HHSs, do you get any feedback to do with that?

Mr Brown: Do we get feedback from—

Mr ANDREW: Do any questions come from the HHSs? Do you know whether the statutory checks are being met—the mechanical and electrical sorts of checks and all that—across the HHSs?

CHAIR: That might be outside the remit.

Mr Brown: Yes, that is outside. Really for us it is about health service complaints—so complaints about the delivery of health services. The definition is pretty broad and it includes support services to health services. Technically we could receive a complaint about maintenance issues, for example.

Mr ANDREW: That is what I was going to.

Mr Brown: To my knowledge, I am not aware of receiving any. We can certainly look into that.

Mr ANDREW: If you do not mind, I would really appreciate it.

Mr MOLHOEK: My question is either to Martin or Heather from Ahpra. Could you expand a little on your comments around the survey and the culture within medicine and some of the issues that you have identified?

Mr Fletcher: This is the medical training survey that you are referring to?

Mr MOLHOEK: Yes. You touched on the issue of culture. I think you mentioned harassment or discrimination. I was interested to know what some of the challenges or issues were that were highlighted.

Mr Fletcher: Sure. I would like to start by saying there was a lot that was very positive in the feedback we received this year. Most doctors in training rate their training experience very highly. Their supervision is very good and they would recommend their training to other doctors in training.

The data that is of concern relates to the question of doctors in training who have either directly experienced or witnessed bullying, harassment or discrimination in the workplace. Just to repeat that data for Queensland, it was 19 per cent of Queensland doctors in training who said they had experienced that and 28 per cent who said they had witnessed that in the workplace. To reassure you, although that figure is concerning, there is no difference in the data we are seeing in Queensland compared to other states and territories. The issue is very much a national issue.

What was also of particular concern was that 67 per cent—so over two-thirds of those doctors in training—did not report the incident they experienced or witnessed. I think one of the areas of focus is to look at what is stopping people raising this concern when it is happening and what we need to do to build a more positive reporting culture within health services.

Mr MOLHOEK: Just to be clear, this is only in regard to doctors in training?

Mr Fletcher: That is correct—doctors in training, yes.

Mr MOLHOEK: I think you said it was 56 per cent who did not report.

Mr Fletcher: Sixty-seven per cent of doctors in training who either experienced or witnessed it did not report it.

Mr MOLHOEK: Can you give me some examples? Is it training doctors being impatient with the trainees and being a bit offhanded? What is bullying or harassment in this context? What does it look like?

Mr Fletcher: One of the things we asked the doctors in training this year—this is the second year we have done the survey—was, if they had experienced or witnessed bullying or harassment or discrimination, what was the source. Just over half said that the source was a senior doctor or consultant. That was the biggest group. The second group was nurses and midwives. The third group was patients and/or their families.

Mr MOLHOEK: What is the pathway forward that Ahpra is looking at in terms of addressing those concerns?

Mr Fletcher: We have made the data widely available in a form that people can actually drill down into the data in relation to their particular area of practice or their particular health service or, indeed, you can look at the data in detail for Queensland. We are doing a lot of advocacy work with leaders across the health system—medical colleges, employers and government—to raise awareness of the data and the findings.

A lot of the levers for change I think probably sit at the health service level and within the colleges. We are working to make sure that this data helps inform the work they are doing. Then, as it relates to codes of conduct—each of our national boards has a code of conduct which sets out the requirements and expected behaviour of registered health practitioners—we work with the Medical Board and we work across all of the health professions to look at how we can strengthen that code of conduct to make absolutely clear that this sort of behaviour is unacceptable on the part of registered health practitioners. It is important to note that, although this data is looking just at doctors in training, I think our view would be that it is not a problem that is restricted to medicine. This sort of behaviour is unacceptable across any of the registered health professions.

Ms PEASE: I would like to explore that further. It is interesting that such a significant number of people have felt comfortable enough to make those statements in your survey but cannot take it further to actually make a complaint. Is there any understanding as to why? Is the survey easier for them to participate in to make a complaint or for their concerns or matters to be heard?

Mr Fletcher: One of the things we have done is work very closely with doctors in training both in the design of the survey and then in promoting the uptake of the survey. As I say, we were very encouraged that 57 per cent of doctors in training completed the survey for 2020. We have also made

sure that the results of the survey are confidential. I think I gave the example before that if you drill down into the data you cannot go below a cell size of 10 in the data. That helps to protect the confidentiality of the data.

I think the third thing that is really important is that we are working with doctors in training and others to make sure that something happens as a result of what the doctors in training have told us. Hopefully it is not just a sense of 'this is a survey and you never hear what happens and nothing changes' but that there is very much a sense of 'this is an issue that we need to do more on' and that the feedback from doctors in training is directly influencing the actions that people need to take.

Ms PEASE: That is very encouraging. I am pleased to hear that. I would like to congratulate the Health Ombudsman. We have heard some stories and you have done really well, so congratulations. There have been some really outstanding results. I am interested to hear your impressive numbers of turnaround within seven days and also that there has been an increase in people who are lodging complaints. Has any thought been given to why people are lodging complaints? Is it easier to access? Have you given any consideration to why?

Mr Brown: I think it is a complicated question to answer. You can theorise about it. I think accessibility is clearly one. In Queensland we have the advantage of the one-stop shop. No matter whether you are complaining about either unregistered or registered practitioners or public or private health service organisations, you can come to the one place. A key part of our role is then not necessarily to deal with each one of those but to be a clearing house and get it to the right place. I think accessibility is a big one. In some other jurisdictions sometimes it is not as clear because you might have a health complaints commission, a commissioner, and you have Ahpra, who also has the ability to receive complaints. I think accessibility is one.

Again this is theorising but in Queensland medical practitioners who do the wrong thing seems to be an issue of significant media interest—potentially more than in some other states, although I think that is changing. I think that can drive complaint numbers. I think you have just the general increase in consumer expectation not just in health but particularly in health. As technologies improve, quite rightly people expect more and better outcomes. We are seeing generally complaints across government increasing as consumers expect more and better service delivery. I think that drives it as well.

I should add that what we have seen this financial year—speaking up until the end of 2019-20—is a slight reduction in complaints. They stopped growing for the first six months and we have seen them reduce by about five per cent, which is encouraging from the point of view of having some respite from this growth. Contacts are still up but what we actually receive and action as a complaint is slightly down. That suggests that it is tapering off a little and we might see that growth slow down.

Ms PEASE: I am also encouraged to hear about the clearance rate with QCAT. That has been a really successful relationship that you have worked through and come up with a really good resolution, so congratulations.

CHAIR: Mr Fletcher, in your report there is a figure of 605 new criminal offence complaints—a growth of nearly 10 per cent. Is that just for Queensland? If it is, putting it in context of 121,000 registered health practitioners, it is a small percentage. That is an increase of nearly 10 per cent in that criminal element. Are there any trends there and what are they around?

Mr Fletcher: That figure is national data. That is not specific to Queensland. The major area of focus for us is this question of what is called holding out under the national law. This is situations where people falsely claim to be registered. That is now a criminal offence under the national law and we prosecute those in a local court. That has been the major area of focus in terms of growth.

Dr ROBINSON: My question is probably both to OHO and Ahpra. In terms of complaint processes against service providers, could you talk us through that complaint process in general? You talked about initial assessments of seven days. What determines an initial assessment going beyond seven days into a more detailed assessment? What sort of feedback do you provide to service providers if there is a complaint lodged against them? The website seems to suggest that it is not an automatic process that a health provider will receive all of that information. It says 'some'. You make an assessment about when to send information about a complaint and what detail. Could you talk us through that process and whether there is any difference if it is the government referring a health provider to OHO or Ahpra?

Mr Brown: Certainly. As I said earlier, we can potentially receive complaints about practitioners, either unregistered or registered, or health service organisations—hospitals, health services, public hospitals. What the complaint is about will to some degree determine where it goes. Let us look at probably the most complicated, which is a complaint about a registered practitioner,

because with the co-regulatory model it involves Ahpra and the boards as well. We receive it and within the first seven days one of the key decisions for us is whether it is potentially a complaint for the OHO to deal with—so potentially whether it is one of those very serious matters that we must retain or whether it is a matter that would be more appropriately dealt with by Ahpra and the board. It is one of the key decisions that has to be made within seven days.

Of around 4,000 registered complaints, we refer about 2,700 to Ahpra and the boards to deal with. The majority of those are referred in that seven-day period. It is simply a test of: what are the allegations at the highest? Can we identify the parties? We do not determine whether there is merit or substance to the case; we just work out whether it can be classified, whether we can make sense of it. Where it falls below the threshold of being a significant issue for the health and safety of the public, we will refer it to Ahpra. If it falls above that, we retain it. In most cases it will then go into assessment, where more information will be obtained. We might obtain medical records. For example, if it is a complaint about an inappropriate boundary violation between a practitioner and a patient, we will obtain medical records and determine whether there is a treating relationship. We may obtain some information from the practitioner. Then it will go into an investigation, where our job is to determine whether we think those allegations can be substantiated.

Similarly with unregistered practitioners, the test for us being involved in a complaint around unregistered practitioners like massage therapists and assistants in nursing is whether they pose a serious risk to the health and safety of the public. If the answer to that is yes, it will follow a similar path. That is a pretty high threshold, so if it does not meet that threshold sometimes there might be some local resolution we can do to try to resolve it, but in most cases we do not play in that space.

When it comes to a health organisation, the first seven days are to work out really whether it should be assessed by us to obtain more information and clarify what the complaint is. If it is a hospital and health service that has pretty sophisticated complaint management handling processes then often we will package it up, identify what the issues are and refer it to the hospital and health service to address and then they can report back to us. Other times it might go into local resolution where we will bring the parties together, not necessarily in the same room but through correspondence or telephone calls, and see whether we can resolve it. It will go there.

Dr ROBINSON: That is all very helpful. How do you make your decision about what information is provided about a complaint to the practitioner or the provider?

Mr Brown: Largely, if the matter progresses and is accepted as a complaint. I think the website is probably referring to a situation where we get a complaint that is poorly particularised or really there is not much we can do with it and we decide to take no further action. We will not normally engage with the health service or practitioner about that. It is only if it progresses. If we decide to refer it to Ahpra to deal with then by law we are required to give notice to the practitioner advising them that it has been referred. If we take it into assessment then the health service or practitioner will receive notice and information and they will engage in the process. It is only for those classes of cases that we decide to take no further action on at the very beginning.

Dr ROBINSON: The final part of that was, if the government refers—

Mr Brown: Can I add one thing that I have just been reminded of. Sometimes we will withhold notice. If they are very serious allegations against a practitioner—sometimes they might be potentially criminal and we want to work with QPS and make sure that we do not prejudice a QPS investigation or our own—we may withhold for a period of time. It happens only in a small number of cases but it will happen.

Dr ROBINSON: If the government is the source of the referral are there any additions or variations to that process?

Mr Brown: Not really. It will largely be managed in the same way. Are you saying for example if a hospital has referred a practitioner to us or notified us about a practitioner?

Dr ROBINSON: If a government source broadly—a department or an MP or someone—was to refer a provider to you, is the process exactly the same or are there other layers to the process?

Mr Brown: No, it is largely the same. If it is a particularly serious issue then there are escalation processes within the office so that various people are notified, but generally it will be the same.

Ms KING: My question is for both Mr Brown and Mr Fletcher. In the context of COVID-19 and the vaccine rollout that is just beginning, are either of your divisions seeing a significant increase in complaints about or actions relating to practitioners or purported practitioners who are perhaps holding out or providing misleading advice around COVID-19 or vaccinations generally?

Mr Brown: If you do not mind, I might hand that one over to Ms Wellard.

Ms Wellard: Last year I attended the parliamentary committee hearing of the previous committee in relation to the government's response to COVID. At that time I provided some data that indicated that the volume of complaints that the OHO received around COVID related issues was quite significant for us. That has actually tapered off significantly over the last few months. The proportion of COVID related complaints and inquiries we are now receiving is not a significant proportion of our overall contacts.

A small number of practitioner complaints are received, and practitioners have been referred to Ahpra for concerns relating to comments made on social media about COVID and vaccines and things like that. That is an issue we do receive complaints about, but it is not a huge volume of complaints. Those are dealt with as practitioner matters and referred to Ahpra for the boards to deal with and determine the appropriateness of the comments.

CHAIR: I asked earlier about trends in terms of complaints. Would you be able to answer that, Mr Brown?

Mr Brown: Certainly. What we are seeing more recently is a trend towards complaints about health service organisations. If you go back to 2017-18, about 50 per cent of the complaints we got were about organisations—public hospitals, private hospitals and correctional centres—and the other 50 per cent were about practitioners. It has gone from 50 per cent in 2017-18 to 58 per cent in 2019-20. That is really where most of the growth has been.

Complaints about practitioners and registered practitioners has been pretty static. Around 42 per cent are about practitioners. Of the 42 per cent about practitioners, 96 per cent are about registered practitioners. When you break the registered practitioners down, 64 per cent are about medical practitioners, 15 per cent are about nurses and then you have a small percentage of the rest. Those percentages and proportions have stayed pretty similar. There is not a growth of any substance in any of those areas. Four per cent are about unregistered practitioners. That has stayed about the same.

When you look at the remainder—the 58 per cent about health services, for example public hospitals—complaints are down proportionately. They have gone from 34 per cent to 32 per cent. Correctional facility complaints are up. They have gone from 25 per cent to 29 per cent. I should say that complaints about correctional facilities make up a significant proportion of our health service organisation complaints. I have not looked recently, but at least 25 per cent of complaints that we receive are from correctional centres.

Medical centres are up by a per cent. Mental health services are up by a per cent. Private hospitals are down by about a per cent. The growth has been in organisations led by largely correctional centres and potentially mental health services, with practitioners staying fairly level.

CHAIR: Mr Fletcher, did you have any comments around trends with Ahpra?

Mr Fletcher: I will invite Mr Hardy to comment on this.

Mr Hardy: In terms of our trends, in terms of referrals from the OHO of registered practitioners and combining that with our national data we continue to see that the biggest growth area in complaints is from patients and members of the public who are reporting to us a negative experience of an engagement with a practitioner. From a regulatory perspective, we see that those sorts of complaints continue to be ripe for supporting performance improvement with a practitioner.

We see that the rates at which we need to intervene and actually take regulatory action in relation to a registered practitioner remain relatively flat, but we are heavily interested in looking at ways that we can contribute as a regulator to performance improvement on the part of individual practitioners. As I said, those are the sorts of concerns that are most likely to come to our attention and they are the areas where we are seeing the biggest growth in the number of concerns raised with us.

Mr ANDREW: Have you seen an increase in veteran complaints about practitioners over the COVID period?

Mr Brown: No, we have not, to my knowledge, but it would be hard to extract that data in the sense that there is no field as to whether a complaint is from a veteran.

Mr MOLHOEK: I have a supplementary question to Mr Fletcher. I wanted to ask about criminal offences. On page 86 of your annual report, by way of example, it notes that there were 96 complaints received and 98 closed. Then on the next page it talks about 11 successful prosecutions. In terms of the matters that were closed, do I assume that there was no prosecution deemed necessary or are they all subject to ongoing investigation?

Mr Fletcher: That would be correct. What we have reported is those matters where we have completed a prosecution. If the matter is reported as closed, that would indicate that we are not intending to take action through the courts.

Mr MOLHOEK: The difference between the 96 and then the 11 that were actually prosecuted would be that those other matters were deemed not to be of concern when they were investigated?

Mr Fletcher: It could mean two things. It could be that they did not meet the threshold for us to be able to take prosecution action or in the case, for example, of a complaint that might relate to unlawful advertising, the practitioner has taken steps as a result of our intervention to correct the problem and therefore there is no need for any further action.

Mr MOLHOEK: Am I correct in assuming that if someone has complained about a misleading claim by a medical practitioner in respect of their job that somebody has actually said they are a doctor and they are not or they are making claims about areas of specialisation?

Mr Fletcher: It could be either. The offence under the national law is called a holding out offence. It could be somebody who is falsely claiming to be registered when they are not. It could be somebody whose registration is suspended, which means they are not able to practise, and they are claiming that they are registered and able to practise. It could be also somebody who is claiming an area of specialist registration in the case of medicine who is not entitled to that. Commonly it is somebody who is no longer registered, has never been registered or has been suspended from registration who is falsely claiming that they are registered.

CHAIR: Mr Fletcher and Mr Hardy, thank you for joining us on the phone today. To Ahpra and the OHO, thank you very much. Mr Brown and Ms Wellard, thank you very much. I think it would be beneficial early in this term for members to go down to the OHO—I think, Ms Edwards, you talked about potentially joining in this—to get a little more informed about how health complaints are handled in your environment. We might write to you and find a time, perhaps in the next quarter, to come down. There is one question on notice, Mr Brown. Can we have that back by 1 March?

Mr Brown: Certainly.

CHAIR: Thank you to both Ahpra and OHO for being here today. I declare the public briefing closed.

The committee adjourned at 10.58 am.